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Public attitudes towards involuntary admission and treatment by mental health services in Norway

Inge Joa [a,b,*], Kjetil Hustoft [a], Liss Gøril Anda [a], Kolbjørn Brønnick [a,b], Olav Nielssen [c], Jan Olav Johannessen [a,b], Johannes H. Langeveld [a]

[a] Network for Clinical Psychosis Research, Division of Psychiatry, Stavanger University Hospital, Norway
[b] Network for Medical Sciences, Faculty of Social Sciences, University of Stavanger, Norway
[c] Faculty of Medicine and Health Sciences, Macquarie University, Sydney, New South Wales, Australia

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ABSTRACT

Purpose: The role of compulsory treatment of serious mental disorders has been the topic of ongoing public debate involving among others mental health professionals, service providers, service user advocates, relatives of service users, media commentators and politicians. However, relatively little is known about general public attitudes towards involuntary admission and compulsory treatment of people with various mental disorders. This article examines the attitudes in a representative sample of Norway's population towards the use of involuntary admission and treatment, and under which circumstances does the general public consider compulsory treatment to be justified in the Norwegian mental health care services.
Method: Data were collected from a representative sample of the population in Norway aged 18 and older. The sample was stratified for gender, geographical region and age distribution ($n = 2001$). The survey was performed in the months of May 2009 ($n = 1000$) and May 2011 ($n = 1001$), using Computer Assisted Telephone Interviews (CATI) by an independent polling company. All respondents were provided a general definition of coercive intervention before the interview was conducted.
Analysis: Univariate descriptions and bivariate analyses were performed by means of cross-tabulation, analysis of variance (one-way ANOVA) and comparing of group of means. Cohen's d was used as the measure for effect size.
Results: Between 87% and 97% of those surveyed expressed strong or partial agreement with the use of involuntary admissions or compulsory treatment related to specified cases and situations. The majority of interviewees (56%) expressed the opinion that overall, current levels are acceptable. A further, 34% were of the opinion that current levels are too low, while only 9.9% of respondents supported a reduction in the level of involuntary treatment. Lower levels of education were associated with a more positive attitude towards involuntary admission and treatment.
There was stronger support for admission to prevent suicide than the possibility of violence by the mentally ill.
Conclusion: The Norwegian adult population largely supports current legislation and practices regarding involuntary admission and compulsory treatment in the mental health services.

1. Introduction

Most advanced countries have laws regulating involuntary admission and treatment of patients with serious mental disorders, and in most jurisdictions, involuntary admission also allows for involuntary treatment of the person's condition. However involuntary hospitalization is a controversial issue in psychiatry, due to the ethical complexity of admitting a person for treatment against their will. The threshold for use of compulsory treatment varies between countries, as do the rates of involuntary admissions, preventing a direct comparison of practices. The use of involuntary admission and coercive treatment (i.e., use of enforced medication, seclusion, use of restraint) is a topic of vigorous public debate in many countries, with mental health services often criticized for excessive use of such measures (Lartey, 2015). However, there have also been calls to increase the use of involuntary treatment, in order to protect the public from mentally ill individuals, and to ensure that people with mental illness who refuse treatment receive care (Brow, Shell, & Cole, 2015; Butler & Drakeford, 2005), and to prevent such individuals from harming themselves (Telegraph, 2015).

Complaints about involuntary admission have mainly come from service users and organizations representing patients, and from organizations working for the protection of civil liberties. However, support of

* Corresponding author at: Stavanger University Hospital, Division of Psychiatry, Postboks 8100, 4068 Stavanger, Norway.
E-mail address: ijo@sus.no (I. Joa).

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involuntary treatment has also been reported. For example, in a community survey conducted in France (Guedj, Sorum, & Mullet, 2012), 95% of participants agreed that involuntary admission is acceptable under certain conditions. Studies of service users' perspectives conducted in Ireland and Sweden also show that many patients accept the need for involuntary admission under certain circumstances. A German study (Angermeyer, Matschinger, & Schomerus, 2013) concluded that the general public almost invariably accepts compulsory admission if the person in question is perceived as violent. The majority of responders also supported involuntary admission in cases where a person threatens to commit suicide, or is unable to care for himself because of mental illness. In the study (Angermeyer, Matschinger, & Schomerus, 2014) the authors reported that >70% was principally for admitting persons to a hospital against their will, under certain conditions. When presented specific case-illustrations (violence, suicidal behavior) 80–95% of the population agreed to involuntary admission.

Previous Norwegian studies on attitudes to coercion report wide variation between the viewpoints of staff (Husum, Bjørngaard, Finset, & Ruud, 2011), the general public (Wynn, Myklebust, & Bratlid, 2006) and other stakeholders (Diseth, Bøgwald, & Høglend, 2011). Wynn et al. found that most members of the general public would permit use of coercion when the patients were violent, and between a third and a half supported coercive treatment when the patients had problems coping with activities of daily life, or when the patients were in the early phase of a psychotic illness, with few symptoms. No studies have found widespread opposition to the current law (Lauber & Rossler, 2007), which allows treatment for those deemed unable to care for themselves, or likely to deteriorate unless treated.

A review of published studies of attitudes to coercive treatment in the general population and among mental health professionals found support for involuntary treatment in most countries surveyed (Lauber & Rossler, 2007). Studies conducted in Ireland and Sweden found that patients also agree with the need for involuntary admission in certain circumstances (O'Donoghue et al., 2010; Wallsten, Ostman, Sjoberg, & Kjellin, 2008). Wallsten et al. interviewed patients admitted on both voluntary and involuntary basis, and their next-of-kin, and reported that "a majority of patients stated that it should be possible to compulsory admit patients", and "strong support for coercion in order to protect the patient and others was found among 'next-of-kins'".

In a study examining compulsory admission and treatment in schizophrenia in four European countries (England, Germany, Hungary and Switzerland) (Steinert, Lepping, Baranyai, Hoffmann, & Leherr, 2005), 1737 persons (psychiatrists, other psychiatric/medical personnel and laypeople) were asked about attitudes to compulsory admission and treatment. When asked whether they would agree with compulsory admission and compulsory treatment with antipsychotic medication based on typical clinical situations with refusal to consent to treatment, rates of agreement varied from 51 to 92% across countries and between 41 and 94% across professional groups. Interestingly psychologists and social workers in all countries presented a lower level of support for compulsory admissions and treatment in all countries than psychiatrists and laypeople. A further study by Lepping, Steinert, Gebhardt, and Röttgers (2004) compared attitudes about involuntary admission and treatment in mental health professionals and laypeople in England and Germany, and found that the attitudes of psychiatrists and other mental health workers were similar to those of the wider community in both countries. Furthermore, public attitudes towards psychiatric treatment appear to be evolving over time. A recently published systematic review of 162 population based surveys conducted between 2000 and 2015 (Angermeyer, van der Auwera, Carta, & Schomerus, 2017) showed that psychiatrists and psychologists were trusted to treat mental disorder, especially schizophrenia, and that the proportion of respondents who favored psychiatric hospital care and treatment with medication increased in the more recently conducted studies.

Involuntary admission and compulsory treatment in psychiatry raises important ethical and legal concerns. Legislation for coercive treatment for patients with severe mental disorders who reject voluntary treatment hinge on two principles: "capacity", i.e., a need for treatment coinciding with a loss of capacity to recognize that need, or "dangerousness", i.e., a conclusion that the person presents "a danger to self or others" because of mental illness, and cannot be cared for in a less restrictive way. In many countries, most notably the United States, the switch from capacity based mental health laws, to laws allowing compulsory treatment only when a person is deemed to be in danger of harming self or others was seen as a way of protecting patient's rights to refuse treatment. Lawsuits initiated by advocates of patient rights (O'Connor v. Donaldson, 1975) were interpreted to mean that dangerousness to self or to others was the only basis for involuntary care, despite the potential harm from non-treatment. However, mental health laws based on dangerousness alone, which apply in most states of the US, Australia and Canada, and in six out of thirty European countries, have the effect of limiting the availability of treatment to people who do not appear to be a danger to themselves or to others, thereby delaying the initial treatment of psychosis for nearly six months (Large & Nielssen, 2011). A delay of initial treatment of psychosis may in turn increase the risk of violent behavior (Large & Nielssen, 2011). The current Norwegian legislation covering involuntary admission and involuntary treatment has been developed gradually over a century and a half, based on the principle of solidarity with fellow citizens. The overall aim has been to ensure that clinical needs of those patients with severe mental illness who do not themselves recognize the need for treatment are still met, within a framework that protects their civil rights. The law not only covers the circumstances for involuntary admission, but also the conditions of care, the judicial review of patients in care and limits on the duration of detention, which protect the patient's rights and confirms the trust placed in services to provide care in the patients' best interests. The Norwegian Mental Health Care Act (Ministry of Health and Care Services, 1999) follows the principles of World Health Organization's (WHO, 2005) checklist which states that involuntary admittance and involuntary treatment; may only be given when A) there is evidence of a mental health disorder of specified severity; B) a serious likelihood that the person might do harm to self or others and/or substantial likelihood serious deterioration might occur in the patient's condition if treatment is not given, and; C) admission is for therapeutic purposes.

Media coverage of mental illness has been influential in shaping public understanding of mental illness and public attitudes towards involuntary treatment, especially among people with no personal experience of mental illness. In a Swedish study (Strömbäck, 2011) interviewing members of parliament and political journalists, most respondents felt that the media, rather than politicians, set the agenda and determine what issues are "important". News media stories often describe adverse events involving the mentally ill, but may also express editorial criticism of the paternalistic nature of services, or highlight scandals involving mental health services, such as the mistreatment of patients in hospitals. Consequently, Norwegian legislators (Authority, 2012) have come under pressure to limit the use of coercive treatment to remove the opportunity to involuntarily admit people at all, or alternatively, to abandon "capacity" criteria and to only retain "dangerousness" as a grounds for involuntary treatment.

The underlying presumption is that "the treatment principle" leads to a kind of overtreatment of people who could do well without, and that it represents a violation of basic human rights. In short "the treatment principle" means that it is possible to admit someone against their own will if there is a serious mental disorder present, such as psychosis, and there is the assumption that the patient will benefit from treatment. "The dangerousness principle" entails that one is allowed to admit someone against their own will if they represent a serious threat to somebody, in addition to having a psychosis.