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The compliant court — Procedural fairness and social control in compulsory community care

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ABSTRACT

Compulsory community care (CCC) was introduced in Sweden in 2008. This article investigates all written court decisions regarding CCC over a 6 month period in 2009 (N = 541). The purpose is to examine how the legal rights of patients are protected and what forms of social control patients are subjected to.

51% of CCC patients are women and 84% are being treated for a psychosis-related disorder. In the court decisions, only 9% of patients are described as dangerous to themselves, while 18% are regarded a danger to others. The most common special provisions that patients are subjected to are medication (79%) and a requirement that they must maintain contact with either community mental health services (51%) or social services (27%).

In the decisions, both the courts and court-appointed psychiatrists agree with treating psychiatrists in 99% of cases. Decisions lack transparency and clarity, and it is often impossible to understand the conclusions of the courts. There is considerable variation between regional courts as regards the provisions to which patients are subjected and the delegation of decision-making to psychiatrists. This means that decisions fail to demonstrate clarity, transparency, consistency and impartiality, and thus fail to meet established standards of procedural fairness.

Surveillance techniques of social control are more common than techniques based on therapy or sanctions. Because of the unique role of medication, social control is primarily imposed on a physical dimension, as opposed to temporal and spatial forms.

The article concludes that patients are at risk of being subjected to new forms of social control of an unclear nature without proper legal protection.

1. Introduction

This article attempts to discuss a relatively new phenomenon within international mental health law – compulsory community care (CCC) – within the framework of two different discourses that have been paramount to socio-legal research about mental health during the past 50 years: (1) the legal rights of patients and (2) mental health care as "social control."

Internationally, the legal rights of patients have been particularly important in discussions of compulsory psychiatric care. Many legal reforms have been justified primarily on the grounds that they are intended to protect patients' rights. The legal regulation of coercive interventions is circumscribed by various international conventions[1] covering human and legal rights as well as ethics in psychiatric and health care (Carney, Tait, Perry, Vernon, & Beaupert, 2011). A crucial concern in legal conventions is procedural safeguards, particularly in the context of court proceedings. Like any other situation in which a state applies coercive measures on its citizens, the standards for procedural safeguards must be high. The legitimacy of compulsory psychiatric care – which also impacts on mental health care in general – rests on well-founded clinical decision making and careful legal monitoring.

Within sociology, mental health care has often been analyzed in terms of a society's means to control deviant citizens. Compulsory care has been characterized as a particularly pertinent example of social control within psychiatry. Social control theory has helped put the issue of mental health into a broader context of deviance, tolerance, and – increasingly in recent years – risk (Kemshall, 2002).

Compulsory community care emerged in the 1980s and has been widely introduced in industrialized democracies during the last 15 years. It seems uncontroversial to claim that it is fruitful to apply classic concepts such as legal rights and social control to this relatively new phenomenon. However, CCC also generates new challenges to these traditional perspectives. Starting with legal rights, one can observe that although psychiatrists retain decision-making power, the actual delivery of care is distributed over a wider variety of personnel, and there is greater diversity of treatment delivered in a multitude of different types of settings. Confident decisions about CCC are hard to

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[1] The United Nation's Universal Declaration of Human Rights and the Convention on the Rights of Persons with Disabilities, the European Convention on Human Rights (ECHR) and the Madrid Declaration on Ethical Standards for Psychiatric Practice of the World Psychiatric Association.

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make since there is considerable debate on the effectiveness of CCC in the research community (Burns & Dawson, 2009; Churchill, Owen, Singh, & Hotopf, 2007; Kisley, Campbell & Preston, 2006; Phelan, Sinkewcz, Castille, Huz, & Link, 2010; Swartz, Swanson, Steadman, Robbins & Monahan, 2009). As a result, the legal bodies that monitor coercive practices face particularly demanding challenges. How do mental health courts, tribunals and similar legal bodies monitor decision-making and the application of coercive measures in the community?

From a social control perspective, CCC might represent a shift from physical control practices to "softer" means that do not openly force individuals to comply. To the extent that CCC fosters individuals to behave according to caregivers' wishes, it can be seen as an illustration of the thesis of the "internalization of control" (cf. Foucault, 1991). Control is no longer exercised by externally enforcing medication and incarcerating patients. CCC offers a softer regime that not only promotes compliance on a behavioral level. It might also affect patients to cognitively adopt caregivers' views on how they should lead their lives and manage their illness. The shift from controlling criminals in prison to control through probation and electronic ankle bracelets might be a parallel to the transfer of mental health care from the asylum to compulsory community care. We are interested in whether CCC comprises a shift in forms of social control and, if so, what it means.

Given this background, the aim of the article is to investigate court decisions regarding compulsory psychiatric care in Sweden. Our focus is legal rights and social control, and we ask the following questions:

1. Who is subjected to compulsory community care and on what grounds?
2. What coercive measures ("special provisions") do courts apply on patients?
3. To what extent is procedural fairness achieved?
4. What forms of social control are present?

Questions 1 and 2 are primarily empirical whereas questions 3 and 4 are primarily analytical.

The data reported here are part of a larger project – *Coercion in freedom: Genesis, implementation and rule of law in psychiatric outpatient coercion in Sweden* – which also includes a study of the socio-political origin of CCC (Sjöström, Zetterberg, & Markström, 2011) and the implementation of the new legislation on the municipal level.[2]

1.1. Compulsory community care in Sweden

Compulsory community care was introduced in Sweden in 2008 following a public discussion of the failures of community care occasioned by media coverage of a few incidents in which persons suffering from mental illness attacked others in public settings (Sjöström et al., 2011). Proponents of the new legislation argued that CCC would be a less restrictive alternative, while also addressing concerns about public safety. Critics argued instead that new groups would be subjected to coercive measures – so-called net widening (Geller, Fisher, Grudzinskas, Clayfield, & Lawlor, 2006) – and that there would be a shift in focus from collaborative support to social control. In the final draft of the legislation that was passed by the parliament, risk concerns gave way to issues about disability rights and the need for care. One explicit purpose of the new legislation was to improve the legal safeguards for patients who were subjected to long-term temporary leave under the previous system. Although some patients were treated under temporary leave for several years, the intention was that such leave should only be applied for shorter periods of time. One means for improving legal safeguards was the introduction of mandatory court hearings for every patient who is transferred to CCC (Sjöström et al., 2011). Similar regulations were introduced for both forensic and "civil" patients. In Sweden, compulsory care for these two groups is regulated in two different laws that share many traits: the Compulsory Psychiatric Care Act and the Forensic Psychiatric Care Act. Through mandatory court approval, patients would be protected against unwarranted use of this new form of coercive intervention (Proposition, 2007, pp. 77, 94). The stated purpose of CCC is to enable the patient to accept treatment voluntarily. Churchill et al. (2007) distinguish between two forms of CCC: "least restrictive" and "preventative". The latter has different admission criteria for in-patient and out-patient commitment and typically aims to prevent deterioration. According to this classification, the Swedish form of CCC qualifies as preventative.

Only in-patients under compulsory care are eligible for CCC. The coercive element of CCC consists of "special provisions" to which the patient is subjected. These are individual orders for treatment and behavior mandates and are to be designed to meet each patient's individual needs. The legislation has been criticized as "toothless" because under the law, patients cannot be forced to comply with special provisions. Legislators have clearly stated that patients should not be recalled to hospital simply because they fail to comply with special provisions. Nor does the law allow for recall to assess and evaluate the patient. Accordingly, the legal criteria to re-admit patients under CCC are the same as for non-patients. These criteria include (1) suffering from severe mental disorder; (2) opposing treatment or treatment cannot be provided without consent; and (3), exhibiting an indispensable need for hospital care.

Decisions to initiate a period of CCC are made by administrative courts after an application has been filed by a chief psychiatrist. The court also decides about special provisions, although it may delegate this responsibility to the treating psychiatrist. Although a psychiatrist is responsible for the application to the court, the actual delivery of services may be provided by different providers, typically both community mental health services and social services. The court can approve CCC for a maximum of six months, after which a new court decision is necessary to prolong it. If the court rejects an application to transfer an in-patient to CCC, the patient is automatically discharged from compulsory care. By applying for CCC, the treating psychiatrist is effectively acknowledging that there is no longer an indispensable need for hospital care.

Court hearings are held at the hospital and typically take about 30 min. They are headed by a judge, who makes a decision together with three lay judges. Formally, there are two opposing parties – the chief psychiatrist and the patient – although the hearings are usually held in a non-adversarial style. The chief psychiatrist is typically represented by the patient's treating psychiatrist, who performs a quasi-prosecutorial role. To protect their legal rights, patients have the right to an attorney, and most of them make use of it. The court is assisted by an independent psychiatrist who asks questions of the parties and delivers an expert opinion towards the end of the hearing (Proposition, 2007). Questions from the attorney and the court-appointed psychiatrist are directed to the parties. It is rare that any other witnesses are heard. Apart from the mandatory hearings for extensions of care every six months, patients can request hearings at any time by filing an appeal with the court.

2. Theory and previous research

Drawing from their international review of CCC, Churchill et al. (2007) conclude that the typical patient is a male of about 40 years old who has an extensive history of illness and previous experience of in-patient care. He has a history of low compliance to medical treatment and is in need of post-hospital care. He has been diagnosed with schizophrenia or affective disorder and has a potential for violence. These characteristics are strikingly similar across different types of jurisdictions, as well as geographical and cultural borders. Burns and Dawson (2009) take this as evidence that there is increasing agreement about the patients for whom CCC is appropriate.

[2] The project is funded through the Swedish Council for Working Life and Social Research (Dnr 2008-0955).