



- Maria Løvsletten
- Management of patients with outpatient commitment in the mental health services

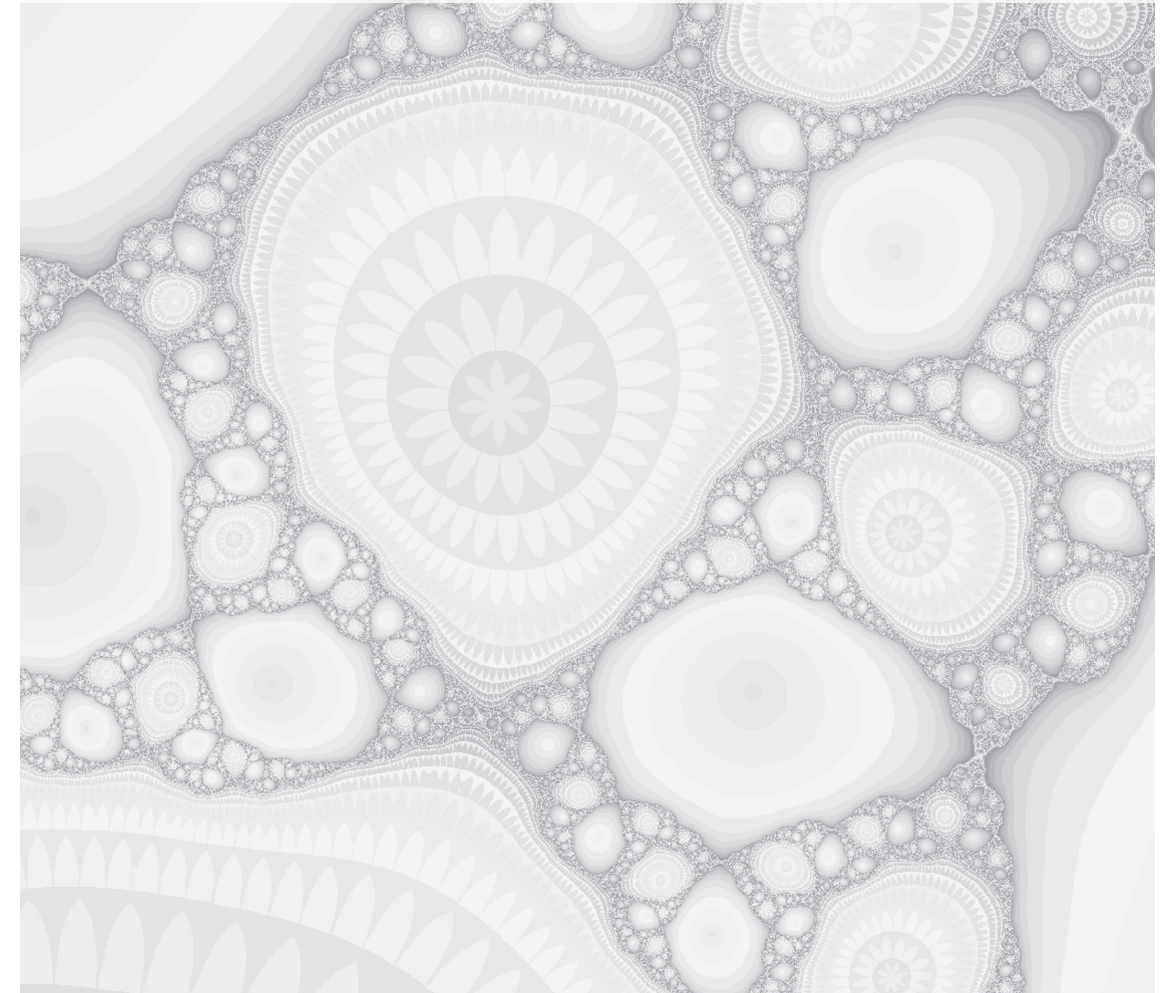
The main issue for this PhD project has been to explore how the OC scheme works from a mental health service perspective based on Norwegian conditions. The study provided a complementary picture of the follow-up of patients with the OC scheme in one geographical area. The study describes patient with the OC scheme and how the mental services collaborate. All the three sub-studies revealed a lack of interaction between the service levels. The responsibility for the follow-up of a patient with an OC decision appears to be somewhat unclear across service levels. The contact person's role and the Individual plan have not functioned as a collaboration tool in accordance with the intention of the Mental Health Act and the Patient Rights Act. When an IP is lacking, there is a lack of an absence of clear user participation and of a rehabilitation perspective for the patients with OC decisions. The new legislation in the Mental Health Act in 2017, with a requirement for consent assessment before an OC decision, has changed the practice and the basis for making an OC decision.

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- Faculty of Medicine



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Centre for Medical Ethics
Institute for Health and Society
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This PhD project has been my work for many years, and I am grateful for having had the opportunity to do this. I have been interested in this field of mental care since I started working as a psychiatric nurse with patients who received Outpatient Commitment (OC) decisions. Later on, my involvement with OC issues was related to my work in the Research and Professional Development Unit (FoU) in the Psychosis Department in Innlandet Hospital Trust, further deepened my interest into this field.

Innlandet Hospital Trust, Division of Mental Health Care, has a strong focus on how coercion is used in treatment and has arranged national conferences on the topic. In addition, FoU has collaborated with the Tvangsforsk network in Tromsø. I have participated in Tvangsforsk research network's seminars, and my PhD project is inspired by this network.

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Summary

Background

This PhD project has examined how outpatient commitment (OC) decisions work. In Norway, the Mental Health Act provides the opportunity to use coercion in the treatment of people with mental disorder. Patients with OC decisions live in their own homes in the municipality, at the same time as they have a compulsory decision adopted by the specialist health service.

Aim

The main issue for this PhD project has been to explore how the OC scheme works from a mental health service perspective. The PhD project has mapped the patient group receiving OC decisions. In addition, it has investigated how health personnel in mental health services experience follow-up and interaction with patients and across service levels.

Design and methods

This PhD project consists of three sub-studies with different issues and different research designs using both quantitative and qualitative methods. These three sub-studies have resulted in three published papers.

Sub-study 1 collected data from electronic patient records including all patients in two counties in Norway. The statistical methods used in this study were descriptive analysis, with frequency analysis and cross-tabulation analysis. The study mapped the patient group of 139 patients who had received an OC decision from 2008 to 2012.

Sub-study 2 collected data using an electronic questionnaire sent to healthcare personnel in the mental health services, who have experience with psychosis and OC decisions in two counties in Norway. There were 230 people who received the questionnaire and 84 of them answered the form. The groups were compared using cross-analysis, correlation analysis (Pearson's r) and non-parametric Wilcoxon's test ($P \leq 0.05$). The sample consisted of various health personnel from both small and large municipalities, and examined which tasks they had in follow-up of patients and how they collaborated with the specialist health services.

Sub-study 3 This was a qualitative study collecting data through focus group interviews with health personnel from the municipal health service and specialist health services. The study explored their experiences with collaboration between municipalities and specialist health care services, for patients with an OC decision. The analysis followed the steps in qualitative content analysis inspired by Graneheim and Lundman.

Results

The first sub-study revealed that the patient group receiving the OC decisions constituted a small group of patients in mental health care who had psychotic disorders, with the majority having a schizophrenia disorder. Most patients had received treatment in mental health care for 10 years before they received their first OC decision. They received parallel mental health services from both specialist health services and their own home municipality. Many patients lacked information about an individual plan (IP) and a contact person in the medical record.

The second sub-study found that the health personnel gave the same follow-up to all patients with psychosis and OC decisions. However, patients who had OC decisions received fewer conversations about their medication. Many among the health personnel lacked up-to-date knowledge of the changes in the Mental Health Act in 2017. In addition, the study disclosed that the health personnel had varied experience of cooperation with the specialist health services.

The third sub-study explored the health personnel experiences with follow-up of patients with OC decisions in municipal housing associations and district psychiatric centres (DPCs). The study disclosed that the health personnel related that they followed up patients with OC decisions in a different way to other patients, and felt more responsibility towards them. Thus, the altered rules for consent competence have made the work with OC decisions more demanding.

Conclusion

All the sub-studies revealed a lack of interaction between the service levels. The responsibility for coordinating the follow-up of the patients with OC decisions on a daily basis appears to be unclear across service levels. The contact person's role and IP have not functioned as a collaboration tool in accordance with the intention of the Mental Health Act and the Patient Rights Act. When an IP is lacking, there is a lack of an absence of clear user participation and of a rehabilitation perspective for the patients with OC decisions. The new legislation in the Mental Health Act in 2017, with a requirement for consent assessment before an OC decision, has changed the practice and the basis for making an OC decision.

Therefore, if an OC decision can contribute to an improved process and function as intended in the law, the decisions must contain more than the control of the decision. These findings show that the laws are not currently applied, which is ethically worrying.

Sammendrag

Bakgrunn

Dette PhD prosjektet har utforsket hvordan ordningen med tvang uten døgnopphold (TUD) fungerer i Norge. I Norge gir Psykisk helsevernloven muligheten til å bruke tvang ved oppfølgingen av pasienter med psykisk lidelser som bor i sitt eget hjem i kommunen, samtidig som de har tvangsvedtak fra spesialisthelsetjenesten.

Formål

Målet for dette PhD prosjektet har vært å utforske hvordan TUD ordningen fungerer ut i fra et psykisk helsetjenesteperspektiv. PhD prosjektet har kartlagt pasientgruppen med TUD vedtak, og undersøkt hvilken oppfølging pasientene får og hvordan samarbeidet mellom kommuner og spesialisthelsetjenesten fungerer.

Design og metoder

Dette PhD-prosjektet består av tre delstudier med forskjellige problemstillinger og forskjellige forskningsdesign og har benyttet både kvantitativ og kvalitativ metode. De tre delstudiene har resultert i tre publiserte artikler.

Delstudie 1 inkluderte 139 pasienter fra to fylker i Norge med TUD vedtak. Data ble samlet inn fra elektroniske pasientjournaler og inkluderte alle pasienter med TUD vedtak fra 2008 t.o.m. 2012. Studien hadde et deskriptivt design og det ble benyttet frekvensanalyse og kryss-tabellanalyse.

Delstudie 2 samlet inn data ved hjelp av et elektronisk spørreskjema sendt til helsepersonell i kommunale psykiske helsetjeneste i to fylker i Norge, som hadde erfaring med pasienter med psykose og TUD vedtak. Det var 230 personer som mottok spørreskjemaet, og 84 personer besvarte skjemaet. Gruppene ble sammenlignet ved bruk av kryssanalyse, korrelasjonsanalyse (Pearson's r) og ikke-parametrisk Wilcoxon's test ($P \leq 0.05$). Utvalget besto av helsepersonell fra både små og store kommuner, og det ble undersøkt hvordan de fulgte opp pasientene i kommunene og hvordan de samarbeidet med spesialisthelsetjenesten.

Delstudie 3 er en kvalitativ studie som samlet inn data gjennom fokusgruppeintervjuer med helsepersonell fra kommunale bofelleskap og spesialisthelsetjenesten. Studien utforsket deres erfaringer med samarbeid mellom kommuner og spesialisthelsetjeneste for pasienter med TUD vedtak. Analysen fulgte trinnene til kvalitativ innholdsanalyse etter Graneheim og Lundman.

Resultater

Den første delstudien viste at pasientgruppen som har TUD vedtak, utgjør en liten pasientgruppe i psykisk helsevern med psykose lidelser, hvor de fleste hadde en schizofrenilidelse. De fleste pasientene hadde hatt oppfølging for sine psykiske helseproblemer i 10 år før de fikk sitt første TUD vedtak. Pasientene mottok parallelle psykiske helsetjenester fra både spesialisthelsetjenesten og sin egen hjemkommune. Mange pasienter manglet informasjon om individuell plan (IP) og hvem fra spesialisthelsetjenesten som var kontaktperson i pasientjournalen.

Den andre delstudien viste at helsepersonell gir samme oppfølging til alle pasienter med psykotiske lidelser uansett om de hadde et TUD vedtak eller ikke. Men, pasienter med TUD vedtak fikk færre samtaler om medisiner. Mange blant helsepersonellet manglet oppdatert kunnskap om endringene i Psykisk helsevernloven fra 2017. Helsepersonellet i kommunene erfarte utfordringer knyttet til samarbeid mellom helsepersonell på ulike tjenestenivåer. IP ble sjelden brukt og fungerte bare i varierende grad som et samhandlingsverktøy.

Den tredje delstudien har undersøkt helsepersonells erfaringer med oppfølging av pasienter med TUD vedtak i kommunale borettslag og distrikt psykiatriske senter (DPS). De svarte at de fulgte opp pasienter med TUD vedtak på en annen måte enn andre pasienter, og følte mer ansvar overfor dem. Lovendringen i Psykisk helsevernloven fra 2017, med krav om samtykkevurdering før TUD vedtak, har gjort arbeidet med TUD vedtak mer krevende.

Konklusjon

Alle delstudiene viste manglende samhandling mellom tjenestenivåene. Informasjon om kontaktpersonen i spesialisthelsetjenesten manglet for mange pasienter. Ansvar for koordinering av oppfølgingen av pasientene med TUD vedtak mellom tjenestenivåer ser ut til å være uklar, og IP fungerer ikke som et samarbeidsverktøy i samsvar med intensjonen i Psykisk helsevernloven og Pasientrettighetsloven. Når en IP mangler, mangler et tydelig brukermedvirkning og rehabiliteringsperspektiv for pasienter med TUD vedtak.

Den nye lovendringen i Psykisk helsevernloven fra 2017, med krav om samtykkevurdering har endret praksis og grunnlag for å gjøre TUD vedtak.

Hvis TUD vedtak skal bidra til bedring som loven tilsier, må TUD vedtaket inneholde mer enn å kontrollere vedtakene. Dette PhD prosjektet viser at noen av lovbestemmelsene ikke brukes, noe som er etisk bekymringsfullt.

List of papers

- I. Løvsletten M, Haug E, Granerud A, Nordby K, Smaaberg T. Prevalence and management of patients with outpatient commitment in the mental health services. *Nordic Journal of Psychiatry*. 2016; 70(6): 401-406.
<https://doi.org/10.3109/08039488.2015.1137969>
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- III. Løvsletten M, Lossius Husum T, Haug E, Granerud A. Cooperation in the mental health treatment of patients with outpatient commitment. *SAGE Open Medicine*. 2020; 8: 2050312120926410.
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Abbreviations

ACT = Assertive Community Treatment

DPC = District Psychiatric Centre

DIPS = Distributed Information and Patient Data System in Hospitals

IP = Individual Plan

NSD = Norwegian Social Science Data Services

OC = Outpatient Commitment

REK = Regional Committees for Medical and Health Research Ethics in Norway

SPSS = Statistical Package for Social Sciences

1 Introduction

In this PhD project I have examined how the outpatient commitment (OC) scheme is carried out in the mental health services in one health trust in Norway with its associated municipalities. The Mental Health Act in Norway provides the opportunity to use coercion in the treatment of people with mental disorders both in hospitals and in the municipalities [1].

Internationally the OC scheme is present in 10 European countries, the USA, Canada and Australia and has been introduced in around 75 jurisdictions worldwide [2, 3]. Norway was one of the first countries to introduce the OC scheme in 1961, and the USA and Australia introduced the scheme in the 1980s [4]. New Zealand and Canada followed in the 1990s [5, 6]. Most European countries introduced the scheme in the 2000s; first Scotland in 2005, Sweden and England and Wales in 2008, and Denmark in 2010 [7, 8]. The changes in legislation came as a result of several tasks within mental health care being transferred to the municipalities, in addition to the downsizing of large mental hospitals.

The legal criteria for the OC scheme vary between jurisdictions, but they assess treatment needs and danger to the patient himself or others [4]. The core elements of the law are medication and clinical judgment calls [9]. Common to all the schemes is to give discharged patients with severe mental illnesses compulsory treatment regulated by their mental health laws. However, many OC schemes allow recall to hospital if the patient is not compliant [10]. Despite differences in legislation, culture and organization of mental health care, several studies found that the patient group consists mainly of men about 40 years old, with mental illnesses and schizophrenia over several years, who have a poor effect of medication and are considered potentially dangerous [4,11,12,13,14].

However, internationally the laws that regulate OC schemes have been criticized in many countries. Although the OC scheme is an alternative to hospitalization, it is criticized for stigmatizing people and preventing them from living their lives as they wish [15]. The criticism is that the OC scheme is more of a social control than it takes care of the patients' actual treatments needs and improved patient outcomes [16,17].

Although Norway has had the OC scheme since 1961, a new Mental Health Act was proposed in 1999 with increased access to make decisions about coercion outside the institution [18]. The law was further amended in 2017, when requirements for consent assessment were introduced. An OC decision involves follow-up and treatment for mental illness through

control and medication, and the specialist health service is responsible for assessing and implementing coercive decisions [1,19]. This means that people with OC decisions are patients within the specialist health service, at the same time as they live in a municipality where they receive municipal health services. In this PhD project, people with OC decisions are therefore referred to as *patients*.

A health inspection survey in 2006 in Norway revealed that 2.9 % of all the patients were registered with an OC decision, and the majority of them had a diagnosis of schizophrenia [20]. In addition, the survey revealed that this patient group had little education, a poor economic situation, few family ties and weak anchoring and support to safeguard their own interests and rights [20].

It is a major intervention in a person's life to be subjected to coercion while staying in their own homes [21]. This challenges the community and the health service to make difficult choices, both therapeutically and ethically because OC-decisions may persist over time [22]. On one hand, the purpose of a coercive decision is to arrive at a position that makes it possible to stabilize and treat mental illness. On the other hand, coercion is not alone a lasting measure for solving a health challenge. The use of coercion is an intervention in a person's life that involves both patients, relatives and health personnel in various ways [23]. It is therefore important to know how these groups are involved in the patient's treatment.

The purpose of Norwegian legislation and Norwegian health care services is to facilitate mental health care based on voluntary consent [1]. Treatment and follow-up of the OC scheme must follow the current legislation with guidelines. Nevertheless, there are no national treatment guidelines that includes treatment to patients with a decision of OC beyond the statutory duties in national documents [24, 25]. Still, these documents provide descriptions of which individual care and are given to the patient groups who need them most [23].

Norway has a two-part health service system in which the inhabitants receive mental health services from both the specialist health service and the municipalities where they live [26,27]. People with OC decisions may have complex needs and need help simultaneously from different health services, which involve both the municipality and specialist mental health across services. This means a shared responsibility for the patient involved.

The quality of services to patients with OC decisions depends on specialized competence of treatment based on updated new knowledge [28]. The services the patient receives can have an impact on the patient's health and duration of the OC decision so it is important that the follow-up provided works well. The requirements for evidence methods in the health service have increased the focus on quality in the health service at the same time as increased awareness of ethical challenges in the use of coercion [28, 29]. Therefore, it is important to gain more knowledge and perform more research about the actual follow-up of patient's takes place in clinical practice.

However, it is also important to focus on how the health personnel involved with patients with an OC decision cooperates, and to investigate how this cooperation functions in practice. If the health personnel and those involved do not cooperate, this could mean that patients with OC decisions do not receive the services that the health legislation should provide. Challenges with cooperation between the health services are well known, and plans and measures have been made to improve this [30,31]. Reports have revealed shortcomings in the transfer of patient information, medication routines and lack of cooperation across the health service levels [32]. These challenges can lead to the health service being perceived as deficient, and various ethical dilemmas might arise.

In Norway, criticism of the use of coercion in mental health has increased, and internationally Norway has been criticized for violating human rights and national conventions on coercion [33,34]. Further, Norway has been criticized for making decisions about coercion based on the treatment criterion, even if the patient was competent to consent.

So far there is no national register with an overview of the patients with OC decisions in Norway. Registration of the extent of OC use was, for many years, completely lacking in Norway, although some statistics have been registered that showed an increase in the use of OC [35]. Norwegian authorities therefore wanted to acquire more knowledge and facts about the extent of OC use, and created strategies to do this [36,37]. An action plan was made where the health authorities outlined four main objectives for both increased knowledge and reducing the use of coercion in Norway [36]. These objectives were; *increased voluntariness in relation to treatment, quality-assured use of coercion, increased knowledge about the use of coercion and better documentation of coercion*.

One strategy was to set up a committee, Paulsrudutvalget, to evaluate the Norwegian coercive laws, which resulted in an NOU 2011:9 (Norges offentlige utredninger) report [25].

This report discussed legislation of the use of coercion and user rights, and proposed changes in the laws to strengthen self-determination and legal security for people with serious mental disorders. This report led to changes in the Mental Health Act in 2017, where the treatment criterion was changed and an assessment of consent competence were introduced. [1]. A professional development project was conducted after the change, that showed a decrease in the number of the patients with OC decisions [38].

Another strategy was to evaluate and increase more knowledge about coercion in Norway. The Network for Research and Knowledge Development on the Use of Coercion in Mental Health Care (Tvangsforsk) was established on behalf of the Norwegian Directorate of Health. Their assignment was to make recommendations to research areas to explore the use of coercion in Norway, and in 2014 research plan was made to do this [39]. This plan indicates that there is a lack of research about coercion in Norway, regarding both inpatients and outpatients stays. In addition, the research plan points out mental health services in municipal services and coercion, the content of coercion and patients' self-determination, and consent competence.

Research on the OC scheme was deficient in Norway for many years, but Norway has a long experience of using the OC form. Therefore, Norwegian experience and knowledge can be important internationally as well.

1.1 The development of mental health services in Norway

Historically, coercion has been used in the treatment of people with mental illness for many decades. Throughout the history there have been different perspectives on treatment and mental illness [40]. The treatment of mental illness has been characterized by various coercive measures. It is a field that has been characterized by the tension between different treatment methods, scientific traditions and different models of understanding mental illness [23, 41].

At the end of the seventeenth century, mental health problems were defined as an illness [42]. People with mental illness were considered to be insane and isolated in houses that were later called asylums. In 1848, Norway passed the first Mental Act law, which led to a government responsibility to ensure the care of people with mental illnesses using humane and scientific measures, and at the same time taking care of society's need for protection [43].

Large institutions were built that isolated patients from society. All admissions were originally seen as compulsory until 1935, when voluntary admissions became possible [44]. The staff consisted mainly of unskilled personnel, together with some nurses and doctors. Many of the patients were subjected to the violations of the old asylums and deprived of any authority in the patient role [43].

The treatment methods used involved long stays in belts, insulin shock, electroshock treatment and lobotomy [45]. As a result of these methods, many patients suffered permanent injuries. In the 1950s, there was a change in the treatment of patients through access to such new medicines as antipsychotics [43]. At the same time, there were changes in the way mental illness was viewed. The medication led to shorter hospital stays, and rehabilitation became more important. The Mental Health Act of 1961 gave guidelines for both inpatient and outpatient stay and treatment [18]. This was both a reform of responsibility and a modernization of legislation.

Mental health services in Norway have undergone major changes since the 1970s as in the rest of the western world. The number of large institutions has gradually been reduced, rehabilitation has become more important and patients can remain in their municipalities while undergoing treatment.

In 1967, the mental health service became the responsibility of the county municipalities [18]. Later, in 1969 there was a modification in the legislation that limited the use of coercion in institutions, with clearer legal provisions such as limited use of coercive measures and coercive actions against patients [18].

1.1.1 New organization of mental health services

The escalation plan for mental health (St.prp. No. 63 (1997–98)) led to a shift in the health services from the institutions to the municipalities [30]. The plan was based on Stortingsmelding 25, *Openness and wholeness*, which dealt with mental disorders and the services offered [46]. The plan restructured mental health services for adults with increased outpatient activity and the development of district psychiatric centres (DPCs). In additions, guidelines were established for the development of mental health services for children.

After the change in the mental health services, the municipalities were given more responsibility and more tasks in the field of mental health services. In the guide *District Psychiatric Centres – with a view to the municipality and specialized hospital functions in the*

back, the division of tasks across the service levels is described [47]. The DPCs were to be a link between hospitals and municipalities, to provide both 24-hour services and outpatient follow-up, and to be the gateway to the specialist health service. Several DPCs were established in connection with somatic hospitals. Substance abuse problems became an integral part of mental health care compared with earlier times, when substance abuse problems were considered to be social problems and the social services were responsible for following up the users [46]. This meant that people with substance abuse problems were given patient status in the specialist health service. In addition to this, substance abuse was seen as an illness. In 2001 the specialist health service became the responsibility of the institutions' for mental health care and interdisciplinary specialized drug treatment [18].

In 2002, health services in the specialist health service were organized as a health trust with its own law, and the Health Enterprise Act came into force in 2002 [27,48]. A total of 47 health trusts were established in Norway, which were in turn organized into 5 health regions. After this establishment, several merged and, in 2019, there were 20 health trusts and 4 health regions in Norway.

At the same time as health trusts were established, the collaboration reform was introduced [31]. This reform meant that the specialist health service and the municipalities would interact to a greater extent, and the municipalities were given more responsibility for the patients (Table 1).

The collaboration reform is a coordination and direction reform, in which financial, legal, organizational and professional instruments promote the overall goal of comprehensive and flexible patient processes [49, 50].

Several key documents were prepared by the Ministry of Health and Care Services, both NOU reports and supervisory documents, to ensure the quality of the services. These reports concluded that the municipal health service in Norway should be the primary foundation in the health service, besides contribute to comprehensive treatment, care, proximity and accessibility [51].

| Service levels | Mental health services |
|--|---|
| Specialist health service, mental hospital | Emergency service, emergency care, diagnostic units, special units for complicated cases, security departments Responsibility for decisions on involuntary admissions and OC assessments |
| Specialist health service, DPCs | Acute and emergency preparedness. Outpatient, diagnosis and treatment, and ward Responsibility for OC assessment |
| Municipality mental health service | Responsibility for prevention and early intervention Mental health care, mental housing association, activity centres. Responsibility for follow-up treatment and rehabilitation |

Table 1 Overview of the responsibility for mental health services in Norway [50,51]

The collaboration reform aims was to show the way forward for the development of health services closer to where people live, and thus ensure better-coordinated services for patients and users. In addition, prevention and early intervention received a stronger focus [31].

In parallel with these plans, in 2016 the Government launched a plan for introduction of packages for treatment [52]. The packages should cover both somatic and mental health treatment with the purpose of ensuring the quality of the content of assessments and treatment courses.

Furthermore, in 2017 the government presented a comprehensive interdisciplinary overall strategy for mental health, *Coping with life* (2017–22) [53]. This is a health-promoting plan that has a special focus on the mental health of children and young people.

These goals were continued in the new *National Health and Care Plan* for 2020–23 [54]. An important focus in the new plan is to create a health community, which aims to create coherent and sustainable health and care services for patients who need services from both the specialist health service and the municipal health and care service.

1.1.2 Changes in patient rights and facilitation of services

An important change during the last 20 years in Norway is the shift in the patient's view, from patient to user, with greater requirements for user participation and patient rights. Patients received new rights, user involvement became more important and treatment was individualized to strengthen the quality of services [30]. Through these changes, patients gained more influence over their own treatment, and in 1999 a law on patient and user rights was passed [55]. Norway was among the first to authorise such a law and user organizations became involved in developing the services. During this time there was a heightened awareness about the use of coercive practices in mental health care. This work contributed in 1999 to new and revised legislation for the implementation of mental health care [1].

In 1996, there was a new view in the approach to and treatment of mental disorders [30, 41]. The tendency was a lesser degree of paternalism and greater emphasis on user participation and respect for autonomy [27]. This gave a stronger user perspective with more active user involvement.

Patients/users who need long-term and coordinated health and care services have the right to have an individual plan (IP) prepared [55, 56]. The IP is a statutory right for patients, an important interaction tool across the service levels. The IP is a provision in the Patient and User Rights Act (§2–5) and the Mental Health Act (§4–1) [1, 55].

In addition, the authorities prepared several national guidelines for the treatment of patients with mental disorders. In 2012, the *National Professional Guideline for the assessment, treatment and follow-up of people with concomitant drug and mental illness – ROP disorders* was published [57]. The following year, in 2013, the *National Professional Guideline for the assessment, treatment and follow-up of people with psychotic disorders* was published [58].

In 2014 the guideline *Together on coping* described methods for collaboration to give patients with mental disorders and substance abuse problems better follow-up in the municipality [26].

The guideline gave directives on the organization of services. This development was followed up with several national guidelines. In 2015 came the *National Health and Hospital Plan* (2016–19), which had a strong focus on strengthening the patient role and giving patients greater opportunities to participate in shaping the content of the treatment on offer, and for relatives to be more involved [59].

1.1.3 Changed view of coercion

At the same time as the development of DPCs and municipal health services, more attention was paid to patients who received compulsory decisions. In the new Mental Health Act of 1999, the conditions for treatment with coercion, both inside and outside an institution, became clearer [1,18].

A study from the Norwegian Directorate of Health mapped patients with compulsory decisions, both patients who were admitted and patients in the outpatient clinic [20]. This report mapped the patients with OC decisions and revealed geographical differences in the use of coercion. Most of these patients most were diagnosed with schizophrenia. Of all patients, 87% had a compulsory decision based on the treatment criterion and 33% had a

decision based on the danger criterion, although some patients had the decision based on both criteria.

In Norway, criticism of the use of coercion in mental health increased, and internationally Norway was criticized for violating human rights and national conventions on coercion [33,34]. Norway was criticized for making decisions about coercion based on the treatment criterion, even if the patient was competent to consent.

Registration of the extent of OC use was, for many years, completely lacking in Norway, although some statistics have been registered that showed an increase in the use of OC [38]. Norwegian authorities therefore wanted to acquire more knowledge and facts about the extent of OC use, and created strategies to do this [36,37]. This led to the creation of an action plan, Report IS-1370, to reduce and quality assure the use of coercion in mental health care [36]. This action plan outlined four main objectives: Increased knowledge about the use of coercion, better documentation of coercive use, increased voluntary nature in relation to treatment and measures to ensure the quality of the coercion used.

To evaluate and increase more knowledge about coercion in Norway, the Network for Research and Knowledge Development on the Use of Coercion in Mental Health Care (*Tvangsforsk*) was established on behalf of the Norwegian Directorate of Health in 2008 [39]. Another strategy was the establishment of *Paulsрудutvalget*, to evaluate the Norwegian coercive laws, which resulted in an NOU 2011:9 (*Norges offentlige utredninger*) report [25].

This report discussed legislation of the use of coercion and user rights, and proposed changes in the laws to strengthen self-determination and legal security for people with serious mental disorders. This report led to changes in the Mental Health Act in 2017, where the treatment criterion was changed and an assessment of consent competence were introduced. [1]. A non-scientific survey was conducted after the change that showed a decrease in the length and number for the patients with OC decisions [38]. Together with national measures to reduce the use of coercion in mental health care, regional measures have also been developed [60].

Nevertheless, the compulsory regulation of mental health services in Norway was implemented in 2017, the authorities wanted to review the entire compulsory legislation further. In 2016, a new commission was appointed to prepare a new law across specialist health services and municipalities. This proposal, the Compulsory Restrictions Act (NOU 2019: 14), was sent for consultation in the autumn of 2019 [61]. The new proposal included

mental health care, specialized drug treatment, somatic health care and the care of persons with intellectual disability. This project will lead to major changes in the use of coercion for people with mental health problems in the future.

1.2 Legal provisions

The Norwegian health care system is organized through several laws. The laws regulate mental health services for people with mental disorders in Norway, and describe patients' rights, the duties of health personnel and collaboration across service levels (Table 2). The laws give patient rights in both the municipality and the specialist health service. Therefore it is important that health personnel from different services have knowledge of all the health laws.

| Health laws | Decided | Function and scope |
|------------------------------|---------|--|
| Public Administration Act | 1967 | This Act contains rules on how public authorities handle cases in a responsible and correct manner Municipal, county and state agencies covered by the Act [62]. |
| Health Personnel Act | 1999 | This Act applies to health personnel professional practices and businesses that provide health care The purpose of the Act is to ensure adequate health and safety of patients and quality of health and care services [63]. |
| Patient and User Rights Act | 1999 | This Act deals with what rights patients have in relation to health and care services Patients must have the information necessary to gain insight into the service on offer and be able to safeguard their rights The Act emphasizes that health care can be provided only with a patient's consent [55]. |
| Mental Health Act | 1999 | The law applies to assessment and treatment in mental health care. Health care must be organized with respect for the individual's physical and mental integrity, and be in accordance with the patient's needs, autonomy and human dignity [1]. |
| Health and Care Services Act | 2011 | The law applies to health and care services offered in the municipality The municipality shall offer persons staying in the municipality, necessary health and care services [64]. |

Table 2 Overview of key laws for mental health services in Norway (www.lovdata.no).

1.2.1 The Mental Health Act

The purpose of the Mental Health Act in Norway is to ensure that the establishment and implementation of mental health care are justifiable in accordance with human rights and basic principles of legal security [1, 33,34]. The purpose of the law is to prevent and restrict the use of coercion [1].

The law regulates the services provided in the treatment of each individual's mental health. Mental health care emphasizes its voluntary nature and is provided in accordance with the provisions of the Patient and User Rights Act [55]. The main principle is that all treatment is given voluntarily on the basis of consent, although, if the patient does not have consent competence, treatment can be initiated by law.

The main criterion for the use of coercion is that the patient must have a serious mental disorder, such as a psychotic disorder, but additional criteria are also needed: the treatment criterion (a reduced prospect of substantial improvement without treatment) and/or the danger criterion (to be a danger to themselves or others). Several aspects of the OC are regulated by legislation (Table 3). The criteria for OC decisions are the same as they are for involuntary hospital treatment [1].

The regulations of the Mental Health Act provide a framework for the implementation of OC [19]. Besides, these regulations provide guidelines for the follow-up that the patient must have through collaboration between the specialist health service and the municipality [1,19].

| Mental Health Act | Guidelines for the Mental Health Act |
|---|---|
| <ul style="list-style-type: none"> • Voluntary treatment has been tried (§3-3) • The patient has been examined by two independent physicians (§3-3) • The patient must have a serious mental issue (§3-3) • The patient lacks consent competence (§ 2-1) • New assessment of compulsion every 3 months by psychiatrist or psychologist (§ 4-9) • Rules for treatment with medication given forcibly (§4-4) • Provision must be made for the preparation of an individual plan for care (§ 4-1) | <ul style="list-style-type: none"> • The person responsible for the decision must be a specialist, psychiatrist or psychologist (§ 5) • The patient must have a known contact person in specialist health care (§ 31) • Patients have the right to participate in treatment choices as far as possible (§15) • The institution takes the initiative for cooperation with relatives in consultation with the patient (§27) • The patient must have a home address in the municipality (§ 11) • The responsible institution takes the initiative for an individual plan for the patient (§32) |

Table: 3 An overview of criteria and framework of OC according to the Mental Health Act with guidelines [1,19].

On 1 September 2017, the law was changed so that the treatment criterion in OC is that patients with the mental capacity to make treatment decisions no longer can be treated without consent, as long as they do not fulfil the danger criterion.

To be able to consent, the patient must have sufficient information and insight to assess their own need for health care, and the consequences of refusing treatment according to the Patient and User Rights Act [1, 55].

Before patients receive OC decisions, voluntary treatment must have been either attempted or clearly futile, and the patients must have the opportunity to express their views. OC must also overall, be the best option for the patient, with its justification to being the best solution for the patient and the environment. In addition, the OC decision must be evaluated every 3 months by a psychiatrist or psychologist who is a specialist in clinical psychology.

If the patient objects to treatment with medication, the patient must be brought to the hospital for treatment because medication cannot be given forcibly in the patient's home. However, a separate decision must be made, so that medication can be given forcibly [1, 19].

The mental health framework also provides provisions for the patient to have a contact person in specialist health care who is known to the patient and relatives [19]. Patients cannot get a decision about OC if they are homeless, and therefore the municipality must help to find a home for the patient in the municipality [19]. Specialist health care has the responsibility to establish contact with the mental health team in the municipality and should also establish collaboration with the patient's relatives if the patient does not object.

Patients with OC decisions have a right to have an IP prepared, and the specialist health service must implement this [1, 19, 55]. The purpose of the IP is to safeguard the patient's wishes and interests for treatment measures, and to ensure that the services are connected to regulate the cooperation across the service levels [56]. The IP may also contain a crisis plan, which is a concrete action plan that the patient or patient's relatives can use when the former experiences deterioration in their condition [58, 65]. However, the patient must consent to the creation of the IP. If the patient does not have consent competence under the Patient and User Rights Act, it is the relatives who can consent on behalf of the patient to safeguard the patient's rights and needs [55].

1.2.3 Mental disorder

If a person is to receive an OC decision, they must have a serious mental disorder as one of the criteria in the Mental Health Act.

Severe mental disorder is not a diagnosis, but a legal term, which can be traced all the way back to the Mental Illness Act from 1848, and continued in the Act from 1961 and the revised version of the Act in 1999 [18]. It concerns clear active psychoses, and certain deviation states of a non-psychotic character that have the same malfunction as a psychosis [18].

Historically, the term ‘psychosis’ dates from 1845, and has received a number of different definitions [66]. Psychoses are symptoms including thought disorders, disorganized speech and behaviour, delusions and hallucinations [67].

Many patients with psychotic disorders have cognitive impairment [68, 69]. These are serious conditions for those who are affected and the symptoms can be difficult to understand and treat [58]. In addition, many patients with psychotic symptoms also have problems with substance abuse [70]. Psychotic symptoms can lead to people exposing themselves or others to danger, and they may need protection and care.

There are several mental disorders that cause psychotic symptoms according to the *International Statistical Classification of Diseases and Related Health Problems*, ICD-10, which is used in diagnostics in the specialist health service in Norway, and in data collection in this PhD project [71]. The most common diagnosis for patients receiving OC decisions is schizophrenia [20]. Schizophrenia is a complex mental disorder characterized by psychotic symptoms and poor functioning and many patients have cognitive impairment as well [72]. It is a complex condition that affects perception, thoughts, and emotional and social behaviour [66].

Antipsychotic medication is often given to treat psychotic symptoms [73]. Some patients with a diagnosis of schizophrenia do not think they have a mental disorder and reject health care and medicines. Patients with a psychotic disorder who stop taking their medication are at increased risk of relapse, which can lead to hospitalization [74]. However, there are also other patient groups with psychotic symptoms who receive OC decisions in Norway. Among these are patients with affective disorders and severe eating disorders with dysfunction, which provide a basis for involuntary hospitalization according to ICD-10 [71].

1.2.3 The patient's appeal options

The Norwegian Mental Health Act is designed so that, in addition to facilitating the use of coercion, it also provides patients with legal security guarantees [1, 19]. It is an old provision in Norwegian law from the establishment of the law in 1848, which was continued in the amendment of the law in 1961 and is still used today [75].

The Control Commission's main task is to ensure the individual patient's legal security when meeting with the mental health service.

For patients with an OC decision, the Control Commission makes an independent assessment 3 months after the decision, to investigate whether the condition resulting in coercion is still present. They must also check whether if the patient has received an IP.

Court decisions

Several patients with OC decisions have appealed their decisions to the courts. The change in consent competence has given patients an increased right to self-determination [55]. In 2018, three Supreme Court rulings were handed down on consent competence [76]. In two of the judgments, the patients' complaints were not upheld due to the risk of aggravation and the danger criterion. But in one of the cases, the patient had their OC decision revoked by the Supreme Court, even though the person in question was not considered to be competent to give consent. The reason for revoking the decision was based on the patient's overall situation. The patient lived an orderly life in his or her own home, and had orderly finances, and close follow-up from health personnel and received maintenance treatment with a depot injection every 4 weeks. This judgment emphasized the importance of a good framework for follow-up of patients with OC decisions, and the judgment suggests that this follow-up may be a substitute for using coercive decisions.

1.3 Ethics and the OC scheme

The health personnel's ethics are challenged through attitudes and actions that can reinforce the patient's experience of coercion [22, 29, 77]. By follow-up and interaction with the patient the health personnel have a responsibility to comply with human rights, work to promote health, personal independence and growth [33, 34, 78].

The main principle for providing health care in Norway is its voluntary nature. An OC decision, affects the patient's autonomy, the principle of not to harm and limits their ability to control their own lives [22, 29]. An OC decision challenges respect for personal freedom and autonomy and it is a duty to ensure that patients receive useful care [9, 79].

The main criterion for OC is mental disorder and lack of consent competence and psychotic symptoms [1]. Psychosis may affect patients' perception of reality causing hallucinations, delusions and impaired functioning [66]. Patients with psychosis may have a different

perception of their health situation than the health personnel [67]. This is ethically challenging, because an OC decision is implemented when a patient lack consent competence and is unable to take care of their own mental health. For some patients who have lost their capacity to consent it can be ethically justifiable to avoid relapse and readmission as a “revolving door” patients with an OC decisions [80].

The goal of the treatment is to make the patient accept help voluntarily, but also provide health and independence, coping and user involvement. The most common ethical model in health service is the Beauchamp and Childress' "four-principle ethics" [81]. This model refers to medical ethical rules and ideals; respect for autonomy, beneficence, the principle of no harm and justice [81]. Patients with OC decisions are deprived of their autonomy and right to control their own lives. In general, the negative effects of the OC scheme on the patient's autonomy, integrity and wellbeing must be assessed. The benefits must presuppose that protection and treatment outweigh the negative effects on patient autonomy and integrity, because using coercion will restore the patient's ability to make independent decisions [77, 82]. Nevertheless, in treatment situations it is necessary to consider whether coercive treatment may violate or cause further harm to the patient [22]. Their experience of coercion may be related to the form of coercion [83]. However, coercion giving by law is a formal coercion that gives the patient legal certainty and user rights [22].

Experience of the coercion for the patient is dependent on the context and how the organization of the mental health services is worked out [84]. A person may feel humiliated and lack of control even if the health personnel's intentions are good. [85]. The experience of coercion may also be related to procedures and arrangements that are related to experience as pressure, attitudes and communication [86, 87, 88]. Informal coercion can be experienced in situations where the patient does not participate in the admission, but involving the patients in the decision-making process and treat them with respect, the experience of coercion can be reduced [89]. However, it is important to safeguard patients' dignity and take account into patient opinions. One way to strengthen patients' rights and co-determination, may be to help patients to write an IP and a crises plan when they have regained consent competence [56].

In the follow-up and care of patients with the OC scheme, many ethical dilemmas can arise. Health personnel must both provide health services in accordance with the mental health

legislation, but also offer mental health care in accordance with their own professional ethics rules [79, 90]. Psychiatrists and psychologist specialists are responsible for the coercive decision but also for the implementation of the decision in collaboration with nurses and other health personnel. In these situations, several ethical issues may arise between the patient and the health personnel. Coercion may have a detrimental effect on the relationship between the patient and the health personnel, so the attitudes and acknowledge to the patients situation is important for the relationship [9, 21, 25, 29]. Situations may arise where the patient may feel their integrity and autonomy is violated. Therefor it is essential that health personnel have the knowledge and experience to meet patients with these challenges with knowledge and respect. However, coercion of people with severe mental disorders is accepted under certain conditions if there is a danger to life [25]. The ideal is the principle of least coercive intervention to avoid coercion [77].

In addition, coercion challenge human rights and is an important principle in the UN's Convention on the Human Rights of Persons with Disabilities (CRPD) [33, 34]. Criticism of the Norwegian mental health laws is related to the use of coercion against patients with consent competence and has been in conflict with the CRPD and amended the Norwegian Mental Health Act in 2017 [25].

1.4 Experiences with the OC scheme in mental health care

Several studies, both quantitative and qualitative, have been published on the experiences of the use of OC in recent years both national and international. To get an overview of published studies, a search was performed in the PschINFO database using the keywords *outpatient commitment* and *outpatient treatment orders*. To supplement this search, Google scholar was used to provide reference literature. In addition, a supplement search has also been made with the keyword *supervised community treatment*.

To present foreign perspectives, review articles from the last 10 years have mainly been selected because they provide a good summary of international experiences with the OC scheme. The Norwegian articles are presented as simple studies. Together, these articles describe studies of factual knowledge about the OC scheme. Additionally, there are also several studies that have examined the experiences of patients and health personnel. These articles shed light on the OC scheme from different perspectives.

However, laws and practices differ in different countries, and different countries have different coercive laws, although some have similar schemes to the Norwegian OC scheme [2,3,4]. As there are differences, it may be of limited transfer value to compare studies across countries.

1.4.1 International studies

The OC scheme is present in 10 European countries, the USA, Canada and Australia, and has been introduced in around 75 jurisdictions worldwide, but the content and laws differ across them [2, 3]. An OC decision is a measure that is implemented in the wake of the deinstitutionalization of the mental health services for those with serious mental illness when other alternatives are not sufficient [3, 91]. Nevertheless the OC scheme is debated because it challenges the tension of improvement, personalization, coercion and ethics [16, 91, 92, 93]. However, the outcome of the OC scheme is currently being debated [94].

Outcome of OC

Three review studies have investigated how the OC scheme works [11, 17, 94]. One qualitative review study provides a systematic review of qualitative studies with individuals who have been subjected to an OC decision [17]. These results focused on understanding the experiences of individuals who have been subjected to the OC scheme that quantitative studies cannot provide. The results show both positive and negative aspects of an OC decision. Opponents of the OC fear that treatment and support will be replaced by control and undermining of the relationship between health personnel and patients [17]. A systematic review and meta-analysis comparing 41 studies found that an OC decision affect the course of the patient's disease [86]. This article did not find that an OC decision reduced admissions, but patients with the OC scheme used the municipal services more. One study, a randomized controlled trial, compared two groups of patients with and without an OC decision over a period of 12 months [11]. The study compared days in hospital between patients with an OC decision and those without a decision, to assess whether OC provides improvement for the patients. The result did not find that the OC scheme made a large difference when it came to hospital stays, social functioning or quality of life.

Another systematic review have explored patients with the OC scheme in Australia and New Zealand [95]. This study found that people from culturally and linguistically diverse or migrant background were nearly 40% more likely to be placed on the OC scheme. A

qualitative review with clinicians from 6 countries worldwide, believed that the OC scheme was both ethical and necessary in many situations, but experienced coercive exercises as demanding [96].

On one hand, studies have found that the OC scheme provides better follow-up for some patients, even if the length of stay does not decrease. Some of these studies show benefits when it comes to readmission, time in hospital and use of local communities, but others show none of these benefits [8, 97]. One literature review, which included over 50 empirical studies, showed mixed experiences with the OC scheme [8]. This study found that the OC scheme was used extensively to prevent relapse and readmission, but it did not benefit the patients. An observational study from England examined a Mental Health Services data set from 2011–to 2015 of 69,832 patients with an OC decision [97]. The study concluded that the use of the OC scheme in England and Wales did not reduce future admissions or time spent in hospital, but reduced the mortality.

On the other hand, there are quantitative studies that have reached the opposite result. These studies show that the number of days in hospital is reduced [98, 99]. An Australian study compared patients with and without an OC decision between 2000 and 2010 [98]. This study showed that the OC scheme reduces the need for hospital stay for patients with major care requirements. Another study from the same research group included patients from the Australian National Death Index from 2000-to 2012 [99]. This study found that the OC scheme gave a lower mortality risk and protected health in a modest way.

A recently published register study from England and Wales, which followed all inpatients who had been discharged between November 2008 and May 2014, found that patients who had received an OC decision were more frequently readmitted sooner, but had lower mortality risk [100]. The study also highlighted the importance of robust community follow-up for discharge of a patients with an OC decision.

Another recently published review study examined the effect of the OC scheme, and believed that previously published articles which reported negative and/or no difference findings of OC have incorrectly compared interventions with outcome measures [101]. Segal believes that the OC scheme is a less intrusive measure than being hospitalized, and that the OC scheme indicates a reduction in threats to health and safety.

Studies with experiences

A couple of literature studies have examined patients' experiences with an OC decision [102, 103]. A literature review including studies from seven different western countries found that the patients' experiences of the OC scheme were related to the information they received and their relationship with the health personnel [102]. Another study found that patients' experience of living with an OC decision was affected by their relationship with their therapists [103]. This study found both positive and negative experiences. The positive experiences were related to prevention readmission and brought hope of recovery; the negative experiences included feeling controlled and a lack of information about the decision. Another survey study interviewed Canadian service users with an OC decision, and a control group who received voluntary treatment, about their views on whether an OC decision has the potential for a positive effect on the treatment and lives of individuals with mental illness [104]. The result showed that both groups thought that an OC decision in treatment could help to create positive affects for stability in the community for individuals with mental health issues.

One literature review including empirical studies from seven countries examined what experiences the health personnel have when planning the follow-up of patients with an OC decision [105]. This study referred to the importance of trust between patients and health personnel based on good communication and empathy.

1.4.2 Norwegian studies

Norwegian studies of experience in the use of OC were in short supply for many years, but this has changed in the last 10 years. Several Norwegian studies on OC have been published in recent years.

Extent of OC

Two quantitative studies of OC have been published with material collected from 6 health trusts in Norway [106, 107]. Both studies collected data from the electronic medical records of six health trusts in Norway. The studies show that the characteristics of the OC population in Norway are very similar to jurisdictions in other countries. The results showed there were more men than women (56.4% vs. 43.6%) and the main diagnosis was the schizophrenia spectrum (F20–29), with medication seeming to be the central focus of OC [106]. In addition, the first study found that patients had received an OC decision several times.

The median time spent on an OC decision was 425.5 days and the length of an OC decision varied from 1 week to 20 years [106]. The second study showed that the incidence of an OC decision varies from year to year, both in the number of decisions and between health trusts [107]. Besides, the study showed that inpatient stays were significantly reduced 3 years after an OC decision compared with the 3 years before the OC decision.

Patients` experiences

Several published studies were based on patients' own experiences with OC decisions [108, 109, 110, 111, 112]. The patients had different experiences, which showed both the advantages and the disadvantages of the OC scheme. One study from the patient's point of view showed that patients believed that they had no choice but to accept the OC decision. Moreover, they also believed that the OC decision could provide benefits, and that it was better to be patients in their own homes receiving an OC decision than to be inpatients [108].

Another study found that the patients accepted the OC decision because they believed that the alternative would be involuntary hospitalization, and they felt that they had little influence on or participation in their own treatment [109].

Many patients who are followed up by the ACT team have an OC decision. A study that interviewed several patients with OC decisions who got help from the ACT team showed that patients' perceptions of coercion are context dependent, and the relationship with the health personnel is of great importance [110].

Findings in a study of patients in ACT teams showed that patients with OC decisions reported a greater potential for recovery than those without an OC decision [111]. Another study of patients with an OC decision in ACT teams found that they had a higher degree of satisfaction with the services than other patients [112].

So far, only one study has been published about the relatives of patients with OC decisions. The study referred to the positive experience with the OC scheme that provided safety and ensured daily life functioning [113].

Health personnel's experiences

Health personnel's experiences with the OC scheme were complex [114,115,116,117]. A study about the health personnel's point of view showed that an OC decision was necessary to

safeguard the patient's long-term health, but it was difficult to balance the therapist's role in dealing with coercion [114].

Another study found that decision-makers viewed the OC scheme as a useful to ensure control, continuity and follow-up care in the treatment of outpatients with a history of poor treatment motivation, but they had little knowledge about how the scheme affected the patient's everyday life [115]. A study that interviewed ACT providers saw an OC decision as an opportunity to provide recovery and person-centred care, and long-term safety measures for some patients [116]. Another study that interviewed health personnel in the ACT team highlighted that they see an OC decision as a tool for achieving patient stability and safety, and that they could facilitate more nuanced assessment and reduce coercion [117].

Summary

Several of the studies, both international and national, have examined the effect of the OC scheme. Many international studies have examined whether an OC decision lead to improvement by measuring the effect of the OC scheme. Different issues and research methods are used and show different experiences with the OC scheme. Some studies show no evidence for outcome of the OC scheme whereas other studies claim that patients get a better quality of life and reduced morality. The OC scheme is a major intervention in a person's life so it is important to consider because it is unethical to implement if it does not have a significant effect.

Most of the Norwegian studies have focused on the experiences of patients, relatives and health personnel on how the OC decision works in everyday life. Patients felt that it was better to have an OC decision than to be hospitalized. Health personnel and relatives saw an OC as a measure to take care of patients and provide health care. Studies of patients with the OC scheme in ACT teams found that the OC scheme provided recovery.

However, it is difficult to compare Norwegian and international studies, because the countries have different structure, different laws and governance, and culture differences that lead to different practices.

2 Purpose of the study

The overall purpose of this PhD project is to conduct research to gain more knowledge about the OC scheme in Norway, but also reveal gaps in knowledge about this topic.

Patients with an OC decision live in their own homes, receive a decision on coercion from the specialist health service and many patients receive municipal health services simultaneously. Therefore, it is important to examine the content and quality of the follow-up the patients with the OC scheme receive. In addition it is important to find out what it actually entails, and whether it differs from the content of voluntary treatment.

Several studies, both international and national, have examined the effect of the OC scheme. Many international studies have examined whether an OC decision leads to improvement by measuring the effect of the OC scheme [11, 17, 94]. The OC scheme is a major ethical intervention in a person's life, so it is to consider the significant effect of the scheme as well [16]. However, some studies show no evidence for outcome of OC whereas other studies claim that patients get a better quality of life and reduced mortality [8, 97].

Nevertheless, it is only in recent years that there has been research on topic of the OC scheme in Norway. There are two Norwegian PhD projects that have examined the OC scheme from different perspectives [118,119]. These examined incidence, patient experiences, and experiences of relatives and health personnel. In addition, there are also two PhD projects that examined assertive community treatment (ACT) teams and the patients' experiences with the OC scheme as well [120,121]. All these studies have provided new knowledge and insights into the OC scheme.

Data from the Norwegian studies were collected before the change in the Mental Health Act in 2017, so there is a need for more studies to investigate how the change in the law has affected mental health care and the OC scheme as well. I believe that this PhD project is one of the first to examine this changes in the Mental Health Act in Norway. Therefore, this thesis also may be of international interest in jurisdictions with the OC scheme worldwide [2, 3].

To explore this topic, the PhD project consist of three sub-studies with both a descriptive and exploratory design [122].

2.1 Aim and research questions

Aim

To examine how OC in the Mental Health Act is carried out for those who receive and provide mental health services, by mapping the patient group, examining the follow-up of patients and assessing collaboration across service levels.

Research questions

1. What is the extent of OC and what are the characteristics of patients who have an OC decision in two counties in Norway?
2. What are the duties of the municipality's mental healthcare personnel in relation to patients who have an OC decision, and how do they collaborate on services for patients with OC decisions from the municipality's point of view?
3. What are the mental healthcare personnel's experiences with collaboration between municipalities and specialist health care, according to patients with an OC decision?

The results from the three sub-studies are presented in three scientific papers that answer these questions, and all three have been published in scientific review journals.

As a research fellow, I was the first author of all three studies.

3 Methods and material

The overall perspective in this PhD project is to examine how the health services is carried out in different situations with patients with the OC scheme. The health service research examines how a health service measure works for those patients who receive services and those who provide the service using different scientific methods [123,124]. Health service research includes both research on experiences of individuals and services levels using various research methods. The research is not rooted in one scientific tradition but has a pragmatic approach based on the individual project [123,124,125]. The complexity of health services makes the focus on health service research relevant to examine further.

3.1 Design – combined methods

Choices of scientific methods are based on ontology and epistemology, which is an assumption about what the world looks like and how we collect objective data about reality [126,127]. The methodological perspective in this project is pragmatism, and the methods used are either deductive or inductive [126]. A deductive method test theoretical ideas or concepts while an inductive method has an open approach [122]. Thus, the scientific perspective affects the choice of research questions and how the research is carried out. The purpose is to develop knowledge that is justified and documented using scientific methods [128].

The research design of this PhD project consist of three independent studies with, a pragmatic approach using both an inductive and a deductive approach inspired by mixed methods design [129]. The dominant pragmatic mixed methods design consists of various methods that are put together as building blocks into target research designs [130,131].

The three studies in this PhD project consist of two studies using the quantitative method and one study uses a qualitative method. The first sub-study has a register study with a descriptive and retrospective design. The second sub-study also has a descriptive design, with using a questionnaire. The third sub-study has a descriptive, exploratory design using focus group interviews. These designs were chosen to obtain patient data, and gain as much experience as

possible from the municipalities and the specialist health service in order to get an overview of how the health services for patients with the OC scheme work in practice.

3.1.1 Methodological point of view - pragmatism

The philosophical superstructure for mixed methods is pragmatism [128,132]. Mixed methods design combines several different methods in the same project [131]. Pragmatism is not rooted in one scientific tradition but has a pragmatic approach based on the individual project and the researcher uses different methods to obtain answers to the research questions [127,128]. Traditional quantitative research is characterized by a deductive methodology, in which objectivity and generalizability can show general connections, whereas the traditional qualitative approach is inductive and has a holistic and subjective approach that describes the context and peculiarities of a phenomenon [127,133].

By combining several different methods in one design provides an opportunity to illuminate a phenomenon from different perspectives and to achieve a more complete understanding of a complex issue and exploring practice [133]. The positive side of pragmatism is tolerance and openness in approaching a phenomenon [127]. In research in health sciences, it is appropriate to use combined methods because issues are often complex and multifaceted. Health services research examine society, systems, those who receive health services and those who provide services [123]. Healthcare providers consist of many different occupational groups that have different theoretical backgrounds, and a pragmatic approach can contribute to common understanding and cooperation. Combining different methods provides giving expanded understanding of a phenomenon [127].

This PhD project sheds light on issues related to the OC scheme in different ways. The structure of the PhD project is shown in Table 4. The studies have mapped the patient population and investigated follow-up and interaction around patients with OC using various research methods. All the sub-studies were conducted in the same geographical area attached to the same health trust, but the data were collected from three different populations. The three studies were conducted as independent studies and analysed separately. Finally in this thesis, the results from the studies are discussed together to shed light on this PhD project's main issue.

| Organization | Research questions | Sample | Data collection | Analyses published |
|---|--|--|-----------------|---|
| Sub-study 1 Research question 1 | What is the extent of OC and what are the characteristics of patients who have an OC decision in two counties in Norway? | All patients with OC during 2008–12 in two counties | Medical records | Quantitative analyses Paper 1 |
| Sub-study 2 Research question 2 | What are the duties of the municipality's mental healthcare personnel in relation to patients who have an OC decision, and how do they collaborate on services for patients with OC decisions from the municipality's point of view? | Healthcare professionals in 2 counties including 48 municipalities | Questionnaire | Quantitative analyses Paper 2 |
| Sub-study 3 Research question 3 | What are the mental healthcare personnel's experiences with collaboration between municipalities and specialist health care, according to patients with an OC decision? | Healthcare professionals in 2 counties including 48 municipalities | Focus groups | Qualitative analysis Paper 3 |

Table 4 The structure of the PhD project.

3.2 The studies

Data from each sub-study were collected separately. Sub-study 1 was conducted first, then sub-study 2 and finally sub-study 3. The studies were analysed as they were collected.

3.2.1 Recruitment and setting

The studies were conducted in the county of Innlandet consisting of the former counties of Hedmark and Oppland. The study involved all treatment facilities in the county with a county-wide population of approximately 400 000 people, covering a geographical area of approximately 52 000 km². It consisting of a total of 48 large and small municipalities in varied geographical size. In addition they consisted of both rural and urban municipalities where the smallest had fewer than 5000 citizens, and the largest had 35 000 citizens. All municipalities offer mental health services to their inhabitants, and in addition received health services from the Innlandet Hospital Trust during the period when data was collected. The health trust then includes two psychiatric hospitals and five DPC. Patients with an OC decision have contact with health personnel from both the specialist health service and the municipalities.

3.2.2 Sub- study 1, register study

The study collected data from patient records and has a descriptive and retrospective design, and includes all patients in the health trust, which include: age >18 years, being registered with an OC decision in the period 1 January 2008 to 31 December 2012, or having a valid OC decision made before 1 January 2008 that are still valid. The study included 139 patients who had received an OC decision at discharge from inpatient stays, constituting 0.8% of all patients admitted in the specialist health care during this period. It was possible to include all patient recorded with an OC decision.

The data collection was carried out from 2012 to 2015. All data were retrospectively retrieved from the hospital patient record system called DIPS. To collect data, a registration form was used consisting of 67 questions with different answer options. This form had two parts: A and B. Part A consisted of nine questions that were registered for all patients included in the study from 1 January 2008 to 31 December 2012. Part B was filled out only by patients who received an index OC decision during the period 1 January 2008 to 31 December 2009. A form was completed for each patient. The scope of the OC scheme and the basis for decisions were registered and the diagnosis that gave rise to the OC decision was reported. In the material for this study, diagnoses according to the diagnostic system ICD-10 were registered [71]. These data were almost complete. The follow-up and contact between patients and the specialist health service were also registered, but these data were somewhat deficient.

The network for research and knowledge development in Norway took the initiative to develop the form for collecting data on Norwegian OC patients [39]. The PhD candidate, together with two of the co-authors in sub-study 1, participated in the preparation of the first draft of the registration form and codebook. This form has since been further developed and a newer version was used to collect similar data from several health trusts in Norway.

The material was analysed with descriptive quantitative analysis with frequency analysis and cross-table analysis [134]. The data were first examined by frequency analysis, which examines one variable, whereas cross-table analysis examines the relationships between variables [134,135]. To examine statistical correlations for the cross-table analyses, Pearson Chi-Square test was performed with a significance level ≤ 0.05 [136]. To ensure anonymity and privacy, two co-authors had access to the patient records system DIPS, and extracted the data and recorded them on the forms. A form was completed for each patient. The data were then transferred to code form in Statistical Package for Social Sciences, version 18.0 (SPSS,

Chicago, IL, USA) [134,137] by the first author. The data entered in SPSS were then checked, and also checked against paper versions of the forms. The results were visualized using tables and figures.

3.2.3 Sub-study 2, questionnaire

The study collected data from health personnel in the municipalities using questionnaire. All 48 municipalities in the health trust's admission area were invited to participate in the study. The leaders responsible for mental health care in the municipalities were contacted although it was difficult to find them in some municipalities. They were essential to facilitate contact with the health personal in the mental health teams. The first enquiry was made via email with a thorough description of the study. Several municipalities answered the emails and others were contacted by telephone as well.

All the municipalities that received the invitation responded to the enquiry. The majority said yes to participate in the study. Those who said no reasoned that the employees had a large workload, so they could not prioritize participating in the study. A minority said that they did not have patients with psychosis or OC in their municipality.

The target group that was recruited for sub-study 2 was health personnel employed in municipalities in the health trust's area of responsibility. Only employees in the municipality who had experience with patients with psychosis, both with and without OC decisions, were included.

The number of employees in the mental health teams varied according to the inhabitants of the municipality. Large municipalities had up to 16 employees with different functions, whereas several of the smallest municipalities had only 2 employees.

The leaders in the municipalities were asked to send the email addresses of those who were appropriate for participation in the study (Table 5). We wanted to bring out as many experiences as possible in the study catchment area.

The questionnaire was sent out three times first: in week 47 in 2017, a reminder in early January 2018 and then a final reminder at the end of January 2018; 84 people answered the form, which gave a response rate of 37%.

A questionnaire collects allows a large amount of data over a relatively short period.

Through a questionnaire, you can shed light on many topics without it being too time-consuming to answer. A questionnaire requires good preparation and there are many aspects that must be clarified before it can be used [138]. The design of the questions is vitally important for the results. The questions must be designed so that their intersubjectivity is based on a common understanding behind the words and terms used in the questions [128].

| Participants | Included municipalities | Municipalities participated | No. of emails |
|----------------|-------------------------|-----------------------------|---------------|
| Oppland County | 26 | 23 | 120 |
| Hedmark County | 22 | 16 | 110 |
| Total | 48 | 39 | 230 |

Table 5 Number of participants included in sub-study 2

The questionnaire in sub-study 2 examines the role of municipality health personnel in the follow-up and interaction with patients who have OC decisions. The questions were based on tasks that are described for health personnel in the authorities' guidelines for mental health work such as the national guidelines: *People with severe mental illness who need facilitated care* and *Assessment, treatment and monitoring of people with psychotic disorder* [24, 58]. The questions in the questionnaire were also designed to provide an opportunity for further exploration of the findings from sub-study 1.

The development of the questions was done in collaboration with the co-authors of the paper and an expert by experience who participated in data collection and analysis. The form consisted of 41 questions with different checkout options. Some of the questions provided an opportunity to elaborate on the answers with comments. A draft of the questionnaire was discussed with colleagues researching the same topic. In addition, a pilot of the questionnaire was conducted in autumn 2017 with the health personnel at a DPC who had experience of patients with OC decisions. Three people filled out the form, which took approximately 20 minutes. The form was adjusted according to the input. The questionnaire was sent out electronically from our research department, and the answers from the participants went straight into a research server.

In sub-study 2, statistical analyses were carried out using the SPSS version 25 [137]. The distribution of all the data was visually inspected. Data were generally skewed.

The statistical analyses were described using frequency analysis and median and range.

This study compared the patient groups with OC decisions with the patient group with psychosis disorders using cross-analysis, correlation analysis (Pearson's r) and non-parametric Wilcoxon's test ($P \leq 0.05$). Wilcoxon's test was chosen to compare the services provided to patients with and without OC decisions [136].

The open-ended questions were analysed by adapted qualitative content analysis, with a view to finding categories [139]. The results were visualized using tables and figures.

3.2.4 Sub-study 3, focus groups

This study included health personnel who had experience with patients with OC decisions. The target group was health personnel who worked in the specialist health service and in staffed housing in the municipalities with patients with an OC decision.

The data were to be collected using focus group interviews. Four focus groups were planned, with six participants invited to each group. Three DPCs and three municipalities were selected in consultation with an expert by experience and invited participants were from DPCs, both outpatient clinics and departments, and employees of cooperatives in municipalities.

Local leaders were asked to select participants for the interviews based on the information they had been sent. The DPCs wanted to include both psychiatrists and psychiatric nurses. The conduct of the interviews had to be adapted to operations at the various locations, and it was difficult to find time for the interviews, in relation both to internal operations, routines and organization, and to when the psychiatrists had the opportunity to participate. The municipalities gave feedback that the health personnel found it difficult to participate in the same focus group within the same municipality, because the housing for patients had low staff levels. Therefore, all three municipalities were invited to participate in the same focus group. Each municipality was asked to find two relevant participants from each housing association.

All four focus groups were carried out between March 2018 and April 2018. The interviews were conducted with 12 health personnel from DPCs and the municipalities, most of whom were women. The health personnel represented municipal housing, wards and DPCs, and consisted of psychiatrists and psychiatric nurses. They all had several years of experience with OC.

The third sub-study explored the health personnel's experiences of following up and interacting with patients with an OC decision. To capture these experiences, a qualitative method was chosen, because the method is suitable for examining experiences, practices and phenomena in different contexts [140]. A focus group interview collects data from several people at the same time and is an open-ended group discussion on a specific topic [141].

An interview guide was developed with six open-ended questions to obtain answers to the research questions. The questions were prepared in collaboration with the co-authors of the sub-study. The questions were also assessed by the expert by experience who participated in the focus group interviews as co-moderator.

The analysis in sub-study 3 followed the steps in qualitative content analysis inspired by Graneheim and Lundman [142]. Qualitative content analyses does not belong to a particular scientific tradition, but has a pragmatic approach [142,143]. The content analyses focus on subject and context, and emphasize variation and similarities within and differences between parts of the text [139]. The text was read through several times to obtain a sense of all the material. Meaningful units were identified and each meaningful unit was condensed into a description close to the text and given a code. The analysis at different abstraction levels identified three categories, each of which had four subcategories. Finally, based on the latent content of the categories, the underlying meaning was formulated into a theme. Meaningful units that belonged together were grouped into themes, categories and subcategories.

3.3 Pre-understanding

My experience with the use of coercion is based on my work as a psychiatric nurse with patients with OC decisions and patients who had their decisions revoked, both in their homes and as inpatients in the specialist health service. The majority of patients had a diagnosis of schizophrenia or another long-term psychotic disorder. Many patients refused health care even though they had psychotic symptoms, isolated themselves at home and had lost contact with working life and their social network. I experienced that many of the patients did not want contact with their family or health personnel when they had severe psychotic symptoms.

In my practice as a psychiatric nurse I have met relatives who were concerned about the patient's condition. In addition, I have experienced challenges in collaboration with municipalities where the patients lived. Furthermore, I experienced differences in the

organization of the services and available resources in the municipalities, and the patients received different follow-up after discharge even though they had the same health problems.

3.4 Ethical considerations

All the data collected in the PhD project have followed research ethics guidelines and received ethical approval to ensure that research is carried out in an ethically sound manner [144]. In this PhD project, three different research and data collection methods were used, and these methods have different scientific roots. This means that each project has had an individual assessment of the research ethics approach to assess the need for ethical approval and consent.

In sub-study 1, an application was made for an exemption from consent approval for individual patients. The completed registration forms were coded and de-identified, and forms and code lists were locked down and stored separately. All participation in the sub-studies 2 and 3 was voluntary, and all the participants gave informed consent and the data were anonymized. All participation in the study were health personnel who were asked about their professional everyday life. The emails in sub-study 2 were forwarded to the research support department at Innlandet Hospital Trust, which sent the questionnaire out electronically. This method was chosen to ensure the anonymity of the study participants, and their answers were stored on the research server at the hospital. In sub-study 3 a written information and consent forms were sent out to the participants who were due to take part in the interviews. Before the focus interview started, the participants confirmed that they had been informed in advance, and consent forms were signed before the interviews started.

The work with the papers connected to the PhD project followed the World Health Organization's guidelines and the Declaration of Helsinki [145,146].

To ensure safe storage of data, all the data in this PhD project were stored on a secure research server at Innlandet Hospital Trust.

The PhD project followed the ethical rules for data collection according to the Health Research Act [145]. All the data used have received research ethics approval from REK (Regional committees for medical and health research ethics; sub-study 1), REK nord (2010/2268) or NSD (the Data Protection Services in Norway), sub-study 2 (project number 54290) and sub-study 3 (project number 54144).

4 Results

The purpose of this PhD project was to gain more knowledge and experience of OC in mental health care in two counties in Norway from a healthcare perspective. The results showed the extent of OC decisions and what services the patients receive, and investigated the experience of cooperation between health personnel in the specialist health service and the municipalities.

4.1 Paper 1

This study had a quantitative descriptive and retrospective design. The study examined patient records including all patients in the years 2008-2012 with OC decisions in two counties in Norway.

Aims

The purpose of this study was to gain knowledge about patients who undergo OC. The study explored the incidence and prevalence of OC in a geographical area, the central characteristics of the patients and how the framework for follow-up treatment for patients to resolve OC worked.

Results

The search for data (2008-2012) resulted in 139 inpatient records that fulfilled the criteria for part A: 31 of these records also fulfilled the criteria for part B. Of the patients, 73% had a schizophrenic spectrum diagnosis and 36% also had a substance abuse problem. Most patients had been mentally ill for many years before the OC decision. The main finding in this study was that the use of OC increased from a total of 51 people with OC decisions in 2008 to 71 people with OC decisions in 2012. Most patients had received treatment in mental health care for 10 years before they received their first OC resolution. An important find is that 74% of the patients have a decision made for OC that is justified by the treatment criterion.

Patients with OC decisions received services from both the specialist health service and the municipality at the same time, and 71 % had a contact person in the hospital named in the patient record. However, there was insufficient documentation on statutory responsibilities for follow-up treatment of OC patients. Only 36% had an available IP in the patient journal.

Conclusion

This study showed that the use of OC has increased and that there is insufficient documentation on statutory responsibilities for the follow-up treatment of OC patients. It revealed shortcomings in central guidance from the authorities for what should be included in the treatment criteria for OC. The criteria in the legislation are vague and should be clarified. It should also be considered whether the implemented measures for reducing the use of coercion have the desired effect.

4.2 Paper 2

This study had a quantitative descriptive design using an electronic questionnaire sent to mental health personnel in the participating municipalities. The study included health personnel from the mental health services in two counties in Norway who have experience with psychosis and OC decisions.

Aim

The aim of the study was to gain more knowledge about how the system with OC works from the municipality's point of view. The study investigated which tasks the health personnel in the mental health service in the municipality perform in relation to patients with psychosis and/or OC decisions, what knowledge they have about the OC scheme, and how they interacted with DPCs and mental hospitals from a municipality's perspective.

Results

There were 230 people who received the questionnaire. The sample consisted of various mental health personnel, mostly nurses, from both small and large municipalities. The health personnel response rate was 37%. The results showed which tasks the health personnel had in follow-up of patients in the municipalities. The findings showed no significant differences between patients with and without an OC decision in relation to follow-up given by the health personnel in the municipality, apart from conversations about medication ($p=0,018$). There were fewer patients who had a conversation about medication in the OC group. About half the mental health personnel lacked knowledge about the OC law. In addition, they lacked information about the contact person in the specialist health service and IP. Moreover, most of the health personnel lacked education about the latest legislative amendment on the assessment of consent competence.

Conclusion

This study investigated how OC works from the municipal health personnel's point of view. The mental health personnel in the municipalities lacked information about the basis of the OC decisions, and experienced challenges in collaborating with the mental specialist health service. The IP was rarely used and worked only to a varying degree as a collaborative tool, although it is a statutory right for patients with OC decisions and a legal right in the Mental Health Act for patients with an OC decision. Mental health personnel in municipalities experienced challenges in collaboration between mental health services in the municipalities and specialist mental health services

4.3 Paper 3

This qualitative study collected data through focus group interviews with health personnel from both the municipal and the specialist health services. All of the included health personnel had education and experience working with patients with OC decision.

Aim

The aim of the study was to gain more knowledge about how the OC scheme works in the municipal health service and specialist health service, and how the health personnel collaborated with patients and across service levels from the perspective of health personnel.

Results

The results described the health personnel's experiences with follow-up and their interactions with patients with OC decisions. A process of reflection and discussion resulted in one theme, three categories and several subcategories (Table 6).

The theme based on the underlying meaning of the data indicated in the meeting between the health personnel and the patients, and across service levels. The health personnel believed that the OC scheme makes a difference. The follow-up of patients with an OC decision was extensive. The health personnel tended to give patients within the OC scheme more time and closer contact than given to other patients.

The first category presented health personnel's experiences with the use of OC. The second category disclosed how the therapeutic relationships with the OC patients worked. The third category dealt with their experiences with collaboration between hospital and municipality.

| Theme | Categories | Subcategories |
|-----------------------|---|--|
| | A framework for follow-up of OC | <ul style="list-style-type: none"> • OC is a statutory duty • Legislative amendment of consent competence makes the OC decision more demanding • OC provides the opportunity to provide assistance • OC gives responsibility to the healthcare service |
| OC makes a difference | Provides flexibility in cooperation with the patient | <ul style="list-style-type: none"> • Predictability creates security • Provides more help than the law requires • Implementation of OC depends on continuity • The dilemma of helping someone who does not want help |
| | The collaboration between the service levels is vaguely defined | <ul style="list-style-type: none"> • Cooperation between municipalities and specialist health services is characterized by coincidence • The IP does not work as a collaborative tool • Collaboration is developed through good meetings • The municipalities are experiencing an increased burden |

Table 6 Overview of the theme, categories and subcategories from analyses of the interviews

Conclusion

The health personnel believed that an OC decision made a difference in how patients with this decision were followed up. They believed that the OC decision gave the patient rights and opportunities for the provision of mental health care. The legislative amendment with new requirements for consent competence was a problem. To make an OC decision was described as more demanding because consent competence could fluctuate along with the psychotic symptoms. Although the change strengthened patient rights, there was also a risk that such patients did not receive adequate health care. The present study pointed to the challenges related to collaboration across service levels. Good routines for collaboration across the service levels for patients with an OC decision were lacking. The IP, which is a statutory collaboration plan, was not used much.

5 Discussion

The main issue for this PhD project has been to explore how the OC scheme works from a mental health service perspective based on Norwegian conditions. The PhD project shows a clear coherence across all three sub-studies, as the three studies together provided a complementary picture of the follow-up of patients with the OC form in one geographical area. The study describes the patient group that receives OC decisions, which mental services they receive from the specialist and municipal health services, how the services collaborate and statutory regulation. Patients with an OC decision have mostly a schizophrenia disorder and live in their own municipality. The patients in this PhD project received parallel mental health services from both specialist health services and their municipality, whereas they receive compulsory decisions from the specialist health services. However, some of the patients lacked information about their contact person. The study found a lack of knowledge about the OC scheme among the health personnel in the municipalities. However, they treated all patients equally except from having fewer conversations about medication with the OC patients. Nevertheless, the health personnel in the specialist health services and municipal housing followed up patients with OC more closely than other patients. However, the new legislation in the Mental Health Act of 2017, has changed their practice with the OC scheme. The findings also point to ethical dilemmas concerning the OC scheme.

All three sub-studies examined the use of the IP. These findings showed that an IP was rarely used. As this document describes, many laws and guidelines have been prepared for the provision of health services in Norway, but the results of this PhD project indicate that not all recommendations and regulations are followed up as intended.

5.1 Challenges across service levels

Collaboration is essential in mental health care [26,37]. This study confirms that patients with OC decisions receive mental health services from both the specialist and the municipal health services at the same time (sub-studies 1, 2 and 3). The findings show that the flow of information from the specialist health service to the municipal health service is often deficient (sub-study 1 and 2). This may affect and have consequences for the follow-up of patients with OC decisions, because essential information does not reach the health personnel in the municipality. In addition, there may be a risk of incorrect information being disseminated to

patients and relatives. Therefore, it is important to receive all relevant information about the patient to be able to provide adapted knowledge-based practice [28, 125].

The study have also found challenges in exchange of experience. These challenges are also common in other western countries. A literature review with seven western countries found that collaboration around patients with complex needs is demanding because different health personnel assess situations differently [147]. Another study found that successful communication across inpatient and outpatient patient health care, depends on close collaboration between health personnel in the specialist health service and the municipality [148].

The health personnel in the municipality in this study lacked information about the rationale for the OC decision. There might be a lack of good routines for exchanging and exchanging thoughts and experiences. This is worrying, because it is important that health personnel have information about the background for the OC decision to be able to provide mental health care and give relevant information to the patient and their relatives.

Another finding in this PhD project (sub-studies 1 and 2) is that the contact person scheme does not function as it was intended in the law, because most patients lacked the name of such a contact person in their medical records and information about the contact person was not provided. A contact person must be known to the patient, the relatives, and the specialist and municipal health services according to the law appointed in connection with the OC decision [1, 19]. Nevertheless, health personnel in the municipalities replied that they did not receive information about who this person was. This means that for some patients with OC decisions the law has not been followed. This can lead to uncertainty and unresolved responsibilities if the patient's situation changes despite legal regulations [1, 19, 55]. It is surprising and worrying that such an important function is not implemented in practice.

Another finding in this PhD study (sub-study 2) is that mental health personnel in the municipalities lacked knowledge about the OC scheme. It is important that health personnel in the municipalities have updated knowledge about the Mental Health Act, because lack of knowledge can lead to incorrect information being given to patients and relatives [1,19,55]. On the other hand this can lead to misunderstanding about the collaboration between the municipality and specialist health services because they do not know the law well enough. Both employers and all health personnel have a responsibility to act in accordance with the

health laws and initiate evidence-based practice in accordance with the laws [28, 63]. Lack of such knowledge is worrying. However sub-study 2 showed that the municipalities are of different sizes, and it might be too demanding for some municipalities to implement teaching of this topic on their own. Possibly the specialist and municipal health services could work together to take care of this. Thus, developing forms of collaboration may be necessary too.

However, the different levels have different functions and tasks, and it is essential that health personnel use the recommendations given in legislation and guides to follow-up of patients [1, 19, 26, 47, 51]. Nevertheless, there are two systems that provide mental health services to the same patient group, although the municipal health service is not involved in the assessment process or the reasoning behind the OC decisions [1, 19]. However, several guidelines have been prepared for follow up of patients with complicated and complex problems both in the specialist healthcare, in the municipalities and in collaboration between them [26, 47, 51]. Because, collaboration is for this reason very important to adapt mental health care to each patient.

Duty of confidentiality, different legislation and medical record systems between the municipality and the specialist health service may present challenges in the flow of information [1, 19, 55, 63]. This may indicate that Norwegian health services, despite laws and guidelines, face challenges in the provision of the services. The Norwegian organization of mental health itself contributes to collaboration problems because the services are offered with different laws for the same patient. Nevertheless, a shared responsibility for mental health treatment presupposes that the municipalities receive the necessary information from the specialist health service. However, previous health service surveys in Norway have shown challenges in collaboration between the municipalities and the specialist health service [32].

5.1.1 IP as a collaborative tool

This PhD project (sub-studies 1,2 and 3) has found that the IP is a tool that is rarely used, even though this is a statutory patient right in the Mental Health Act for patients with OC decisions [1, 55]. Lack of an IP affects the possibility of user participation, and this is worrying. User participation is important for the patients' ability to achieve improvement by being able to actively participate in designing their own treatment plan [55]. All treatment of patients must support the patient's control of their own health. One study of patients found that an individual action plan could empower patients` during compulsory treatment and

improve their experience of care [149]. Thus, user participation in writing such a plan, can also prevent traumatic situations where compulsory treatment is to be implemented [56].

On one hand, legislation and guidelines refer to the interaction and use of an IP as an important measure and opportunity to collaborate for the patient and their network [26, 56]. Experience from England shows that co-ordinated planned care is of great importance for the quality of life for patients with long standing care with multiple and complex needs [150].

On the other hand, an IP is also an important tool that may have socioeconomic benefits in that it provides more ‘seamless’ and more effective treatment [56]. IP provides plans for follow-up and documentation of this. A shortage of IPs can lead to poor interaction, communication and continuity in the service across service levels and give patients inadequate follow-up. Therefore, an IP is an important tool to be able to provide adequate treatment and follow-up with real patient involvement and genuine patient involvement in their own care plans [56, 150].

However, there is no national standardized form for the IP design in Norway. Possibly an IP is too difficult to use as described in the laws and guidelines, or the IP scheme needs to be evaluated to make it more user friendly. In this PhD project, it was a problem that patients' mental state could make them unable to participate in the making of the IP.

If all patients with OC decisions had an IP with a crisis plan, the plan could ensure predictable follow-up description of the services and what to do in case of relapse, even after the OC decision has been revoked [1,25,35]. Evidence shows that involuntary admissions can be prevented by the use of a crisis plan [151]. A study of OC from England and Wales, described a treatment plan being part of the OC decision [152]. However, different countries organize health services differently and have different laws for the use of coercion, so it is not easy to compare how services work across countries [93]. However, experience from other countries can inspire further development of the use of an IP in Norway.

5.2 Content in the follow-up of OC

Patients with the OC scheme in this study receive health services in the follow- up from both the municipality and the specialist health service (sub-studies 1, 2 and 3). However,

municipalities and the specialist health service represent different levels of mental health care and has different legislation [1,19, 55, 64]. Most of the patients with an OC decision had a psychotic disorders and a third of the patients had substance abuse problems as well (sub-study 1). The same patient population as has been found in international studies, despite some differences in legislation [4, 100]. Although, most patients in this PhD project (sub-study 1) had mental health issues and contact with specialist mental health care for more than 10 years before they received their first OC decision. The same findings are found internationally of patients with the OC scheme, who have had a history of none adherence and multiple admissions [4]. Nevertheless, in this sense, an OC decision is not something that is implemented before other measures have been tried, as required by the Norwegian Mental Health Act. Nonetheless, several studies have found that patients who receive coercive measures often have many associated problems over time and a wide-ranging need for specialized mental health care [100, 153].

However, most of the patients (sub-study 1) have had ordinary services as recommended in national guidelines for 10 years. This indicates that the ordinary offer may not be sufficient without more specialized mental health care to these patients. The OC scheme can provided a position for taking action on a patient's health, considering their needs based on the Mental Health Act's criteria, even if the patient rejects help [117]. Although, sub-studies 2 and 3 have investigated how health personnel in the municipalities and the specialist health service follow up patients and interact with each other from different perspectives. In sub-study 2, data was collected from health personnel who worked in mental health services on how they followed up patients with OC decisions in their homes. The response was that they mainly treated all patients equally, but fewer patients with OC decisions had a conversation about medication. This is an interesting finding because it may be that health personnel do not address this issue to the patient, or the patients with OC decisions avoid discussing the use of medication. On one hand, it is important that health personnel inform and observe any side effects of medications. On the other, hand this becomes difficult without counselling the patients about medications. According to the Mental Health Act, the municipality is not directly involved in the OC decision although medication may be a part of the OC decision. Even so, it is important that health personnel inform and observe any side effects of the medications because it is important in evaluation of an OC decision with medication measures. The patient may have side effects or have stopped taking medication [74, 154]. However, it is difficult to medicate without talking about medication.

Nevertheless, the fact that patients with psychosis in the municipalities receive almost the same follow-up for their health challenges regardless of the OC scheme, provides predictability in the service. In addition, it ensures that all patients have equal access to services in the municipality regardless of an OC decision.

In sub-study 3, health personnel in municipal housing and DPCs were asked how they followed up patients with an OC decision. They replied that they followed-up these patients differently from other patients. Although, the specialist health service responded (Sub-study 3) that they have statutory responsibility for patients with the OC scheme, and emphasized that the individual follow-up of patients with OC decisions was facilitated by the patient's needs [1, 19, 55]. In addition, follow-up and interaction of patients with OC decisions also result in ethically challenging situations, where the patient rejects mental health care. Therefore, it is important that mental health personnel have the competence to follow up the patients' needs even if the patient is ambivalent.

Nevertheless, no national guidelines besides the Mental Health Act have been written for what measures should be implemented to follow-up patients with an OC decision. Despite that there are national guidelines for monitoring psychotic disorders, but these do not mention patients with the OC scheme explicitly [57, 58]. Nonetheless, the guidelines emphasize conditions and continuity with the user as key factors in achieving an alliance between health personnel and patients. Although, there are several studies mentioning this [110, 149].

However, the specialist health service has the main responsibility for the follow-up of the OC patients because they are responsible for the OC decision (sub-study 3). Some of the interviewees suggested that the specialist health service should have a primary responsibility for all follow-ups of patients with OC decisions, in addition to making the decision. They claimed that such an organization of the OC scheme could ensure equal practice of the law for all patients to ensure quality for patients, relatives and health personnel. Such a proposal will involve a change of several laws [1,19,55, 64]. On one hand, for small municipalities with few resources and few employees, it can be demanding to take care of patients with extensive needs. On the other hand, such a proposal may ensure that patients receive the same follow-up regardless of which municipality they live in.

Nevertheless, the follow-up of patients with an OC decision has an impact on their quality of life. Several international studies point to the importance of frameworks around patients with

an OC decision for follow-up, improving the quality of life and reducing premature deaths [8,94,104]. Norwegian studies by the ACT team have found that systematic follow-up of patients with the OC scheme across systems in a given framework facilitate an increased recovery and improvement processes for the patients [111,112]. Although, the OC scheme is an interventionist measure, it is important to provide content in the follow-up to ensure patients' mental health care without the use of coercion. Therefore active user involvement can provide measures that could prevent the need for an OC decision.

However, the OC scheme is important to help improve processes. The use of the OC scheme in treatment could help create a framework for achieving a position that can provide a closer and targeted follow-up of patients [104,149]. A recent study from England and Wales, which followed all hospitalized patients with compulsory post-discharge, found that there was a lower mortality rate among patients who received an OC decision at discharge than among those who had their compulsory decision revoked at discharge [100]. In this sense, the OC scheme can be a measure that ensures follow-up and mental care for those with severe mental disorders.

5.3 The OC scheme

The OC scheme take care of people who lack autonomy to take care of their own mental health. The common legal concern is need for treatment and/or danger to the patient or others, or preventive measures [4]. Several studies found that there is no difference in symptoms between patients with and those without OC decisions; which could justify the use of the OC scheme in the treatment approach [11,16,94]. However, other studies claim the opposite. Several studies, both national and international, point out that the OC scheme prevents hospitalization, provides a better quality of life and prevents premature death [101,103,108,112].

Nevertheless, the purpose of the regulation is the same although the laws are adapted to different countries with different structure, culture, laws and governance. The OC scheme balances ethically between care and control of the patient [91,114]. In Norway, the purpose of the law is to ensure the establishment and implementation of mental health care, human rights and basic principles of legal certainty [1, 19].

5.3.1 Legal experiences

An important finding in this PhD project (sub-study 3) is that the change in the condition for making an OC decision and requirements for competence to consent in the Mental Health Act has led to changes in the practice of the OC scheme [1]. The psychiatrists who participated in the focus groups (sub-study 3) felt that they had changed their own practice in assessing OC decisions by spending more time and documenting more thoroughly than previously. As such, this amendment strengthened the rationale for an OC decision.

However, in sub-study 3 the problem has been raised that consent competence can be difficult to assess when the patient has an active psychosis [66]. It may result in some patients with active psychosis not receiving an OC decision, whereas others may receive a decision on wrong terms. Both these situations can cause patients to suffer unnecessarily.

Assessment of competence to consent after the 2017 amendment to the Mental Health Act, has strengthened patient rights by safeguarding the right to self-determination and legal certainty. Nevertheless, the change in the law has given health personnel new challenges in assessing OC decisions. This means that patients who have consent competence have autonomy to end treatment, even if health personnel may believe that the patient needs further treatment. In some situations in which the patient is clearly confused, lacks consent competence or does not understand their health hazard, it may be legitimate to use coercion. Nevertheless, in such situations the patient must be treated humanely, and with respect to safeguard the patient's dignity [34, 55]. If the patient is unable to participate actively in co-determination, the family or relatives can represent the patient's wishes. Therefore, it is important that health personnel involve relatives in order to also safeguard patients' rights. Nevertheless, if the patient has expressed treatment wishes when they are competent to give consent, it is important to take this into account. Therefore, an IP with a crisis plan can be a useful tool for promoting advance treatment wishes [56, 65]. However, the wishes must be feasible according to recognized treatment methods [22].

However, increased emphasis on consent competence has changed the case law for patients with the OC scheme and strengthened their legal rights. There is currently no published research on how these changes affect practice, although, in February 2020, the Norwegian Directorate of Health published a report (IS-2888) of the experiences to date [38]. This report shows that there has been a decline in the use of OC in Norway since the change in the law in 2017.

Nevertheless, the Norwegian legal system has received several cases for assessment of competence to consent since the changes. Several patients with OC decisions have appealed their decisions in the courts. The change in consent competence has given patients an increased right to self-determination [55]. In 2018, three Supreme Court rulings were handed down on consent competence [76]. In two of the judgments, the patients' complaints were not upheld due to the risk of aggravation and the danger criterion. But in one of the cases, the patient had the OC decision revoked by the Supreme Court, even though the patient was not considered to be competent to give consent [76]. The patient had the OC decision revoked because the patient had been given maintenance depot injections for 5 years. The rationale behind this was that the patient had had close follow-up within a good framework. This judgment emphasized the importance of a good framework for follow-up of patients with OC decisions, and the judgment suggests that this follow-up may be a substitute for using coercive in the future.

However, this judgment indicates that the organization and framework for follow-up of patients have consequences for practice. The judgment can be interpreted so that follow-up by health personnel is significant and can replace coercion. This judgment may lead to changes in practice, by emphasizing autonomy, user intervention and prevention as a stronger approach to follow-up and treatment. The focus in Norway on reducing the use of unnecessary coercion is high [37]. Follow-up and frameworks around patients are important for the assessment of the OC scheme.

Nevertheless, the legislation makes the coercion legal and "visible". One purpose of amending the Mental Health Act in 2017 was to strengthen patients' rights by emphasizing consent competence in the assessment of the use of coercion [1]. This makes the OC scheme predictable, and a decision that is regulated by law is a formal coercion that gives the patient legal certainty [22].

However, an important part of the Mental Health Act also contains regulations to control the decisions and that the law is followed. The Mental Health Law is controlled by government-appointed control commissions [1,19]. This is a strength for the patient's rights and the Norwegian Mental Health Act. The Control Commission controls the basis for the coercive decision and the IP plan for follow-up, and they also handle appeals on the OC decisions from patients` [1]. This has been a part of the Mental Health Act since 1961 [75]. However, the functioning of the law presupposes that health personnel have in-depth knowledge of the law.

Nevertheless, patients can also appeal decisions to the Control Commission. This strengthens the user participation and patient rights, and is a strength of the Norwegian Mental Health Act.

5.3.2 Ethical challenges

The use of the OC scheme creates ethically challenging situations that involves patients, relatives and health personnel in various ways. It is a challenge that patients with an OC decision are deprived of responsibility for their own mental health even if they live in their own home (sub-study 1). Situations may arise where the patient may feel violated. In spite of that, it is important how health personnel meet patients with mental health challenges in situations where coercion is used. Their approach possibly enhances the patient's experience of violation. Health personnel's attitudes and actions are very important in a patient's experience of coercion [153]. However, it is important that the health personnel have up-to-date knowledge about the OC scheme. Therefore, it is ethical worrying that some health personnel lack such knowledge (sub-study 2). To handle situations within the OC scheme, it presupposes that health personnel have knowledge of the law and take ethical considerations into account.

In addition, the mental health status of patients is also a challenge. Patients with OC decisions in this PhD project (sub-study 1) had a psychotic disorder, and a third of the patients with psychotic symptoms also had challenges with drug abuse. These are common challenges for patients with an OC decision because some have serve symptoms who make their capacity for autonomy reduced [66, 70]. In these situations, it is important that health personnel meet patients with knowledge, dignity and a respectful manner.

However, in situations where the patient lacks the ability to consent and voluntary treatment is not possible and the patient makes unfortunate choices that could harm their own health, the health personnel must take control of the situation. One dilemma in this PhD project (sub-study 3) has been the challenge in helping a person who may show strong psychosis symptoms, but rejects health care. In such situations the patients lack insight into their own situation, and they can refuse health care even if relatives and health personnel believe that they need help [82]. Nevertheless, in these situations, health personnel must provide paternalism, to prevent the patient from harming themselves [78, 81].

However, these situation are challenging for health personnel to deal with. The use of coercion against a person is a serious intervention, so it is important to provide health care without the use of coercion when possible. In general, the negative effects of the OC scheme on the patient's autonomy, integrity and well-being must be assessed.

However, an OC decision usually means that the patient receives antipsychotic medication [73]. All the patients in sub-study 1 used antipsychotic medication. In recent years, there has been much criticism of the use of medication in the treatment of psychotic disorders.

Antipsychotic drugs reduce the acute symptoms of psychosis, but they also cause possible side effects related to the long-term efficacy the physical health of the users [77].

However, if the patient opposes medication, an additional decision can be made of compulsory medication, where it is given by force [1]. Such a situation can be traumatic for the patient. At the same, this raises ethical dilemmas, because it can inflict new health challenges to the patient and it must be considered whether coercive treatment may violate or cause further harm to the person [22].

Even so, several studies have discussed the long-term efficacy of antipsychotic medications and the possible side effects [154,155]. Moreover, conversations about medication between patient and health personnel is important. Nevertheless, the lack of conversations about medication (sub-study 2) between patient and health personnel in the municipality is ethically worrying. This may indicate (sub-study 2) that the responsibility between the municipality and the specialist health service is somewhat unclear. Therefore, it is important to clarify the roles between health personnel in the municipality and the specialist health service when following up daily medication to the patient.

Experience shows that an OC decision is a measure to provide care and treatment, may prevent death and give the patient a better life [99,104,112]. At the same time, the health personnel must accept that people want to live their lives marginally. In these situations, it can be ethically demanding for health personnel to experience patients who refuse help and expose themselves to health risks. This challenges health personnel to find other ways of providing health care in their own practice [78].

6 Methodological considerations

In this PhD project, both quantitative and qualitative methods were used. Choosing different research methods to investigate the OC scheme, provides an opportunity to investigate the phenomenon from different perspectives. The qualitative method is concerned with understanding, whereas the quantitative method is concerned with explaining [133].

The PhD project collected data from patient journals, questionnaires and focus group interviews to illuminate the aim and issues in different ways with accepted research methods in all three sub-studies.

The different research methods represent two different scientific directions, and use different approaches and requirements for assessing the validity of the results. Quantitative studies strengthen the validity and reliability of the data by looking at the measurement quality and the possibility of repeating the study with similar results [140].

Qualitative research validates the findings by looking critically at the implementation of the study and the researcher's interpretations [156]. When interpreting qualitative research, the credibility and integrity of the studies are assessed through reflexivity [157]. Reflexivity is a competence and a researcher position that enables the researcher to see the importance of their own role in the interaction with the participants, the empirical data and the theoretical perspectives; the understanding that the researcher brings to the project could affect the researcher's reflexivity [144]. The methods of progress in all three sub-studies in this project are all accounted for and thoroughly described.

An important approach in this PhD project has been to follow research ethics rules and take ethical considerations into account.

6.1 Reliability

Reliability is about the extent to which the results from quantitative studies are valid for the sample and the phenomenon that has been examined, and whether it is possible to transfer the results to other samples and problems [140]. In two of the sub-studies, 1 and 2, we used quantitative methods. To strengthen the reliability in sub-study 1, only two people were responsible for collecting all the data and they had access to all the patient data in the patient record system. This meant that all relevant data was included.

When recording data, accuracy has been important to ensure the reliability of the studies and all data were stored on a research server. In sub-study 2, the collected data from the questionnaire was placed directly in an excel file and later converted into an SPSS file. This ensured that all the responses were included.

To increase the response rate, the questionnaire was sent out three times. As a researcher, I was responsible for ensuring that the research appeared credible and to justify that the findings were not changed to produce other results.

All the registered data from sub-study 1 and 2 were entered in the codebook in SPSS. All data were reviewed and checked before the analysis was performed. The analysis was repeated several times to ensure that it had been implemented properly.

The data collections in sub-studies 1 and 2 were done by registration form and a questionnaire. This means that it would be possible for others to repeat similar data collection using these forms, and comparing the results.

6.2 Validity

Validity concerns whether the research questions are illuminated sufficiently in the analyses of quantitative data [140]. The researcher has the responsibility to follow good referral practices that ensure verifiability and the opportunity for further research [144].

A strength of sub-study 1, is that the registration form has been used for similar studies in Norway. The questionnaire in sub-study 2 has been validated by testing on one group of health personnel before the study was carried out, and necessary changes were made. Thus, the questionnaire can be used by others for similar results.

The data in sub-study 1 were transferred from the paper form to an SPSS file. The registered data were checked several times. The analyses performed were checked by repeated analyses.

The data collected in sub-study 2 was collected using an electronic questionnaire, where the data were transferred directly to an SPSS file. These analyses were also performed by repeated analyses.

To ensure the validity of the analysis of the collected data, all supervisors and an expert by experience participated (study 2) actively in the process to reach a different perspective and interpretation of the results. After a discussion, the final analysis results were approved by all the co-authors.

6.3 Reflexivity

Reflexivity is an attitude of attending systematically to the context of knowledge construction and deals with the consistency and credibility of qualitative data [156,158].

The purpose of the study was to gain knowledge about the interaction between health personnel and patients with OC decisions from the health personnel's perspective. During the planning of sub-study 3, I have actively listened to input to the question in the questionnaire from my supervisors and an expert of experience. The data collection was carried out through four focus group interviews. To ensure intersubjectivity, the interviews were summarized at the end of each interview [159].

As the date for the focus group interviews approached, written information and consent forms were sent out to the participants who were due to take part in the interviews. At the start of the focus group interview, the participants confirmed that they had been informed in advance, and consent forms were signed before the interviews started. At the end of the interviews, the researcher summarized the interviews with the participants in the focus group to validate their answers. The collected data were anonymized and transcribed and stored at the research server. To validate the text, I listening through all the interviews several times.

However, qualitative data collection is affected by the researcher's pre-understanding and the way in which the interview is conducted. I have tried to conduct the focus group interviews to make them as similar in structure as possible. Therefore I chose to let the participants in the interview speak quite freely without commenting too much.

To strengthen validity, the expert of experience also participated in the interviews, and actively participated in the analysis work. To ensure a critical look at the interpretation of the results, all the supervisors participated in the discussion of the findings in sub-study 3. Under the analysis process I have reflected on my objectivity towards the material by trying to be aware of my pre-understanding may have affected my attention to the material.

6.4 Strengths and limitation

A strength of this PhD project is the use of combined methods inspired by mixed methods. The study consist of three sub-studies with different scientific methods who have explored the follow-up and management of patients with the OC scheme in the same geographical area. The catchment area consist of one health trust and its municipalities. By using combined methods, I have collected data that have shed light on the issues from different perspectives and contributed to a broader understanding of the complexity of the OC scheme which involves both patient care and involvement of health personnel.

However, a limitation is that the amount of data in the three sub-studies varied. In sub-study 1, all patients were included. Even so, the response rate in sub-study 2 was low, even though the questionnaire was sent out three times. There were few participants in the focus groups in sub-study 3. Although, the interviewees had an extensive experience with the OC scheme. However, the findings from the three sub-studies provide a wide picture of the follow-up of patients with the OC scheme within the same geographical area.

A limitation in this project is that my pre-understanding may have affected my interpretation of the data, both quantitative and qualitative, although I have tried to be objective. Anyway, my pre-understanding may prevent me from noticing details that seemed too obvious or familiar.

A strength in the project is that two experts by experience have participated in this PhD project with preparation of questionnaires, interview guides and interviews. To involve a critical look at the interpretation of the results, both experts by experience together with the supervisors actively participated in the analysis work, and the discussion of the findings.

Thus we cannot be sure that the data are representative. Therefore, to generalize the findings we need more similar studies.

7 Conclusion

The objective for this PhD project has been to explore how the OC scheme is carried out in the mental health care from a health service perspective. The project had mapping the patient group, examining the follow-up of patients and collaboration across service levels. The PhD project consisted of three independent studies, which investigated issues related to the OC scheme in various ways at both specialist and municipal levels in one geographical area with one health trust.

The main finding in the first sub-study revealed that the patient group receiving an OC decision constitutes a small group of patients in mental health care with most having a schizophrenia disorder, who had been mentally ill for many years. The second sub-study found that health personnel in the municipal mental health service follow-up all patients with psychosis and OC decisions equally, but patients with the OC scheme receive fewer conversations about medication. The third sub-study explored health personnel's experiences with follow-up of patients with OC decisions. They followed up patients with an OC decision more closely. The new legislation in the Mental Health Act in 2017, has changed their practice with the OC scheme.

The project also found quality challenges in the mental health services related to knowledge, communication and collaboration. All three sub-studies showed that IPs for patients were lacking, and therefore the IPs have not functioned as a collaborative tool. When an IP is lacking, there is a lack of a clear plan for user participation and rehabilitation perspective as, for a patient with an OC decision too. In addition, there was a lack of information about who the contact person was in the medical record and the cooperation between the specialist health service and the municipalities varies and appears to be deficient.

Together, the results in this PhD project show common challenges related to follow-up and regulations of patients with OC decisions and interaction between service levels and the framework for the OC scheme. This is worrying and questionable ethically.

7.1 Implications for practice

Teaching about the Mental Health Act

There should be organized systematic teaching of the Mental Health Act for health personnel working within mental health. It would be an advantage if this were organized by collaboration between the specialist health service and the municipality's mental health team. This could also help to strengthen the interaction between service levels.

Assessment of consent competence

Assessment of capacity to consent has led to changes in practice. Although the requirement for consent assessment strengthens patients' legal rights, a need for a longer observation period has also been revealed. Consent competence should be observed over a longer period of time because symptoms may change from day to day. Relatives should be involved in the assessment. In addition, it is also important that psychiatrists and psychologists who can make coercive decisions are competent to make such an assessment. They should receive training and guidance in making consent assessments so that the assessments are carried out in an equivalent fashion.

The role of the contact person

The role of the contact person should be more clarified in the legislation and guidelines, and the tasks should be made clearer. The contact person could also be responsible for coordinating the follow-up of patients with OC decisions across service levels and ensure that there is a plan for follow-up after an OC is revoked.

Individual plan

A national evaluation of the IP should be made. An IP is important for user participation and follow-up of the patient. As the plan stands today, it is seldom used. Perhaps the IP could be developed further and have a universal design, or else it should be replaced with something else.

7.2 Suggestions for further research

Coercion is a serious intervention in a person's life. This PhD project has found shortcomings in the follow-up and interaction of patients with OC decisions based on the current legislation and guidelines. More research is needed to explore the effect of the OC scheme, development and implementation of these measures.

The measures in the legislation, with an IP and contact person, should be tested. It should be done through systematic intervention and to examine the effect that these measures may have on the follow-up of patients with an OC decision, especially in relation to the length of the decisions and the recovery process after an OC decision is revoked.

This PhD project found changes in the practice of assessing decisions on consent competence since the amendment to the Mental Health Act in 2017. However, this is a small study from one geographical area, so further research should be done to gain more experience and insight will affect the use of the OC scheme in the future.

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RESEARCH ARTICLE

Prevalence and management of patients with outpatient commitment in the mental health services

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Background People with mental health problems are mostly treated within the community. The law allows for the use of compulsory mental health care both in hospital and in the community. Various forms of outpatient commitment (OC) have been adopted in much European legislation. To be subjected to OC is a serious intervention in a person's life. **Aim** The purpose of this study is to gain knowledge about patients who undergo OC. The study explores the incidence and prevalence of OC in a geographical area, the central characteristics of the sample, and how the framework for follow-up treatment for patients to resolve OC works. **Methods** The data were collected from a review of electronic patient records. The statistical methods used in this study were descriptive analysis, with frequency analysis and cross-tabulation analysis. **Results** The main finding in the present study is that the use of OC has increased. An important finding is that most of the patients have a decision made for OC that is justified by the treatment criterion. The present study shows that there is insufficient documentation on statutory responsibilities for follow-up treatment of patients with an OC. **Conclusions** This study shows that the use of OC has increased. It should be considered whether implemented measures to reduce the use of coercion have the desired effect.

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Over the last 20 years mental health treatment has changed from mostly inpatient treatment to more outpatient treatment, coinciding with increased treatment in towns and communities (1). The use of compulsory mental health care is common in many western countries, but the rules differ from country to country (2). In Norway, the law allows the use of compulsory mental health care in both hospital and the community, when it is justified as the best solution for the patient and the environment (3,4). Outpatient commitment (OC) means a legal decision for compulsory mental health care even if the patient stays in his or her own home (5). For the patient it means having patient status in his or her own home, while receiving municipal health services.

Various forms of OC have been adopted in much European legislation over the course of the last 20 years (6,7). Studies have been conducted on the use of various forms of force in western countries, but less on the relationship to OC (6). Studies from the USA (8,9), Australia (10) and England (11–14) show that there are mixed experiences with the use of compulsory community treatment. There were no major differences in treatment outcome or number of compulsory admissions for patients with and without OC. However, a Spanish study from 2013 showed that seriously ill patients with schizophrenic disorders had fewer admissions to hospital when they received an OC (15). A Norwegian study from 2014 interviewed patients with OC about their experiences, and these patients responded that it was better to be

patients in their own home receiving OC than to be inpatients (16).

It is difficult to compare the use of OC in western countries because the psychiatric treatment facilities are organized differently, with different use of treatment models (17). In Scandinavia, OC is often used in the treatment context, whereas, in some parts of the USA OC is mainly used to protect society (2). Although the rules are different, there are similarities for monitoring and implementation of OC between the Norwegian model and the models used in the rest of the western world (7). There is a need for more studies investigating the use of OC in western countries (18).

To be subjected to compulsory mental health care while staying in their own home is a serious intervention in people's lives. For the authorities in Norway the goal is that use of compulsory mental health care should be reduced, and in 2012 the Ministry of Health and Care Services presented a national strategy (2012–2015) to reduce compulsory mental health care (19). In 2013, according to the Norwegian Patient Register, a total of 2364 people received OC, most of whom had a psychotic disorder (20).

According to Norwegian law a patient's mental health must fulfil conditions in the Mental Health Act §3-3, and voluntary treatment should be tried before making a decision about compulsory mental health care (5). The main criterion for using compulsory mental health care is that the patient must have a serious mental illness, such as a psychosis or serious eating disorder. In addition, the patient must be an

obvious and serious danger to the patient's or others' lives and health, as a result of his or her mental disease, or the patient has to fulfil the treatment criterion, which means a reduced prospect of substantial improvement without treatment (5).

The limits for an OC decision mean that the patient is assessed by a psychiatrist or psychologist every 3 months. The patient should also have a named contact in the hospital that is available during the daytime. In addition, patients should be offered an individual plan (21), which is a follow-up plan for planning and implementation of individualized support measures for the individual patient. This is a collaboration tool for patients, municipalities and hospitals which should be offered to all patients with an OC decision (5). A supplement to an individual plan is an emergency plan, which proposes measures with an overview of what to do and whom the patient and the relatives can contact to get help if the patient's disease is aggravated (21).

Daily monitoring of patients with OC means that professionals should follow up on patients' medication. Medication cannot be given forcibly in patients' homes (5). Living conditions are also significant for patients with an OC, because the patient must have a fixed address to receive it.

Aims

The purpose of this study is to gain knowledge about patients who receive an OC. The study explores the incidence and prevalence of OC in a geographical area, the central characteristics of the sample, and how the framework for follow-up treatment for patients to resolve the OC works.

Materials and methods

The study is of a descriptive and retrospective design, and includes all patients in two counties in Norway. The study involved all treatment facilities in these two counties with a county-wide population of approximately 400,000 people, covering a geographical area of approximately 52,000 km², and comprising a total of 48 large and small towns.

The area is a large combined rural/urban catchment area, and all psychiatric services in the area are public, so the study population has a relatively high level of inclusion criteria, which include age >18 years, being registered with a decision of OC after the Mental Health Act §3-3 in the period 1 January 2008 to 31 December 2012, or having valid decisions made before 1 January 2008 that are still valid. The study included 139 patients who had received a decision of OC at discharge from inpatient stays, constituting 0.8% of all patients admitted during this period.

The data were collected at Innlandet Hospital Trust, by a review of all electronic records (DIPS), plus paper records for some older data. The data were transferred to a registration form consisting of two parts: part 1 is the registration form and includes the entire sample and record about sex, place of residence and decisions of OC. In addition, it contains a registered diagnosis for all patients. Part 2 includes a sub-sample from the period 1 January 2008 to 31 December

2009, and records socio-demographic factors, registration of illness, and treatment monitoring. The registration form was developed in collaboration with the University of Tromsø.

Statistical analyses were carried out using the Statistical Package for Social Sciences Version 18.0 (IBM, Armonk, NY). The statistical methods used in this study were descriptive analysis with frequency analysis and cross-tabulation analysis. The level of significance is $p \geq 0.05$.

The study followed the applicable ethical rules for data collection. All collected data were de-identified before they were recorded by two of the authors, who received the necessary approval from Innlandet Hospital Trust to research medical records. The study was approved by REK North, with approval number 2010/2268/REC north. The study followed the relevant Health Research Act and the Declaration of Helsinki (22,23).

Results

The search for data inpatient records resulted in 139 records that fulfilled the criteria for part 1; 31 of these records fulfilled the criteria for part 2.

The sample consisted of 64 men and 75 women who received a decision of OC (Table 1). There were significantly more women who received a decision of OC ($p = 0.039$). Most patients in the study were older than 40 years (Table 1). There were significantly more men than women younger than 40 years when they received their first OC decision ($p = 0.043$). The number of patients per year who receive new

Table 1. Age, gender, sociocultural factors and mental illness in patients with decisions about outpatient commitment (OC) ($n = 139$, part 1; $n = 31$, part 2).

| Part 1 | Male | Female | Total |
|---------------------------------------|------|--------|-------------|
| Gender | 64 | 75 | 139 (100%) |
| Age at first OC (years) ($n = 139$) | | | |
| 20–29 | 13 | 8 | 21 (15.1%) |
| 30–39 | 17 | 11 | 28 (20.1%) |
| 40–49 | 21 | 24 | 45 (32.4%) |
| 50–59 | 7 | 21 | 28 (20.1%) |
| 60–69 | 6 | 9 | 15 (10.8%) |
| 70–79 | 0 | 2 | 2 (2.2%) |
| Diagnosis ($n = 139$) | | | |
| Schizophrenic spectrum disorder | 52 | 50 | 102 (73.4%) |
| Other psychoses | 6 | 9 | 15 (10.8%) |
| Bipolar disorder | 5 | 12 | 17 (12.2%) |
| Affective disorders | 0 | 2 | 2 (1.4%) |
| Organic brain disorder | 0 | 2 | 2 (1.4%) |
| Personality disorder | 1 | 0 | 1 (0.7%) |
| Part 2 | | | |
| Gender | 17 | 14 | 31 (100%) |
| Substance abuse problems ($n = 31$) | | | |
| Yes | 8 | 3 | 11 (35.5%) |
| No | 9 | 11 | 20 (64.5%) |
| First hospitalization ($n = 31$) | | | |
| 1–2 years ago | 0 | 1 | 1 (3.2%) |
| 3–4 years ago | 3 | 1 | 4 (12.9%) |
| 5–10 years ago | 5 | 2 | 7 (22.6%) |
| >10 years ago | 9 | 10 | 19 (61.3%) |
| Economic situation ($n = 31$) | | | |
| Ordinary work | 1 | 2 | 3 (9.7%) |
| Disability pension | 15 | 11 | 26 (83.9%) |
| Social grants | 1 | 1 | 2 (6.4%) |
| Housing ($n = 31$) | | | |
| Owns/rents | 10 | 9 | 19 (61.3%) |
| Municipal housing | 5 | 3 | 8 (25.8%) |
| Supervised | 2 | 2 | 4 (12.9%) |

OC decisions varies between the sexes. In the years 2010 and 2012 it was mostly women who received decisions of OC. There was no significant difference between the sexes in terms of how long they had been on decisions about OC.

Frequency analysis of the patient group showed an incidence of 17 decisions in 2008 and 27 decisions in 2012 (Figure 1). Many of the patients already had an OC decision at the time of the survey. The prevalence was 51 decisions in 2008 and 71 decisions in 2012 (Figure 1). During this period there were several patients whose OC was terminated.

Most of the patients, 74%, received their first OC decision for the treatment criterion, and 26% received it because of being a danger to themselves or others (danger criterion) (Figure 2). There were six men and two women who received a decision for the danger criterion. All patients with a decision for the danger criterion had a parallel decision for the treatment criterion.

Of the patients included in the study, 73% had a schizophrenic spectrum diagnosis, with no significant difference between the sexes (Table 1). There were more women than men in this sample with a diagnosis of bipolar psychosis (Table 1).

In the sample of 31 patients (part 2), 36% had a diagnosis of substance abuse as a co-morbid diagnosis. There were no registered suicides in the study.

Most patients had their first hospitalization more than 10 years ago and had been granted a disability pension

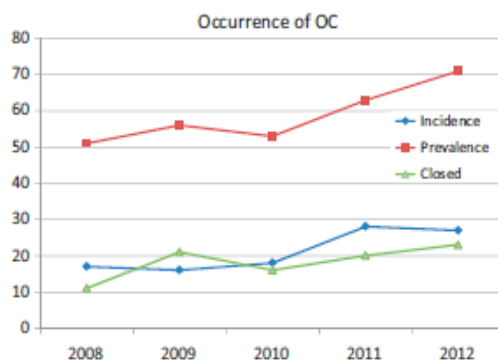


Figure 1. The graph shows the total incidence of outpatient commitment (OC): prevalence, incidence and completed (closed) per year, during the sample ($n = 139$).

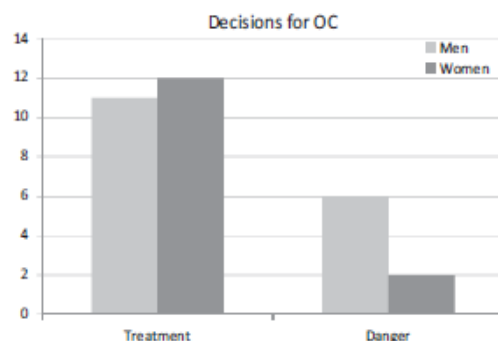


Figure 2. The figure shows grounds for outpatient commitment decisions divided between the sexes ($n = 31$).

(Table 1). Ninety-four per cent of the patients lived alone. All the patients in the sample had defined housing, 61% had their own or rented housing, and the rest lived in municipal communities or institutions (Table 1).

Patient records from part 2 were examined for monitoring of legislation in treatment (Table 2). Of the patients, 71% had a named contact in the decision and 36% had an individual plan available in the patient journal. Among those who did not have an individual plan, seven patients had an emergency/follow-up plan. All patients with bipolar psychosis had an individual plan, but only half the patients with schizophrenic spectrum disorders had such a plan.

The need for treatment with drugs was considered together with the OC decision. In sample 2 all patients were treated with antipsychotic medication, 48% received depot medication and 52% received oral medication (Table 2).

All the patients in the study were assessed every 3 months by a psychiatric specialist with decision-making authority. Patients from sample 2 were followed up at home by staff from both the hospital and the community. Of these, 65% received parallel monitoring from the hospital and the community, 19% were followed up by the hospital alone and 16% had only monitoring from the community (Figure 3).

Discussion

The main finding of the present study is that the total number of patients with an OC decision had increased in the period 2008–2012 (Figure 1). This is contrary to what the public authorities have decided, which is that the use of compulsory treatment should be reduced (19). A possible explanation for the increase could be that during the period from 2008 to 2012 the total number of patient admissions to the hospital had increased by 5%; as this is a low figure this cannot be the entire explanation. Unfortunately it was not

Table 2. How frames for treatment were safeguarded for the sample in part 2.

| | Male | Female | Total |
|-----------------------------------|-----------------|--------|------------|
| Gender | 17 | 14 | 31 (100%) |
| Named contact person ($n = 31$) | Yes | 14 | 8 (22.6%) |
| | No | 3 | 6 (9.0%) |
| Individual plan ($n = 31$) | Yes | 8 | 3 (35.5%) |
| | No | 6 | 11 (54.8%) |
| Medication ($n = 31$) | Not in journal | 3 | 0 (9.7%) |
| | Depot | 9 | 6 (48.4%) |
| | Oral medication | 8 | 8 (51.6%) |

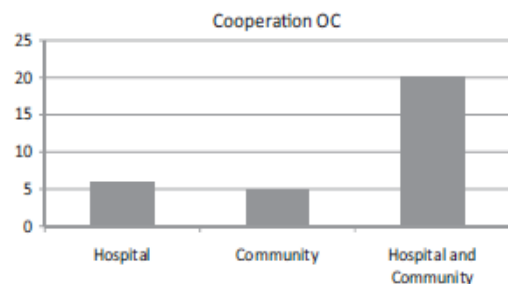


Figure 3. Follow-up for patients with OC decisions from hospital, the community or both ($n = 31$).

provided data on the number of psychiatric patients in the hospital prior 2008 to compare with.

Another explanation could be that during the current period there have been 12.6% fewer hospital beds for psychiatric treatment. Over the years 1998–2008 the government allocated money to a national mental health project, with extra money for treatment facilities outside hospitals in the towns (24). This project resulted in fewer beds in psychiatric hospitals, and could result in faster discharge. However, referral to treatment facilities outside the hospitals has not been extended to cover the needs of the patients with serious mental illnesses (24). This may explain the increase in OC decisions.

The number of patients with OC decisions in the present study represents just a small group of patients registered at the hospital. National figures from 2013 showed that there were fewer OC decisions in relation to the population at Innlandet Hospital's catchment area than elsewhere in Norway (20). One explanation for this may be that smaller hospital environments provide stability and predictability for the patient. On the other hand, because of the long travelling distances to the nearest hospital, it may be that fewer decisions were made for patients who actually did need an OC.

In the present study most of the decisions for OC were justified using the treatment criterion. According to the Norwegian authorities and a national strategy goal, the use of compulsory mental health should be reduced (19).

The use of the treatment criterion is debated in interested organizations for patients with mental disorders, because this criterion is considered to violate the principle of autonomy in human rights (25). These organizations claim that compulsory mental health care should be used only when it is necessary to prevent the patient exposing him or herself or others to dangerous situations (25).

A decision of OC implies patients having the right to housing and monitoring of health care with the assistance of their medication. One possible explanation for the use of the treatment criterion may be that medical professionals are more concerned that patients get treatment and care than with legal matters (26). This decision ensures treatment resources for patients, especially in the municipalities that have limited resources (24).

A surprising finding in the present study is that there were more women than men with a decision of OC. In other European studies there are usually more men (7). One possible explanation may be the different laws of European countries, which allows force only when justified by the dangerousness criterion (2). The present study shows that most women have a decision of OC based on the treatment criterion. There was also a difference between the sexes in the annual distribution of the decision of OC. In 2010 and 2012 it was mostly women who received decisions on OC. However, the present study represents a small sample, thus these findings must be interpreted with caution.

What kind of treatment should be offered to patients with a decision of OC beyond the statutory duties has not been described in national documents; the statutory duties state that the patient should be evaluated by a psychiatrist or psychologist every 3 months, have a named contact person

at the hospital, be monitored for medication, and have an individual plan and a permanent residential address (5). There are no national guidelines for management of patients with OC decisions in Norway. However, there are national guidelines for psychotic disorders that can be used which contain treatment guidance. These should be integrated into the guidelines for legislation to ensure the best possible treatment for all patients with a decision of OC.

No patients in the current study were registered as suicides, although it is known that serious psychotic disorders increase the risk of suicide (27). Current research indicates that OC may have positive effects for the patient (28). A decision of OC over a period of time may provide a better quality of life through safer medication, less use of violence and self-harm and earlier detection of recurrence (17,28). One hypothesis is that that OC may prevent suicide through special attention to patients with elevated suicide risk.

Most patients in sample 2 were diagnosed with a psychotic disorder, and a third had a diagnosis of a concurrent substance use disorder. Substance abuse is a risk factor for developing symptoms of psychosis (29). Patients who have a severe mental illness and a concurrent substance use disorder often have extensive malfunctions and major social problems (29). These patients need more assistance, including more extensive cooperation between the hospitals and the municipal treatment facilities.

For a small group of patients with OC, the municipal treatment facilities took care of the patients with no assistance from the hospital. This is surprising given that patients with OC are considered to be hospital patients even if they stay at home. Most patients with an OC decision had a diagnosis of a schizophrenic spectrum, which is a disorder that often causes major disability and suffering, and often becomes chronic; thus, these patients require prolonged treatment and help functioning in daily life (30). A committed relationship between the hospital and the municipal treatment facilities seems to be the best model to ensure this support.

The need for drug treatment is considered together with decisions on OC. All patients in this study were taking antipsychotic medications. Adequate medication can help to improve the quality of life for patients and discontinuation may cause relapse of the psychosis symptoms (31). A risk with oral medication is that the patient can stop taking it him- or herself, or take it irregularly. An OC decision can ensure stable medication; however, patients may feel that the medication is not helpful and the side effects may impair quality of life (4).

Most patients had documented a named contact that was available at the hospital during the day and was known to both the patient and the family, as stated in law (5). However, in some journals there was no documentation of such a contact. This could lead to uncertainty among patients, their relatives and the personnel at the municipal treatment facilities and it may be harder to get help quickly if the patient were to suddenly become more ill.

It was surprising that only a small group of patients had such a plan available in their patient records. Several patients had it written in their patient records that they had an individual plan registered in municipal documents. The purpose

of creating an individual plan is to contribute to improved quality of life and predictability for the patient (32). It is an important tool to ensure individualized services for patients who need long-term, coordinated help. The patients have the opportunity to influence their own treatment through the plan, even if they receive compulsory mental health care.

In a paper from 2014 O'Reilly et al. discuss which frames provide the best follow-up for patients with OC decisions, with the least possible use of force, by comparing different countries (28). The paper concludes that stable medication with depot, and a clear follow-up plan with fixed agreements between the patient and the support system provides good results in addition to the collaboration of clinicians, patient and family. Many of these frames coincide with guidelines in Norwegian legislation. In the present study several patient records lacked documentation on how the statutory duties were safeguarded. It is therefore uncertain whether patients with OC decisions are followed up according to the law.

Limitations

One of the challenges in this study has been whether we found all the current patients in the record system. Two of the authors collected data together. All the data in this study were taken from the patient records system known as DIPS. To ensure that all data were found, two different reports were printed from the OC. This resulted in the discovery of more patients to include in the study. We found different practices in the same hospital for registration of judicial decisions in the patient journal. Official figures from the hospital show decisions from just one of the reports in the record system. It was not possible to do a significant test of these results because the correct data on the number of psychiatric patients hospitalized during this period to compare with were not available. This is also a relatively small sample, thus we must be cautious about generalizing from these findings.

Conclusion

The main findings in the present study are that the use of OC has increased and there is insufficient documentation on statutory responsibilities for follow-up treatment of OC patients. It should be considered whether the implemented measures for reducing the use of coercion have the desired effect. We need more Norwegian studies examining the practice of law, the civic role for patients with OC, and how cooperation between the hospital and the municipal treatment facilities works.

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Outpatient commitment in mental health services from a municipal view

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ABSTRACT

Background: Outpatient commitment (OC) is a legal decision for compulsory mental health care when the patient stays in his or her own home. Municipal health-care workers have a key role for patients with OC decision, but little is known about how the legislation system with OC works from the municipality's point of view.

Method: The present study has a quantitative descriptive design using an electronic questionnaire sent to health-care workers in the municipalities that participated. The study included health-care workers from the mental health services in two counties in Norway who have experience with psychosis and OC decisions.

Results: There were 230 people who received the questionnaire. The sample consisted of various health professionals from both small and large municipalities. The results show which tasks they have in follow-up of patients in the municipalities.

Conclusion: From the municipality's point of view, there are no significant differences in follow-up for patients with or without an OC decision, apart from conversations about medication. An individual plan is rarely used to facilitate follow-up, although this is the statutory right of patients with OC decisions. The health-care workers lack knowledge and education about the OC scheme. The cooperation between municipalities and the specialist health-care services is not clearly defined.

1. Introduction

Compulsory outpatient psychiatric care, referred to as outpatient commitment (OC), is a legal opportunity in many western countries (Kisely, Campbell, & O'Reilly, 2017). These countries have different legislation and provide different services (Rugkåsa, 2011; Turnpenny, Petri, Finn, Beadle-Brown, & Nyman, 2018). The intention of OC is to provide and secure treatment for, and stability in the life of, patients who stay in their own homes (Campbell & Kisely, 2010; Kisely et al., 2017).

1.1. Experience with outpatient commitment

There are various experiences with the use of OC in different countries (Rugkåsa & Burns, 2017). In recent years, several summary studies have been made, both qualitative and quantitative, about research on OC. A systematic review and meta-analysis of 41 studies, both randomized and non-randomized, did not find that OC reduced

admissions, however, OC provided some benefits such as enforcing the use of outpatient treatment and increasing the provision of services (Barnett et al., 2018). A randomized study, comparing two groups of patients with and without OC over a period of 12 months; it did not show that OC makes a large difference when it comes to hospital stays, social functioning or quality of life (Burns et al., 2013). A literature review of 50 non-randomized studies showed mixed experiences with OC. Some of the studies found no benefits, but showed changes in terms of hospitalization, hospital time and community use (Rugkåsa, 2016). Some see OC as a form of care, whereas others believe it compromises freedom and the patient's autonomy (Sjöström, Zetterberg, & Markström, 2011). Some think that, in certain circumstances, OC is necessary to avoid repeated admissions and bring stability to the lives of people with severe mental illnesses (Stroud, Banks, & Doughty, 2015).

Opponents of OC fear that treatment and support will be replaced by control, undermining the relationship between health-care professionals and patients (Kisely et al., 2017). Several qualitative studies of

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OC show that patients' experience of living with OC decisions are affected by their relationship with the therapists in both positive and negative ways (Corring, O'Reilly, & Sommerdyk, 2017). Positive experiences prevent readmission and bring hope of recovery; negative experiences include a feeling of being controlled and lacking information about the decision. A review article of empirical studies from seven countries, has examined what experiences the health-care workers have when planning the follow-up of patients when it comes to OC decisions (Dawson, Lawn, Simpson, & Muir-Cochrane, 2016). This study refers to the importance of collaboration between patients and health-care workers with good communication, empathy and trust. Other countries are actively using health professionals to assess OC. In United Kingdom, Ireland, Victoria, Australia and Ontario Canada, mental health laws have been changed, and mental health social workers are involved when decisions about coercion are to be considered (Campbell, Brophy, Davidson, & O'Brien, 2018).

Laws and practices differ in different countries, so foreign studies may be of limited transfer value to our country. It is probably more meaningful to compare our study with other Norwegian studies. In recent years, a number of Norwegian studies have been conducted about the experience of using OC from both a patient and a health-care perspective. In one study patients with OC decisions responded that it was better to be patients in their own homes receiving OC than to be inpatients (Stensrud, Høyer, Granerud, & Landheim, 2015). Another study showed that patients who had OC decisions in an assertive community treatment (ACT) team had a greater recovery potential than patients without OC decisions (Lofthus, Weimand, Ruud, Rose, & Heiervang, 2018). ACT provides an opportunity for health-care workers to follow patients closely and can provide a safe environment as an alternative to OC (Stuen, Landheim, Rugkåsa, & Wynn, 2018a). In one study when health professionals worked with patients with OC decisions, they believed that OC was necessary to safeguard the patient's health in the long term, but it was difficult to balance the therapist's role with the management of coercion (Stensrud, Høyer, Beston, Granerud, & Landheim, 2016).

1.2. Regulation of outpatient commitment in Norway

In Norway The Mental Health Act (1999) regulates the framework for use of OC. The main criterion for using outpatient commitment is that the patient must have a serious mental disorder such as a psychotic disorder, but additional criteria are also needed: *the treatment criterion* (a reduced prospect of substantial improvement without treatment) and/or *the danger criterion* (to be a danger to themselves or others). OC must also be considered to be the best option for the patient overall. Voluntary treatment must have been attempted, and the patients must be given the opportunity to express their opinion. The term "serious mental disorder" mainly includes psychotic disorders, but also includes other serious mental disorders. On 1 September 2017, the Mental Health Act changed the treatment criterion in OC. Patients with mental capacity to make consent competence, can now no longer be treated with OC against their will as long as they do not fulfil the danger criterion. Several aspects of OC are regulated by legislation. According to the law, psychiatrists or clinical psychologists in the specialist health service make decisions about coercion, and the patient must be evaluated by a psychiatrist or clinical psychologist every three months. In addition, the patient must have a known contact person in the hospital, have a home in the municipality and have an individual plan (IP) drawn up. If the patient opposes treatment, he or she is taken to the hospital for treatment, but medication cannot be given forcibly in patients' homes.

There are also other laws in Norway in addition to The Mental Health Act (1999), that regulate services for people with OC: The Health Personnel Act (1999), The Patient Rights Act (1999) and The Health and Social Services Act (2011). All these laws refer to IP as an important patient right for patients/users with extensive care needs, to

promote the patient's wishes, needs and resources, cooperation and coordination between services. All patients with OC must have an IP prepared. It is the specialist health service that is responsible for the work with IP for patients with OC decisions, but health-care workers in the municipality must follow up the IP work in the patients' homes.

1.3. Municipal role in outpatient commitment

During the last 20 years several western countries have reduced the number of inpatient beds in psychiatric hospitals (Thornicroft & Tansella, 2013). In Norway, the Escalation Plan for Mental Health Services (1999–2006) gave municipalities more responsibility for mental health care and was passed through the Coordination Reform (2009). Mental health services in Norway are organized on two main levels; specialist health service and mental health service in the municipality. The specialist health service is divided into the Hospital and District Psychiatric Center (DPC). DPC is the link between the hospitals and the municipalities. It is the specialist health service that evaluates OC decisions. Municipal health-care workers are not formally involved when decisions about coercion are to be considered.

Municipal health-care workers have a key role around patients with OC because they live in local community settings. In addition the municipality has a duty to provide daily health service to all their inhabitants according to The Health and Social Services Act (2011). This law does not say anything specific about the rights of patients with OC in the municipality, but provides an obligation to assist in obtaining housing and coordinating the need for mental health care.

Research shows that patients with OC often receive services from both hospital and municipality, and most of these patients have a psychotic disorder (Brown, Taylor, Mackay, Macleod, & Lyons, 2012; Løvstetten, Haug, Granerud, Nordby, & Smaaberg, 2016; Rugkåsa et al., 2019). Patients with psychotic disorders often have significant functional impairment. Often they do not experience psychotic symptoms as disease and some may need close supervision by qualified personnel to function in daily life (Dam, 2006; Nakhost, Simpson, & Sirotich, 2019). Thus, service from both levels is essential to provide good-quality mental health care (Thornicroft & Tansella, 2004).

There are national Norwegian guidelines from the Directorate of Health for the follow-up of patients with different mental health disorders including psychoses. Nevertheless, these guidelines; *People with severe mental illness who need facilitated care* (2008) or the guideline; *Assessment, treatment or follow-up of people with psychotic disorders* (2013) contains no clear recommendations for follow-up of patients with OC decisions.

1.4. Challenges with outpatient commitment

Municipal health-care workers in Norway have an important role to play in relation to patients with OC decisions. To develop good health services, it is important to gain more knowledge about how OC works in the municipality where the patients live. In Norway, there has been research on health professionals' experiences with responsibility for OC patients in the municipalities through an ACT team (Stuen, Landheim, Rugkåsa, & Wynn, 2018b). Apart from this, as far as we know, no research has described the role of municipalities in mental health care for patients with OC in Norway.

The aim of the present study is to gain more knowledge about how the system with OC works in a healthcare perspective from the municipalities' point of view. The present study investigates which tasks the municipalities perform in relation to patients with psychosis and/or OC decisions, what knowledge they have about legislation regulating OC, and how the municipality and the hospital interact from a municipality's perspective.

2. Methods

The present study has a quantitative descriptive design using an electronic questionnaire (Robson, 2011). The questionnaire consists of 41 questions with several tick options. The questions in the questionnaire are based on tasks that are described for health professionals in the authorities' guidelines for mental health work such as the National guidelines: "Assessment, treatment and monitoring of people with psychotic disorder" (2008) and "People with severe mental illness who need facilitated care" (2013). Some of the questions provide the opportunity to comment on the answer in an open answer field. The study included health-care workers in municipalities in two Norwegian counties, with a countywide population of approximately 400,000 people living in 48 municipalities of different sizes where the smallest had fewer than 5000 citizens, and the largest had 35,000 citizens. All the municipalities in this area cooperate with the same specialist health service. It was the leaders who decided whether the municipality should participate in this study. Thirty-nine municipalities agreed to participate in the study, and 230 health-care workers received the questionnaire. A previous study of the OC population in the current study catchment area showed that most of the patients had a psychotic disorder (Løvsetten et al., 2016). We wanted to compare health care given to similar patient groups with and without OC. Because psychotic symptoms are common for patients with an OC decision, we chose to compare health care given to this group with health care given to patients with psychosis who did not have an OC decision. It became a strategic choice to include health-care workers from the mental health services who have experience with both psychoses and OC decision. The questionnaire was sent out three times to get a higher response rate. All municipalities had mental health services, but not one had established an ACT team or something similar.

2.1. Analysis

Statistical analyses were carried out using the Statistical Package for Social Sciences Version 25.0 (SPSS, 2019, Chicago, IL). Distributions of all data were visually inspected. The data were generally skewed, so data are described using frequency analysis. The groups were compared using cross-analysis, correlation analysis and non-parametric Wilcoxon's test. The level of significance was set at $p = 0.05$, two-sided.

The qualitative comments from the respondents in the open answer field in the questionnaire, were analysed with a view to finding categories based on qualitative content analysis (Graneheim, Lindgren, & Lundman, 2017).

2.2. Ethics

The present study followed the ethical rules for data collection according to the Health Research Act and the Helsinki Declaration (2013), and it was approved by Data Protection Services in Norway, project number 54290.

3. Results

There were 230 people who received the questionnaire. The response rate was 37%, which gave a total of 84 respondents, with women being in the majority. The sample consisted of various professionals, most of whom had a Bachelor's degree with further education (Table 1). Nurses constituted the major group of health-care workers, of whom 44% had further education qualifications. The majority worked in jobs that were 75% of a full-time post and had worked for more than five years in the municipality. They were employed in both small and large municipalities; 54% of the respondents worked in small municipalities (fewer than 10 000 citizens) and 47% worked in larger municipalities (more than 10,000 citizens).

Table 1

The table shows demographic factors among the respondents.

| | | |
|---|--------------------------------|------------|
| Education | High school | 11 (13.1%) |
| | Bachelor | 9 (10.7%) |
| | Postgraduate | 59 (70.3%) |
| | Master's degree | 5 (5.9%) |
| | Other | 11 (13.1%) |
| Function in the municipality | Nurse | 42 (50.0%) |
| | Social educators | 11 (13.1%) |
| | Social worker | 6 (7.1%) |
| | Occupational therapist | 1 (1.2%) |
| | Care worker | 5 (5.9%) |
| | Nursing assistant | 8 (9.5%) |
| | Other | 11 (13.1%) |
| Percentage position in the municipalities | 0–25% | 3 (3.7%) |
| | 25–50% | 5 (6.2%) |
| | 50–75% | 3 (3.7%) |
| | 75–100% | 70 (86.4%) |
| Workplace in the municipalities | Municipal housing | 9 (10.7%) |
| | Treatment team drugs addiction | 43 (51.1%) |
| | Mental health team | 24 (28.0%) |
| | Home nursing | 2 (2.2%) |
| | Other | 6 (7.1%) |
| Working experience in the municipalities | 1–5 years | 22 (26.2%) |
| | 5–9 years | 26 (30.9%) |
| | 10–15 years | 23 (27.3%) |
| | 15 years or more | 13 (15.4%) |

3.1. Interaction with the patients

Respondents ($n = 84$) were asked how often they visited their patients every week. The contact between patients and health-care workers varied from daily visits to one visit every 14 days. The majority talked to the patients once a week (Fig. 1). It was mainly nurses who visited the patients, but social educators and social workers also had such contact.

The respondents answered questions about which tasks they assisted the patients with (Table 2). A total of 63 responded about which tasks they performed with patients with psychotic disorders without OC decision, and 54 responded about which tasks they performed with patients with OC decisions. Wilcoxon's test was used to compare the contents of services for patients with and without OC.

The analysis showed that there were no significant differences in the way patients with and without OC were monitored, except for conversations about medication ($p = 0.018$). It was mostly nurses who have these conversations. There were no significant differences in other tasks the health-care workers followed up.

Of the respondents, 15 commented on the question of *emphasizing user participation*. Those who followed patients with psychoses without OC decisions, believed that user involvement is about finding solutions by including the user in decisions, and actively listening to the patient

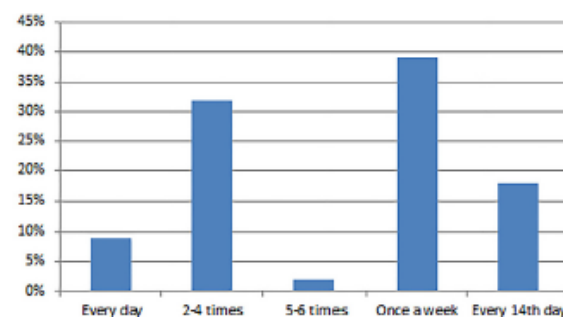


Fig. 1. The table shows how many visits the patients receive per week from health-care workers in the municipality ($n = 84$).

Table 2

The tasks the health-care workers in the municipalities assist patients. Wilcoxon tests show differences when comparing tasks to patients with psychosis with tasks to patients with OC decisions. $P \leq 0,05$ Wilcoxon.

| Psychosis | | | | | OC | | | | Wilcoxon P |
|-----------------------------------|----------------------------------|--------|---------------------|-----------------|--------|--------|---------------------|-----------------|---------------|
| | Interaction with the patient (n) | Always | Occasionally/Rarely | Never/Not tried | N (63) | Always | Occasionally/Rarely | Never/Not tried | |
| Conversation (planned) | 35 | 24 | 3 | 62 | 22 | 23 | 9 | 54 | 0.116 |
| Conversation (not planned) | 14 | 45 | 1 | 60 | 15 | 31 | 7 | 53 | 0.118 |
| Conversation about medications | 5 | 54 | 2 | 61 | 7 | 36 | 11 | 54 | 0.018 |
| Give medication | 18 | 23 | 20 | 61 | 18 | 20 | 15 | 53 | 0.329 |
| Develop CMP | 5 | 51 | 6 | 62 | 10 | 32 | 12 | 54 | 0.814 |
| Monitoring CMP | 11 | 45 | 5 | 61 | 17 | 30 | 7 | 54 | 0.663 |
| Create crisis plan | 11 | 41 | 9 | 61 | 12 | 31 | 9 | 52 | 0.417 |
| Provide housing | 5 | 38 | 15 | 58 | 6 | 32 | 13 | 51 | 1.00 |
| Follow to meetings | 16 | 40 | 2 | 58 | 15 | 33 | 2 | 50 | 0.822 |
| Activities together with the user | 5 | 48 | 4 | 57 | 7 | 43 | 4 | 54 | 0.666 |
| Treatment-related meetings | 20 | 35 | 3 | 58 | 16 | 34 | 4 | 54 | 0.856 |
| Follow to doctor/social office | 8 | 49 | 4 | 61 | 7 | 43 | 4 | 54 | 0.942 |
| Go for a walk | 2 | 49 | 6 | 57 | 3 | 44 | 5 | 52 | 1.00 |
| Coping with life | 25 | 34 | 1 | 60 | 26 | 24 | 4 | 54 | 0.797 |
| Coordinate measures | 21 | 39 | 4 | 62 | 24 | 25 | 5 | 54 | 0.282 |
| Emphasis on user participation | 56 | 7 | 0 | 63 | 43 | 10 | 1 | 54 | 0.157 |
| Contact with relatives | 10 | 49 | 4 | 63 | 10 | 39 | 5 | 54 | 0.713 |

to win trust; one such comment was: 'User involvement in decisions concerning them to the extent that is possible.'

The respondents, who followed up on patients with OC decisions, pointed out that user participation is difficult when the patient disagrees with the OC decision, but they must show respect by allowing the patient to express their views. Others commented that collaboration over patient needs is important to help the patient follow-up their own plans.

3.2. Knowledge of OC

The respondents ($n = 84$) were asked about their knowledge about OC. 54% did not know the OC scheme well, and 70% had never received education on OC regulation. 52% did not know about the last amendment to the Mental Health Act for assessment of competence to consent. However, the health-care workers from small municipalities (less than 10,000 inhabitants) had received more education about OC, although the difference was not significant.

Twelve respondents gave a detailed comments about their knowledge of OC. Respondents replied that they lacked knowledge about OC and did not think they had enough education. Some had learned through experience with patients with OC decisions and several stated that they wanted more education.

3.3. Facilitation of services

The respondents ($n = 54$) who had experience of cooperation, monitoring and facilitation with patients with both a psychotic disorder and an OC decision answered on how they facilitate services in their work (Table 3). Half of the health-care workers responded that they

follow-up patients with and without OC in the same way, and believed that OC sometimes gave better quality of life. Most of the health-care workers had never been informed by the specialist health services of the rationale for OC decisions. In varying degrees, the health-care workers have received information about their contact person in the specialist health services. About half of the respondents said that they worked in teams with the specialist health service and had contact with the person responsible for the OC decision. A third of the respondents said that they never had received any guidance from the specialist health service.

In the open answer field, 15 commented on how they have experienced IP as a collaboration tool. The answers were split into two categories; "Own knowledge of IP" and "Interaction with patients".

Own knowledge of IP: many commented that they had little experience with IP. Others replied that IP did not work as a cooperation tool between service levels.

Interaction with patients: several mentioned that IP depends on user functioning; "The experience is that many patients do not want an IP and are unable to relate to it as a tool." The respondents experienced that IP works when the user participates, but sometimes the plan is made without the user's participation. It was widely reported that the IP is dependent on the interaction between the patient and the health-care workers; "IP works well when the patient is stable enough to be able to participate". A crisis plan, which is included in an IP, was mentioned as a plan that worked.

3.4. Cooperation between the service levels

The respondents ($n = 84$) were also asked about their experience of cooperation between the specialist mental health services and the municipality services. The meetings between the services took place

Table 3

Health-care workers' experience of cooperation, monitoring and facilitation of OC ($n = 54$).

| Cooperation with patients | Yes | Sometimes | No | N = 54 (100%) |
|--|------------|------------|------------|---------------|
| Patients with OC get different assistance | 12 (22.2%) | 13 (24.1%) | 28 (51.9%) | 54 (100%) |
| OC improves patients quality of life | 14 (25.9%) | 32 (59.3%) | 8 (14.8%) | 54 (100%) |
| Cooperation between services | Yes | Sometimes | No | |
| Receives justification for OC decision from the hospital | 13 (24.1%) | 6 (11.1%) | 35 (64.8%) | 54 (100%) |
| Has used IP as a collaboration tool | 2 (3.7%) | 38 (70.4%) | 14 (25.9%) | 54 (100%) |
| Receives information about who the contact person is | 17 (31.5%) | 17 (31.5%) | 20 (37%) | 54 (100%) |
| Collaborates in teams with specialist | 12 (22.2%) | 25 (46.3%) | 17 (20.2%) | 54 (100%) |
| Cooperates with responsible psychiatrist or psychologist | 17 (31.5%) | 26 (48.1%) | 11 (20.4%) | 54 (100%) |
| Receives guidance from the specialist health service | 6 (7.1%) | 18 (21.4%) | 30 (35.7%) | 54 (100%) |

both at the specialist health service (51%) and in the municipality (37%). Sixty-two per cent responded that they were satisfied with the cooperation between service levels from their perspective, although 37% said that they were only somewhat satisfied with the cooperation.

Twenty people commented on their response. Analysis of the comments showed two distinct categories; *"lack of understanding"* and *"challenges with communication"*.

Lack of understanding: Health-care workers in the municipality had the impression that those who worked in the specialist health service did not understand their tasks and responsibilities, and experienced the limits between the service levels being unclear; *"In everyday life, we in the municipality feel left alone and perceive that the specialist health service does not understand our problems."*

Challenges with communication: Health-care workers in the municipality found that the specialist health service was hardly available in the daytime, and it was difficult to get help for patients who had a worsening of their disorder. A minority commented that the cooperation varied but some units in the specialist health service did provide good follow-up; *"The hospital unit provides great security if difficult situations arise, both day and night."*

4. Discussion

The present study has investigated how the follow-up of patients with an OC decision works from a municipal point of view. Patients with OC constitute a small group who have been ill for a long time and have been offered voluntary treatment without being able to accept this treatment (Løvsetten et al., 2016). The vast majority of patients with OC have a psychotic disorder and need coordinated health services. This study has revealed challenges in follow-up of patients with OC decision in the municipality.

4.1. The health-care worker's interaction with patients

The main finding in the present study is that there are no significant differences in the follow-up of patients with psychosis whether or not they have OC decisions, apart from conversations about medication. It may be that conversations about medications can contribute to cause conflict for some patients, or that patients with OC decisions receive their medications directly from the specialist health service, and the conversations take place there.

Patients with OC decisions are entitled to the same treatment and follow-up as other patients with similar disorders. It can be seen as positive that all patients receive equal mental treatment in the municipality, regardless of an OC decision, and that health-care workers in the municipality can give the same follow-up even if patients do not receive treatment voluntarily.

On the other hand, it is surprising that there are no major differences between patients with and those without OC decisions. According to legislation, patients with OC decisions must have an IP to promote the patient's wishes, needs and resources, cooperation and coordination between services. They also have to be awarded a contact person in the specialist health service who is known to both the patient and the health-care workers in the municipality. Therefore, you could expect more interaction and meetings between service levels to facilitate individual treatment and follow-up of patients with OC decisions, such as an IP plan outline, as a lawful right. This suggests that the legal rights of patients on CO are not fulfilled.

The principal intention of the introduction of an IP has been to strengthen user rights and give patients the opportunity to influence their own treatment (Langhammer et al., 2015). This is an important statutory tool to safeguard the patient rights, even if they have OC decisions, so it has been surprising that it is used only occasionally. At the same time, the health-care workers state that they emphasize user involvement for patients with psychosis regardless of OC decisions. They thought it was difficult to involve patients in this work because

many did not want an IP. Thus it is a dilemma, because such plans ensure user involvement and treatment follow-up.

Previous research has found organizational challenges in implementing an IP when it is described as a demanding system (Holum, 2012). Perhaps an IP should be evaluated as a tool for patients with OC decisions. To ensure cooperation between service levels, a discussion can be instituted of whether there are other forms of interaction for patients with OC decisions with or without user involvement. This is a topic for further research.

The findings in the present study show that health-care workers in the municipality follow-up most patients with OCs once a week. It is somewhat surprising that patients treated against their will, because of their mental illness, do not receive closer follow-up. However, there are no national guidelines on this. The psychosocial guidelines for Assessment, treatment and follow-up of people with psychotic disorders (2013) do not say anything about the interaction with the patient, but emphasize the importance of user participation and individual facilitation. Maybe there is a need for national guidelines for patients with OC decisions.

Research shows that patients' experience of OC is related to user involvement and relationships with treatment staff (Corring et al., 2017; Pridham et al., 2015). Research on patients with OC decisions who receive follow-up in ACT teams, shows that the patients feel well taken care of and have a reduced need for admission (Aagaard, Tuszewski, & Kolbæk, 2017; Lofthus et al., 2018). Close supervision of the health-care workers can also provide improvement of psychotic symptoms in patients with OC decision (Schneeberger et al., 2017). This indicates that the structure and framework of the health service around the patients have an impact on the patients' experience of OC. These experiences with ACT-teams in Norway may influence a new practice for monitoring patients with OC decisions.

4.2. The health-care worker's knowledge of OC

The present study found that many of the health-care workers in the municipalities lacked knowledge about OC legislation. They lacked both education and knowledge of the latest legislative amendment about the assessment of consent competence. Thus, it was surprising that so many of the workers lacked knowledge of OC. According to the law, the municipality is responsible for ensuring that the health-care workers receive the necessary education in *The Health Personnel Act (1999)*, *The Mental Health Act (1999)* and *The Health and Social Services Act (2011)*.

The change of conditions for consent competence to assess the basis for coercion, may also lead to increased responsibility for the municipalities, because the criteria for obtaining a decision on OC have become narrower. It is worrying that the health-care workers responsible for the patients with OC decisions in the municipality do not know what legal framework patients with OC decisions have. Such competence is important to be able to convey the correct knowledge and answer questions from patients and relatives. When the health-care workers have different understanding and knowledge of OC decisions, but are responsible for the same patients at different service levels, this could be confusing for patients and increase the risk of giving wrong information. If the health-care workers have different understanding of and knowledge about the decision-making basis for OC, this can affect the municipality's interaction with specialist health service.

Maybe the municipality health-care workers in Norway should be more engaged in supported decision-making to prevent coercion, similar to the roles of mental health workers in United Kingdom, Ireland, Australia and Canada (Campbell et al., 2018).

Use of coercion is a serious intervention in a human's life. If an OC is adopted on the wrong basis, this could pose a risk to legal certainty and human rights. It is therefore important to ensure that the health-care workers in the municipalities have sufficient knowledge, training and ethical awareness. One of the safeguarding of human rights is that

health-care workers have enough expertise about the legislation.

4.3. Collaboration challenges between service levels

Another finding in the present study was that cooperation between mental health service in the municipalities and the specialist mental health service can be challenging. The health-care workers in municipal experience that no practice has been established to safeguard follow-up of the OC patient between the service levels. There were no established procedures between the responsible therapist in the specialist mental health service and the municipality health-care workers. The municipality health-care workers lacked information from the specialist about the assessment of the OC decision, the name of the contact person and guidance from the specialist. It may seem that cooperation between the different service levels is not clearly defined. The roles are also not clearly defined in regulations and guidelines.

In order to improve the interaction between the specialist mental health service and the mental municipal health service for patients with OC decisions, regular meeting points between service levels should be established. The contact person in the specialist health service could coordinate these meetings. Patients and their relatives should also be invited to the meeting.

The present study indicates that an IP is only used to a small extent as a collaboration tool between service levels, although it is a statutory right. It is worrying that an IP, which has a central role in the organization of services and collaboration between service levels, does not work as intended. This is both worrying and ethically demanding.

4.4. Strengths and limitations

There is little research about what kind of follow-up patients with OC decisions receive from the health-care workers in the municipalities in Norway. Thus, it is important to gain more knowledge about this. The findings in this paper are from a limited geographical area, but there is a diversity with both small and large municipalities represented in the present study. We do not have the estimates about the number of municipal health care workers involved in mental health services across the country or the proportion of distinctive professional roles, thus we do not know if our respondents are representative. The participants could comment on some of the answers, but there were few who chose to do so. In addition, the comments pointed in different directions. It is therefore difficult to generalize the results. Larger studies are needed to gain more knowledge of this.

5. Conclusion

This study has investigated how OC works from a health care perspective from the municipals health-care workers view.

The findings show no significant differences between patients with and those without OC decisions in relation to follow-up given by health-care workers in the municipality, apart from conversations about medication. Most of the health-care workers lacked education and knowledge of the latest legislative amendment about the assessment of consent competence. This may be a threat to basic human rights and safeguarding of patients' rights.

The study also shows that the cooperation between the service levels does not work well in many areas. The health-care workers in the municipalities lack both information on the basis of the OC decisions, information on contact people, and guidance from the specialist health service. IP is little used and works only to varying degrees as a collaboration tool, although it is a statutory right for patients with OC decisions and should facilitate follow-up and interaction. This may indicate that follow-up of patients with OC decisions in the municipality is somewhat random, and it should be more clearly rooted in legislation and guidelines. There should be regular meeting points between service levels, patients and relatives of patients with OC decisions. The contact

person in the specialist mental health service should coordinate these meetings. Working with IP could be part of this collaboration.

There is a need for further research to gain more knowledge about how the system with OC works from the municipalities' point of view.

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Author statement

Maria Løvsletten: Conducted the statistical analyses and also wrote the first draft of the manuscript.

Tonje Lossius Husum: Discussed the analysis and participating in writing of manuscript draft.

Arild Granerud: Discussed the analysis and participated in critical revision of manuscript drafts.

Elisabeth Haug: Contributed to the analyses and participated in critical revision of manuscript drafts.

All authors and approved the final version.

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III

Cooperation in the mental health treatment of patients with outpatient commitment

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Abstract

Background: Patients with outpatient commitment have a decision on coercive treatment from the specialist health services even if they are in their own home and receive municipal health services.

Objective: The aim of this study is to gain more knowledge about how the outpatient commitment system works in the municipal health service and specialist health services, and how they collaborate with patients and across service levels from the perspectives of healthcare professionals.

Methods: This is a qualitative study collecting data through focus group interviews with health personnel from the municipal health service and specialist health services.

Results: The results describe the health personnel's experiences with follow-up and interactions with the patients with outpatient commitment decisions, and their experiences with collaboration between service levels.

Conclusion: The study shows that outpatient commitment makes a difference in the way patients with this decision are followed up. The legislative amendment with new requirements for consent competence was challenging. Collaboration between service levels was also challenging.

Keywords

Mental health/psychiatry, consent competence, coercion, collaboration in mental health care, community treatment order, individual plan

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Introduction

Outpatient commitment (OC) is an arrangement that has been debated frequently by healthcare professionals and patient organizations.

OC is present in many European countries, the United States, Canada, and Australia, but the content and laws are different.^{1,2} The purpose of these schemes is to contribute to the improvement and stability of patients' mental health. International studies, both qualitative and quantitative, show that patients' experiences with this scheme have both positive and negative aspects.³ An Australian study showed that OC reduces the need for hospital admissions for patients with major care requirements, but it is an ethical dilemma that treatment given against a patient's will compromises a patient's autonomy.⁴ Another major study literature review study found no significant correlation between readmissions

and treatment measures, although patients with OC used the municipal services more.⁵ Yet another literature review study has examined the experiences with OC in seven different western countries and found that patients' experiences of coercion was related to the information they received and the

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Table 1. An overview of outpatient commitment (OC) according to the Mental Health Act with guidelines.

| Criteria and framework for OC |
|--|
| <ul style="list-style-type: none"> • The patient's mental condition must meet the criteria of OC • The patient must have a known contact person in the hospital • The patient must have a home address in the community • The patient has the right to an individual plan for care • The patient must meet treatment appointments • The patient can be retrieved at home if the patient opposes treatment • New assessment of compulsion every 3 months by psychiatrist or psychologist |

relationship with health professionals.⁶ Another literature review, including 48 papers, found that planning for follow-up was important in the experience of those receiving an OC decision.⁷

In Norway, OC is a legal decision of the Mental Health Act for compulsory mental health care when the person stays in their own home.⁸ The law governing the use of compulsory mental health care in both specialist health care (hospital and district centers) and municipal mental health services.

Several Norwegian studies have highlighted different experiences in the interaction of patients, families, and healthcare professionals. A study of patients in the assertive community treatment (ACT) teams showed that patients with OC decisions had greater potential for recovery than those without an OC.⁹ A study that interviewed health professionals highlighted the dilemma of combining the role of the therapist with a control function, even if they saw that OC provided a secure framework for treatment.¹⁰ Another study of relatives of patients with OC decisions referred to the positive experience of OC providing safety and ensuring functioning in daily life.¹¹

The mental health service in Norway is organized on two main levels: a specialist health service and a primary care level in the municipality. The specialist health service is divided into hospital and district psychiatric centers (DPCs), which both provide diagnosis and consider coercive decisions. The hospitals have predominantly acute functions and the DPCs offer treatment, long-term follow-up and rehabilitation, and consist of both wards and outpatient clinics. DPCs are a link between the hospitals and the municipalities. The municipalities offer treatment, rehabilitation, and habitation to any resident in the municipality who has such needs.

The criteria for placing a patient on OC under the Mental Health Act are the same as they are for involuntary hospital treatment.⁸ The main criterion for using compulsory mental health care is that the patient must have a serious mental disorder. The patient must also be an obvious and serious danger to themselves and their health or to others' lives and health as a result of the mental disease—or the patient must fulfill the treatment criterion, which is a reduced prospect

of substantial improvement without treatment. Before patients receive OC decisions, voluntary treatment must have been either attempted or clearly futile, and the patient must have the opportunity to express their views. OC must also, overall, be the best option for the patient, with its justification as the best solution for the patient and their environment (Table 1).

OC has been debated over the last 20 years in Norway, and the government appointed a committee, to review the use of coercion in Norway.¹² This work led to changes in the Mental Health Act.⁸ On 1 September 2017, the law changed the treatment criterion, and patients are no longer subject to compulsion if the patient has competence to consent. To be able to consent, the patient must have sufficient information and insight to assess their own need for health care, and the consequences of refusing treatment according to the Patient Rights Act.¹³

Most patients with OC decisions have a psychotic disorder, with the most frequent diagnosis being schizophrenia.^{4,14} Patients with a diagnosis of schizophrenia often have significant functional impairments and may need close supervision by qualified personnel to function in daily life.^{15,16} Norwegian guidelines for the follow-up of OC are lacking. What treatment patients with OC decisions should be offered is not described in the national guidelines. Nevertheless, guidelines have been written about the follow-up and treatment of patients with psychosis, but they are not specifically related to OC: *People with severe mental illness and needs for specific services*, and the *National guidelines for assessment, treatment, and monitoring of people with psychotic disorders*.^{17,18}

An individual plan (IP) is an interaction tool for patients who need long-term mental health services and coordinated offers, according to the Mental Health Act, the Act on Patient and Service User Rights, and the Health and Care Services Act.^{8,13,19,20} If a patient with OC does not have an IP, the specialist health service must initiate its preparation. If the patient also needs healthcare services in the municipality, the specialist health service must cooperate with the municipality.

Over the last 10 years, however, there has been a noticeable reduction in the number of hospital beds in Norway. At the same time, the health authorities introduced the National Health Reform.²¹ This provides guidelines recommending that most of the treatment should be in the municipalities. Several guidelines in mental health care outline what should be included in the different service levels, but none highlights collaboration around patients with OC. The guideline *Together on coping* emphasizes the interaction of municipalities and the specialist health service for mental health work, but does not mention patients with OC decisions in particular.²²

Patients with OC decisions live in the community but are patients in the specialist health service, so it is useful to generate knowledge about how health professionals interact with patients, families, and each other. Thus, more research

in this area is needed. In Norway, “*Tvangsforsk*” (Network for research and knowledge about the use of coercion in mental health care), has made a research plan, 2014–2019, for this.²³ This plan points to the need for more research-based knowledge about decision-making processes when using coercion, and the content and frameworks for municipal health and social services.

The aim of the present study is to gain more knowledge about how the OC system works in the municipal health service and specialist health services, and how they collaborate with patients and across service levels from the perspectives of healthcare professionals.

Method

This qualitative, descriptive, exploratory study examines the health personnel’s experiences using focus group interviews.²⁴ The focus group interview is an open-ended group discussion on a specific topic.²⁵ For the present study, an interview guide was developed in collaboration with the research group. An interview guide with six open questions was developed to answer the study’s aim. The topics in the interview guide were: *The health personnel’s experiences with OC, how they follow up patients with OC, experiences of collaboration between service levels, and how OC works in a treatment context.*

Data collection and sample

The present study included two counties in central Norway with a countywide population of approximately 400,000 people. The health personnel provide services to patients with OC decisions in the mental health hospital, DPCs, and municipalities. We conducted four focus groups with health personnel from three DPCs and three municipalities. The leaders of the different units selected the participants in the study. All of the included health personnel had education and experience working with patients with OC decision. Six participants were invited to each group, although not all invitees met in the actual interview. It was difficult for the invited units to participate in the focus group interviews, although the participants decided on the time of the meeting. There were, therefore, two focus groups with four participants and two with two participants. We conducted interviews with altogether 12 health personnel, most of whom were women. The health personnel represented municipal housing, the wards, and DPCs, and consisted of psychiatrists and mental health nurses. The four focus group interviews were carried out between March 2018 and April 2018. There was a good range of experience in the groups, despite there being few participants in two of them. The main author was the moderator during all the interviews, and expert by experience was the assistant moderator for two of the interviews. The interviews lasted between 60 and 90 min and were digitally recorded and transcribed.

Data analysis

The analysis followed the steps of the qualitative content analysis inspired by Graneheim and Lundman.²⁶ Qualitative content analyses focus on subject and context, and emphasize variation, and similarities within and differences between parts of the text.²⁷ The main author, a co-author, and an expert by experience were responsible for the analysis. The expert by experience was engaged to ensure the user perspective during reflections on the study’s findings.

The text was read through several times to get a sense of all the material. Meaningful units were identified; each meaningful unit was condensed into a description close to the text and given a code. The analysis at different abstraction levels identified three categories, each of which had four subcategories. Finally, based on the latent content of the categories, the underlying meaning was formulated into a theme. Meaningful units that belonged together were grouped, and the theme, categories, and subcategories are shown in Table 2. The analysis of the four focus group interviews showed many views that coincided, which helped fill each one out.

Ethical considerations

All participants in the study were asked to take part voluntarily and had the decisional capacity to provide consent and gave their written informed consent. All the data were anonymized and the study. The present study originally received ethics approval from the Data Protection Services, in Norway, NSD project number 54144. The current study followed the principles defined by the Declaration of Helsinki.²⁸

Findings

The results describe the health personnel’s experiences with follow-up and their interactions with the patients who had OC decisions. A process of reflection and discussion resulted in one theme, three categories, and several subcategories (Table 2).

The theme based on the underlying meaning of the data indicates that “OC makes a difference” in the meeting between the health personnel and the patients, and across service levels. The health personnel believe that OC makes a difference, and that the follow-up of patients with an OC decision is extensive. The health personnel tend to give patients in the OC regime more time and closer contact than given to other patients.

The first category presents health professionals’ experiences with the use of OC. The second category discloses how the therapeutic relationships with the OC patients work. The third category deals with their experiences with the collaboration between hospital and municipality. The subcategories are presented under the three categories in Table 2. Later in the text, they are presented using example quotes.

Table 2. Overview of the theme, categories, and subcategories from the analyses of the interviews.

| Theme | Categories | Subcategories |
|-----------------------|---|--|
| OC makes a difference | A framework for OC follow-up | <ul style="list-style-type: none"> • OC is a statutory duty • Legislative amendment of consent competence makes the OC decision more demanding • OC provides the opportunity to give assistance • OC gives responsibility to the healthcare service |
| | Provide flexibility in cooperation with the patient | <ul style="list-style-type: none"> • Predictability creates security • Provide more help than the governing law • Implementation of OC depends on continuity • The dilemma of helping someone who does not want help |
| | The collaboration between the service levels is vaguely defined | <ul style="list-style-type: none"> • Cooperation between municipalities and specialist health services is characterized by coincidence • The individual plan does not work as a collaborative tool • Collaboration is developed through effective meetings • The municipalities are experiencing an increased burden |

OC: Outpatient commitment.

A framework for OC follow-up

A strongly evident category in the analysis was the framework that OC constitutes when following up patients outside the institution. The interviewees showed depth in their reflections on how they thought OC worked in practice, both for those as health personnel and in meetings with the patients.

OC is a statutory duty. Several of the interviewees referred to the OC as an “important duty” for the community to carry out to follow the law:

It's kind of part of our duties; however, once in a while this can be both heavy and difficult. (Psychiatrist)

All considered OC as a regulation to be used when patients cannot take care of themselves because of severe psychosis. Some said that OC should not be seen as an assault and used only when necessary—especially in situations where the patient is a danger to themselves or others. One said that the OC scheme has been criticized by several people and believed that public debate lacks the nuances about the reason for coercion.

Legislative amendment of consent competence makes the OC decision more demanding. The interviewees pointed out that it was becoming more demanding to make OC decisions. To make proper reviews of consent assessment, one must have good knowledge of both psychosis and the patient, because the competence to consent can often fluctuate rapidly in patients with psychosis:

I need more time . . . both on and thinking of writing . . . it is discretionary, and opinions differ among psychiatrists. (Psychiatrist)

Several mentioned that it could be difficult to assess a review, because many patients do not experience symptoms as a disease but as part of their self-image, even if their

experience lacks internal logic. Changes in the Mental Health Act have led to demands for more documentation:

Consent competence is a very relative thing and not universal in any way; it will fluctuate and that is perhaps the biggest problem with the new law. (Psychiatrist)

Several highlighted that it requires a lot of experience to be able to undertake good reviews before decisions are made, especially if they do not know the patient. All those who were interviewees believed that OC provides the opportunity to follow up the patients with the greatest assistance needs, including those with drug problems:

What we see as a huge problem is drugs, very complex issues. When drugs are in the picture, it makes things much more difficult. (Mental health nurse)

Some thought that OC not only is a control function but also gives meaning and purpose to the treatment.

OC provides the opportunity to give assistance. The interviewees emphasized that OC enables health personnel to be in a position to help people who cannot assess the risk of the situation in which they find themselves. They believe it to be unethical not to give help, even if the patient does not want this. Several said that OC might be necessary in certain periods:

I must say that the experience I have . . . so there has been a necessity in the period and it is not as if people are standing on the OC if they do not need it—a thorough assessment is made to give informed consent. (Mental health nurse)

OC gives responsibility to the healthcare service. During the interviews, many of the psychiatrists in DPCs said that they felt stronger responsibility for following up patients with an OC because there is a duty according to the law:

I feel more responsible for the OC patients and I want to give them the best deal. (Psychiatrist)

Interviewees from the municipality say that patients with an OC receive faster help from the hospital than other patients with psychotic symptoms. Several believed that an OC ensures use of medication to avoid relapse. They emphasized that it was important to end controlled forms of OC to prevent relapse. An OC decision provides a patient with a status that involves free health care in hospital:

Patients with OC do not pay deductibles, receive medication, are observed and have dinner for free. (Mental health nurse)

Those interviewed assessed OC as a protection for the patients, because the constraint is regulated and requires documentation, so the legislation safeguards patients' legal rights.

Provide flexibility in cooperation with the patient

This category shows that cooperation between the health personnel and the patients was essential. The interviewees emphasized the importance of flexibility in meeting patients with OC decisions, when following up patients both in their own home and at DPCs.

Predictability creates security. The interviewees pointed out that they considered patients with OC decisions to be a small vulnerable group, and it was important for these patients to feel taken care of. They were concerned that they have to provide a safe environment for patients with OC decisions, and it was important to define clearly who was responsible for the patients. Several of the interviewees mentioned the importance of creating an alliance with the patients, and that the health personnel have to show consideration in their approach:

These are not the patients who want a lot of collaboration . . . they keep people at a distance and are insecure and paranoid around them all . . . (Mental health nurse)

Some thought that this means taking "the whole package," by helping patients with everything they need. Several of the interviewees said that the patients seemed safer when they had OC decisions, and this was something that the patients themselves had told the health personnel.

Provide more help than the governing law. The interviewees believed that monitoring of OC involves providing assistance beyond what the law says. Several of the personnel from the DPC pointed out that OC meant showing "generosity," in addition to what is required by law. The health personnel showed this "generosity" and accepted the patients even if they came with no appointment:

The patient can show up without an appointment because they are scared or have something to discuss with the psychiatrist . . . then we clear a little space for them . . . (Mental health nurse)

The interviewees found that many patients felt a connection to the DPC after cancellation of the OC decision and wanted further contact. They pointed out that OC assumes comprehensive follow-up and this is much more than only medication:

So it is a lot about practicing habits and routines; things are as predictable as they have always been and . . . it helps to create the structure that they have so much trouble making themselves. (Psychiatrist)

Implementation of OC depends on continuity. The interviewees emphasized that follow-up of OC requires the follow-up to be holistic, with user involvement and facilitation of the patient's need for help. Frames and agreements were highlighted as important in meetings with patients. This was mentioned as an important part of environmental therapy, because external frameworks can help patients with the internal chaos resulting from their mental state. The interviewees saw it as a problem that it can be difficult to obtain frameworks for outpatient care, but it can also be difficult to get environmentally therapeutic measures into patients' homes. Some patients in the DPC are offered a "user-controlled bed," which patients can use as they wish. Many of the interviewees said that patients with OC decisions have often had long-term needs and extensive problems:

It's a fairly large system around every patient, quite demanding stories . . . some have a user-led voluntary admission agreement . . . (Mental health nurse)

However, for many patients, the interviewees felt that it was best to be followed up at home and not at the DPC. User participation was an area that interviewees felt was hard to achieve and explain to patients with psychoses:

Getting into a position to achieve dialogue is difficult; some who have been ill for many years and have been coerced several times do not want to talk about medications or vulnerable topics . . . (Mental health nurse)

The interviewees emphasized that the understanding and knowledge of health personnel were important in understanding patients' situations:

If we have someone who does not take the medicine or does not relate to their weekly schedule, we have conversations and wonder what the cause is—so we wait a few days before contacting therapists or the contact person in the emergency plan. We are trying to achieve some kind of understanding and cooperation to solve the situation. (Mental health nurse)

The dilemma of helping someone who does not want help. The interviewees spoke about patients with psychotic symptoms who do not want contact and isolate themselves. Some patients with an OC decision do not experience symptoms of psychosis as health issues, but as problems caused by others, and medication is identified as coercion. The interviewees found that many relatives reported their concerns about the support system. Many relatives assume a great deal of responsibility:

Relatives have often been overinvolved, and are tired both physically and mentally . . . and have given money to the patient. (Psychiatrist)

Some of those interviewed questioned whether there should be a human right not to receive treatment.

The collaboration between the service levels is vaguely defined

This category deals with collaboration between the service levels for patients with OC. This collaboration was a problem for the interviewees, who felt that collaboration between service levels was vaguely defined in relation to their experiences.

Cooperation between municipalities and specialist health services is characterized by coincidence. The interviewees believed that the responsibility shared by the DPC and the municipality seems to be fragmented both organizationally and in relation to responsibilities and roles—and that this could prevent cooperation:

I find it challenging here too, to get on with help, that it gets fragmented . . . there can be many levels and people, and who is really responsible? (Mental health nurse)

Many of the interviewees felt that cooperation depends on the individual and the distribution of responsibilities appears unclear. The municipalities were organized differently and the services consisted of many parts, which could be challenging. The interviewees had a problem in that follow-up of patients requires a lot of cooperation, which may be difficult to achieve. The DPC interviewees believed that, as a specialist health service, they were responsible for the patients with OC decisions, and they should be responsible for all the follow-up of these patients:

The way we do it with day care is most correct and justifiable and really easiest for healthcare personnel and patients to practice. Because we see the patient more often we have better control of medication and collaboration, and we often have more people who can ensure that this works. (Psychiatrist)

The IP does not work as a collaboration tool. The legislation provides guidelines, for patients who need coordinated and compound services, to put an IP in place to achieve good

health services. The interviewees experienced this collaboration tool not working. In particular, they found it difficult when the patient had psychotic symptoms:

He was very psychotic and it was not possible to get any writing at all from this patient. We collaborated, but it was simply not practical to write. We tried a few times, but the psychosis was so serious that what was written was not understandable. (Psychiatrist)

The interviewees said that many patients did not want the treatment being offered and did not want an IP; others did not understand what an IP was. Instead, they highlighted that patients were more positive about making a crisis plan:

A crisis plan is a simple and sometimes a good document; it is quite easy to work out and very concrete and . . . yes—pretty easy to relate to then. (Psychiatrist)

Several of the interviewees reported that the crisis plan was part of the patient safety program at the DPC.

Collaboration is developed through effective meetings. To achieve interaction that works across the service levels, the interviewees emphasized the importance of having effective meetings. They highlighted the importance of being able to work together around patients with OC decisions. The interviewees highlighted good dialogue as important across the levels for discussion and assessment of patients' situations. They pointed out that regular meetings and guidance from the specialist health service are of great importance for a good interaction:

I think we work more systematically with management group meetings and the collaborative meetings for the patients we have with OC. (Mental health nurse)

The interviewees highlighted teams from specialist health care, who traveled to the DPC and the municipalities to assist health personnel, as important for a good interaction between service levels:

A few years ago there was a patient who had been in the system for many years, with several admissions. The patient got a new home in the municipality, and the personnel group felt completely helpless. We used two full days where we went out and gave guidance to half the personnel group one day and the other group the next day, and since then the patient has not been admitted to us. (Mental health nurse)

The municipalities are experiencing an increased burden. The interviewees stated that the municipalities have had greater challenges and increased strain over recent years, since the introduction of the Cooperation Reform, because they have more responsibilities and treatment tasks:

One is, of course, required to have people who are pretty much worse than before in the municipality—more difficult to get into

admission where we see that it might be needed . . . (Mental health nurse)

The interviewees saw a problem with health personnel in the municipalities having little expertise with psychoses, and several thought that low competence leads to more coercion:

Now it says that treatment should happen where you live, which means that health personnel could prevent admissions and require a higher level of competence. (Mental health nurse)

Some of the interviewees believed that, among some employees in the municipalities, there was a fear of patients with psychosis; they believed that more resources in the municipality could have provided the opportunity for better follow-up of such patients, with perhaps fewer OC decisions. The interviewees pointed to relatives as a resource, so better follow-up of relatives is important. Some felt that improved collaboration across the health services could give patients with OC decisions a different follow-up in the municipality.

Discussion

OC and competence to consent

All those interviewed showed great insight into OC legislation, and the focus groups were surprisingly consistent in their views across service level and professional groups. An important finding in the present study is that the assessment of OC decisions became more demanding, following the law change in the Mental Health Act on 1 September 2017, related to the ability to consent. The purpose of this change was to strengthen patient rights, but also to respond to the criticism that an OC decision based on the treatment criterion is contrary to human rights.²⁹ From this perspective, the amendment of the law contributes to a strengthening of patients' rights, because the criteria for receiving an OC decision have become stricter.

On the other hand, the present study showed a problem with the fact that the change in the law can prevent patients with psychosis from receiving the necessary health care. It became a problem that consent assessments may have uncertain value when assessing OC decisions. Many patients with psychosis have fluctuating symptoms which can make them appear consensual, but, soon after, the psychosis may fluctuate again to create difficulties in making the right decision.

However, the present study also points out that assessment of consent competence depends on the competence of the specialist making the decision on an OC. To make a proper assessment, the patient should be well known to the specialist. If not, the patient's consent could be considered as made on the wrong basis.

As can be seen in the present study, it may seem that the existing criteria, including the consent competence, are not enough to make a complete assessment of a patient's condition. It is possible that more criteria are needed to ensure that

assessments of the needs for OC decisions are as accurate as possible.

OC and follow-up in treatment

The present study points to the dilemma in the use of coercion in the provision of mental health care. A challenge to the follow-up of patients with psychosis is that many such patients may not feel that they are ill and do not think that they need treatment; however, the health personnel experience the situation differently from the patients. A psychosis presents challenges to functioning in everyday life.¹⁵ The interviewees were concerned with creating a safe relationship with the patient, but they sometimes experienced the symptoms of psychosis making it difficult to establish a good relationship with the patient. This topic needs to be debated more widely.

The present study raises questions about what additional criteria should apply to OC decisions: what kind of follow-up is best for patients receiving such OC decisions and what OC treatment should include. On the other hand, the interviewees point out that a patient with an OC decision is followed up more closely than one with psychotic symptoms with no OC decision. Patients with OC decisions often receive their health care fast, so, in this way, the OC scheme also benefits the patient.

However, the OC decision itself may be an obstacle to establishing trust between patients and health personnel, and gaining user involvement. Patients with OC decisions receive assistance from both the municipality and the specialist health service based on different guidelines. Instead, the interviewees suggested that a small group of health personnel should have overall responsibility for patients with OC decisions across several health service levels. One Norwegian study showed that patients with follow-up from one permanent team experienced better recovery from symptom pressure.⁹ That study also points out that high competence in such a team can reduce the use of coercion.

Collaboration across health service levels

A key finding in the present study is that collaboration between municipality health services and specialist health services for patients with OC varies widely, and that the responsibility is too fragmented. The present study points out that there is no clear structure for cooperation across service levels for a patient with OC decisions. The Mental Health Act provides guidelines for patients with OC, stating that they should have a contact person in the specialist health service available to the patient, family, and municipality.⁸ However, the specialist health service has a responsibility for patients with OC decisions because these patients have patient status and need to be monitored regularly. Perhaps the contact person in the specialist health service should also be responsible for coordination between the municipality and the specialist health service for patients with OC decisions.

Patients with psychosis often need a lot of follow-up.¹⁶ Separate guidelines have been prepared to assist patients with psychosis between service levels, but there are no specific guidelines for patients with OC decisions, as the present study points out. However, these guidelines for psychosis point to the IP, which is an important interaction tool in the Mental Health Act and the Patient Rights Act provides user rights, and is mandatory for patients with OC decisions.^{8,13} However, the coordinating function for the IP is at the municipal level, although the specialist health service also has responsibility to implement the IP when the patient has an OC decision. Some of the interviewees have had good experiences with a crisis plan, as part of the IP, for patients with OC decisions.

Those interviewed in the present study believe that the IP does not act as a collaborative tool; this is justified by the fact that patients with an OC decision often do not interact with the IP or even want it. Possibly the patients are not sufficiently familiar with the IP or it is not a suitable tool for this patient group. Perhaps a patient lacks knowledge about what an IP is or should have improved mental health and consent competence before an IP is introduced. However, an IP shall ensure user involvement, so it is worrying that it does not work as it should.

Limitation

Focus group interviews for data collection is well known and have confirmability. To strengthen the validity in the interviews with the health personnel, the same moderator conducted the interviews together with an expert by experience. We conducted four focus groups, to achieve the necessary breadth of material.³⁰ A limitation in this study was that two of the groups was rather small because it was more difficult to recruit participants than we expected. However, the study participants had extensive experience working with patients with OC decisions, and the four group interviews showed that the interviewees shared many similar experiences, which indicated that the present study had reached data saturation.

To strengthen credibility and dependability, all the authors participated in the discussions through the analysis process. It was also important that the expert by experience participated in the analysis work to provide her perspective on the findings. The analysis process gave neutrality of the data, strengthened through the systematic documentation in the analysis process. However, this material was collected from some of the health personnel from a limited geographical area. More studies that are similar are needed before the findings can be generalized.

Conclusion

The present study investigated how OC works in treatment as seen from a healthcare perspective, and how collaboration between municipalities and specialist health services works. The health personnel believe that an OC decision makes a difference in the way patients with this decision are followed up.

They believe that the OC decision gives the patient rights and opportunities for the provision of mental health care. The legislative amendment with new requirements for consent competence was a problem. To make an OC decision was described as more demanding because consent competence could fluctuate along with the psychotic symptoms. Although the change strengthens patient rights, there is also a risk that such patients do not receive adequate health care. The present study points to the challenges related to collaboration across service levels. Good routines for collaboration across the service levels for patients with an OC decision are lacking. The IP, which is a statutory collaboration plan, was not used much.

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Author contributions

M.L. conducted the first analysis and statistical analyses of the manuscript and also wrote the first draft. T.L.H. discussed the analysis and wrote the manuscript draft. E.H. discussed the analyses and participated in critical revision of manuscript drafts. A.G. contributed to the analysis and participated in critical revision of manuscript drafts. All authors approved the final version.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Ethical approval

The study originally received ethics approval from the Data Protection Services, in Norway, NSD project number 54144. The current study has followed the principles defined by the Declaration of Helsinki (World Medical Association, 2013).


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Errata

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Dissertation title: *Management of patients with outpatient commitment in the mental health services*

Changes:

Page 12, tables:

Table 3: An overview of criteria and framework of OC according to the Mental Health Act with guidelines.....23

Page 17, paragraph 2: As a result of these methods, many patients suffered permanent injuries.

Page 26, paragraph 5: Psychosis may affect patients' perception of reality causing hallucinations, delusions and impaired functioning [66].

Page 30, paragraph 3: This study showed that the OC scheme reduces the need for hospital stay for patients with major care requirements.