


# Cooperation in the mental health treatment of patients with outpatient commitment

SAGE Open Medicine  
Volume 8: 1–9  
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DOI: 10.1177/2050312120926410  
journals.sagepub.com/home/smo



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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

Date received: 16 October 2019; accepted: 16 April 2020

## 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.<sup>1,2</sup> 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.<sup>3</sup> 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.<sup>4</sup> Another major study literature review study found no significant correlation between readmissions

and treatment measures, although patients with OC used the municipal services more.<sup>5</sup> 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"> <li>• The patient's mental condition must meet the criteria of OC</li> <li>• The patient must have a known contact person in the hospital</li> <li>• The patient must have a home address in the community</li> <li>• The patient has the right to an individual plan for care</li> <li>• The patient must meet treatment appointments</li> <li>• The patient can be retrieved at home if the patient opposes treatment</li> <li>• New assessment of compulsion every 3 months by psychiatrist or psychologist</li> </ul>

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

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.<sup>8</sup> 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.<sup>9</sup> 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.<sup>10</sup> Another study of relatives of patients with OC decisions referred to the positive experience of OC providing safety and ensuring functioning in daily life.<sup>11</sup>

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.<sup>8</sup> 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.<sup>12</sup> This work led to changes in the Mental Health Act.<sup>8</sup> 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.<sup>13</sup>

Most patients with OC decisions have a psychotic disorder, with the most frequent diagnosis being schizophrenia.<sup>4,14</sup> Patients with a diagnosis of schizophrenia often have significant functional impairments and may need close supervision by qualified personnel to function in daily life.<sup>15,16</sup> 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*.<sup>17,18</sup>

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.<sup>8,13,19,20</sup> 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.<sup>21</sup> 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.<sup>22</sup>

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.<sup>23</sup> 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.<sup>24</sup> The focus group interview is an open-ended group discussion on a specific topic.<sup>25</sup> 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.<sup>26</sup> Qualitative content analyses focus on subject and context, and emphasize variation, and similarities within and differences between parts of the text.<sup>27</sup> 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.<sup>28</sup>

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

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 cancelation 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.<sup>29</sup> 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.<sup>15</sup> 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.<sup>9</sup> 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.<sup>8</sup> 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.<sup>16</sup> 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.<sup>8,13</sup> 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.<sup>30</sup> 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.

### Acknowledgements

We wish to thank Elisabeth Håland Hals, who has worked as an expert by experience in Inland Norway University of Applied Sciences, for her role as co-moderator during the focus group interviews and her input into the work on the article. In addition, we thank everyone who participated in the focus group interviews.

### 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).

### Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Innlandet Hospital Trust and the Inland Norway University of Applied Sciences.

### Informed consent

Written informed consent was obtained from all subjects before the study.

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