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Absence of insight as a catch-all extra-legislative factor in Swedish mental health law proceedings

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Previous research indicates that insight is frequently used but rarely defined in mental health proceedings. This article examines how participants in Swedish administrative court proceedings use the concept of insight when discussing decisions regarding involuntary psychiatric care. Open-ended qualitative interviews were conducted with professional mental health court participants. The results show that lack of insight is used by the informants as an argument for all three legal criteria for involuntary psychiatric care in Sweden, as well as the criterion for release from forensic psychiatric care. It is concluded that there are troublesome legal and ethical implications of courts relying on a poorly defined concept such as insight in their rulings.

Keywords: civil commitment; compliance; conceptual analysis; ethics; insight; involuntary psychiatric care; mental health court.

Introduction

In this article, we examine how participants in Swedish administrative court proceedings use the concept of insight when discussing decisions regarding involuntary psychiatric care. In such proceedings, questions of the patient's mental condition and need for involuntary care are brought to the fore. While psychiatrists will argue in their applications to the administrative court that a patient is too mentally ill to manage their own psychiatric care, the patients in question will sometimes present a contrasting view to the court, arguing that they have the capacity to take care of their own medical

needs on a voluntarily basis, or that the need for such care is altogether lacking.

Previous research has shown that the concept of insight is frequently used but rarely defined in mental health proceedings (Arnold et al., 2019; Brophy, Roper, & Grant, 2019; Case, 2016; Diesfeld, 2003; Diesfeld & Sjöström, 2007; Freckelton, 2010; Holstein, 1993; Höyer, 2000; Peay, 1989; Perkins, 2003; Perkins, Arthur, & Nazroo, 2000; Sjöström, 1997). Elizabeth Perkins (Perkins, 2003) observes that insight was the single most consistently referenced psychiatric symptom [*sic*] during hearings in England. Kate Diesfeld and Stefan Sjöström's study of

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mental health review proceedings in Victoria, Australia, found that that term ‘insight’ appeared in 19 of their 25 cases (Diesfeld & Sjöström, 2007). In an ethnographic study in a Swedish context conducted by Sjöström, it was concluded that decision-makers placed extra-ordinary emphasis upon patients’ insight (Sjöström, 1997).¹

Several authors have drawn attention to the legal and ethical implications of courts relying on poorly defined concepts in their rulings on involuntary psychiatric care (Diesfeld, 2003; Freckelton, 2010).² A related topic concerns the use of insight in assessments of mental capacity. Paula Case points to how cases that come before the Court of Protection in England tend to import a clinical discourse of ‘lack of insight’ and ‘non-compliance’ in assessments of capacity to consent to care, despite insight not being explicitly mentioned in the Mental Capacity Act 2005 (Case, 2016). In Australia, The Victoria Supreme Court ruled that the capacity test under the *Mental Health Act 2014* had been misinterpreted in the lower court.³ Justice Bell opined that lack of insight, in the sense of not agreeing with the diagnosis received, is not alone determinative of a lack of decision-making capacity. Furthermore, he states that relying on insight is discriminatory against people with mental disorders, since lack of insight is not considered to be a decisive factor in assessments of capacity in relation to people not suffering from a mental disorder).

Involuntary psychiatric care represents a major infringement of the individual’s right to liberty, self-government and integrity. This places a high demand on fairness, legality and other due process-standards. To meet the legal requirements, it is important that there is a consensus among relevant actors regarding concepts that are used in legal arguments and verdicts. For that reason, it is important to investigate how the participants in court proceedings understand and operationalize insight (or the lack thereof) in assessments of whether a person should be subjected to involuntary psychiatric care.

Aim and method

We use conceptual analysis of qualitative data to provide an understanding of how participants in mental health court proceedings define the concept of insight in their practice. Open-ended qualitative interviews were conducted with professional court participants. Informants were not asked explicitly to provide a definition of, or even talk about, insight. When describing their work practices and experiences of mental health law cases, the informants themselves invoked the concept of insight.

The project *Expertise, Evidence and Ethics in Decisions on Involuntary Care (EEE)* takes an inter-disciplinary approach and combines qualitative in-depth interviews with documentary analyses. The results presented in this paper are based on the interviews with judges, attorneys, court-appointed psychiatrists (experts) and psychiatrists (parties). In addition to these categories of informants, interviews have been conducted with clerks, lay judges, prosecutors and civil servants at the National Board of Health and Welfare. Interviews with patients have been conducted in a parallel study. To date, 36 interviews have been conducted in the overall project. The interviews were conducted between February 2014 and May 2016. (Five follow-up interviews were conducted in 2018.) Interviewees included seven psychiatrists, four court-appointed psychiatrists, 11 judges, six attorneys, five lay judges, one prosecutor, one clerk and one civil servant.

A majority of the informants are active in the administrative courts in two larger Swedish court districts. Several recruiting techniques have been used. In one district, all judges, lay judges and law clerks were given the opportunity to participate in the study, while court-appointed psychiatrists, chief psychiatrists and attorneys were recruited using a combination of snowball sampling and randomized selection from court verdicts. In the other district, snowball sampling was used.

The design of the interview study is iterative; interviews have been conducted in stages, alternating with analysis of the material and calibration and development of interview questions and themes. All interviews were recorded, transcribed verbatim, and imported into nVivo 11, a software developed for qualitative research. Analyses were carried out using a constant comparisons method, whereby codes were derived from the data and emerging themes repeatedly checked against the material and codes. After an initial exploratory analysis, themes pertinent to the research questions of this paper were reanalysed separately. Repeated cycles of formulating themes and checking them against codes and raw data were carried out.

The interviews lasted approximately 1.5–2 hours, and informants were initially asked to describe their own role, as well as that of the other participants in the court room, and discuss their experiences of mental health law cases. The comparatively long interview sessions have aimed at generating a rich material with both scope and depth. Informants were given the opportunity to identify and define central aspects of the process and assessments at the heart of decisions on involuntary care, thus resulting in data that are governed by the actors' own understandings of their practices (Bryman & Burgess, 1994; Glaser & Strauss, 1967; Hammersley & Atkinson, 1995). Towards the end of the interviews the conversation has been increasingly guided by the interviewer, in order to render possible comparative aspects in the analysis. References to insight were repeatedly made by the informants when describing their work practices and experiences of mental health law cases.

Background

Criteria for involuntary psychiatric treatment tend to be broadly similar regardless of country: The patient must suffer from a serious mental disorder, meet a certain level of need for treatment, and involuntary treatment must

be necessary for the sake of the patient's health or safety, or for the protection of others (see Zhang, Mellso, Brink, & Wang, 2015, for an international overview of legal criteria for involuntary psychiatric care).

Swedish mental health law

The criteria for administrative involuntary psychiatric care in the Swedish Act on Involuntary Psychiatric Care [lag (1991:1128) om psykiatrisk tvångsvård] are initially three-fold: The patient should (a) suffer from a severe mental disorder, (b) have an indispensable need for qualified psychiatric in-patient care, and (c) refuse such care, or there are well-founded reasons to assume that the care cannot be given with his/her consent.⁴ The risk that the patient poses a danger to someone should be taken into account when assessing the patient's need for care, but is not a necessary condition. The criteria for outpatient civil commitment are similar; however, these rules and cases have not been specifically discussed in our material.

Sweden also has mental health legislation that is specific for criminal offenders: the Forensic Mental Health Care Act [lag (1991:1129) om rättspsykiatrisk vård]. The Swedish model for attribution of criminal responsibility is different from that of many other countries since it does not include a legal insanity defence. This means that mentally disordered criminal offenders are held responsible for their criminal acts if the elements of a crime (a prohibited voluntary act with a proper mental state) can be established. According to the Swedish penal code, persons found guilty of a serious crime that was committed 'under the influence of a severe mental disorder', and who are still suffering from such a disorder at the time of the trial, cannot be sentenced to prison (the so-called prison prohibition), but may instead be sentenced to forensic psychiatric care, which is a legal sanction among others.⁵ Whether or not an offender is sentenced to such care depends on the type and severity of the mental disorder, its relation to

the crime and the need for treatment. Forensic psychiatric care in most cases is tied to a ‘special court provision’, and a decision by the administrative court is required to grant release from the forensic care. Discharge of the care is only possible if there is no longer a risk that the patient relapses into serious criminality as a result of the mental disorder. The ‘dangerousness criterion’ is, hence, explicit in the forensic care legislation.

The Council of Europe’s Convention on the protection on human rights and fundamental freedoms is effective in Sweden as a statute. European Convention on Human Rights ECHR, Article 5. Article 5 states that no one shall be deprived of their liberty save in some specific cases and in accordance with a procedure prescribed by law. It is permitted for a public authority to interfere with the right to private life (European Convention on Human Rights, ECHR, Article 8) if it is in accordance with the law and deemed necessary. The concept ‘in accordance with the law’ has been subject to a wide range of requirements in the legislation as well as in the legal proceedings. A general rule is that when health care personnel decide to take measures that is limiting a patient’s freedom, such a measure is to be decided by a court (Instrument of Government, Chapter 2 Article 9). This rule is complemented by the right to a fair trial in ECHR Article 6 where it is stated that the determination of someone’s civil rights and obligations entitles them to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. This right, as all rights in the ECHR, is to be interpreted in line with the extensive case law from the European court. The conditions set in the Instrument of Government and the ECHR have led to the specific rules in the Swedish mental health legislation. Central requirements for this purpose are the right to an oral hearing, the right to a cost-free legal representative and the demand on the court to hear a specialist in psychiatry as an expert witness (the Act on Involuntary Psychiatric Care,

paragraph 36–38). Forensic Mental Health Care Act (the Swedish code of statutes 1991:1129)

The meaning of insight in psychiatry

Insight has been used and treated as an important concept in psychiatry since the middle of the nineteenth century (Markova, 2005). Around this time, it started to be considered relevant for diagnostic purposes whether patients realized or did not realize that they were mentally ill. Patients who did not understand that they were ill were thought to suffer from disturbances of a different and more severe kind than patients who recognized and labelled their own condition as a psychiatric disorder. Preserved insight was considered a sign of a better prognosis and a lesser need for psychiatric care.

In 1913, Karl Jaspers distinguished between the *experience of being* ill, which he called ‘*krankheitsbewusstsein*’, and *insight proper*, which he described as an *objectively correct assessment* of the nature and severity of the illness.⁶ In the latter case, the patient should be aware of the illness as a whole and be able to label each individual symptom as either sick or healthy (‘*krankheitsinsicht*’; Jaspers, 1963). The emphasis on making a correct assessment of one’s mental health status is replicated by Aubrey Lewis in the 1930s. Lewis defined insight as ‘a correct attitude toward a morbid change in oneself’ (Lewis, 1934, p. 333). The emphasis on the ‘correctness’ of the patient’s attitude implies that disagreement with the psychiatrist on the fact of illness requires ‘correction’. Paula Case (Case, 2016) points out that it is a questionable assumption since it presupposes that psychiatrists, unlike other professionals, never get assessments wrong. She continues: ‘Clearly Lewis’s definition speaks to a bygone era in which the process of diagnosis was assumed to be infallible and the patients’ perspective on their experiences was marginalised’ (Case, 2016, p. 367).

Not quite as bygone an era as Case (2016) might have wished for, however, as

present-day emphasis on compliance in definitions of insight suggests that patients' own understandings are still marginalized or even interpreted as signifying the opposite of what they themselves are arguing. Since the late 1970s compliance with medication became a frequently used interpretation of insight. If insight can be operationalized as compliance with the prescribed medical treatment, it seems to be assumed that the suggested medical treatment rests on a 'true understanding' of the patient's experiences – that is, that they are symptoms of a serious mental disorder that must be treated. Anthony S. David (David, 1990) proposed an often-cited definition in 1990, which includes compliance:

- (1) The recognition that one has a mental illness,
- (2) compliance with treatment,
- (3) the ability to relabel unusual mental events (delusions and hallucinations) as pathological.

Lack of insight in the context of clinical psychiatry hence denotes several different but interrelated phenomena. To lack insight can mean: that you do not know or recognize that you have a mental disorder (at all); that you are unable to distinguish veridical experiences from hallucinations, or ordinary beliefs from delusions; or that you for some reason fail to comply with the prescribed treatment.⁷

The meaning of insight in mental health courts

Despite the fact that lack of insight is often a central theme for discussions in court hearings, its meaning is difficult to derive from the written court decisions. It is thus not clear *how* insight is relevant to psychiatric discharge. As part of his work chairing an Australian review board, Ian Freckelton conducted an analysis of insight based on discussions in hearings concerning one specific case in 2000 (see Freckelton, 2010). The ruling made by the Mental Health Review Board revealed that insight was referred to as having a number of

different meanings: (a) acceptance of having a mental illness; (b) acceptance of having a particular mental illness, howsoever termed; (c) recognition of the signs and symptoms of the mental illness for the particular person – for example, delusions about persecuting neighbours or about a family member poisoning their food; (d) acceptance of requiring medical treatment for a mental illness; (e) acceptance of requiring a particular form of treatment for a mental illness – for example, antipsychotic medication, not just vitamin C; (f) recognition of the efficacy of pharmacotherapy or other interventions for maintenance of their mental health; (g) acceptance of the need for lifestyle limitations as a result of having a mental illness – for example, not drinking alcohol, not using marijuana and avoiding certain stressors; (h) recognition of the person's relapse signature – that is, the pattern of the return of symptoms; (i) ability to identify suitable remedial steps when symptoms are returning; and (j) capacity to formulate and implement a plan for responding when symptoms are recurring. In sum, when the concept of insight is used in mental health court, it may denote an array of possible targets of acceptance, understanding and recognition.

We know, then, that insight is considered to be a highly relevant factor in decisions regarding involuntary psychiatric care, and that the concept has a variety of different meanings. In the study at hand, we do not examine written court decisions, nor deliberations in the court room, but instead we analyse narratives provided by participants in the court about the proceedings, how they are conducted, the different roles played by the participants and what are considered to be central factors for the court's decisions. In the following section, results from interviews with psychiatrists, court-appointed psychiatrists, judges and attorneys are presented with analytical focus on how these actors use the concept of insight when discussing decisions regarding involuntary psychiatric care. Quotes and excerpts from interviews are used to highlight

and exemplify findings and interpretations from the study.⁸

Results

Interviewees in the study at hand refer to insight in different contexts when they describe and discuss their work practices and experiences of court hearings. Five broad themes can be discerned in the material for lack of insight:

- (a) mark of a serious mental disorder (by way of failure to recognize that one is ill),
- (b) failure to accept one's pressing need for care,
- (c) diminished decision-making capacity,
- (d) non-compliance with medication, and
- (e) inability to self-risk-assess –that is, to be able to foresee possible relapse in the future.

It is worth noting that each theme can be directly tied to one or more of the legal criteria for involuntary psychiatric care in Sweden – namely that the patient should (a) suffer from a severe mental disorder, (b) have an indispensable need for psychiatric in-patient care, and (c) refuse such care, or there are well-founded reasons to assume that the care cannot be given with his/her consent. Moreover, insight as self-risk-assessment can be linked to the 'danger criterion' in decisions concerning release from forensic psychiatric care. In the following we present each theme with exemplifying quotes.

Theme A. Absence of insight as a mark of a serious mental disorder

Absence of insight is described as demonstrating both the nature and severity of a psychiatric illness, and lack of recognition that one is ill per se is considered to be a sign of serious mental disorder. Informants describe how they can show to the court that the patient is very ill by leading the patients to display their lack of insight.

In Quote A1, a court-appointed psychiatrist describes techniques one can use to demonstrate to the court that a person has a severe mental disorder, by posing questions that will result in the patient demonstrating their lack of insight (see also Eriksson, Kindström Dahlin, & Radovic, 2017, for an analysis of how patients' statements are understood in court).

A1. I often want to illustrate the problem, for example severe mental disorder and the illness insight around it, then you can ask the patient 'do you have an illness? Yes, what kind of illness and how does it affect you? What kind of symptoms do you or do you not have, and so on. And then they get to articulate that and fairly open. And sometimes immense symptoms emerge really clearly. Some behave both manic and psychotic and so in the court room, and then it becomes sort of an own goal, if they contest the application.⁹ (Court-Appointed Psychiatrist 3)

In Quote A2 the same process is described from an attorney's perspective; clients who are very ill tend to talk themselves into rather than out of involuntary care measures, by way of demonstrating a lack of insight.

A2. [I]t is in the nature of the matter that you meet clients who are severely ill and do not have any illness insight... so why would you... it is not really a problem since the clients who are convinced that they are well, against better judgment if I put it like that... they present this standpoint so insistently that I don't have to do anything but to present this position and then I pose the question to the client and the client himself can answer and then the person concerned expands upon how wrong everything is and yes... then delusions and such may appear as well.¹⁰ (Attorney 1)

In the next quote, the psychiatrist describes a group of patients typically in need of involuntary care as individuals who have been ill for a long time, and who lack insight about their illness. This group of chronically ill

patients are partly described by their complete lack of insight about their condition.

A3. There are patients who have been chronically ill for many many years, they have their schizophrenia, they have no insight about that... they become really angry every time you mention the word and have been on numerous hearings like this in the administrative court and are equally provoked and offended every single time and then stop showing up.¹¹ (Psychiatrist 2)

An inability to accept that one suffers from a psychiatric illness, or a readiness to contest a diagnosis, is in itself considered to be an indication that the medico-legal criteria ‘suffering from a severe mental disorder’ is met. Attorney 1 is discussing how the potential ethical dilemma of effectively representing the client’s best interest – when attorney and client do not necessarily agree on what that is – does not really present itself. The attorney only needs to present such clients’ position, and the clients themselves will show to the court how untenable their position is, by way of demonstrating a lack of insight. The court-appointed psychiatrist describes how absence of insight – and thus presence of severe mental disorder – can be brought to the court’s attention by the patient him- or herself, and Psychiatrist 2 explains how this process is par for the course for an entire group, who in the end will stop attending the court hearings altogether. Their lack of insight is exhibited by their refusal to accept the diagnosis with which they are labelled every time they enter the court room.

Theme B. Absence of insight as failure to accept a pressing need for care

Absence of insight in relation to the need of in-patient psychiatric care is expressed on different levels. On some occasions lack of insight is cited as the primary reason that in-patient psychiatric care is needed. The judge in Quote B1 explains how lack of insight in turn

means lack of medical care, which means lack of medication, which the person needs:

B1. [T]hen it is about whether you should, whether you need to be in a hospital because you are in such bad shape that you have an indispensable need to be in a psychiatric clinic. And that is often related to what insight you have of being ill, because if you don’t understand that you are ill, then you don’t understand that you need care, that you need medication.¹² (Judge 3)

In Quote B2 a court-appointed psychiatrist discusses patients that she or he knows from previous experience will stop following the treatment plan as soon as they leave the inpatient care and relates this to the need of care. If it can be made probable that the patient in the future will be non-compliant with the medical treatment, this is an argument for an indispensable need for involuntary psychiatric care.

B2. And also, if, as often is the case, that there are paradoxes like yes, ‘the doctor says I’m ill, but I take the medications that are prescribed for me’, but the patient has a repeated history of stop taking their medications as soon as they are out of inpatient care. And then you can problematize this in the room and say: ‘okay but you mean that you have this and then you know that it is a chronic illness and that it needs treatment. That’s what chronic illnesses need, true?’ ‘Well, I suppose you can think that.’ ‘Yes, but how come that it has been like this and like this and like this, what is it that makes this time different?’ Yes, like that. It has a lot to do with, like the intention is that it should work for the patient, if you can show both for the lay judges and the judge, and yes, everybody that there is a need for care.¹³ (Court-Appointed Psychiatrist 3)

In Quote B3 the judge brings up an example of when a person who does understand that he is mentally ill, and who agrees that treatment is needed, but who predicts that such insight might not be solid enough to last.

Lack of insight can thus be established in a predictive mode, shaped in the form of a temporary awareness of the risk of losing insight in the future.

B3. Some patients have some form of illness insight too and may agree that they are severely ill . . . that they almost want to have involuntary care sometimes because they don't trust themselves . . . even if they somewhere understand that it is good, they don't trust that they will want to stay voluntarily tomorrow.¹⁴ (Judge 1)

Insight is thus also conceived of as related to a pressing need of psychiatric care. Lack of insight can be seen as an expression or symptom of an indispensable need of psychiatric care, either as a reason to be committed to involuntary care in the first place or to prolong the ongoing involuntary care.

Theme C. Absence of insight as diminished decision-making capacity

Some informants explicitly relate the absence of insight to the capacity to make a well-founded stance about one's treatment needs. The judge quoted in C1 argues that lack of insight negates altogether the ability to make a well-founded decision.

C1. If you lack insight, one does not think you are able to make a decision, a well-founded decision. It has a lot to do with insight.¹⁵ (Judge 3)

In the next quote, the judge specifically relates the inability to accept (the very much needed) care on a voluntarily basis.

C2. But also, when it comes to the question of consent [to receive care voluntarily], if someone is completely psychotic, one could expect that that person is unable to take a well-founded stance towards his or her need of care.¹⁶ (Judge 3)

Furthermore, according to the judge in Quote C3, since the capacity to take a position towards psychiatric care is jeopardized by a

diminished illness insight, a statement on part of the patient in favour of voluntary psychiatric care should not be accepted at face value. In such cases, patients need to demonstrate that they understand on a 'deeper level' – that is, not simply agree that they need the medication.

C3. [B]ut then it is also about assessing whether the person can receive care on a voluntary basis, for example . . . you assess whether he/she at all has the capacity to give consent. Sometimes, they may have the capacity to take a position, but sometimes they don't have . . . diminished illness insight, so that even if they say that they can agree to all this, you know, from previous experience that no, they don't really believe that because they don't understand on a deeper level why they should take all these medicines and then they will not do it.¹⁷ (Judge 1)

Insight is thus believed to be a key ingredient for any sort of informed decision-making, as the insight goes to the core of what it is to be informed. Thus, if there is reason to believe that a patient lacks insight, there is reason to doubt any claims signalling that an alternative, voluntary route to psychiatric treatment or care might be open.

Theme D. Absence of insight as non-compliance with medication

Another distinct theme in the material is that of compliance. Informants expand on how insight alone does not make a difference unless it translates into compliance with medication. In some cases, an explicit distinction is made between compliance with treatment, on the one hand, and realising that you are ill, on the other. The judge in Quote D1 describes how, at the end of the day, it all boils down to 'an ability to receive care'. Patients might demonstrate insight both in terms of awareness that they are ill and in terms of awareness that they need medication, but if that realization does not manifest itself as actually complying

with the prescribed medication, compulsory measures will need to continue. Even if the decision not to take the medication is informed, in the sense that the patient fully understands potential consequences of not taking it, compulsory measures are considered to be warranted.

D1. [O]r they do understand why they should take the medicine but they choose themselves not to do it because they get such side effects so they would rather receive... it may even be a decision that is really thought through, but the consequences could nevertheless be that they want to... and then you have to use coercive medication even though they know exactly what they do and has weighed in... but anyway.¹⁸ (Judge 1)

In Quote D2 below, an attorney makes the distinction between illness insight and compliance explicit, and states that compliance with medication is what is truly relevant to the court cases, rather than understanding that you are ill. She or he exemplifies with an instance that makes this unusually clear; the court wrote off the involuntary care despite a marked absence of insight on part of the patient, because compliance with medication could be demonstrated.

D2. You don't need to have illness insight. It is enough that you understand that if you don't follow these, you will be ill... And if the person does, well let's see. Goes to work, takes their shots. . . . There is no reason for compulsive care. The criterion that you need to understand that you are ill, you don't need that. It's not written anywhere. And to my great surprise, they wrote off the care.¹⁹ (Attorney 3)

Finally, the judge in Quote D3 discusses how insight can be elusive for a legal professional when trying to gauge whether or not someone meets the criteria of severe mental disorder, while compliance is tangible and possible to assess.

D3. While someone who has some illness insight, but still states that I don't want to medicate because I... it gives me such side effects, so I think I can manage without this, I will be okay anyway. Then... well, it is easier for me to assess that, than assess the disorder... well the question of whether there is a severe mental disorder.²⁰ (Judge 3)

Accepting one's medicines without complaint is presented in the material as a form of the litmus test for insight, so much so that scrupulous adherence to medical treatment can actually *replace* insight, as in D2 above. Conversely, insight without compliance lacks real value in court, as it does not translate into the desired behaviour on part of the patient.

Theme E. Insight as ability to self-risk-assess

A fifth analytical theme emerging from the interview material specifically addresses the assessment for release from forensic psychiatric care with special court supervision. The informants explain what they believe is required by the patient in terms of insight in a prospective sense, in order to be released from care. Here, insight is described as an overall ability to risk-assess the self, and to take adequate measures if need be. The judge in Quote E1 describes that the patient should not only be accepting the diagnosis, but also be profoundly aware of what the impairments entail, be prepared to recognize symptoms of relapse and be ready to seek help should such symptoms re-appear.

E1. [A]nd see if the personal circumstances, or the person's mental condition are such that the person still needs forensic psychiatric care, that the necessary care must be given with these special conditions, then I think that an important aspect when you should taper off the care is that the person realises his difficulties, his limitations. And can describe them and not just say 'I have paranoid schizophrenia', but also 'I know

about these difficulties, I have these warning signals, I know them and I know that I should seek care when this and this happens'. And there I think the illness insight is super important. That the patient shows the court that the patient knows his limitations and what the patient can do. Because it says a lot about the mental condition.²¹ (Judge 7)

Compliance with medication transpires as a central factor in decisions when interviewees discuss prospects of release from forensic psychiatric care. In Quote E2, a psychiatrist describes insight in terms of understanding that you suffer from a psychiatric illness, an understanding that also needs to be operationalized in the form of an acceptance to be on medication for life.

E2. I mean, the goal is to try to re-integrate these persons in the society, to have an understanding that you have an illness. That is one of the major issues, that you... that is that you can have an understanding that you might need medication perhaps for the rest of your life. This acceptance and the insight into that, it is a huge part of it.²² (Psychiatrist 1)

The psychiatrist in Quote E3 lists everything that needs to be in place for a release from care to be considered, finishing with insight as expressly synonymous with compliance.

E3. Then it is... we are talking about writing off then, you will have to say that most of them still have their illness, but it is well treated and it is stable and we can say that the risk of relapse in to criminality is low, if you look at it from the assessment model we have... So, when everything, the mental disorder is stable and you have not been admitted to hospital care, you have not had any substance abuse problems for at least the last six months, preferably a year, and you have stable housing conditions. Then you can write off the care. But then it is the illness insight too of course. The compliance, that is.²³ (Psychiatrist 1)

In Quote E4, the psychiatrist places extraordinary demands on the patient's willingness to take medication, defining it not only as compliance with medication, but rather as a willingness on the part of the patient to medicate despite what future, less rigorous psychiatrists may think.

E4. That you should have been free from substance abuse for at least two years, that's what I think anyway. That you should be prepared to continue to medicate in the future and I am almost inclined to think... but that you should be set up to defend your medication in the future, so even if another psychiatrist comes along and says, but perhaps we should try to taper off this, or something like that, then you should say, no, I want to continue with the medication in the future.²⁴ (Psychiatrist 5)

Finally, the judge in Quote E5 discusses insight regarding the need for medication, not merely as adherence to treatment, but as an understanding or acceptance that there is a future need for continuous medical treatment.

E5. That is what you try to look at, it has a lot to do with seeing how things have developed and that it is moving in the right direction and it might perhaps move in the right direction, but yet some further time of more stable... that is, you try to make certain that this stability has been achieved and that there is an insight about the need for medication, and yes, something like that.²⁵ (Judge 3)

Insight as the ability to risk-assess and hence be able to recognize and steer away from future precarious situations or hazardous impulses emerges distinctly – albeit not exclusively – from the material concerning forensic psychiatric care. Like the reasoning in Themes B and C above – insight as acceptance of need for care, and presence of decision-making capacity, respectively – it contains a temporal aspect. Insight proper must not be momentary but instead demonstrably and measurably ongoing, moored to observable behaviours

such as compliance with medication, or the identification and stifling of unsound impulses.

A note on the mental phenomena of insight

From the material can be extracted not only what the patient is expected to have insight about – the content of the insight – but that insight is described in states or acts of believing, recognizing, understanding and accepting. Insight is to *really believe* that you need psychiatric care. This can be contrasted against *agreeing* with what the psychiatrist says about the need for psychiatric care. Insight is also described as an *understanding* why medical treatment is needed, and the understanding sought after is, in turn, captured in terms of something that is *really thought through* or an *understanding on a deeper level*. Insight is to understand that one has an illness and that one might need medication for the rest of one's life, in combination with an acceptance of this situation. Mere understanding that one needs to take medicines in order to stay healthy does not necessarily equal insight. Moreover, insight is operationalized as a *realization* that one has certain difficulties and limitations. In descriptions of the ability to self-risk-assess, not having *reached* insight means a higher risk of relapse since the lack of illness insight suggests or implies a failure to be able to *process* earlier behaviour.

It might be concluded, from our results in combination with definitions of insight provided in textbooks, that there is – delicately put – an uncertainty about what kind of mental state insight is. David (1990), for example, describes it as an act of recognition (Peay, 1989), as an act of compliance (Holstein, 1993) and as an ability (Höyer, 2000). Compliance is best described in purely behavioural terms. One can only be compliant in a compliant manner. An ability or capacity is manifested through behaviour, but it denotes something further than what is shown in behaviour. It is possible to possess the ability

to perform a kind of action while not actually performing it. Recognition is something else again. While the recognition that you are ill or perhaps that someone else is hurting may be exhibited through your actions, the act of recognition is in itself neither an ability nor a behavioural act, but something that may be known from a purely subjective point of view. We do not explore this issue in depth here, but it stands out as an area worthy of further exploration.

Discussion

As we have demonstrated above, (lack of) insight is used in a variety of senses when participants in mental health court hearings describe and discuss their practice. A finding of great importance is that insight is used by the informants in relation to all legal criteria for administrative involuntary psychiatric care, as well as the criteria for release from forensic psychiatric care. To fulfil the Swedish legal criteria for administrative involuntary care the patient must (a) suffer from a severe mental disorder, (b) have an indispensable need for psychiatric in-patient care, and (c) refuse such care or there are well-founded reasons to assume that the care cannot be given with his or her consent. When the court is making a decision on release from forensic psychiatric care, it should be deemed that there is no longer a risk that the patient, as a result of the mental disorder, should relapse into serious criminality. In the following, we discuss the results in relation to these four legal criteria.

Informants describe how a lack of insight manifested in the courtroom will show to the members of the court that the patient is very ill. Court-appointed psychiatrists can illustrate to the court that the patient meets the first legal criterion for involuntary psychiatric care – suffering from a *severe mental disorder* – by means of showing to the court that the patient lacks insight that his or her experiences and beliefs are in fact symptoms of a mental disorder. By asking questions about the mental

disorder and symptoms, prompting the patient to describe experiences as unrelated to illness and letting them, in the words of Holstein (Holstein, 1993), ‘hang themselves’ (p. 103) – or, in the words of one of our participants, an ‘own goal’.²⁶ The simultaneous display and denial of symptoms are viewed as a clear sign that the patient suffers from a severe mental disorder. Attorneys in the material confirm that when clients argue their own cases in court, the presumed absence of insight will show to the court that the person is suffering from a severe mental disorder. To argue in court that you are not ill is considered to be a strong indication that you are.

Being non-compliant with treatment is further used as an argument for *indispensable need for qualified psychiatric in-patient care*. If there is reason to believe that the patient will not follow treatment instructions outside the hospital and therefore ultimately endanger his or her health, non-compliance is an argument for a need of involuntary care. Lack of insight in the sense of not realising that you are ill is also used as an argument for the existence of an indispensable need of psychiatric in-patient treatment. In short: lack of understanding that you need care indicates an indispensable need of care.

Impaired ability to make a well-founded stance about one’s treatment needs is also a sign of the need for coercive methods. The third criterion for involuntary psychiatric care states that either the patient must *refuse such care* or *there are well-founded reasons to assume that the care cannot be given with his or her consent*. Lack of insight is viewed as a factor that negates the ability to make a well-founded decision and that, in turn, is interpreted as a clear indicator that the care cannot be given with the patient’s consent. The patients are required to truly and on a deeper level understand that they must receive in-patient psychiatric care in order to not be subjected to involuntary care.

An interesting finding is that some informants (both physicians and lawyers) mention

patients’ own insight about their need for *involuntary* psychiatric care. It seems possible to express a desire to be coerced because you realize that the insight you have today may falter by the next morning.²⁷ In the situation described, the patient is not refusing but gives his or her consent to involuntary inpatient psychiatric care; however, it is assumed that there are well-founded reasons to think that a lack of insight blurs this consent, which, in turn, makes involuntary care possible.

Finally, intact insight speaks in favour of a possible release from forensic mental health care, and lack of insight is a hindrance for release. Release is only possible if there is no longer a risk that the patient, as a result of the mental disorder, will *relapse into serious criminality* and if it is *no longer deemed necessary with regard to the patient’s mental condition and other personal circumstances to be admitted to a psychiatric institution*. The demands for the proper level of insight for release is here considered to be high. It is required to have a deep understanding of how your disorder disables you, recognizing experiences as possible symptoms of a new psychotic episode and taking measures to prevent such an episode or even objecting to a hypothetical future doctor’s treatment plan if it involves tapering off medication.

Absence of insight as a catch-all argument for involuntary psychiatric care

Absence of insight, then, is a catch-all argument for involuntary psychiatric care. Recognition that one suffers from a mental disorder, capacity to understand whether one’s choices pose a serious threat to one’s health, capacity to assess whether one might be heading for a relapse and one’s willingness to go along with the medical recommendations made by the psychiatrist are all arguably relevant factors to consider when assessing whether or not a person may lawfully be coerced to receive care. It is, however, troublesome if a seemingly precise concept with a nebulous content is frequently used as part of

a legal argument in a court of law. There are of course numerous examples of concepts used in legal settings without being strictly defined; severe mental disorder [allvarlig psykisk störning] being one example of special relevance for the discussion at hand. The concept severe mental disorder is not clearly defined, neither in the legislation nor in the preliminary works, and might be evoked in different senses in different court hearings. In contrast to *lack of insight*, however, *severe mental disorder* is an explicit criterion for involuntary psychiatric care, while the former is as implicit as it is frequently used.

Ian Freckelton (Freckelton, 2010) labels insight as an ‘extra-legislative’ factor. To rely on factors not formally defined by law is also in his view deeply problematic. He writes:

Thus, there is a problematic gap between considerations actually taken into account in making important decisions about involuntary status, and the criteria formally stipulated for the exercise by legislatures. Disjunctions between law and practice of this kind do not conduce either to transparency or confidence in decision-making processes. (Freckelton, 2010, p. 203)

Freckelton (2010) further stresses that insight together with other such concepts used in mental health courts must be used with great care and that the courts need to assess whether their employment is justified by reliable evidence or whether they primarily are the product of subjective judgments.

During proceedings, the core issue concerns the person’s mental condition. The psychiatrist argues for the existence and severity of the patient’s mental disorder, while the patient may present a contrasting view of his or her mental status. Both parties try to persuade the court to accept their version of the person’s condition in relation to the legal criteria. If ‘lack of insight’ can be used to counter anything the person has to say about his or her mental health, need of treatment and possible consent to undergo such treatment on a

voluntary basis, there is not much room (if any) for the person to argue their case. It appears to be presumed that whenever patients express that they are not ill or that they do not need in-patient care, this is because they do not know that they are ill or they fail understand what is in their best interest. It is not because they do *not want* to be in a psychiatric hospital, or that they are, in fact, *not ill*. Furthermore, this assumption is shared by most participants in the courtroom. Even the attorneys appear to assume, more or less by default, that the standpoint and descriptions given by the client are false since they are the product of a lack of insight. The latter is especially troublesome from the perspective of everyone’s right to a fair trial. As one attorney describes it: ‘I have to argue that my client has said that he is completely healthy and should be released immediately. Of course . . . I cannot sit there and argue my own case . . . it cannot be done. Then I will do something wrong. It is against my instructions and I would probably be reported to the Bar Association.’ The duty of the attorney is to represent his or her client, meaning advocating the client’s wishes as they are expressed, not to represent some hidden ‘true beliefs’ that the client may have but be unaware of.

It thus appears as if Jasper’s (1913) and Lewis’s (1934) emphasis on a ‘correct’ attitude towards one’s (unhealthy) experiences is still very much present in today’s usage of insight in mental health courts. Having insight means that you agree with the psychiatrist about your diagnosis, your need for treatment and what kind of treatment you need. There is little or no room for presenting a position that is not in line with the psychiatrist’s testimony. This is not just problematic from a legal point of view, if involuntary care is invoked whenever the patient disagrees with the treatment plan or with the treatment period, this is also a potential problem for the psychiatric health care as such. Health care should, according to Swedish law, be based on an informed consent as well as patient participation and cooperation

(e.g. the patient's Act, the patient safety Act and the health care Act). How can this be fulfilled if diverging opinions are interpreted as grounds for involuntary care?

We do not argue that insight is irrelevant to the question of whether you need to be cared for against your expressed wishes, but it should not be given the testimonial weight it appears to have according to the results of this study. It cannot be assumed by default that the psychiatrist is right and the patient wrong with explicit or implicit reference to lack of insight. The latter entails that the meaning of insight comes dangerously close to obedience. Disagreeing with the psychiatrist's assessment does not necessarily entail lack of insight about your condition. Being non-compliant may be an informed decision (albeit perhaps a bad one) on the patient's behalf.

The right to make bad decisions

Different reasons for being non-compliant with medical treatment are offered up in our material. Patients may be non-compliant because they do not understand that they are ill or because they do not want the medication prescribed for some other reason, for instance because it has unpleasant side effects. Arguably, a multitude of conceivable examples on why someone might be non-compliant with the care can be provided: The reason you are reluctant to go with the pharmaceutical plan prescribed by the psychiatrist could be while you recognize that there is something wrong with you, you are unwilling to subscribe to the diagnosis provided by the psychiatrist and hence sceptical towards the particular kind of treatment offered; it could also be that you recognize that you are ill (and even that you have the specific diagnosis the psychiatrist provided you with) but you wish to remain ill. Conceivable reasons for the latter might be that you would rather suffer (if that is in fact what you do) or that you feel quite the opposite and want to continue doing so, or even that you feel neither, but just want to be what you are, even if that is ill. Further

possible explanations for being non-compliant could be that you for some reason (religious or other) are against medication, or that you would just prefer some other treatment, such as psychotherapy. Or you might think that you are ill but want to solve your problems on your own, without any help (or interference) from the medical services.²⁸

It can be questioned whether or not these possible reasons for not taking the medication prescribed and/or staying at the hospital are sufficient grounds for evoking involuntary psychiatric care.²⁹ Most of us make poor choices in relation to our health and well-being. We eat too much sugar, we drink too much alcohol, we fail to exercise. We spend our money to risk our lives by climbing Mount Everest, continue to live with a partner who is physically abusing us, and so on. Making bad choices for ourselves does not normally warrant coercive measures. Respect for autonomy and the right to make free choices is a corner stone in our society, and it is worth considering what degree or kind of insight people in general have when they make poor life choices.³⁰ Do we have to *really believe* in what we do instead of just *accepting* the consequences of a hasty decision? Do we have to understand ourselves and our experiences on a *deeper level*, and must our choices always have to be *really thought through* in order for us to be described as having the capacity for autonomy? It appears unreasonable to demand deeper, better or more profound insight from people who face involuntary psychiatric care than from the rest of us.

Ethical standards

Declaration of conflicts of interest

Susanna Radovic has declared no conflicts of interest

Lena Eriksson has declared no conflicts of interest

Moa Kindström Dahlin has declared no conflicts of interest

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent

Informed consent was obtained from all individual participants included in the study.

Notes

1. In some countries, e.g. Iceland, Portugal and Spain, lack of insight by the patient is one of the legal criteria for involuntary psychiatric care (Zhang et al., 2015).
2. It has also been disputed whether lack of insight provides a valid argument for civil commitment at all (Höyer, 2000).
3. The Victorian Civil and Administrative Tribunal.
4. A short note about the third criterion; the criterion was changed in 2000. Before, it read: ‘the patient refuses such care and as a consequence of his mental state, it is evident that he/she lacks the capacity to express a well founded reasoning with regard to that question.’
5. For a more thorough presentation of the Swedish model for the handling of mentally disordered criminal offenders see, for example, Radovic, Meynen, and Bennet (2015) and Bennet and Radovic (2016).
6. In a related and often rehearsed discussion in the field of medical sociology, a distinction is made between ‘illness’ and ‘disease’, where the former term broadly refers to an individual’s lived experience and understanding of a health complaint, while the latter denotes an ‘objective’ and recognized condition that is defined by medical practitioners, and which will grant the patient access to both healthcare provisions and benefits such as sick leave (Anspach, 2011; Eriksson, 2015; Jutel, 2009).
7. The usefulness of the concept in psychiatric practice has been challenged. The concept is imprecise and may often serve the function of pathologizing patients’ disagreement with the care offered (or coerced; Beaupt, 2018).
8. All interviews have been conducted in Swedish; quotes used to illustrate and present the research findings have been translated. The Swedish translation of ‘insight’ in the context of mental disorders is ‘sjukdomsinsikt’, which literally translates ‘illness insight’. The informants interchangeably use ‘sjukdomsinsikt’ and ‘insikt’ in the material, which is translated as ‘illness insight’ and ‘insight’, respectively. In instances when a straightforward translation of a term or expression has been difficult to find, the Swedish term is included in brackets.
9. Jag vill ofta belysa problematiken, till exempel allvarlig psykisk störning och sjukdomsinsikt kring den, så kan man fråga sig om patienten då ‘har du någon sjukdom? Ja, vad är det för sjukdom då och vad innebär det för dig? Vad har du för symptom eller vad har du inte eller har du haft symptom?’ och så där. Och då får de berätta om det, och ganska öppet. Och ibland så framkommer det väldiga vanföreställningar väldigt tydligt. Vissa betar sig både maniskt och psykotiskt och så i rummet, och då blir det lite självsmål, om de nu bestrider ansökan till exempel. Men jag försöker inte att visa upp en patient eller utsätta, exponera patienten för onödigt lidande, men samtidigt vara tydlig för rätten så att de fattar att patienten är sjuk då exempelvis. (Sakkunnigläkare 3)
10. [D]det ligger i sakens natur att man träffar klienter som är svårt sjuka och som inte har sjukdomsinsikt... så varför skulle man... det där är ju inget problem heller därför att dom klienter som är övertygat friska mot bättre vetande om jag uttrycker mig så... dom för ju fram den ståndpunkten så pass ihärdigt att det är ingenting jag behöver göra utan jag presenterar den inställningen och sedan ställer jag frågan till klienten och så får klienten själv berätta och då blir breder ju vederbörande ut sig kring det där om hur fel allting är och ja... det kan ju vara vanföreställningar och så som kommer fram också. (Advokat 1)
11. Det är patienter som har varit kroniskt sjuka i väldigt många år, dom har sin schizofreni, dom har ingen insikt i det... blir jättearga varje gång man nämner det ordet och har varit på ett otal sådana här förhandlingar i förvaltningsrätten där dom blir lika provocerade och kränkta

- varje gång och därför slutar dom att gå. (Läkare 2)
12. S]jedan handlar det ju också om huruvida man skall... om man behöver vara på sjukhus för att man är i sådant dåligt skick så att man oundgängligt behov av att vistas på en psykiatrisk klinik då. Och det hänger ju ofta samman med vilken insikt man har om att man är sjuk, för att förstår man inte att man är sjuk, då förstår man inte heller att man behöver vård, att man behöver medicinera. (Domare 3)
 13. Och också om det är då som det ofta är att det finns paradoxer, som att ja, 'doktorn säger att jag är sjuk, men jag tar medicinerna som är ordinerat till mig', så har patienten en uppvisade gånger i historien slutat med sina mediciner så fort de kommit utanför slutenvården. Och då kan man problematisera det lite i rummet och säga 'okej, men du menar att du har detta och sen så du vet att det är en kronisk sjukdom och den behöver en behandling. Det behöver kroniska sjukdomar, inte sant?' 'Jo, men så kan man tycka.' 'Ja, men hur kommer det sig då att det har varit så här och så här och så här, vad är det som gör att det inte kommer bli så den här gången?' Ja, så där. Det handlar mycket om liksom man syftar ändå till att det ska fungera för patienten, om man kan visa för både nämndemän och domaren och ja, alla att det finns ett vårdbehov. (Sakkunnigläkare 3)
 14. Vissa patienter har ju någon form av sjukdomsinsikt också och kan hålla med om det att dom är väldigt svårt sjuka... att dom nästan vill ha till och med tvångsvård ibland för att dom inte litar på sig själva... även om dom någonstans förstår att det är bra... så är dom inte säkra på att dom kommer att vilja stanna kvar frivilligt i morgon. (Domare 1)
 15. Har du ingen insikt så tycker man att du inte kan ge något ställningstagande, ett grundat ställningstagande. Det är mycket den där insikten. (Domare 3)
 16. Men och även när det gäller frågan om samtycka, om det är någon som är helt psykotisk så kan man ju tänka sig att den personen då inte kan ta ett grundat ställningstagande till sitt vårdbehov. (Domare 3)
 17. [Men det är ett sådant begrepp som är både lite juridiskt och lite medicinskt men sedan så handlar det också om att kunna bedöma om personen kan ta emot vård på frivillig väg till exempel... bedömer om den har förmåga att överhuvudtaget lämna ett samtycke. Ibland kanske dom har förmåga att ta ställning men ibland kan det också vara så att dom inte har så... bristande sjukdomsinsikt så att även om dom säger att jag kan tänka mig allt det här så vet man av tidigare erfarenheter att nej men så tycker dom egentligen inte för dom förstår i grunden inte varför dom ska ta alla dom här medicinerna då kommer dom inte göra det. (Domare 1)
 18. [E]ller dom förstår att dom borde ta medicinerna men dom väljer själva att inte göra det för dom tycker att dom får sådana biverkningar så dom vill hellre ha... det kanske till och med är ett genomtänkt beslut men konsekvensen kanske ändå blir att dom vill vara... då måste man tvångsmedicinera ändå trots att dom kanske vet precis vad dom gör och har vägt... men i alla fall. (Domare 1)
 19. Du behöver inte ha sjukdomsinsikt. Det räcker att du förstår att om du inte följer dessa så kommer du bli sjuk... Och gör personen det då ja, får se. Går till jobbet, tar sin spruta... Finns ingen anledning med tvångsvård. Kriteriet att förstå att man är sjuk det behöver man inte. Står ingenstans. Och till min stora förvåning så avskrev de. (Advokat 3)
 20. Men... och även när det gäller frågan om samtycka, om det är någon som är helt psykotisk så kan man ju tänka sig att den personen då inte kan ta ett grundat ställningstagande till sitt vårdbehov. Medans någon som ändå har viss sjukdomsinsikt men ändå säger att, jag vill inte medicinera för att jag... det här har sådana biverkningar på mig, så att jag tycker att jag kan klara mig utan det här, det går bra ändå. Då kan det ju... alltså, det är ju lättare för mig att bedöma det än att bedöma sjukdoms... alltså frågan om det finns någon allvarlig psykisk störning. (Domare 3)
 21. [O]ch titta på om de personliga förhållanden, eller personens psykiska tillstånd är sådana att personen alltjämt behöver rättspsykiatrisk vård, att den nödvändiga vården behöver ske med stöd av de här särskilda villkoren, så tycker jag att det är en viktig aspekt när man ska skriva ut en person att personen känner till sina svårigheter, begränsningar. Och kan beskriva dem, och inte bara säga 'jag har paranoid schizofreni', utan att 'jag känner

- till de här svårigheterna, jag har de här varningssignalerna, jag känner till dem, och jag vet att jag ska söka vård när det här och det här uppkommer'. Och där tycker jag att sjukdomsinsikten är jätte viktig. Att patienten visar för rätten att patienten känner till sina begränsningar och vad patienten kan göra. Därför att det säger väldigt mycket om det psykiska tillståndet. (Domare 7)
22. [J]ag menar målet är ju ändå att försöka integrera dom här personerna åter i samhället, att få förståelse för att man har en sjukdom. Det är ju en av dom stora sakerna, att man... alltså att man kan ha en förståelse för att man kan behöva medicin kanske resten av livet ut. Alltså den här acceptansen och insikten i det, det är ju ett jättestort moment i det. (Läkare 1)
23. Sedan är det ju... man pratar ju om när man skall få avskriva då, så får man ju säga så att dom flest har ju kvar sin sjukdom då men den är välbehandlad och den är stabil och vi kan säga så här att risken för återfall i brott är låg om vi nu ser utifrån den skattningsmodellen vi har då... Så när allting, det psykiska sjukdomen är stabil och man inte har legat inne på sjukhus, man har inte haft en missbruksproblematik minst på det senaste halvåret, gärna ett år och du har ett stabilt boende och runtomkring. Då kan du skriva av det. Men då är det sjukdomsinsikten också så klart. Följsamheten alltså. (Läkare 1)
24. Att man skall varit missbruksfri två år, tycker jag i alla fall. Att man skall vara inställd på och fortsätta medicinera för framtiden och jag är nästan benägen och tycka det... men att man skall vara inställd på att man försvarar sin medicinering för framtiden, så även om det kommer någon annan läkare och säger, men skall vi inte pröva och sätta ut den här eller någonting sådant där, så skall man säga det, nej jag vill fortsätta med medicinering för framtiden. (Läkare 5)
25. Det är ju det som man försöker titta på, där handlar det väldigt mycket om att se hur liksom saker och ting har utvecklats och att det går åt rätt håll och det kanske går åt rätt håll men att det krävs ytterligare en tid av lite mer stabila... alltså att man kan se att den här stabiliteten har uppnåtts och att det finns en insikt om att man behöver medicinera och, ja lite så. (Domare 3)
26. For a closer examination of this practice, see Eriksson et al. (2017).
27. How this reasoning relates to the legal criteria is somehow unclear. Either the patient must refuse necessary care, or there must be well-founded reasons to assume that the care cannot be given with his or her consent. If none of these prerequisites are fulfilled a decision on involuntary care cannot be made.
28. It should be noted that non-compliance with medication is not special to treatment for psychiatric disorders. For example, Dorothy Faulkner and colleagues showed that after one year 54% of patients were non-compliant with hormone replacement (Faulkner, Young, Hutchins, & McCollam, 1998). In a systematic literature review, Holger Schmid and colleagues documented that more than half of the included studies reported non-adherence rates of more than 50% of dialysis patients (Schmid, Hartmann, & Schiffl, 2009).
29. Conversely, a patient may be compliant, while not realizing (or agreeing that he is mentally ill). Ian Freckelton (Freckelton, 2010) recollects a story of a person with no insight about his illness, but who was highly motivated to not being coerced and therefore went along with the treatment. The judge argued: '[a]lthough the applicant does not have insight into his condition or is not prepared to accept that he suffers from schizophrenia, nevertheless I am satisfied on the evidence that he appreciates that it is necessary for him to comply with conditions of a like nature that have been imposed as a condition for him being granted leave including his compliance with a medical regime prescribed for him, if he is to continue to live in the community' (Re An Application by DC, unreported, Victorian Supreme Court, 9 December 1998, p. 24–5.) In this example, compliance without acceptance seems related to the possible alternative (threat) of coercive treatment.
30. The construction of special legislation pertaining to people with mental disorders has been questioned on both ethical and legal grounds. For example, it has been argued that the discrepancy between somatic and psychiatric care is unmotivated on ethical grounds and that capacity for informed consent should be used in both cases (see, e.g., Doyal & Sheather 2005). Szmukler, Daw, & Dawson, 2010). A

recent discussion also pertains to whether involuntary psychiatric care is in fact in conflict with the Convention on the Rights of Persons with Disabilities (CRPD; Nilsson 2017).

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