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How do they unfold in primary mental health care settings, and what can be done to prevent them?

Doctoral thesis

NTNU
Norwegian University of Science and Technology
Thesis for the Degree of
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Tittel på avhandlingen:
Forløp mot tvangsinnleggelser. Hvordan utfolder de seg i kommunale helsetjenester, og hva kan gjøres for å forebygge dem?

Tema:
Kommunale helsetjenesters rolle og muligheter for forebygging av tvangsinnleggelser.

Sammendrag:

WHO og FNs menneskerettighetsorganer, helsepolitiske myndigheter og brukerorganisasjoner har de siste årene kommet med krav om å redusere bruken av tvangsinnleggelser av voksne i psykisk helsevern. Denne avhandligen handler om hva som skjer før slike tvangsinnleggelser, og har fokus på kommunale helsetjenesters rolle og muligheter for forebygging.

I denne studien har jeg og mine kolleger samarbeidet med personer i fem norske kommuner. Ansatte som jobber i tjenestene, personer med egenerfaring med alvorlige psykososiale utfordringer og/eller tvangsinnleggelser og pårørende deltok i studien. Målsetningen var å finne ut hva som kjennetegner forløp mot tvangsinnleggelser og hva som kan gjøres i kommunale psykiske helsetjenester for å forebygge slike innleggelser. Vi ønsket også å utvikle en helhetlig intervensjon for kommunale psykiske helsetjenester som kan bidra til å redusere antall tvangsinnleggelser. For å undersøke dette samlet vi inn data gjennom kvalitative intervju, både individuelt og i grupper, og avholdt dialogkonferanser og tilbakemeldingsmøter med personer i de fem kommunene.

Vi avdekket flere mangler og forbedringsområder i kommunale psykiske helsetjenestesettinger, og det var ikke jobbet systematisk med reduksjon av tvangsinnleggelser i disse tjenestene. Resultatene tyder på at det kan være mulig å redusere tvangsinnleggelser gjennom målrettede tiltak i kommunale psykiske helsetjenester. I tråd med dette utviklet vi sammen med deltakerne en helhetlig intervensjon for kommunale psykiske helsetjenester og deres samarbeidspartnere. Intervensjonen består av seks strategiområder med ulike tiltak som kan implementeres i tjenestene for å jobbe mot redusert bruk av tvangsinnleggelser.

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enthusiasm, and go-ahead spirit on behalf of the services and the people you set out to help – it has been tremendously inspiring to collaborate with you!

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LIST OF PAPERS

Paper 1

Wormdahl, I., Husum, T. L., Kjus, S. H. H., Rugkåsa, J., Hatling, T., & Rise, M. B. (2021). Between No Help and Coercion: Toward Referral to Involuntary Psychiatric Admission. A Qualitative Interview Study of Stakeholders' Perspectives. *Frontiers in Psychiatry, 12*(1348). doi:10.3389/fpsyt.2021.708175

Paper 2

Wormdahl, I., Husum, T. L., Rugkåsa, J., & Rise, M. B. (2020). Professionals' perspectives on factors within primary mental health services that can affect pathways to involuntary psychiatric admissions. *International Journal of Mental Health Systems, 14*(1), 86. doi:10.1186/s13033-020-00417-z

Paper 3

Wormdahl, I., Hatling, T., Husum, T. L., Kjus, S. H. H., Rugkåsa, J., Brodersen, D., Christensen, S. D., Nyborg, P. S., Skolseng, T. B., Ødegård, E. I., Andersen, A. M., Gundersen, E., Rise, M. B. (under review). The ReCoN intervention: A co-created comprehensive intervention for primary mental health care aiming to prevent involuntary admissions. *Under review in BMC Health Services Research*

SAMMENDRAG (Norwegian summary)

Kommunale psykiske helsetjenester yter tjenester til voksne med alvorlige psykiske lidelser, ofte over lang tid. På tross av primærhelsetjenestens sentrale rolle er de fleste studier om reduksjon av tvangsinnleggelser i psykisk helsevern relatert til tjenester på spesialisthelsetjeneste nivå. Vi mangler så langt kunnskap om primærhelsetjenesters rolle i forløp mot tvangsinnleggelser, og hvordan man kan forebygge slike innleggelser allerede i de kommunale psykiske helsetjenestene. Det er heller ikke utviklet helhetlige intervensjoner for kommunale psykiske helsetjenester som har til hensikt å redusere tvangsinnleggelser. Målsetningen med denne avhandlingen var derfor å undersøke hvordan forløp mot tvangsinnleggelser fremstår på primærhelsetjenestenivå, og hva kommunale psykiske helsetjenester kan gjøre for å forebygge slike innleggelser.

Aktører i fem norske kommuner deltok i kvalitative intervjuer, fokus grupper, dialogkonferanser og digitale feedback møter. Avhandlingen inkluderer tre studier hvor vi; (1) undersøkte hva som karakteriserte personers forløp mot henvisning til tvangsinnleggelse, (2) kartla barrierer og muligheter i kommunale psykiske helsetjenester, og (3), basert på denne kunnskapen, samskapte en helhetlig intervensjon for kommunale psykiske helsetjenester med mål om å redusere tvangsinnleggelser.

Avhandingens resultater viser at det er mangler (artikkel 1) og barrierer (artikkel 2) i de kommunale psykiske helsetjenestene som kan vanskeliggjøre forebygging av tvangsinnleggelser. Det tyder på et potensiale for å redusere tvangsinnleggelser ved å intervenere på dette tjenstenivået. Basert på disse resultatene ble ReCoN intervensjonen utviklet med seks strategiområder, hver med to til fire tiltaksområder som inneholder konkrete tiltak (artikkel 3). Avhandlingen bidrar med ny og praksisrelevant kunnskap som kan implementeres i kommunale psykiske helsetjenester ved målsetting om å redusere tvangsinnleggelser. Det trengs videre studier for å vurdere ReCoN intervensjonens effekt, og skaffe kunnskap om primærhelsetjenesters rolle i andre kontekster.

SUMMARY

Primary mental health services, which in Norway is the responsibility of the municipalities, provide services to adults with severe mental illness, often long-term. Despite primary health care's central role, most studies regarding reducing involuntary psychiatric admissions relate to specialist mental health care. We lack knowledge about primary mental health care's role in pathways towards involuntary admissions and how such admissions can be prevented already at this care level. This thesis aimed to explore how pathways towards involuntary admissions unfold in primary mental health care and what primary mental health services can do to prevent such admissions.

Stakeholders in five Norwegian municipalities participated in qualitative interviews, focus groups, dialogue conferences and digital feedback meetings. The thesis includes three studies where we; (1) examined what characterised individuals' paths towards referral to involuntary admissions, (2) mapped barriers and opportunities within primary mental health services, and (3), based on this knowledge, co-created a comprehensive intervention for primary mental health care intending to reduce involuntary admissions.

The thesis's results reveal gaps (study 1) and barriers (study 2) within primary mental health care that can impede the prevention of involuntary admissions. It shows a potential to reduce such admissions by intervening at this care level. Based on these results, the ReCoN intervention was created with six strategy areas, each with two to four action areas with specific measures (study 3). The thesis adds new and practice-related knowledge that can be implemented within primary mental health care when aiming to reduce involuntary admissions. Further studies are needed to assess the effect of the ReCoN intervention and get knowledge about the role of primary mental health care in pathways towards involuntary admission in other contexts.

ABBREVIATIONS

CRPD	The UN Convention on the Rights of Persons with Disabilities
GP	General practitioner
ReCoN	Reducing Coercion in Norway
SMI	Severe mental illness
WHO	World Health Organisation

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1 INTRODUCTION

This thesis concerns what happens before involuntary psychiatric admission of adults. The focus is on the role of primary mental health care and the potential to intervene at this care level to reduce such admissions. The studies included in this thesis form part of the first stage of the Reducing Coercion in Norway (ReCoN) trial. The ReCoN trial aims to develop (stage 1) and test (stage 2) a comprehensive intervention for primary mental health care intending to prevent involuntary admissions (ClinicalTrials.gov, NCT03989765). In this thesis, involuntary admission refers to admissions of adults involving the legally regulated use of coercion in the sense that the individuals have no choice but to be admitted for inpatient treatment at a psychiatric hospital/mental health care facility against their will (Szmukler, 2010). Other forms of coercion used in mental health care settings, like community treatment orders/involuntary outpatient treatment, involuntary medical treatment, coercive inpatient measures, informal coercion, or experienced treatment pressure, are not included. The pathway toward an involuntary admission only goes as far as the involuntary admission. Factors regarding the actual involuntary admission and how they are carried out are thus beyond the scope of this thesis.

Involuntary admissions are commonly related to severe mental illness (SMI). Mental illness constitutes a significant challenge. It is estimated that up to one in four people worldwide, including Norway, will experience a mental health condition during their lifetime (Norwegian Institute of Public Health, 2014; United Nations Department of Economic and Social Affairs, 2022). According to the World Health Organization (WHO, 2019a), depression is one of the most common causes of disability, suicide is the second topmost cause of death among young persons aged 15-29, and schizophrenia and other psychoses affect approximately 24 million people (1 in 300 people). Further, persons with psychosis are 2 to 3 times more likely to die earlier than the general population. In addition, they commonly experience stigma, discrimination, and human rights violations (United Nations Department of Economic and Social Affairs, 2022; WHO, 2019a).

The use of involuntary admission to treat and care for persons with SMI has apparent implications for their liberty and is ethically and professionally controversial as it contradicts the fundamental principle of patient autonomy (Mezzina, Rosen, Amering, & Javed, 2019; Sashidharan, Mezzina, & Puras, 2019; United Nations, 2006). The 2006 United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) outlined the value of eradicating the use of coercion in mental health care (United Nations, 2006). The convention, which came into force in 2008, clarifies the human rights to liberty, autonomy, and free choice in health and treatment for individuals with SMI. According to the United Nations human rights status of ratification interactive dashboard (2021), the CRPD is now endorsed by most countries globally, with 184 state parties and eight signatories (numbers as of 16 December 2021).

Psychiatry is the only medical speciality that treats a significant number of their patients against the patients' will (Claassen & Priebe, 2010). Over the last few decades, national and international organisations, health authorities, and advocacy organisations have called for a reduction in the use of involuntary admissions (Mezzina et al., 2019; Norwegian Ministry of Health and Care Services; The Norwegian Directorate for Health and Social Affairs, 2006; United Nations, 2006; United Nations Special Rapporteur, 2017; Zinkler & von Peter, 2019). Some also advocate for no involuntary admissions (Sugiura, Mahomed, Saxena, & Patel, 2020). Despite the widespread support for the CRPD, the practice of involuntary admission is still considered applicable in mental health care settings worldwide (Mezzina et al., 2019; Rains et al., 2019). Some dissents pivot around weighing the value of individual rights to autonomy and free will versus their right to health and (evidence-based) treatment (Appelbaum, 2016). Although, according to Sugiura, Mahomed, et al. (2020), there is evidence that effective non-coercive models of care can better serve the right to health.

1.1 The extent of involuntary admissions

The rate of involuntary admissions differs between and within countries (Gandre et al., 2018; Hofstad, Rugkåsa, Ose, Nyttingnes, & Husum, 2021; Hofstad, Rugkåsa, Ose, Nyttingnes, Kjus, et al., 2021; Rains et al., 2019). Rains et al. (2019) found that rates of involuntary admissions varied from 14.5 per 100,000 people in Italy to 282 in Austria in 2015. Norway has a relatively high rate compared to other Western countries (Wynn, 2018). In 2018 the rate was 186 involuntary admissions per 100,000 people 16 years and older (The Norwegian Directorate of Health, 2020). The rate of referrals to involuntary admissions was considerably higher, with a rate of 275, as 38% of the referrals to involuntary admission did not result in involuntary admission (Bremnes & Skui, 2020). The differences in rates might reflect differences in legislation and service context, but can imply there is potential to decrease numbers where rates are high (Gandre et al., 2018; Hofstad, Rugkåsa, Ose, Nyttingnes, & Husum, 2021; Hofstad, Rugkåsa, Ose, Nyttingnes, Kjus, et al., 2021; Rains et al., 2019).

The rates of involuntary admissions have increased or been stable in several Western countries over the last few decades (Rains et al., 2019), including Norway (Bremnes & Skui, 2020). Comparing annual rates available from 2008-2017, Rains et al. (2019) found that Australia, the UK, France, and the Netherlands had an average annual percentage increase in rates of involuntary admissions by 3.44, 4.13, 4.71, and 5.18, respectively. During the same period, Norway reported an average annual percentage decrease of 1.45 (Rains et al., 2019). However, numbers available from the Norwegian Directorate of Health show this trend has changed during the last few years. As shown in Figure 1, from 2017 to 2020 the number of involuntary admissions increased from 7508 to 8682 (The Norwegian Directorate of Health, 2018), equal to an average annual percentage increase of 5.2. Various explanations have been set out as to why involuntary admissions tend to rise in several Western countries. Some examples include shorter hospital stays, which leads to increased readmissions; increased community mental health service provision, which identifies more psychiatric patients; urbanisation; and a decrease in the general public’s tolerance of deviant and strange behaviour (de Jong et al., 2017). The increasing numbers result in growing concerns and intensify the call to reduce this practice in Norway and other European countries (Parliamentary Assembly of the Council of Europe, 2019; The Norwegian Equality and Anti-Discrimination Ombud, 2019).

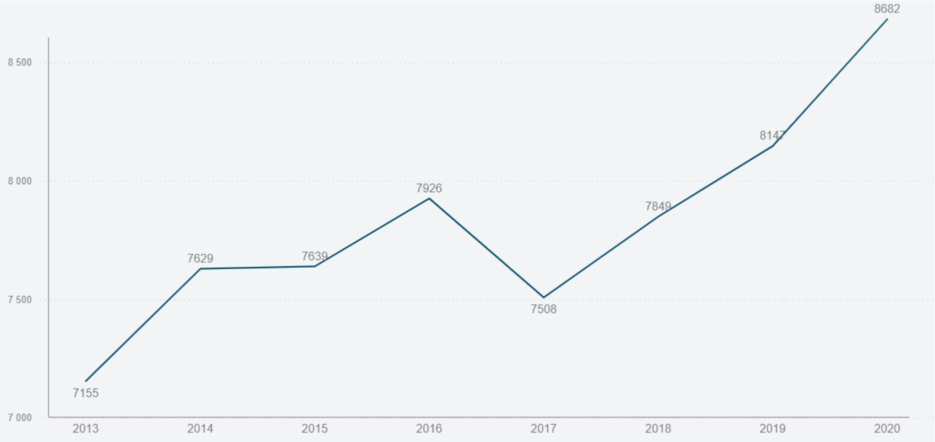

Figure 1: Number of involuntary admissions in Norway 2013-2020 (graph retrieved from https://www.helsedirektoratet.no/statistikk/kvalitetsindikatorer/psykisk-helse-for-voksne/tvangsinnleggelser-i-psykisk-helsevern-for-voksne. Access date: 29 December 2021). The drop seen in 2017 can relate to the legislative change that came into force on September 1st 2017, where lack of capacity to consent to treatment became part of the legal criteria (Bremnes & Skui, 2020).

Those who get involuntarily admitted are a heterogeneous population. However, some characteristics are associated with an increased risk of involuntary admissions. Several studies have examined clinical and social factors associated with increased risk of involuntary admissions. A systematic review, meta-analysis, and narrative synthesis by Walker et al. (2019), including 77 studies from 22 countries, found that the clinical characteristics of being diagnosed with psychotic disorder and previous involuntary admissions were the risk factors most strongly associated with involuntary admission. These factors more than doubled the chances for involuntary admissions. A bipolar disorder diagnosis and positive symptoms of psychosis also increased the risk.

Further, an increased risk was seen when individuals had reduced “insight” into their illness, reduced adherence to treatment before hospitalisation, and were perceived as a risk to others. Among demographic factors, male gender, single marital status, unemployment, and receiving welfare benefits were associated with an increased risk of involuntary admission. In addition, a positive relation was found between living in deprived areas and involuntary admissions (Walker et al., 2019).

1.2 Primary mental health care’s essential role

Deinstitutionalisation has dominated major mental health care reforms across the Western world since the 1950s (Claassen & Priebe, 2010; Davidson, Mezzina, Rowe, & Thompson, 2010; Keet et al., 2019; Mezzina et al., 2019). As a result, smaller locally embedded hospitals and services in the community have replaced large hospitals and asylums. This has also been the case in Norway, where this shift was followed by an upscaling of primary mental health services directing, among other things, the responsibility of long-term care for individuals with SMI to this care level. Consequently, some issues of deinstitutionalisation are closely linked with specific aspects of locally embedded mental health services providing care where people live and work (Claassen & Priebe, 2010; Keet et al., 2019).

Norway is a high-income country with a publicly funded welfare state and extensive public services. In Norway, two independent administrative levels provide health services: primary health care and specialist health care. Four state-owned Regional Health Trusts (The Norwegian Government, 2021) are responsible for specialist mental health care. Their 22 Regional Hospital Trusts (The Norwegian Government, 2021) and 77 Community Mental Health Centres (Norwegian Institute of Public Health, 2019) provide acute and long-term inpatient treatment and specialist community-based outpatient treatment, including ambulant/outreach treatment. In 2020, specialist mental health care reported a labour force of 3.61 full-time equivalents per 1000 inhabitants (Statistics Norway, 2020). Regulated by the Norwegian Mental Health Act, the specialist services hold the legal authority to decide and effectuate involuntary admissions (Norwegian Ministry of Health and Care Services, 1999). According to this act’s § 3-2 (involuntary observation) and § 3-3 (involuntary admission), criteria for involuntary admission are that the individual has a severe mental disorder, needs treatment, and/or pose a risk to themselves or the life and health of others. The regulations also require that options for voluntary engagement have been exhausted or are obviously futile. Since 2017, only those who lack the capacity to consent to treatment can be involuntarily admitted unless there is a risk (Norwegian Ministry of Health and Care Services, 2017).

Further, a medical practitioner independent of the secondary inpatient unit must assess the need for involuntary admission (Norwegian Ministry of Health and Care Services, 1999). This is typically done by a primary health care medical practitioner who, if assessed as necessary, refers the individual to involuntary admission (Røtvold & Wynn, 2016). The gatekeeper role of primary health care general practitioners (GPs) and out-of-hours medical emergency services towards other services thus includes involuntary admissions. When referred, the individual is dispatched to specialist mental health care. Normally, the acute inpatient psychiatric hospital unit that has the legal authority to decide and effectuate involuntary admissions (Norwegian Ministry of Health and Care Services, 1999).

Primary health care has a central role in treating and caring for individuals with SMI at risk of involuntary admissions. They are typically those providing non-acute services and general support to individuals with SMI and are thus frequently in contact with adults at risk of involuntary admissions (Gooding, McSherry, & Roper, 2020). Accordingly, primary mental health services can be vital in detecting early signs of deterioration or relapse and be an essential provider of premises to prevent involuntary admissions.

The Norwegian Municipal Health and Care Service Act regulate primary health care in Norway. This act does not authorise services to decide and effectuate involuntary admissions (Norwegian Ministry of Health and Care Services, 2011). Primary health care in Norway is the responsibility of the 365 Norwegian municipalities. They provide, among other things, primary mental health care to persons with SMI, including individuals at risk of involuntary admission. Primary mental health care is often interdisciplinary with primary addiction services. It includes various services like sheltered housing, daycare facilities, leisure activities, therapeutic counselling, home-based care and support, transport to doctor’s appointments or leisure activities, and medication distribution. In 2021 Norwegian municipalities reported 3.1 full-time equivalents working within primary mental health and addiction services per 1000 inhabitants (The Norwegian Directorate of Health, 2021). The municipalities also provide general medical services, including GPs and out-of-hours medical emergency services. GPs operate as family doctors, and all living in a Norwegian municipality have the right to be affiliated with a GP. GPs have a central role in primary health care as they are professionally responsible for their patients’ medical coordination and referrals to specialist health services and other primary services (Norwegian Ministry of Health and Care Services, 2013).

Over the last few years, primary mental health services in many countries, including Norway, have increasingly adopted the values of recovery orientation as the framework for their service provision (Keet et al., 2019; Slade & Wallace, 2017). Recovery-oriented mental health services have a comprehensive approach, not merely focusing on an individual’s illness and symptoms. Services with a recovery-oriented approach promote citizenship, support individuals living with SMI in having meaningful and productive lives, and foster hope by believing recovery is possible (Le Boutillier et al., 2011; Slade & Wallace, 2017). They value individual autonomy and view people living with SMI as experts in their own experiences (Le Boutillier et al., 2011; Slade & Wallace, 2017). In this perspective, when aiming to prevent individuals from ending up in pathways towards involuntary admissions, the search for solutions needs to include personal, relational, social, and contextual aspects that are related and interact within the context of such pathways (Ramon, 2018; Sommer et al., 2021).

1.3 Interventions to reduce involuntary admissions

To be subject to involuntary admissions can be traumatic and cause fear and distress for both the person in question and family carers (Akther et al., 2019; Sashidharan et al., 2019). In addition, such admissions are expensive for services and the wider society (Sashidharan et al., 2019). Moreover, although some say they experienced getting better (Hem, Gjerberg, Husum, & Pedersen, 2018), there is limited evidence that coercive practices in mental health care lead to better outcomes for those subjected to them (Kallert, Glockner, & Schutzwohl, 2008; Luciano et al., 2014; Sashidharan et al., 2019). Accordingly, there has been a call for measures to reduce the use of involuntary admissions (Parliamentary Assembly of the Council of Europe, 2019; The Norwegian Directorate for Health and Social Affairs, 2006; United Nations Special Rapporteur, 2017; Zinkler & von Peter, 2019).

We know little about outpatient mental health care factors associated with lower levels of involuntary admissions. Studies have found some factors like access to alternatives additional to hospital services (Gandré et al., 2017; McGarvey, Leon-Verdin, Wanchek, & Bonnie, 2013), having contact with multiple services (Priebe et al., 2004), regular outpatient contacts (de Jong et al., 2017; van der Post et al., 2009), involvement of family members, and the use of sheltered housing and voluntary admissions (de Jong et al., 2017), to be preventive strategies. In addition, studies of the admission process and the involuntary admission report stakeholders experienced a lack of collaboration between services (Sugiura, Pertega, & Holmberg, 2020), lack of information and involvement in treatment decisions (Akther et al., 2019), difficulties in getting preventive help before an acute crisis (Stuart et al., 2020), domination of a biomedical view (Sugiura, Pertega, et al., 2020), and lack of adequate support for family carers (Stuart et al., 2020).

Research on involuntary admissions has primarily been done at the specialist health care level. Primary mental health care's role during individuals' paths towards involuntary admissions thus remains largely undocumented (Hatling, 2013; Røtvold & Wynn, 2016). For instance, none of the 74 articles included in a review focusing on involuntary admissions in Norway looked at factors within primary mental health care (Wynn, 2018). However, in a recent register data study, Hofstad, Rugkåsa, Ose, Nyttingnes, Kjus, et al. (2021) examined the association between selected characteristics of primary mental health services and level of involuntary admissions in Norwegian municipalities. They found that higher labour-year levels of GPs and mental health nurses were associated with a lower level of involuntary admissions. The total number of labour-years in primary mental health and addiction services did not show the same association. Further, more public housing per population was associated with a lower level of involuntary admissions. In contrast, supported employment services, services managers' scores of the level of recovery perspective, and the systematic inclusion of service users' experiences in services were associated with higher levels of involuntary admissions (Hofstad, Rugkåsa, Ose, Nyttingnes, Kjus, et al., 2021).

So far, there is little research on interventions aimed to reduce involuntary admissions and what exists has almost exclusively been conducted at the specialist mental health care level. Bone et al. (2019) searched for evidence for psychosocial intervention in a rapid evidence synthesis. Of 949 randomised controlled trials reporting on 15 psychosocial interventions, only 19 studies reported involuntary admission as an outcome. The findings supported measures for crisis planning and self-management effectiveness. Other reviews found advance statements effective, including advance directives and crisis plans (Dahm et al., 2017; de Jong et al., 2016; Sashidharan et al., 2019), although some single studies report no effect (Papageorgiou, King, Janmohamed, Davidson, & Dawson, 2002; Thornicroft et al., 2013).

Including a broad range of coercive practices, Gooding et al. (2020) found that many studies focusing explicitly on efforts to prevent/reduce coercion showed an effect in prevention, reduction or discontinuation. In inpatient settings, comprehensive approaches have shown more significant effect than less comprehensive approaches in reducing coercive measures such as seclusion or restraint (Mann-Poll et al., 2018; Van Melle, Noorthoorn, Widdershoven, Mulder, & Voskes, 2020). Examples are the Six Core Strategies (Gooding et al., 2020; Huckshorn, 2011; Lebel et al., 2014; Putkonen et al., 2013), Safe Wards (Bowers, 2014; Bowers et al., 2015; Gooding et al., 2020), and the High and Intensive Care model (Van Melle et al., 2020). These approaches comprise strategies to facilitate organisational, practice, and culture change and address interventions towards different system levels, from leadership, staff, and physical environment to participation and individual treatment (Bowers, 2014; Gooding et al., 2020; Huckshorn, 2011; Van Melle et al., 2020). Despite primary mental health care's central role in providing services to individuals with SMI, equivalent comprehensive interventions developed for primary mental health care seem to be lacking. Gooding et al.'s (2020) review, referred to above, performed a broad scoping review of studies concerned with preventing and reducing multiple forms of coercion and compulsion in the mental health context. They identified 121 studies, of which only ten were referred to under the category of community-based strategies, and most were performed at a specialist mental health care level. None of the 74 articles in the abovementioned Norwegian review examined interventions at primary mental health services (Wynn, 2018).

Furthermore, most studies examining how to reduce involuntary admissions are quantitative; qualitative studies are sparse (Gooding et al., 2020). How to target primary mental health care interventions according to the needs of service providers and individuals at risk of involuntary admissions is thus not known. To successfully implement primary mental health care interventions they have to "fit" the stakeholders affected by pathways towards involuntary admissions (Greenhalgh, Jackson, Shaw, & Janamian, 2016). More detailed knowledge of how services in primary mental health care settings affect pathways towards involuntary admissions is needed in order to target primary mental health care interventions.

As shown above, knowledge about primary mental health care's role during pathways towards involuntary admissions and interventions to reduce involuntary admissions developed for this care level are lacking. To address this knowledge gap, this thesis focuses on primary mental health care and explores how pathways towards involuntary admissions unfold and what can be done to prevent them. Since in-depth knowledge of primary mental health care's role during pathways towards involuntary admissions is mainly lacking, the thesis uses qualitative research methods.

2 AIMS

The aim of this thesis was to explore how pathways toward involuntary admissions unfold in primary mental health care and what can be done within these services to prevent such admissions. To answer this aim, we performed three studies with the following aims:

Aim of study 1

To explore what characterises individuals' paths that end in referrals to involuntary admissions, as experienced by relevant stakeholders.

Aim of study 2

To explore mental health professionals' experiences with factors in primary mental health services that might increase the risk of involuntary admissions and their views on how such admissions might be avoided.

Aim of study 3

To co-create a comprehensive intervention for primary mental health care intending to reduce involuntary admissions.

3 METHODS

As just shown, with a focus on primary mental health care, my aims were to explore how involuntary admission pathways unfold and can be prevented and use this knowledge to create a comprehensive intervention that could be implemented by the collaborating services in the second stage of the ReCoN trial. We found that an overall qualitative approach was suitable to address these aims due to its ability to explore stakeholders' experiences (Brinkmann & Kvale, 2018; Malterud, 2017) and include them in the co-creation of the intervention (Adelman, 1993; Gergen, 2015; Greenhalgh et al., 2016; Ness & von Heimburg, 2020). Providing a detailed, reflexive account of how research is conducted is vital to assessing qualitative research quality and the validity, relevance, and transferability of the results (Kvale, 1995; Malterud, 2001, 2017). In this chapter, I will first outline the theoretical positioning of this thesis. Then I describe its design and methodological approach. Following that, a detailed report is given on the recruitment of participants, the sample, data generation, and analysis used throughout studies 1-3. I return to a discussion about the strengths and limitations of the methodological approach in Chapter 5.

3.1 Theoretical positioning

The theoretical positioning of a research project guides the understanding and interpretations of the researchers and forms the basis for methodological and analytical approaches (Malterud, 2017). In this section, I will account for this thesis's philosophical and theoretical underpinnings.

Social constructionism

I associate the philosophical framework of this thesis with a social constructionist stance, presuming that our understanding of the world is socially constructed (Gergen, 2015; McNamee, 2010, 2014). Gergen, who has been an important voice within social constructionism, proposed, "what we take to be the truth about the world importantly depends on the social relationships of which we are a part" (Gergen, 2015, p. 3). In this perspective, knowledge is constructed through people's interactions in social, historical, and cultural contexts (Gergen, 2015). Collectively established traditions and shared values will affect how we perceive and act. Relations and interactions in context, therefore, become essential. Language and communication become central to knowledge construction when assuming meaning is collectively constructed through our interactions. This is also where the potential for change is present (Gergen, 2015; Hersted & McNamee, 2021).

In social constructionist research, the research phenomena are studied as situated in their contexts, and the knowledge obtained is one of several potential social constructions of the phenomena (Hersted & McNamee, 2021; McNamee, 2010). Knowledge is assumed to be constructed *with* others through our relations and interactions. Mutual understandings are formed among individuals within a context through social interactions (Gergen, 2015). Communication with and between the stakeholders involved in pathways towards involuntary admissions was thus central for this research project to facilitate new knowledge about the researched phenomenon. As Gergen (2015, p. 32) stated, "the moment we begin to speak together, we have the potential to create new and more promising ways of being." Thus, we found qualitative methods and a participatory research design to be suitable for operationalising the research aims of this project. They allow for methods that rely on central elements in social constructionism like relations, communication, and contextual dependency. We could invite those involved in pathways towards involuntary admissions to question and reflect upon their culture of treatment and care and collectively construct mutual insights and new joint actions for future service provision.

This project's qualitative and participatory approach, which I elaborate on below, facilitated knowledge construction *with* the stakeholders affected by pathways towards involuntary admissions (Adelman, 1993; Brinkmann & Kvale, 2018; Malterud, 2017). It facilitated access to people's experiences (Hummelvoll, 2021) about pathways towards involuntary admissions. Further, it allowed the knowledge to be constructed through interactions and related to the context where such pathways unfold (Borg, Karlsson, Kim, & McCormack, 2012; Gergen & Gergen, 2015; Ness & von Heimburg, 2020). Taking a social constructionist perspective made me recognise that those with first-hand experience of pathways towards involuntary admissions have a unique insight into how such pathways unfold. It acknowledged that all stakeholders that interact throughout pathways towards involuntary admissions were essential to obtaining the polyphony needed for the knowledge construction in this research project. We thus aimed to include the full range of stakeholders in the project.

Power relations are present in people's relations and interactions (Gergen, 2015). Such power relations affect our interactions and communication (Gergen, 2015; Olesen, 2020). Larger institutions or systems often impact the construction of knowledge and define our contextual traditions, interactions, and communication (Gergen, 2015). The view of what is the proper treatment and care to provide when persons get severely mentally ill, for example, falls within this category. Given the relational power differences among those participating in this research project, it was essential to be aware of and regard such power relations (Hersted & McNamee, 2021) – both between participants and researchers and participants. However, we cannot eradicate all power relations influencing our interactions (Gergen, 2015). How different power relations were present in this research project, what we did to minimise them, and how they could have affected the data generation and knowledge construction will be further addressed in the methodological discussion in chapter 5.

According to Gergen (2015), there is a connection between knowledge and social action – different views of reality lead to different actions. Former research regarding involuntary admissions and reducing such admissions are mainly related to specialist mental health services (Gooding, McSherry, & Roper, 2020). In this project, the focus is on primary mental health care. As such, the knowledge construction in this project can contribute with new knowledge, supply existing knowledge, and add knowledge generated from a different perspective or context than former research, which were mainly done at the specialist mental health care level. From a social constructionist perspective, adding new or alternative views of reality can contribute to new action alternatives (Gergen, 2015). By adding new knowledge from primary mental health care, the new and different perspectives of the results in this research project thus hold the potential to challenge traditional interaction patterns.

Systemic theory

In a social constructionist perspective, pathways to involuntary admissions can be seen as formed by the mutual interactions of those involved and the culture and common traditions within its context (Gergen, 2015). How such pathways unfold are thus affected by the relations and interactions of multiple stakeholders. Within primary mental health care organisations, the culture, staff interactions, and common assumptions about the world affect how primary mental health managers and staff act when faced with individuals with SMI at risk of involuntary admissions. Organisational conditions of the primary mental health care form part of its context, affecting how those working within primary mental health care act when faced with situations along pathways towards involuntary admissions. In addition, their social relations and interactions with other services, those in need of help, and their family carers also play a part in how everybody (inter)acts.

In systemic theory, the individuals within a unit like primary mental health care, communities, or families are seen as parts of a system that operate as a whole (Hersted, Ness, & Frimann, 2020). Within a community, systems are related to and interact with other systems (Hersted et al., 2020). Systemic theory has evolved to incorporate a social constructionist perspective (Lorås, Bertrando, & Ness, 2017) and see social interaction, language, and communication as vital to facilitating systems change (Hersted et al., 2020). From a systemic theory perspective, the primary mental health care system represents a set of facilitating and limiting structures regarding service provision to individuals with SMI at risk of involuntary admissions. I found the systemic theory perspective helpful when exploring the role of primary mental health care and the potential to intervene at this care level. It guided the foci for knowledge construction to be related to the primary mental health care as a system or organisation. The gaps and limitations experienced by the participants to have been present in an individual’s treatment and care could be related to the primary mental health care system. As opposed to an individual action controlled by personal choices and the capacities of the professionals themselves. This perspective ensured an ethical consideration of directing potential criticism towards a mutual understanding of the primary mental health care system and not the professional participants as individuals.

Participatory research

Participatory or collaboration-oriented knowledge construction became central to how I selected to address my research aims (Gergen, 2015; Hersted & McNamee, 2021). Participatory research is an overarching concept in which researchers collaborate with other stakeholders involved in the processes or practices under study (Askheim, Lid, & Østensjø, 2019). According to Groot, Haveman, and Abma (2020), participatory research is increasing in mental health service research. Participatory research takes various forms and expressions, including different research methods and designs (Askheim et al., 2019). Participatory research makes more democratic knowledge construction possible and can facilitate research questions relevant to stakeholders (Borg & Askheim, 2010). Further, it can get results better fit for practice, facilitate implementation (Greenhalgh et al., 2016), and decrease resistance towards change (Breimo & Røiseland, 2021). In addition, it might help reduce the translational barriers between academics and practice (Greenhalgh et al., 2016). Karlsson and Borg (2021) call for research to include those with experience from the phenomenon under study during the whole research process.

A participatory research design aligns well with this thesis's theoretical perspective of social constructionism, facilitating knowledge construction through interaction and communication with those affected by the research phenomenon. To develop an intervention fit for primary mental health care, the experiences of those with "the shoes on" were deemed essential to the data generated in this project. Including their experiences facilitated the development of an intervention that follows stakeholders' needs regarding services and service development. A participatory research design was thus deemed as vital to make the intervention relevant for practice, facilitate what Kvale (1995) refers to as "use value", and increase chances for successful implementation in practice in the second stage of the ReCoN trial (Breimo & Røiseland, 2021; Greenhalgh et al., 2016).

Various terms are used to describe participatory research in which researchers and affected stakeholders collaborate to develop an intervention, like co-creation, co-production, collaborative governance, and co-design (Ness & von Heimburg, 2020). The various terms are often used interchangeably. In this thesis, I use the term co-creation. Greenhalgh et al. (2016) define co-creation in research as “the collaborative generation of knowledge by academics working alongside stakeholders from other sectors” (Greenhalgh et al., 2016, p. 393). Co-creation can be achieved in different ways. In this project, the process went from researchers and stakeholders exploring experiences of pathways towards involuntary admissions in interviews and focus groups to joint actions and collaboration in dialogue conferences and digital feedback meetings (ref. Figure 2, p. 29).

With a social constructionist stance, the pathways toward involuntary admissions are viewed as socially constructed through the relationships and interactions of those involved. Further, the context of where it unfolds is essential (Gergen, 2015). The stakeholders involved will view and construct their assumptions about the phenomenon from different perspectives, depending on their positions within its context. The individuals who get involuntarily admitted will have one view or construction of the reality of such pathways, and the professionals working within primary mental health care another. GPs, those working within specialist mental health care, and the general society represent even more additional perceptions. Further, staff and managers within a health service also hold different positions, potentially constructing different assumptions. All of this illustrates that pathways towards involuntary admissions involve a complex web of interactions with multiple stakeholders and services. Accordingly, in this study, we included managers and staff in relevant primary and specialist mental health services, primary health care general practitioners (GPs, medical emergency services, and chief municipal medical officers), police, individuals with lived experience, and family carers as relevant stakeholders.

In addition to the stakeholders mentioned above, to secure the inclusion of lived experience during the whole research process, a peer researcher with lived experience of SMI and involuntary admissions was employed as part of the research team. I use the term "individuals with lived experience" for the participants who have/have had SMI and have received mental health services and/or have been involuntary admitted. This term was chosen based on input from our peer researcher and representatives from the participating advocacy organisations. Since our focus was involuntary admissions, it was argued that some of those who had been involuntary admitted could find it contradictory to be referred to as "users" of a service/treatment they did not want to receive. I recognise that all of our participants have lived experiences of relevance to pathways towards involuntary admissions. Even so, I choose to reserve the term "lived experience" to this group and refer to the remaining participants according to the stakeholder group they represent (such as GPs and family carers). Participants in participatory research projects and peer researchers are sometimes referred to as co-researchers. In this thesis, for the purpose of distinction, I use the terms participants, stakeholders, or the term for the role they represent for the research participants, and the term peer researcher for my research team colleague with lived experience.

3.2 Design and methodological approach

To answer the research aims, the overall design and analytical approach relate to strategies within a constructionist grounded theory (Charmaz, 2014, 2017). This analytical strategy is empirically suited to construct theories about social phenomena that are well-grounded in stakeholders' experiences (Charmaz, 2014; Chun Tie, Birks, & Francis, 2019; Strauss & Corbin, 1994). It is consistent with a social constructionism epistemology, seeing knowledge as socially produced (Charmaz, 2017). According to Charmaz (2014), constructivist grounded theory acknowledges both the researchers' and the participants' roles and realities and situates the research in its production context. It is a strategy that helps lift the contextual, local behaviour patterns from tacit social knowledge to articulated conscious knowledge and allows the knowledge construction to be grounded in the research context (Charmaz, 2014, 2017). This thesis aimed to construct knowledge about how pathways towards involuntary admissions unfold in primary mental health care and what can be done within these services to prevent such admissions. Constructivist grounded theory strategies were suitable for constructing new and context-specific theories regarding pathways to involuntary admissions and creating a comprehensive intervention for primary mental health care (Charmaz, 2014, 2017; Chun Tie et al., 2019; Strauss & Corbin, 1994).

Furthermore, Charmaz (2014) emphasized that constructivist grounded theory is flexible, and its strategies were adaptable for the mix of data generation and inductive thematic analyses methods used in the first stage of the ReCoN trial. Thus, the grounded theory strategy of iterative data generation and analysis was used for the overall design (Charmaz, 2014, 2017). This strategy allowed for the data generation and analysis from one phase to prepare for the subsequent phase. Iterative data generation and analyses linked studies 1-3 together and complemented their different methodological approaches. Further, this strategy facilitated the knowledge constructed in this project to be well-grounded in the stakeholders' experiences, perceptions, and research context.

Data were generated through qualitative research interviews in studies 1 and 2. Knowledge is constructed in the interaction between the interviewer and the interviewee in qualitative research interviews. During analysis, the interaction continues in the dialogue between the data material and the researcher (Brinkmann & Kvale, 2014). Further, qualitative interviews allowed for the complexities of the participants' lives and context to be explored and integrated into the project's knowledge construction (Brinkmann & Kvale, 2014; Malterud, 2017). We employed two interview methods: individual interviews (studies 1 and 2) and focus groups (study 1). These two interview methods have a somewhat different distinctive stamp. The individual interviews allowed us to explore an individual's subjective experiences and perceptions and gave more time to single, unique stories unaffected by others' perceptions (Brinkmann & Kvale, 2014; Malterud, 2017). This was reflected in the way we explored the participants' experiences. In the interviews we asked the participants to describe one of the latest real-life experiences in which they had been involved in an individual's path towards an involuntary admission. Then we used this example for further exploration during the interview. We did not ask the participants to describe their personal real-life experiences in the focus groups. Still, we left it up to the participants to decide whether they would share such personal experiences or not. The facilitators of the focus groups – one researcher and the peer researcher – focused on getting the participants to elaborate further on each other's perceptions as they appeared within the group communication. This way, we utilised the group dynamics and interactions to explore the given topic (Brinkmann & Kvale, 2014; Malterud, 2012a). Qualitative research interviews were well suited to the operationalisation of the research aims of studies 1 and 2, exploring pathways towards involuntary admissions through stakeholders' experiences.

Dialogue conferences (Gustavsen, 2001; Norwegian Institute of Public Health, 2016), followed by digital feedback meetings, were used to co-create the intervention with relevant stakeholders in study 3. The dialogue conferences and digital feedback meetings facilitated a collaborative process. The stakeholders could collaborate on suggestions for service improvements and collectively question established perceptions regarding pathways towards involuntary admissions (Gergen & Gergen, 2015; Gustavsen & Pålshaugen, 2015; Hersted & McNamee, 2021; Ness & von Heimburg, 2021). In addition, these methods helped the stakeholders find joint solutions and actions for future service advancements.

The dialogue conferences were similar to a method developed within action research and organisational development in Scandinavia in the 1980s (Gustavsen, 2001). At such dialogue conferences a set of discourse criteria underline the interactions, including the principles of dialogue (not one-way communication with monologues). This also includes broad participation of relevant stakeholders, equality among participants, and generating decisions that provide joint actions (Gustavsen, 2001; Norwegian Institute of Public Health, 2016). Dialogue conferences were suitable to the ReCoN trial's second stage aim of intervention implementation, as such conferences foster collective awareness, generate new possibilities, and facilitate stakeholder-driven changes (Gustavsen, 2001). Further, they provided a structure for democratic communication and interaction where all stakeholders got the chance to express themselves and influence the result (Gustavsen, 2001; Gustavsen & Pålshaugen, 2015; Norwegian

Institute of Public Health, 2016). Dialogue conferences can facilitate collective agreement on which measures to include in the intervention (Gustavsen, 2001) and was thus suitable for the co-creation process of study 3. In addition, the following digital feedback meetings secured stakeholder contribution and consolidation towards the finalisation of the developed intervention. This operationalisation of the research aim of study 3 was thus fit to contribute to a broad organisational anchoring of the intervention as it facilitated multiple stakeholder groups to participate in its development (Greenhalgh et al., 2016).

Figure 2 illustrates the design and methodological approach of this thesis. The figure shows the iterative process of going back and forth between data generation and analyses through interviews and focus groups, dialogue conferences, and digital feedback meetings.

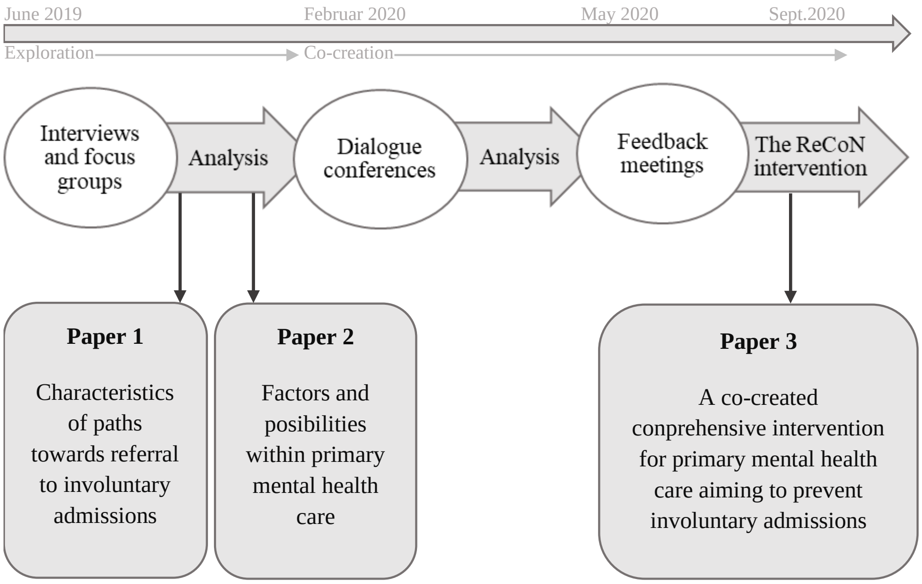

Figure 2: The design and methodological approach of this thesis

3.3 Participants and recruitment

The ReCoN trial is a cluster randomised controlled trial. The trial inclusion criteria for its ten included municipalities were that they should have: (1) 20-50K inhabitants, (2) a municipal rate of involuntary admission in 2016-2017 above the national average, and (3) motivation to change service delivery to tackle such admissions. Eligible municipalities were ranked in descending order of rates of involuntary admissions and paired (first and second, third and fourth, etc.). Paired stratification (Eldridge & Kerry, 2012) was applied to randomly draw one municipality of each pair into the intervention arm and the other to the control arm. Starting at the top of the list, the primary mental health services in the municipalities in the intervention arm were invited to participate in the trial (ref. Appendix 3). Inquiries were made until five municipalities had accepted to participate (ref. Appendix 4). Their matching controls were then allocated to the other arm of the trial. The five intervention municipalities comprise the context of this thesis.

Participants and recruitment to the interviews and focus groups

A total of 103 participants representing multiple stakeholder groups participated in the interviews and focus groups (studies 1 and 2). Inclusion criteria were: (1) working in relevant services and having experience supporting individuals who had been involuntarily admitted, (2) individuals with lived experience of SMI and/or involuntary admission, and (3) family carers of individuals with lived experience of SMI and/or involuntary admission. Recruitment of the sample was done as purposive sampling to obtain participants representing relevant stakeholders (Malterud, 2017). This recruitment strategy was suitable for including the desired mix of participants from various services, participants with lived experience, and family carers who had experience with SMI and/or involuntary admissions and not, for instance, mild to moderate depression.

In studies 1 and 2, participants from services were recruited through service managers. The researchers directly contacted chief municipal officers, which were also the link to recruit GPs. The local groups of the advocacy organisations Mental Health Norway and

Mental Health Carers Norway assisted in recruiting individuals with lived experience and family carers. As shown in Table 1, the number of participants in the respective municipality varied from 13 to 29. One difference in the number of participants was that in municipalities without an active local advocacy organisation it was difficult to recruit participants with lived experience and family carers, giving fewer participants from these stakeholder groups in these municipalities.

All 103 participants from the interviews and focus groups were included in study 1. The represented stakeholder groups were: primary mental health services (n=32), chief municipal medical officers, GPs, medical emergency services (n=16), police (n=2), outpatient specialist mental health services, inpatient specialist mental health services (n=16), individuals with lived experience (n=16), and family carers (n=21). Table 1 gives an overview of the distribution of participants in study 1.

Table 1: Distribution of participants study 1. Table retrieved from Wormdahl et al. (2021, p. 3)

Variable	**Informants** (N=103)	**Percent**
Sex		
Male	43	42
Female	60	58
Role/service		
Primary mental health services	32	31
Secondary mental health services	16	16
Primary medical services*	16	16
Police	2	2
People with lived experience	16	16
Carers	21	20
Level of education among participants working in services (n=66)		
Vocational education training	1	2
3 years higher professional education	9	13
>3 years higher professional education	56	85
Municipality		
Municipality 1	29	28
Municipality 2	13	13
Municipality 3	22	21
Municipality 4	17	17
Municipality 5	22	21
Type of interview		
Individual interviews**	68	66
Focus groups	35	34

**Primary medical services include general practitioners (GPs), medical emergency services (GPs and nurses), and chief municipal officers.*

***Three were conducted as group interviews with four, two, and two participants, respectively.*

The thirty-two interview participants who worked at primary mental health services were included in study 2. The participants were both managers (n=14) and staff (n=18) and represented a variety of primary mental health services like ambulant care, home-based care and support, sheltered houses, and daycare/activity centres. Their level of education and work experience within mental health services was high. Thirty-one had three years or more of higher professional education, and twenty-nine had more than five years of work experience. Table 2 displays the distribution of the participants in study 2.

Table 2: Description of the research participants study 2. Table retrieved from Wormdahl, Husum, Rugkåsa, and Rise (2020)

Variable	**Informants** (N = 32)	**Percent**
Sex		
Male	10	31.3
Female	22	68.7
Position		
Manager	14	43.8
Staff	18	56.2
Age group		
25-39	10	31.2
40-49	11	34.4
50-59	7	21.9
60-69	4	12.5
Level of education		
Vocational education training	1	3.1
3 years higher professional education	7	21.9
> 3 years higher professional education	24	75.0
Work experience within mental health services		
1-5 years	3	9.4
5-10 years	7	21.9
> 10 years	22	68.7
Work experience within the present municipality		
< 1 year	5	15.6
1-5 years	8	25.0
5-10 years	4	12.5
> 10 years	15	46.9

Participants and recruitment to the dialogue conferences

A total of 117 stakeholders participated in the dialogue conferences in study 3. The participation in the five dialogue conferences varied from 33 to 13 participants. As a direct consequence of the conference's date being just a few days before the Covid-19 pandemic lockdown in Norway in March 2020, two of the municipalities had considerably lower participation than the others, with 13 and 18 participants, respectively. Some health care staff were redirected to pandemic crisis management, which resulted in quite a few last-minute cancellations. Multiple stakeholder groups were represented at the dialogue conferences: primary mental health services (n=64), specialist mental health services (n=13), primary health care medical practitioners (n=7), police (n=5), persons with lived experience (n=9), family carers (n=7), and others (n=12). Table 3 summarises the participants distributed by stakeholder groups and municipalities. The participants were recruited through the same managers and advocacy organisations described above for the interviews and focus groups. All participants digitally registered for the dialogue conferences.

Table 3: Participants at dialogue conferences distributed by stakeholder groups and municipality (Table retrieved from paper 3 with status In review)

Municipality **Stakeholder groups**	**A**	**B**	**C**	**D**	**E**	**Total**
Manager primary mental health service	4	2	7	2	4	**19**
Staff primary mental health service	13	8	12	7	5	**45**
Secondary mental health service	4	1	4	4		**13**
Primary health care medical practitioners[1]	2	1	2	2		**7**
Police	2		2	1		**5**
Other primary level services[2]				2	5	**7**
Persons with lived experience	1		1	4	3	**9**
Family carers	3	1	1	1	1	**7**
Students in primary health services	3			1		**4**
Police student	1					**1**
Total	**33**	**13**[3]	**29**	**24**	**18**[3]	**117**

1: Primary health care medical practitioners include chief municipal medical officers, general practitioners (GPs), and medical emergency services (doctors/nurses).

2: Other primary level services include social welfare, housing, and municipal purchaser offices.

3: Dialogue conferences in municipalities 2 and 5 were due just a few days before the Covid-19 pandemic lockdown in Norway in March 2020 and thus had some last-minute cancellations from health care staff redirected to pandemic crisis management and other clinical tasks.

Participants and recruitment to the digital feedback meetings

Digital feedback meetings were conducted following the dialogue conferences for study 3. Twelve managers with key project management roles for the ReCoN trial in the municipal’s primary mental health services participated in the digital feedback meetings. They were purposively recruited (Malterud, 2017) by virtue of having a coordinating and management role for the ReCoN actions in the municipalities. Four researchers participated in these meetings. Furthermore, four representatives from the advocacy organisation Mental Health Norway and three from Mental Health Carers Norway participated in separate digital feedback meetings. The representatives were purposively recruited (Malterud, 2017) based on their former participation in the co-creation process. This recruitment strategy secured that they were informed of the results from the earlier phases of the co-creation process. Two researchers participated in these meetings.

3.4 Data generation

Qualitative research interviews

We used semi-structured interview guides for the interviews and focus groups in studies 1 and 2. Semi-structured interview guides gave us flexibility and allowed the interviewers to explore the participants’ unique experiences (Brinkmann & Kvale, 2014; Malterud, 2017). The research team developed the interview guides in team meetings and repeated rounds of draft revisions. Representatives from the advocacy organisations Mental Health Norway and Mental Health Carers Norway were consulted about the themes of the interview guides. The research team also exemplified some open-ended follow-up phrases for the interviewers in case they experienced difficulties prompting the interviewee (Brinkmann & Kvale, 2014). In both individual interviews and focus groups, interviewers probed for contextual information, sequence of events, and who was involved and how. Separate interview guides were made for the different stakeholder groups. Still, all included the same themes. The difference was mainly that the wording of the support questions exemplified in the interview guides was adjusted according to the respective stakeholders. The themes of the interview guide can be seen in Appendix 6.

A total of 103 participants were interviewed individually (n=68) or in focus groups (n=35), totalling 70 interviews. Professionals were interviewed individually (n=58) with the exemption of three interviews, which, upon request, were conducted as group interviews (n=8). We interviewed the participants with lived experience and family carers in focus groups (n=35). We only managed to recruit one family carer in two municipalities (n=2). These two participants were thus individually interviewed. The interviews and focus groups were conducted face-to-face, except for four conducted by phone. The individual interviews lasted between 25 and 80 minutes, and the focus groups lasted between 90 and 110 minutes. The interviewers took comprehensive notes during the interviews. We also logged our perceptions of the group dynamics in the focus groups. The notes were used to write condensed summaries and reflection memos after a day of interviews. In addition, the interviews were audio-recorded and transcribed verbatim.

Dialogue conferences and digital feedback meetings

After the interviews and focus groups were completed, the intervention was co-created with multiple stakeholders in study 3. Dialogue conferences and digital feedback meetings were carried out. The research team planned and facilitated the dialogue conferences. Service managers from primary mental health care in the five municipalities participated in their respective municipalities' practical planning and arrangement. Representatives from the advocacy organisations Mental Health Norway and Mental Health Carers Norway were consulted about the intention and structure of the dialogue conferences. Four or five researchers with various clinical and research backgrounds participated at the dialogue conferences as facilitators and lecturers, including the peer researcher. They did not participate in the group works. All dialogue conferences consisted of a combination of brief theoretical lectures and group work sessions and had the following structure:

1. The preliminary results from the interviews and focus groups in studies 1 and 2 were presented. The preliminary results consisted of the following eight themes: (1) follow-up of individuals, including the use of plans/tools, (2) primary health care service development, (3) housing/living conditions, (4) employment/activity, (5) social network/loneliness, (6) staff competence training, (7) collaboration between services at primary and secondary care level, and (8) individuals with lived experience and carers' involvement and training. The theme headings were written separately on eight posters used during the group work sessions throughout the conference day, as described below.
2. In the first group work session, as far as possible, stakeholders from the same service/organisation had a brainstorming session to suggest all potential measures. They wrote the suggested measures on Post-it notes. In addition, the groups got a set of pre-completed notes with suggestions from the preliminary results from the interviews, which they were free to include or not include. At the end of this group work session the groups distributed all their suggested measures on posters representing the eight themes identified in the preliminary results of the mapping of current practice.
3. Brief theoretical lectures about intervention development and implementation were given. Here, the Six Core Strategies (Huckshorn, 2011) concept was used as an example of comprehensive intervention.
4. New groups were formed for the second group work session. One of the researchers organised the groups to get, as far as possible, proportional distribution of representatives from the different stakeholder groups. Two theme posters with measures from the first group work were given to each group. The groups collaborated to prioritise the measures on each theme poster down to a maximum of ten measures. They were also asked to concretise measures if some of the ten measures they kept on a poster were not specific enough.
5. The groups remained the same in the third group work session while the theme posters were rotated. In this session, the group members collaborated to further prioritise the measures ranking them from one to ten, one being the measure they thought the most important to implement.

6. After the third group work session, the posters with the ranked measures were hung on the wall in a mingling area so everyone could see the results of each theme. Each participant was given three stick-on stars to place behind the individual measures they thought were the most important to include in the intervention. They could place all three stars at one measure or distribute them between several measures.

The final part of the co-creation process, the digital feedback meetings, is described below in steps four and five of the analytical process of the inductive thematic analysis following the dialogue conferences (p. 40).

3.5 Data analysis

Grounded theory

In study 1, the data material consisted of notes, condensed summaries, and reflection memos from all 70 interviews and focus groups. Qualitative research interviews can generate an enormous amount of data material, leaving the researchers to “drown” in words (Malterud, 2002). To prevent us from ending up in a position where the enormous amount of data from 70 interviews and focus groups became incalculable, we applied analytical strategies from constructionist grounded theory in study 1 (Charmaz, 2014, 2017; Chun Tie et al., 2019; Strauss & Corbin, 1994). The analysis involved an iterative process of going back and forth between data generation and analysis throughout the interview period (Charmaz, 2014, 2017). This process can be divided into four analytical steps:

1. The comprehensive notes the interviewer took during the interviews constitute an analytical step. Although we made the notes as comprehensive as possible, we could not manage to note all information that appeared during an interview. What the interviewer chose to prompt and make notes of were thus the first part of the analysis. After conducting a day of interviews, the comprehensive notes were subject to the interviewer's preliminary analysis of the participant's experiences written into condensed summaries. The interviewer also made a reflection memo in which characteristics and patterns seen within and across interviews were summarized.
2. Iterative loops between data generation and analysis were performed with constant comparison (Charmaz, 2017; Chun Tie et al., 2019) throughout the data collection, typically after conducting interviews in one municipality before moving on to the next.
3. When all interviews and focus groups were completed, the interviewers read and conducted a further inductive thematic analysis of the overall condensed summaries and reflection notes. Themes and characteristics relevant to the aim of study 1 were brought forward to the next analytical step.
4. The extended research group reviewed the results several times in meetings and shared written drafts until reaching a consensus. After reaching a consensus, a conceptualised model grounded on the data was constructed. The model is shown in Figure 3 (p. 45) and consists of the following themes: (1) deterioration and deprivation, (2) difficult to get help, (3) insufficient adaption of services provided, and (4) when things get acute. In addition, non-verbatim quotes from the data material were prepared to illustrate and elaborate on the results.

Three researchers participated in the three first steps. An extended research group with three additional researchers participated in the last step.

Systematic text condensation

The data material for study 2 was the verbatim interview transcripts from the 32 participants working in primary mental health services. In study 2, the transcripts were analysed according to the principles of systematic text condensation, an inductive thematic analysis approach seeking to describe informants' experiences (Malterud, 2001, 2012b, 2017). The analytical procedure consisted of four steps that ensured what Malterud (2012b) calls a systematic review of the empirical data:

1. All transcripts were read to get an overview of the data material and identify preliminary themes associated with factors that might affect pathways to involuntary admissions and suggestions for improvements that could facilitate the prevention of such pathways. The preliminary themes are further referred to as code groups because the data coding in the further analysis connected and grouped data within these themes.
2. The transcripts were read line by line, marking text containing relevant information. The marked text was given a code descriptive to its content and connected to one or several of the code groups from stage one. The analytical software Nvivo 12 Pro was used for this step. Labelling the marked text with codes gathered text in subgroups within the code groups. As new insight and understanding emerged, code groups and subgroups were reviewed, merged, sorted, and renamed several times during the analysis. They were also seen in connection to previous research and theory.
3. Text fragments in each code group were condensed into an artificial quote that contained the meaning content of the code group. In addition, verbatim quotes were identified from the data material.
4. The artificial and verbatim quotes guided the writing of an empirical description of the results. The transcripts were reread to see whether the results reflected the original data material, which it was assessed to do.

Figure 4 (p. 47) shows the final analytical code groups with associated subgroups that resulted from the analysis in study 2.

Inductive thematic analysis including feedback from stakeholders

In study 3, the prioritised measures from the five dialogue conferences were subject to the inductive thematic analysis of the research team (Braun & Clarke, 2006). Only the participants' final prioritised measures from the last group work session at the dialogue conferences were taken into this explicitly data-driven analysis. First, all measures were plotted in an Excel chart, giving an overview of the distribution within the themes from the dialogue conference posters, municipalities, prioritising, and stars. Then each measure was printed on a piece of paper. These notes were physically used to move measures in and out of thematic groups in the further analysis. Five researchers, including the peer researcher, participated in the analytical process that can be described in six steps:

1. Compared with the Excel chart, measures in each theme were sorted based on their priorities across municipalities. For example, measures appearing only in one municipality or with a low priority across municipalities were set aside, while measures highly prioritised in several municipalities were kept.
2. The researchers sorted the remaining measures back and forth, revised themes, and sorted measures into sub-categories within the emerging themes. This resulted in six main themes equalling the strategy areas of the ReCoN intervention, as shown in Figure 5 (p. 49).
3. The researchers prepared drafts of the results for each strategy area. During the preparation of drafts, the results were seen in relation to previous literature, and their significance and implications were included in the drafts.
4. As part of the co-creation process, in a series of four digital feedback meetings, stakeholders with a management role for the ReCoN trial in the municipalities gave oral feedback on the results as they appeared in the drafts. Some also returned drafts with written comments after the meetings. The drafts of one or two strategy areas were e-mailed to the participants before each meeting. All said they found the results recognisable in light of their perception of the results from their respective dialogue conference. They mainly assessed and gave feedback on whether measures were specific and realistic to implement within

the current practice during the first year of implementation. During this step the participants requested templates for the measures crisis plans and post-incident reviews, which were developed by the research team before the next step.

5. Four digital feedback meetings with representatives from the advocacy organisations Mental Health Norway and Mental Health Carers Norway (two meetings each) addressed all the strategic areas in one meeting and the associated intervention templates for crisis plans and post-incident reviews in the other. The participants gave oral feedback in the meetings, emphasising that the measures and templates were perceived as positive and not experienced as violating, stigmatising, or having other adverse effects for individuals or their family carers.
6. Finally, the researchers revised the results according to the feedback, finalised the consolidated intervention, and wrote an intervention manual to inform implementation.

Figure 5 (p. 49) shows the ReCoN intervention's six strategy areas with associated action areas that resulted from the co-creation and analysis in study 3.

3.6 Changes in design due to Covid-19

Initially, the digital feedback meetings following the dialogue conferences were planned as a sixth dialogue conference. At this sixth conference, participants from all five municipalities were supposed to meet and collaborate on the feedback related to the researchers' analysis of measures to include in the intervention. This dialogue conference was cancelled due to the Covid-19 pandemic lockdown in Norway in spring 2020. In close collaboration with primary mental health managers, and in line with their perception of the capacity of health services during this first phase of the pandemic, it was replaced with the digital feedback meetings described above.

3.7 Ethical considerations

The Norwegian Regional Committee for Medical and Health Research Ethics considered the ReCoN trial stage 1 to fall outside the regulations of the Health Research Act (Appendix 1). The Norwegian Centre for Research Data assessed the ReCoN trial stage 1 to satisfy the requirements of current regulations (Appendix 2). The data collection, processing, and storage were carried out in accordance with the national legislation and the EU General Data Protection Regulation (Regulation (EU) 2016/679). The PhD candidate had no competing interests, nor did the remaining researchers involved in this project. All methods were carried out in accordance with relevant guidelines and regulations. No names or personal identification information was registered in the condensed summaries, reflection memos, interview transcripts, or dialogue conference data material. Information about the participants and services in disseminating results were held to a minimum to secure anonymity. Information about participants and services in condensed summaries and quotes are anonymised.

All participants gave informed consent to participate. For the interviews and focus groups in studies 1 and 2, after receiving both written and oral information about the ReCoN trial, the interview study, and their rights as informants, the participants gave written consent before the interviews started (ref. Appendix 5). Information about the dialogue conferences was sent by e-mail, and participants digitally consented when they registered for the conferences in study 3 (ref. Appendix 7). There can be an ethical dilemma of staff autonomy and free consent to participate when managers decide the service will participate in the ReCoN trial. The managers can thus expect that staff take part and contribute as part of their professional work (Locke, Alcorn, & O’Neill, 2013). This manager-staff power relation can potentially also affect how freely staff feel they can voice their opinions. The interviewer resolved this for the interviews by informing them about their right to withdraw before the interview started. However, this could not be secured at the dialogue conferences since a staff member’s physical absence would be visible to managers. Given the non-sensitive and non-personal contributions and data generation at the conferences, this was assessed as not a challenge to research ethics.

Persons with lived experience of SMI and involuntary admissions and family carers can be personally vulnerable in interactions with health services and professionals because they can be dependent on getting service provision and treatment. To represent an advocacy organisation in a co-creation setting can give an element of empowerment (Røhnebæk & Bjerck, 2021). Thus, to avoid placing individuals in vulnerable relations during the co-creation process, we recruited participants with lived experience and family carers from the local advocacy organisations of Mental Health Norway and Mental Health Carers Norway.

4 RESULTS

In this section, I will shortly summarise the results of each study before summing up the overall results ot the thesis.

4.1 Summary of results study 1

The results in study 1 constitute a conceptualised model “Between no help and coercion: Toward referral to involuntary psychiatric admission”, as shown in Figure 3. Based on data from the 70 interviews and focus groups with a total of 103 participants, the model consists of four categories comprising the factors that characterised individuals’ paths towards referral to involuntary admissions.

The category “deterioration and deprivation” is descriptive for the various clinical, behavioural, and sociodemographic/epidemiological factors that characterised individuals’ paths towards referral to involuntary admissions. The two categories “difficult to get help” and “insufficient adaption of services provided” mainly illustrate the multiple factors experienced as lacking or insufficient in current service provision before individuals’ illness deterioration became critically acute. The fourth category, “when things get acute”, describes factors experienced to characterise the last phase of such paths – when the situation was experienced as critically acute, and referral to involuntary admission was in the cards.

The categories in the model are not necessarily sequential. Individuals’ paths could include characteristics from one or several of the four categories. The timeline and when different categories appeared also differed between individuals. However, to all, the endpoint was a referral to involuntary admission.

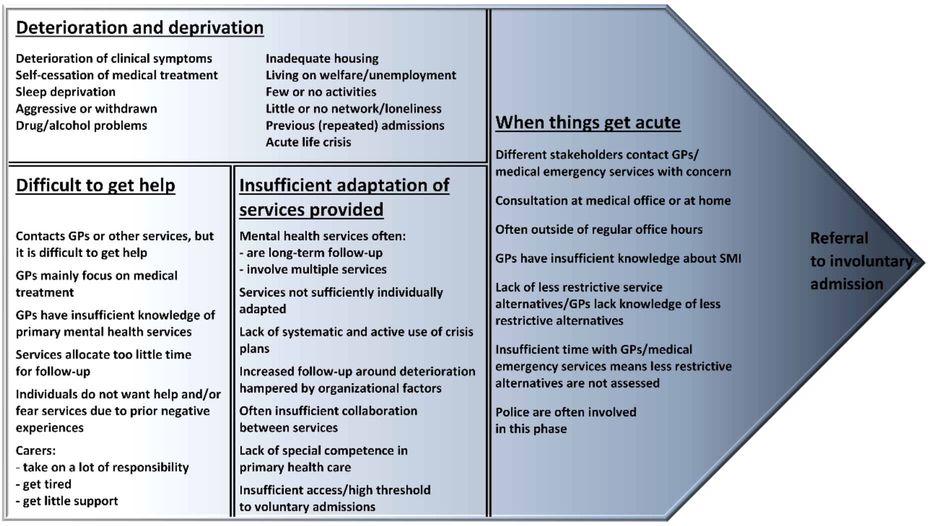

Figure 3: The conceptualised model "Between no help and coercion: Toward referral to involuntary psychiatric admission" from study 1. Figure retrieved from Wormdahl et al. (2021, p. 5)

4.2 Summary of results study 2

Based on the experiences of thirty-two primary mental health care professionals, the results in study 2 showed multiple factors within current services that could increase the risk of involuntary admissions. Accordingly, various measures with the potential to improve practice and prevent such admissions were suggested. The results also showed that no one knew the extent of involuntary admissions in their municipality, implying this had not yet been systematically addressed at this care level.

Five main analytical code groups represented the results; 1) facilitating sufficient time and flexibility, 2) planning for crises, 3) improving everyday life, 4) pointing in the same direction, and 5) developing the workforce.

Among the primary mental health care factors experienced to hamper the prevention of involuntary admissions were limited resources, insufficient time and flexibility in long-term follow-up, lack of or arbitrary use of crisis plans, lack of tailored housing, few employment opportunities, little diversity in activities offered, limited voluntary admissions opportunities, inadequate collaboration between services, and lack of competence.

Examples of measures suggested to improve primary mental health services and reduce involuntary admissions were a more flexible allocation of service provision, increasing availability of 24/7 primary mental health care, workforce development, GPs gaining better knowledge about less restrictive service alternatives, improving collaboration between services, more structured and active use of joint crisis plans, and establishing more diversity in housing, employment, and activity opportunities for persons with SMI.

Figure 4 summarises the results by visualising the main analytical code groups and their respective subgroups.

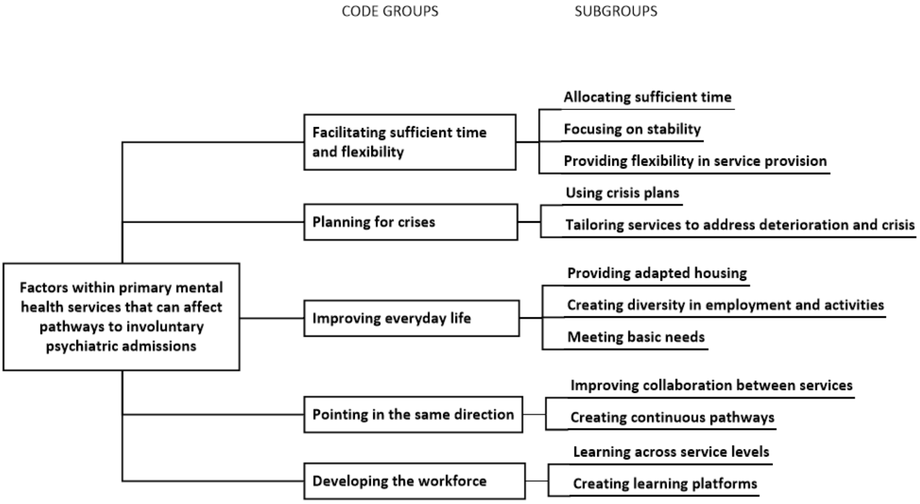

Figure 4: Final analytical code groups and subgroups of study 2. Figure retrieved from Wormdahl et al. (2021, p. 5)

4.3 Summary of results study 3

Multiple stakeholders participated in the co-creation of the ReCoN intervention in study 3 via dialogue conferences and digital feedback meetings. The ReCoN intervention is a comprehensive intervention for primary mental health care intending to reduce involuntary admissions.

The co-creation resulted in the intervention to include six strategy areas: (1) Management, (2) Involvement of people with lived experience and family carers, (3) Competence development, (4) Collaboration between primary and specialist health services, (5) Collaboration between primary services, and (6) Individual service needs. Each strategy area comprised two to four action areas with associated measures for the services to implement. The measures involved service development at both organisational and individual service provision levels.

At the organisational level, measures to facilitate a knowledge framework of recovery-orientation, better structures of collaboration between services, monitoring and evaluating the events of (referral to) involuntary admissions, user involvement, and staff competence development were included, among other things.

The individual service provision level comprised measures related to structured use of joint crisis plans, post-incident reviews, the collaboration between services, and individual service tailoring of housing, economy, and activities.

Figure 5 shows the ReCoN intervention's six strategy areas and their associated action areas. In paper 3, tables 2-7 give an overview of the measures related to each action area. A more comprehensive description of the ReCoN intervention is found in the Norwegian intervention manual developed to inform implementation (Hatling, Husum, Kjus, & Wormdahl, 2020). The intervention manual is available upon request of its authors.

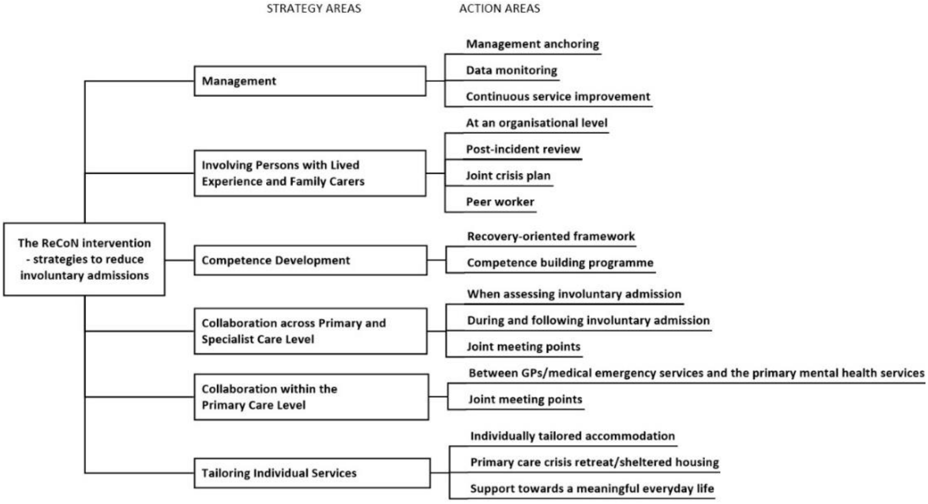

Figure 5: The ReCoN intervention’s strategy areas with associated action areas

4.4 Main results

The results in this thesis reveal multiple gaps and barriers within primary mental health care that can increase the risk of involuntary admissions and provide a comprehensive intervention that can be used to address these limitations.

Study 1 showed multiple gaps and limitations in primary mental health care during individuals' paths ending in referral to involuntary admissions. The conceptualised model "Between no help and coercion: Toward referral to involuntary psychiatric admission" (Figure 3, p 45) shows that factors perceived to impede the prevention of involuntary admissions were present from the early phases of an individual's illness development, throughout living with SMI, and in crises situations where deterioration had become so severe that referral to involuntary admission was in the cards. This impression was strengthened by the results in study 2, showing that those working within primary mental health services experienced multiple barriers within their services that potentially increased the risk of involuntary admissions. Providing sufficient time and flexibility in service provision, making better use of joint crisis plans, increasing competence within primary health care, improving collaboration between services, and improving individual tailoring of services were among the suggestions that could potentially reduce involuntary admissions. In line with the results shown in studies 1 and 2, the ReCoN intervention, a comprehensive intervention for primary mental health care intended to reduce involuntary admissions, was co-created in study 3. The intervention includes six strategy areas, each with two to four action areas with measures for the services to implement. Figure 6 illustrates how the results from the three studies are linked and collectively form part of the development of the ReCoN intervention in the first stage of the ReCoN trial.

The results in this thesis add new knowledge about the role of primary mental health care in pathways towards involuntary admissions and what these services can do to prevent such admissions. Overall, the results show a potential to reduce involuntary admissions by intervening at the primary mental health care level. In addition, reducing involuntary admissions had not been systematically addressed within the primary mental health services in the participating municipalities, further strengthening the implication of reduction potential. The ReCoN intervention co-created in this research project delivers strategies and measures that services can implement to utilize this potential. Furthermore, with its qualitative and participatory methods, the results of this thesis show that when stakeholders gather to collaborate and reflect upon pathways to involuntary admissions and how such pathways can be prevented, they agree on solutions and measures to improve future service provision. This implies a will and desire among stakeholders, including primary mental health care providers, to effectuate joint efforts to improve services to meet the needs of those with SMI in ways that reduce the risk of involuntary admissions.

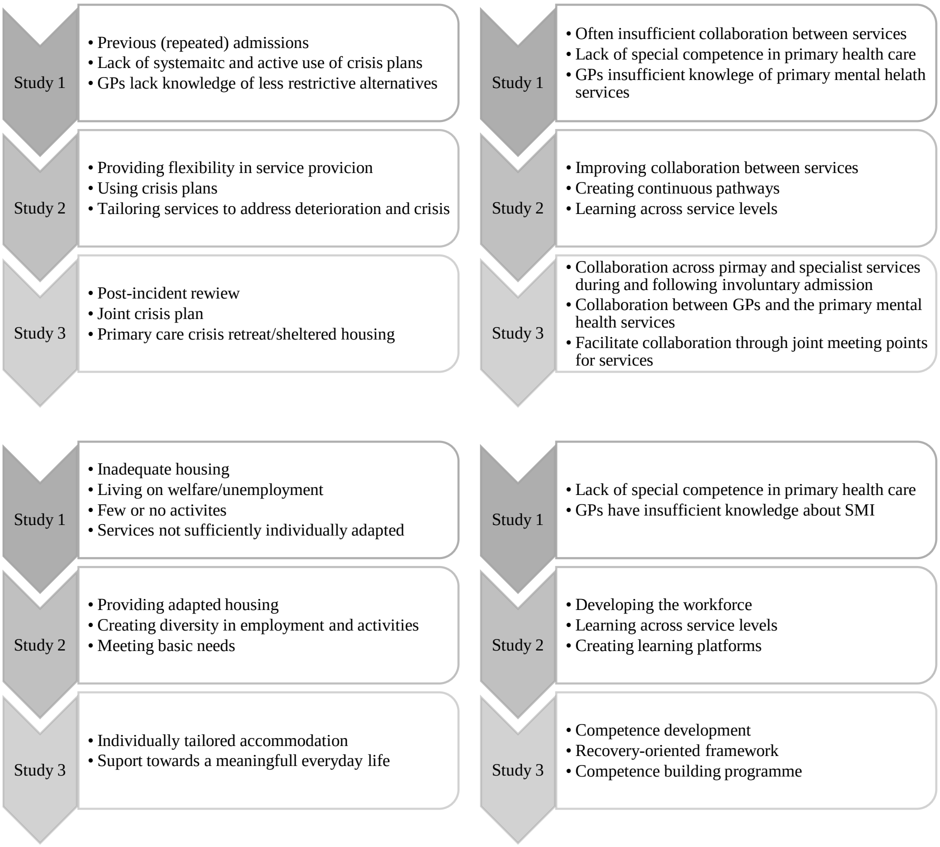

Figure 6: Examples of how the development of the ReCoN intervention emerged throughout the three studies of this thesis

5 DISCUSSION

The results in this thesis revealed gaps (study 1) and barriers (study 2) in primary mental health care that can increase the risk of involuntary admissions. Further, reducing involuntary admissions has not been systematically addressed within the primary mental health services in the participating municipalities. The results suggest the potential to improve services by intervening at this care level. Accordingly, the ReCoN intervention was co-created with six strategy areas, each with two to four action areas with specific measures for the services to implement (study 3). This chapter will discuss some of the results shown in this thesis before some methodological strengths and limitations are addressed.

5.1 Discussion of results

I will first discuss some organisational barriers that can impede the prevention of involuntary admissions. Here, primary health care level factors and the primary and specialist care split will be addressed. Further, I will discuss how the local customs and opinions of services and society can hamper the prevention of involuntary admissions and how these results can contribute to overcoming such issues. Finally, I look at the potential of the ReCoN intervention to support the international health policy aims of facilitating human rights-based and locally embedded community-based mental health care with services promoting shared-decision making and recovery orientation.

Barriers within primary mental health care

An organisational barrier in the primary health care shown in study 2 to challenge the prevention of involuntary admissions was the municipalities' purchaser-provider split for service provision. Many municipalities in Norway, including the five participating in the ReCON trial, operate with a purchaser-provider split to allocate health and social services, including primary mental health and addiction services. This means individual service allocation is done at the municipal Purchaser Office, which specifies what services and the extent of support an individual gets from primary mental health care. Providing services by time estimates per task hampered flexibility and individual tailoring of services for individuals with SMI at risk of involuntary admissions. This way of organising service provision for clinical work, which asks the professional and the individual to understand and agree on how to provide help, has been disputed (Steihaug, Johannessen, Ådnanes, Paulsen, & Mannion, 2016). It challenges mental health care professionals' possibilities to use their professional judgment and tailor service provision for the fluctuating needs of individuals, potentially impeding personal recovery. Thus, whether services are organised according to those with SMI or the providers' needs can be questioned.

During the co-creation process, to make the intervention feasible to implement within the research frames of current practice, the stakeholders excluded measures that they believed were likely to have an effect, such as increased resources and staff. This limitation can be a potential barrier to reducing involuntary admissions because the results in study 2 showed that limited resources, insufficient staff levels, and rigid service allocation in primary mental health care were potential barriers to preventing involuntary admissions. A recent study by Hofstad, Rugkåsa, Ose, Nyttingnes, Kjus, et al. (2021) supports the importance of staffing levels. They found that municipalities that reported higher GP and mental health nurse full-time equivalent rates were associated with lower involuntary admissions levels. Also, insufficient staffing levels affected coercive measures in inpatient settings. For instance, a study by McKeown et al. (2019) found it hampered efforts to reduce physical restraint. Furthermore, not increasing staff levels and resources can impede implementation and affect the ReCoN intervention's service development performance as a comprehensive intervention is time-consuming to implement.

The results can spur primary mental health services to overcome some of the organisational barriers that can impede the prevention of involuntary admissions. For the participating municipalities, the research project's participatory design with co-creation can be an intervention affecting organisational barriers. The relations, communication, and interactions among participants during such studies can facilitate a relational construction, leading to a change in the way stakeholders act or assess the situation and opportunities in how to (inter)act in the future (McNamee, 2014). Further, the results can guide service managers and health policy providers to focus on organisational factors, not just individual characteristics, when aiming to reduce involuntary admissions. For instance, by addressing poor collaboration and including measures to improve it, the ReCoN intervention can increase the comprehensiveness and tailoring of services for individuals with SMI. The gaps and shortages in primary mental health care settings experienced to hamper the prevention of involuntary admissions can thus potentially be improved by implementing the intervention.

An implementation of the ReCoN intervention is also likely to have synergy effects across services and target groups. For instance, improved structures for collaboration inherent in the intervention are likely to establish collaborative relations that can improve how services collaborate in cases regarding other target groups. Another example is involving persons with lived experience and family carers in service development. Setting routines and gaining experience in including representatives from these stakeholder groups in the service development at the organisational level will be generalisable to other service areas in the municipality.

Fragmentation of service organisations

The results showed that the degree and nature of collaboration between primary mental health services and other services varied (studies 1 and 2). Poor collaboration was perceived as a risk for involuntary admissions, and this was reflected in the ReCoN intervention through extensive measures intending to improve collaboration between services. Lack of collaboration between health services can lead to fragmented service provision (Steihaug et al., 2016). It can also be assumed to go the other way around – that a fragmented service organisation impedes collaboration. The division of mental health services in primary and specialist mental health care has been experienced by health care professionals in several European countries and seen to cause fragmented services and impact collaboration (Triliva et al., 2020). To overcome organisational barriers affecting collaboration and optimise care provision, health care professionals have, among other things, recommended integrating primary care and specialist outpatient services (Triliva et al., 2020). A multidisciplinary service model like Flexible Assertive Community Treatment is an example of an organisation where one service team has the overall responsibility of service provision to individuals with SMI – a kind of in-between service including both primary and specialist health care (Trane et al., 2021). Trane et al. (2021) found that professionals experienced that this type of service organisation enhanced collaboration between services. Furthermore, it has been associated with a decrease in involuntary admissions (Landheim & Odden, 2020).

According to Rugkåsa, Tveit, Berteig, Hussain, and Ruud (2020), the current organisation with two health care levels, particularly the silo-based finance arrangement, makes it challenging to formalise collaborative care. Regarding involuntary admissions, Norway’s referral and decision process can illustrate how this two-parted fragmentation of services can adversely affect individuals. In 2018, 38% of the referrals for the involuntary admission of persons 16 years or older did not result in the establishment of involuntary admission in specialist mental health care (Bremnes & Skui, 2020). For the individual, a referral in which they involuntarily get brought to the hospital for up to 24 hours for further assessment (Bremnes & Skui, 2020) can be experienced as coercive as an involuntary admission. Could some of these referrals have been prevented if the services had been organised differently? If these services were co-organised or co-localised, perhaps the barriers for GPs and psychiatrists to collaborate on these assessments would decrease. Locally situated and co-organised services could also facilitate the participation of primary mental health care. Better collaboration between primary mental health services, GPs and specialist mental health care could give more integrated medical assessments and collaboration on assessing other service alternatives than involuntary admissions. Furthermore, it could facilitate joint efforts and better collaboration regarding voluntary long-term treatment and care.

Services and society's local customs and opinions

Reducing the use of involuntary admissions in mental health has been on the international and national agenda for decades (Mezzina et al., 2019; NOU 2019:14, 2019; The Norwegian Directorate for Health and Social Affairs, 2006; United Nations, 2006; United Nations Special Rapporteur, 2017; Zinkler & von Peter, 2019). However, study 2 showed this had not been addressed systematically within primary mental health services, implying the need to put involuntary admissions on the agenda at this care level. The geographic variation seen in rates of involuntary admissions indicates that local custom and practice is highly influential (Szmukler, 2010). Suppose the call for efforts to reduce the use of such admissions continues unaddressed in primary mental health care settings. In that case, local "taken for granted" or "this is how we do it here" attitudes within primary mental health services can remain unquestioned. Those working within the services can then maintain a stable and continuing perception of how to act in these situations (McNamee, 2014). The current legal regulations in many countries can also represent a signal towards maintaining substitute decision-making as it confirms the superiority of the assessments of clinicians and professionals. Laws can thus contribute to substantiating established attitudes that the decision of an individual with psychosocial disabilities is inadequate in given situations, and views that individuals with these kinds of challenges lack the intellectual capacity to decide whether to accept or refuse offered treatment is maintained (Sugiura, Mahomed, et al., 2020).

Public debates are another factor potentially affecting how staff in mental health care address involuntary admissions. Serving as an example is the public debate in Norway in autumn 2021 that followed an incident in which an individual who had formerly been in contact with mental health care injured and killed several people (Hagesæther, Røen, Sætran, & Christiansen, 2021). The debate could leave an impression of a mental health care system that failed to care for individuals with SMI, reinforcing societal attitudes to lower the threshold for involuntary admissions (Døvik & Holm-Nilsen, 2021; Honningsøy & Radøy, 2021). The debate was multifaceted (NRK TV, 2021), and some argued that involuntary admissions was not the answer and called for more and better voluntary services (Arild, 2021; Gundersen, 2022; Johansen & Skogstrøm, 2021). However, many media headings directed towards the general population favoured a lower threshold for involuntary admissions and treatment (Døvik & Holm-Nilsen, 2021; Honningsøy & Radøy, 2021; Quist, Holmes, Elgaaen, & Muladal, 2021). For example, with headings like “An increasing number of serious cases of violence and murder can be linked to mental illness” (Døvik & Holm-Nilsen, 2021), “Believes psychiatry does not deal with ‘aggressive, threatening men’: – A societal problem” (Honningsøy & Radøy, 2021), and “Police warned: Mentally ill will pose a serious threat” (Quist et al., 2021), the public debate can lead to a risk-averse society in which a public call for a lower threshold for involuntary admissions makes it difficult for primary mental health care to focus on service development and measures to prevent such admissions. As part of a community with societal pressure towards lowering the threshold for involuntary admissions, the risk factors can become the focal point for primary mental health services. This kind of public opinion can thus direct the focus of those providing and working in the services towards involuntary admissions instead of aiming to develop good quality services and early intervention to prevent such admissions.

Furthermore, media debates can also increase stigmatisation and exclusion of individuals with SMI and become a barrier to their recovery. Risk prevention being over-stressed potentially leads health professionals to admit individuals too frequently (Claassen & Priebe, 2010). The contrary might also be harmful to the individual if admissions are too rare, for example, when suicidal (Claassen & Priebe, 2010). According to Claassen and Priebe (2010), the challenge lies in striking a balance between the two opposing extremes. Hence, mental health care providers need to direct attention to quality and sufficient availability (Szmukler, 2010). Furthermore, health authorities need to include primary mental health care to a greater extent in their policy directives regarding reducing involuntary admissions. It seems illogical to mainly address responsibility to specialist mental health care when aiming to reduce such admissions. The primary health care level needs to be included to focus efforts prior to crisis situations and the severe deterioration of individuals. Then, to a more significant degree, efforts can include early detection and intervention to prevent individuals’ paths from ending in involuntary admissions.

Implementing the ReCoN intervention can improve the knowledge of primary mental health care regarding pathways towards involuntary admissions and thus make them better equipped to raise questions about and reflect upon their current practices regarding individuals’ paths towards involuntary admissions. Hence, the knowledge constructed in this project can contribute to challenging local customs and incorporated patterns and practices, and advance mental health care towards a more balanced practice regarding involuntary admissions.

Human rights- and community-based mental health care

The call to reduce involuntary admissions is part of a call to reduce the widespread use of coercion within mental health care and facilitate a shift towards a human rights-based approach and shared decision-making practices (Mezzina et al., 2019; NOU 2019:14, 2019; The Norwegian Directorate for Health and Social Affairs, 2006; United Nations, 2006; United Nations Special Rapporteur, 2017; Zinkler & von Peter, 2019). Scaling up community-based services, integration into primary health care to support early identification and intervention, facilitating good service quality, and effective collaboration between services to facilitate integrated and coordinated care are among the actions the United Nations Special Rapporteur points out as the right way forward to scale-up and develop mental health services (United Nations Special Rapporteur, 2017). With its focus on voluntary measures, involvement, and empowerment of those receiving services and family carers, and service development at the primary mental health care level, the ReCoN intervention can contribute to service development in line with a rights-based approach and facilitate a shared decision-making practice within mental health care.

Involuntary admissions are to be the “last-resort”. A set of “first-resort” options that meet the need of those in need of help are thus essential. Adequate services of good quality must be present to provide alternatives other than referral to involuntary admissions. If not, substituting voluntary for involuntary care becomes challenging. Studies 1 and 2 point to a scarcity of adequate service options in current primary mental health care. Lately, this has been supported by both professionals and advocacy organisations in Norway, who point to gaps and limitations in current mental health services as barriers to providing individuals with SMI essential and proper treatment and care (Arild, 2021; Gundersen, 2022; Johansen & Skogstrøm, 2021; NRK TV, 2021). Together, this calls for an increase in resources, competence, and collaboration between care levels to redress this shortage.

According to Sugiura, Mahomed, et al. (2020), evidence shows that effective non-coercive models of care can fulfil the right to health and treatment for individuals. Crisis plans and peer support are examples of supported decision-making measures included in the ReCoN intervention that, according to Sugiura, Mahomed, et al. (2020), can contribute to transforming mental health services. The results shown in this thesis provide a framework for development within primary mental health care settings that support individual autonomy for individuals with SMI at risk of involuntary admissions. Further, a development towards more supported decision-making and individual tailoring of psychosocial factors like home, work, activity, income, and social participation also make the measures in the ReCoN intervention in line with the aim of WHO’s QualityRights Initiative to create community-based and recovery-oriented services (WHO, 2019b). The ReCoN intervention can thus be a tool for local mental health care organisations worldwide in developing services outside hospitals in line with international health policy aims.

5.2 Discussion of methods

I will start this section by giving a reflexive account of my background that can be of significance for the quality of the research. Further, I will discuss some methodological strengths and limitations of this thesis regarding recruitment and data generation, power relations between stakeholders, and the researchers' role and power. Finally, external validity regarding the relevance and transferability of the results are addressed.

Personal reflexivity

Comprehensive reflexivity is a vital backdrop in qualitative research to assess the quality of the research (Gergen, 2015; Kvale, 1995; Malterud, 2017). This also includes reflexivity about the researcher's background, knowledge, and perceptions and how this could affect the research (Kvale, 1995; Malterud, 2017).

I have a master's degree in children and adolescent mental health and clinical background in child welfare services, family therapy, and primary mental health services. In recent years, before I started working on this PhD, I worked with knowledge and service development in primary mental health care settings. A systemic and social constructionist stance has been central to my professional career, and I have endeavoured to understand people's challenges within the context of their experiences from social interactions with family and a more comprehensive network, society, organization, and community. This background has guided me in the direction of a research project with a philosophical stance on social constructionism.

I have also been engaged in promoting individuals' participation and their rights to autonomy. These perceptions have guided me to have a resource, strength, and motivational orientation, where personal growth/change was sought through interactions *with* the persons and their surrounding network and organisations. In my clinical work, I have endeavoured to be open-minded to persons' voices and adapt my interactions to support their personal recovery. I experienced that this background strengthened my ability as a researcher to listen to the participants' voices and facilitate a knowledge construction grounded in a research context. Hopefully, my experiences made me a sensible contributor to the interactions and co-creation with the multiple stakeholders participating in this project.

Recruitment and data generation

The ReCoN trial's aims were defined before participants were recruited. The recruiting could have been affected by the project's title, "Reducing Coercion in Norway", and the aim to develop an intervention intended to reduce involuntary admissions. Potentially, it became more attractive to participate for those already favouring a decrease in involuntary admissions. For example, this could have affected which experiences the participants shared in the interviews and focus groups of studies 1 and 2. For instance, it favoured examples characterised by cases in which participants experienced gaps in services. Cases in which participants experienced no gaps in service provision did not characterise the data material.

In a semi-structured research interview, the interview is led towards specific themes (Brinkmann & Kvale, 2018; Malterud, 2012a, 2017). The interview seeks the interviewee's experiences and perceptions and what they find essential regarding the research phenomenon. It is not intended to direct the interviewees towards specific opinions (Brinkmann & Kvale, 2018). Given the objectives in studies 1 and 2, the interviewers' exploration contributed to getting detailed descriptions of the challenges, gaps, and barriers within the services. This could have further contributed to a data generation characterised by cases in which participants experienced shortages within the services that hindered the prevention of such admissions. Given the studies' scope, this could also generate the "right" data to explore potential service improvements related to reducing involuntary admissions, thus strengthening internal validity (Malterud, 2017). Alternatively, according to Greenhalgh et al. (2016), if healthcare professionals with other views do not find relevance in the results, this can decrease chances for successful implementation.

Another potential limitation in the data generated for study 1 that could have followed through to the preliminary results presented to the participants at the dialogue conferences was that the interviewers could not write down all that was said during an interview. Some of the information given by interviewees and focus group participants may have been left out. The grounded theory strategy of iterative data generation and analysis may have compensated for some of this limitation, revealing themes and factors not covered in the written data material. The interviewers could then elaborate this further in the following interviews or focus groups. This limitation was not present in study 2 since verbatim interview transcripts were used for the analysis. The preliminary analysis from the interviews and focus groups were fed back to the participants in the dialogue conferences. This secured potential weak points of the data generated during interviews and focus groups to be “patched” by the participants, including or excluding information in their further collaboration on measures for the intervention.

Only participants working within primary mental health services were included in study 2. The results of this thesis may have been strengthened if they had been supplemented with equally aimed studies for each of the other stakeholder groups.

Power relations between stakeholders

We used a participatory design with co-creation to facilitate research *with* rather than *on* or *about* people. The research design thus allowed multiple stakeholders to participate, contribute, and collaborate in the development of the intervention with us researchers. However, relational power imbalances can be present among stakeholder groups and thus affect data generation and interpretation (Gergen, 2015; Greenhalgh et al., 2016; Groot et al., 2020). Consequently, we needed to be aware of potential power imbalances and facilitate a research process that promoted equality among the participants (Hersted & McNamee, 2021; Karlsson & Borg, 2021). Acknowledging such power relations meant that we tried to facilitate the research process in ways that minimised their influence and opened up for mutual dialogues and possibilities for all stakeholder voices to be heard. Then the desired polyphony in which all participants could contribute with their experience and perceptions could be achieved (Borg et al., 2012; Groot et al., 2020). If not, participants could have been placed in positions that excluded rather than included, and the voices of those less powered could be silenced (Hersted & McNamee, 2021).

Power imbalances have traditionally been present between the stakeholder groups that collaborated at the dialogue conferences in study 3. Examples include staff and managers, people with lived experience and professionals, and primary mental health care staff and psychiatrists from specialist mental health care. This could have made it difficult for some to disagree and freely speak their mind in the collaborative contexts of this project. The perceptions of those superior in the power relation can have been left unquestioned by participants with less power, leaving their experiences and perceptions out of the generated data. Participants with lived experience and family carers participated as representatives from local advocacy organisations to facilitate equality in power and increase the chances that all felt comfortable contributing to the collaboration (Røhnebæk & Bjerck, 2021). Further, as far as possible, stakeholders from the same service/organisation constituted the groups during the first group work session. Finally, all got the chance to individually prioritise measures at the end of the dialogue conferences while placing sticker stars on the measures they perceived most important to prioritise. Hopefully, facilitating equality and enabling all to contribute gave a result that formed relevance within all stakeholder groups.

Although the research team was conscious and aware of the potential power relations and tried to structure interactions favouring equality, some relative power differences remained. For instance, the primary mental health services had more participants than other stakeholder groups at the dialogue conferences. This could have resulted in the domination of primary mental health care voices. Further, we did not recruit as many participants with lived experience and family carers as planned. Outnumbered, these participants could have been placed in an inferior power relation towards the professional participants. In particular, participants with lived experience and family carers were not represented in some groups during the second and third group work sessions. Measures that those with lived experience and family carers would have argued for prioritising could thus have been left out of the developed intervention. For instance, there is a chance they could have prioritised early intervention and prevention measures to a greater extent, as results in study 1 showed many with lived experience and family carers experienced a lack of help in the early phases of an individual's illness development. The results in paper 3 show that the ReCoN intervention primarily includes strategies and measures oriented towards those who have developed a severe illness. However, we do not know if priorities would have been different without similar co-created interventions to compare.

The changes in design due to the Covid-19 lockdown gave the primary mental health managers power to influence the finalisation of the intervention through a series of digital feedback meetings. The other professional stakeholder groups did not get this opportunity. Interaction, communication, and reflection between all stakeholder groups might have given different perspectives and choices in the finalising phase of the intervention development. For instance, with regard to their service resource frames, the primary mental health care managers might have given a result more limited by the services' resources than would have been the case if all stakeholders had been gathered to collaborate in a sixth dialogue conference. The feedback meetings with representatives from the advocacy organisations Mental Health Norway and Mental Health Carers Norway contributed to the empowerment of more voices. Moreover, it consolidated the acceptability of measures included in the ReCoN intervention across stakeholder groups.

The researchers' role and power

Potential power relations among stakeholders were addressed in the previous section. The researchers can also hold power relations towards the participants. For instance, we planned the research aim and design and facilitated the co-creation process. Our preferences could thus guide decisions about aim, methods, and design. We endeavoured to minimise the impact of personal preferences by having a research team of several researchers with a broad background, including a peer researcher – a form of investigator triangulation (Malterud, 2017). The participatory design and co-creation process further reduced the researchers' power as this design gave us less control over the research outcome (Greenhalgh et al., 2016). Based on theory and former research, we could not fully predict what features would end up in the results (Greenhalgh et al., 2016; Hersted et al., 2020). The research team set the co-creation process in motion, but after that we could not predict what measures would be included in the intervention. Instead, we had to go along *with* the participants and whatever they brought into the process.

Data analysis is another phase where we, as researchers, held power to define during the co-creation process. However, the feedback of results to participants served as a member check of the analysis and results (Malterud, 2017), decreasing our power relation in this phase. For instance, after the interviews (studies 1 and 2), preliminary results were presented to the participants in the dialogue conferences (study 3). Results that did not find relevance among stakeholders were thus left out in the following co-creation process. Therefore, the iterative process of going back and forth between data generation and analyses worked as continuous quality control (Kvale, 1995) and validated if our analytical work reflected the discourse of the stakeholders and the research context, weakening the researchers' power to affect the result.

Further, none of us researchers participated in the group works at the dialogue conferences in study 3. Given the nature of the data generated at these conferences, the researchers could not know, unlike for the interview data, who proposed or prioritised which measure. Accordingly, we could not intentionally prioritise or emphasise the voices of some stakeholder groups or individuals in our analysis. This increased the intervention's chances of reflecting the participants' collaboratively generated measures from the dialogue conferences.

External validity – relevance and transferability

External validity can, in this case, refer to the results' relevance and transferability to primary mental health care settings (Kvale, 1995; Malterud, 2001b, 2017). Our results are based on stakeholders' experiences from five Norwegian municipalities and may thus not necessarily be directly transferable to other contexts. The high number of participants and variation of stakeholders might have strengthened transferability across settings. Further, consolidating the intervention to be eligible across several municipalities might have increased the chances for relevance among stakeholders elsewhere and thus strengthened transferability. Further, potential relevance across different settings are supported because many of the intervention’s measures are related to factors known from the literature to potentially affect involuntary admissions (Barbui et al., 2021; Gooding et al., 2020; Molyneaux et al., 2019).

Although many of the measures in the intervention – like management anchoring, use of joint crisis plans, and post-incident reviews – are potentially transferable to different contexts, additional measures might need local adaptation. For instance, other competence-building subject areas might match different local needs better. Furthermore, in settings where mental health care is differently organised, differently financed, or in regions where locally situated services are not yet equally well-developed, adjustments of included measures might be needed for eligibility and to facilitate implementation.

The participatory research design, in which researchers and stakeholders collaborated to reflect upon current practices and new solutions, facilitated results well-grounded in the research context. This can have increased the relevance of the results for the stakeholders intended to implement the ReCoN intervention into practice (Greenhalgh et al., 2016; Hinchcliff, Greenfield, & Braithwaite, 2014), strengthened external validity (McNamee, 2014), and thus enhanced transferability of the results across primary mental health care contexts.

6 CONCLUSION

The results in this thesis add new and practice-related knowledge that can be used in primary mental health care settings when aiming to reduce involuntary admissions. Revealing multiple gaps and barriers within primary mental health care that can increase the risk of involuntary admissions, the results suggest the potential to intervene at this care level to reduce such admissions. The ReCoN intervention developed in this research project can meet this potential. Further, the results showed that reducing involuntary admissions had not been systematically addressed within the primary mental health services in the participating municipalities. Future service development at this care level should thus include targeted efforts to decrease or eradicate gaps and barriers in primary mental health care that can increase the risk of involuntary admissions. Stakeholders should be involved in the service development to meet better the needs of those affected. Furthermore, health policy directives and incentives regarding reducing involuntary admissions should include primary health care.

Additionally, collaborative efforts across and within care levels aimed to decrease involuntary admissions are needed. Increased competence within primary mental health care on SMI, involuntary admissions, and alternatives to involuntary admissions is also requested. Integrating shared decision-making tools like joint crisis plans (preferably collaboratively used across services and service levels) and increasing the diversity of recovery-oriented services like housing, employment, and activities within primary mental health care could promote individual tailoring of service provision, prevent involuntary admissions, and promote personal recovery. The results also imply a need to lower the threshold for receiving treatment and care in the early phases of an individual’s deterioration.

The ReCoN intervention can be employed to address these implications for practice. However, further research is needed to assess the effectiveness and implementation facilitators and barriers of the ReCoN intervention. This is currently being done in the second stage of the ReCoN trial. Additional research is required to evaluate whether the experiences and results in the ReCoN trial are similar across contexts. Developing a fidelity measure for the intervention could also strengthen future effect assessments and advances. Furthermore, primary mental health care factors affecting pathways towards involuntary admissions should be explored in additional settings, such as middle- to low-income regions, to provide knowledge on how the ReCoN intervention can be applied in different contexts and support the integration of mental health services into primary health care.

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PAPERS

PAPER 1

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Between No Help and Coercion: Toward Referral to Involuntary Psychiatric Admission. A Qualitative Interview Study of Stakeholders' Perspectives

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Objective: Paths toward referral to involuntary psychiatric admission mainly unfold in the contexts where people live their everyday lives. Modern health services are organized such that primary health care services are often those who provide long-term follow-up for people with severe mental illness and who serve as gatekeepers to involuntary admissions at the secondary care level. However, most efforts to reduce involuntary admissions have been directed toward the secondary health care level; interventions at the primary care level are sparse. To adapt effective measures for this care level, a better understanding is needed of the contextual characteristics surrounding individuals' paths ending in referrals for involuntary admission. This study aims to explore what characterizes such paths, based on the personal experiences of multiple stakeholders.

Method: One hundred and three participants from five Norwegian municipalities participated in individual interviews or focus groups. They included professionals from the primary and secondary care levels and people with lived experience of severe mental illness and/or involuntary admission and carers. Data was subject to constant comparison in inductive analysis inspired by grounded theory.

Results: Four main categories emerged from the analysis: deterioration and deprivation, difficult to get help, insufficient adaptation of services provided, and when things get acute. Combined, these illustrate typical characteristics of paths toward referral for involuntary psychiatric admission.

Conclusion: The results demonstrate the complexity of individuals' paths toward referral to involuntary psychiatric admission and underline the importance of comprehensive and individualized approaches to reduce involuntary admissions. Furthermore, the findings

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indicate a gap in current practice between the policies to reduce involuntary admissions and the provision of, access to, and adaptation of less restrictive services for adults with severe mental illness at risk of involuntary admissions. To address this gap, further research is needed on effective measures and interventions at the primary care level.

Keywords: involuntary admission, severe mental illness, mental health services, primary mental health care, mental health, psychiatry

INTRODUCTION

Involuntary psychiatric admissions go against the fundamental health care principle of patient autonomy (1, 2). Many individuals exposed to such admissions, along with their carers, report experiences of fear and distress (3, 4). Moreover, evidence that coercive practices lead to better outcomes is limited (5–7). Despite international and national policies to reduce the use of involuntary admissions in mental health, numbers indicate that rates of this practice have increased in several European countries (8). This is cause for growing concern, and less restrictive alternatives and effective measures in mental health services to prevent involuntary admissions are called for (9).

Reported rates of involuntary admissions vary (8). In Italy and Austria, the rates per 100,000 people in 2015 was 14.5 and 282, respectively (8). Norway reports relatively high numbers, with a rate of 186 per 100,000 persons 16 years and older in 2018 (10). Different clinical and social factors have been associated with an increased risk of involuntary admission; a recent review found that a psychotic disorder, previous involuntary hospitalization, lack of adherence to medication, police involvement in admission process, male gender, being unemployed, living on welfare, being single, limited social support, and living in deprived areas are associated with higher risk of involuntary admission (11).

In most Western countries, care for people with severe and long-lasting mental illness has moved from psychiatric hospitals to communities, where individuals' paths toward referral to involuntary admissions unfold within complex contexts, often with the involvement of multiple stakeholders (12). Although services at the primary health care level play a key role in providing services to people with severe mental illness (SMI), the role of these services in such paths remains largely undocumented (13, 14). Persons with lived experience of involuntary admission have reported lack of information and involvement in treatment decisions (3); carers experience difficulties getting preventive help prior to an individual's acute crisis and report lack of adequate support for themselves in such situations (4). A systematic review and meta-synthesis of multiple stakeholders' experiences with involuntary psychiatric admission decision-making found that collaboration between the services involved was lacking, that medical views dominated assessments, and that the admission process could be experienced as heavy-handed (especially given that it often involves police) (15). Previous studies have largely been limited to experiences during detention, of the admission process, and of the admission decision-making process (3, 4, 15). In the Norwegian context, studies focusing on the involuntary admission process have primarily been quantitative (16). Thus, studies incorporating multiple stakeholders' experiences in earlier phases of individuals' paths, including how primary health services are involved and interact, can contribute to understanding how to target further development of services at this care level so as to reduce involuntary admissions. Therefore, this study aimed to explore multiple stakeholders' experiences with paths toward referral to involuntary psychiatric admission.

MATERIALS AND METHODS

Study Setting

The current study is part of a cluster randomized controlled trial that sought to develop and test a primary care-level intervention aimed at reducing involuntary psychiatric admissions (ClinicalTrials.gov, NCT03989765). Ten mid-sized Norwegian municipalities with twenty to fifty thousand inhabitants participated. The associated regional psychiatric hospitals and their community mental health centers from the secondary care level, who serve the municipalities' populations, were also involved. The municipalities receiving intervention took part in developing and testing the intervention. To prepare for this, comprehensive mapping of current practices was conducted using qualitative methods, and the analysis presented here is based on these data. In the following, involuntary psychiatric admissions are those sanctioned by the Norwegian Mental Health Care Act § 3-2 (involuntary observation) and § 3-3 (involuntary admission) (17).

In Norway mental health care is provided by two separate health care levels: primary and secondary level. Primary mental health care, often organized jointly with primary addiction services, is provided by the 356 municipalities. Among other things, it includes supportive housing (with or without resident staff), day-care facilities, home care, therapeutic conversations, and leisure activities. General practitioners (GPs) are organized at the primary health care level. This includes both the GPs (family doctors) and primary medical emergency services. In addition, social care, (un)employment services, municipal housing, and local police are among the services provided by the municipalities.

The power to subject people to involuntary admission is held by services at the secondary mental health care level. At this level, regional psychiatric hospitals and community mental health centers provide specialist inpatient and outpatient treatment, including community-based ambulant treatment.

Abbreviations: SMI, severe mental illness; GP, general practitioner; PTSD, posttraumatic stress disorder.

Norwegian mental health legislation sets out stringent criteria for involuntary admissions, requiring that options for voluntary engagement have been exhausted (17). It is also required that the need for involuntary admission is assessed by a medical practitioner outside of the secondary inpatient unit (unless the individual is under a community treatment order). Thus, referral to involuntary psychiatric admission is usually carried out by a primary care-level GP. The GP conducts a medical assessment of the need for a referral. If an individual refuses the assessment, the chief municipal medical officer has the authority to decide on an involuntary medical examination. When a person is referred, the individual and the referral are dispatched to secondary care, typically the acute inpatient hospital unit.

Participants and Recruitment

This study involved 103 participants, including multiple stakeholders from the five intervention municipalities who had experienced or been involved in individuals' paths to involuntary admissions. Eligible participants were: (1) people currently working in various services and who had experience supporting individuals who had been involuntarily admitted; (2) people with lived experience of SMI and/or involuntary admission; and (3) carers of individuals with lived experience of SMI and/or involuntary admission. The stakeholder services represented were primary mental health services, chief municipal medical officers, GPs, medical emergency services, police, outpatient specialist mental health services, and inpatient specialist mental health services. Eligible participants in primary and secondary services were recruited through service managers; GPs were recruited through the chief municipal medical officers. People with lived experience were recruited through the local groups of the advocacy organization Mental Health Norway, and carers were recruited through the local groups of the advocacy organizations Mental Health Norway and Mental Health Carers Norway. Purposive sampling was used to obtain a sample with a wide range of participants representing multiple stakeholders. See **Table 1** for sample description.

Data Collection

A mix of individual interviews and focus groups were conducted. For the most part, professionals were interviewed individually, and people with lived experiences and carers participated in focus groups. In the focus groups, the participants' joint experiences could be utilized but not to the same degree as an individual focus, given that the theme of the study involved possibly traumatic personal experiences for participants with lived experience and for carers.

A total of 60 individual interviews were conducted. Upon request, three interviews of professionals were conducted as group interviews with four, two, and two participants, respectively ($n = 8$). Seven focus groups were conducted ($n = 35$). The focus groups had between two and seven participants. Two interviews with carers were conducted as individual interviews because we did not manage to recruit more people in their municipalities. All interviews in one municipality were conducted before we moved on to the next municipality. Data collection was conducted in the period June 2019 to December 2019.

TABLE 1 | Distribution of participants.

Variable	Informants ($N = 103$)	Percent
Sex		
Male	43	42
Female	60	58
Role/service		
Primary mental health services	32	31
Secondary mental health services	16	16
Primary medical services*	16	16
Police	2	2
People with lived experience	16	16
Carers	21	20
Level of education among participants working in services ($n = 66$)		
Vocational education training	1	2
3 years higher professional education	9	13
>3 years higher professional education	56	85
Municipality		
Municipality 1	29	28
Municipality 2	13	13
Municipality 3	22	21
Municipality 4	17	17
Municipality 5	22	21
Type of interview		
Individual interviews**	68	66
Focus groups	35	34

**Primary medical services include general practitioners (GPs), medical emergency services (GPs and nurses), and chief municipal officers.*
***Three were conducted as group interviews with four, two, and two participants, respectively.*

The interviews were based on a semi-structured interview guide. In individual interviews, the participants working in different services were asked to describe one or two of the most recent situations they had been directly or indirectly involved in that ended up with someone being involuntarily admitted. The interviewer probed for contextual information and the sequence of events, including who was involved and how. People with lived experience and carers were asked to describe paths to involuntary admissions more generally, not necessarily about their personal experiences (although several of them chose to talk about this). Examples of questions included what they believed are typical circumstances leading up to an involuntary admission, who could be involved and how, what services individuals commonly receive prior to an involuntary admission, what happens in situations where an individual is referred to involuntary admission, and how services collaborate with the individual and their carers. All interviewees were also asked if they were aware of the rate of involuntary admissions in their municipality. Other themes in the semi-structured interview guide, such as factors in current practice that can affect pathways to involuntary admissions, and suggested measures to prevent such admissions, are and will be published elsewhere (17).

All interviews were conducted face-to-face except four that were conducted by phone. IW and TLH jointly carried out the interviews with the participants working in different services in the first municipality, then worked separately in two municipalities each. The interviews lasted 25–80 min and were conducted in meeting rooms in the municipality's offices. Upon request, two interviews were conducted at the participants' home. The focus groups and individual interviews with people with lived experience and with carers were carried out by IW, TLH and SHHK jointly in the first municipality, then in pairs; SHHK worked in all municipalities, and IW and TLH worked in two municipalities each. The focus groups lasted 90–110 min and were conducted in meeting rooms at the primary mental health services' location or on the premises of the local groups of the respective advocacy organizations.

Data Analysis

The analysis was inspired by grounded theory (18). The inductive analysis resulted in a conceptualized model revealing the characteristics of individuals' paths toward referral to involuntary admission.

In the first analytic step, IW, TLH, and SHHK wrote comprehensive notes during the interviews and focus groups. In the focus groups, we also logged our perceptions of the group dynamics. After a day of interviews, the notes were immediately used to write condensed summaries of the interviews. These condensed summaries were then used to write a reflection memo, including the interviewers' preliminary analyses of the participants' experiences. The first reflection memo was written after the first seven interviews of primary mental health professionals in one municipality; for the focus groups, reflection memos were written after each group session. In this phase, we included characteristics seen in single interviews as well as patterns across interviews. Throughout the interview period, the reflection memos were regularly subjected to constant comparison. Typically, this was performed within the scopes of participants in the same stakeholder group and municipalities. As we moved from one municipality to the next, new characteristics evolved and merged into categories, which were subjects for further exploration in new interviews. In the second analytic step, after all the interviews were completed, IW, TLH, and SHHK read the overall condensed summaries and reflection notes. During this process, characteristics were merged and rearranged, and categories were reviewed. In the third analytic step, all authors participated in further analysis. Preliminary categories and characteristics were reviewed several times until consensus was reached. In the final step, we prepared quotes from the data material to illustrate and elaborate the results. These quotes are non-verbatim condensations of the participants' descriptions.

Ethics

The Regional Committees for Medical and Health Research Ethics in Norway (REC) considered the study outside their remit (REC reference number 2018/2382 C), and the study was approved by the Norwegian Centre for Research Data (NSD reference number 743586). Informed written consent in accordance with the General Data Protection Regulation (GDPR) was obtained from all participants. No names or personal identification information were registered in the condensed summaries or reflection memos from the interviews. Information about users, participants and services in the condensed summaries presented as examples of situations are anonymized and kept to a minimum to ensure anonymity.

RESULTS

Drawing on the experiences of multiple stakeholders in five Norwegian municipalities, the analyses identified four main categories: deterioration and deprivation, difficult to get help, insufficient adaptation of services provided, and when things get acute. In **Figure 1**, the model *"Between no help and coercion: Toward referral to involuntary psychiatric admission"* displays the categories and their characteristics. Although the mutual ending point is referral to involuntary admission, the categories in the model are not necessarily sequential. For instance, an individual's path could comprise characteristics from two, three, or all four categories. Moreover, various characteristics could apply at different times for different people, and some were present throughout an individual's path. Furthermore, some described an unexpected acute life crisis that caused deterioration of clinical symptoms without the presence of other characteristics in the category *deterioration and deprivation*; these situations quickly moved on to the category *when things get acute* without including other characteristics shown in the two other categories. Nevertheless, the majority described multiple characteristics that were present before the severity of mental health deterioration was said to be acute, extending the paths' timeline and often including characteristics from several categories.

Deterioration and Deprivation

As seen in **Figure 1**, the category *deterioration and deprivation* indicate that a variety of clinical symptoms, behavioral symptoms, and socioeconomic factors were present in individuals' paths toward referral to involuntary admission. Examples of clinical symptoms described were psychosis, suicidality, self-harm, drug addiction, comprehensive trauma history (PTSD), cognitive impairment, and severe depression. In addition, many linked self-cessation of psychotropic medication and sleep deprivation with deterioration of clinical symptoms. Both reserved/withdrawn behavior and aggressive behavior were mentioned as typical symptoms, with the latter being the dominating characteristic of described paths.

> *This man lived in a municipal apartment related to a supported housing service with day-care staff. Prior to his last involuntary admission, we understood a deterioration was in progress when he withdrew more and more. Usually when he got like this, he had stopped taking his medication without anybody noticing. He would not let us in when we came to see him, and we had to persuade him to talk to us. For a while he let himself be persuaded to let us in, and we could motivate him to eat and go for a walk with us. But as he kept on not taking his medication, he deteriorated more and more. This is a man with a massive trauma history, and gradually*

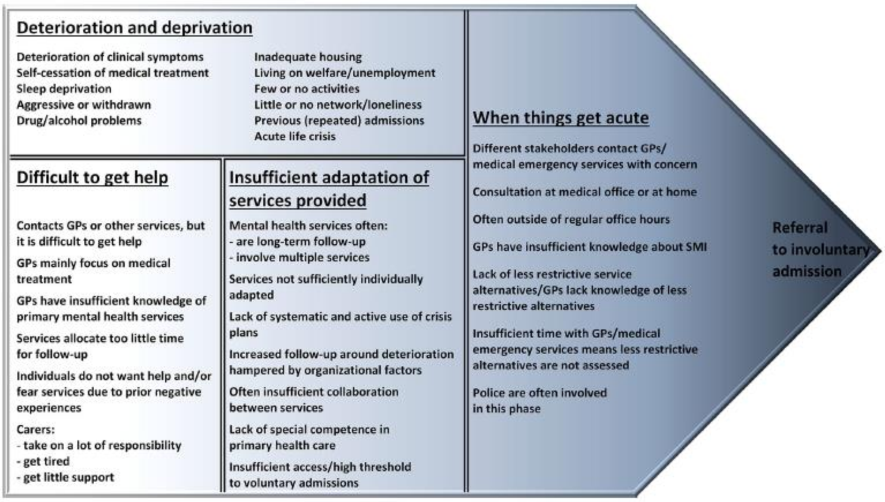

FIGURE 1 | Between no help and coercion: Toward referral to involuntary psychiatric admission.

> *he appeared more and more psychotic, until the situation became acute. At that point, he had not slept for several days, probably not eaten a lot either, and he started acting out, appeared aggressive, and threatened mental health staff that tried to get in contact with him.* (Staff, primary mental health service)

Many explained that these characteristics had been present over time, while a few talked about acute appearance of clinical and behavioral symptoms due to an acute life crisis.

> *My sister had always had a seemingly well-functioning life with a husband, kids, house, car, and a dog. But when her husband filed for divorce, she did not cope well. She went into an acute major depression and tried to kill herself.* (Carer, sibling)

Participants described how many individuals who were subjected to referral to involuntary admission ended up as "revolving door patients," with repeated involuntary admissions. Some professionals knew of individuals who had been involuntarily admitted as much as 50–100 times in 1 year.

> *He goes out on the edge to jump in front of the train and says he will kill himself. This happens again and again and again. When he stands there someone from the public calls 911, the police and ambulance turn up, get him down from the bridge, and the police drive him to the medical emergency service, who then refers him to involuntary admission. After a short stay at the acute ward of the psychiatric hospital he gets discharged, usually within a few days. Last year I think he did this over 50 times!* (Staff, primary mental health service)

People with these kinds of vulnerabilities were also described as being exposed to combinations of the sociodemographic vulnerabilities shown in *deterioration and deprivation* in **Figure 1**. This was believed to increase the likelihood of entering a path ending in a referral to involuntary admission. Participants described individuals living in a variety of contexts: some lived in private accommodations, others in municipal housing, supported housing with milieu staff, or had no fixed residence. Some lived with family members, others lived alone. Many participants observed that inadequate living conditions were prevalent; they described individuals with unstable housing situations, reduced capability to manage residential living, and poorly adapted municipal housing facilities. For instance, municipal housing contexts where people felt unsafe were mentioned as a barrier to recovery for individuals with SMI.

> *It is not ideal for him to live in that municipal building downtown where everybody else also has severe problems. People with all kinds of problems live there, and he gets anxious when the neighbors act out or make noise. In addition, he is not too good at comprehending and interpreting others when they communicate; he often misunderstands and gets into conflict with neighbors. In his worse periods, all this can enhance his deterioration and make it difficult for him to regain good daily functioning. I think he should have lived in another place where he could retire and protect himself*

> *a bit more from people who don't serve him well.* (Staff, primary mental health service)

Lack of suitable employment opportunities or meaningful daily activities were described as resulting in inactivity and passivity. In addition, many individuals were described as having little or no social network, which combined with inactivity often led to loneliness. Participants with lived experience and carers especially emphasized loneliness, and many experienced that the stigma around SMI in the wider society heightened the individuals' loneliness; several participants said the cares became the only social network for the individual. Employment, meaningful activities, and personal networks were emphasized as factors that, when present, could facilitate personal recovery and could prevent deterioration and the risk of referral to involuntary admission.

> *There is too much focus on just illness and too little focus on the fact that life consists of more than just illness. You need to have a place to live, practical help, and things that can make life a bit easier. I think a more diverse offer of activities to those who need it would be good, because there is not much to choose from now, especially for men. We have a day center but they offer mostly knitting, crocheting and reading the newspaper and stuff like that. They should organise things like data, golf, bowling and outdoor activities. It is time for some innovation. It is important to have good arenas to meet, generally in the community, in the city, or where you live, but the municipality here has no other activities to offer outside the day center.* (Individual with lived experience)

Difficult to Get Help

As seen in **Figure 1**, the category *difficult to get help* indicates how many participants experienced that insufficient support was available for at-risk individuals in the early phases of illness development. In their experience, the process often started before services got involved. Several participants with lived experience and carers described how they had tried to contact both GPs and other primary services several times in this phase of an individual's path, without receiving adequate help.

> *But I think there is something wrong with the system when they did not notice my signals earlier because I did not become psychotic overnight. Looking back, I think that it was not difficult to see the signals. When I did not dare going to the pharmacy or did not go to work back then when I was working, then the signals are visible. It is strange that they could not react earlier to my deterioration. Then, perhaps, I just needed a little more follow-up than once a week over a period of time. And that my GP, the mental health service, and my employer could collaborate a little more. I see that it would cost something, but I think that socio-economically it must be cheaper than me ending up being involuntary admitted. Maybe if I had gotten help earlier the total cost would be less, and my symptoms would be milder and quality of life better.* (Individual with lived experience)
>
> *She already started to get ill when she dropped out of high school, almost a year before the involuntary admission. She isolated herself, withdrew from her friends, and kind of changed personalities. We suspected that she had started doing drugs. We tried to get help, both through school and her GP, but no one seemed to understand how severe it was. And when, several months later, she finally got some follow-up from the mental health and addiction team in the municipality, she had become so severely ill with psychosis and all that it did not help. There must be something more between coercion and absolutely nothing.* (Carer, parent)

Many participants with lived experience and carers said that GPs often relied on medication as the main treatment option for people with SMI. In addition, participants from all stakeholder groups, including GPs, mentioned that GPs had limited knowledge of the available low-threshold services in primary mental health care. Several participants with lived experience and carers stated that GPs did not have sufficient time to conduct comprehensive assessments of their needs and match them with available services. This was also mentioned in relation to other services, such as when specialist outpatient mental health services only allocated a 1-h follow-up each week; according to participants with lived experience and carers, this was insufficient to help someone with SMI who deteriorated.

> *I felt that we did not get help fast enough when the crisis appeared. It was like there was nothing between no help and coercion. My wife had to become very, very, ill before they understood the severity of her condition, and then it ended in an involuntary admission. I believe that if the doctor had taken better time to hear us out and gotten more insight into her problems, she could have gotten better help and recovery before she got so ill that she had to be involuntarily admitted.* (Carer, spouse)

Some participants from the primary mental health services described how some individuals with SMI refused to receive mental health services in the periods prior to or between involuntary admissions. In these situations, the professionals felt that there was little they could do until the individual became so ill that a referral to involuntary admission was necessary. They described how they had limited opportunities to work more thoroughly with individuals unless their time allocations and work-load were reorganized to allow extra effort to prevent further deterioration. At the same time, participants with lived experience and carers discussed how some individuals with SMI withdrew from services because they had experienced former admissions as traumatic. Among other things, they talked about being roughly handled, and often the police had been involved. When this happened in public, the participants experienced additional strain and stigma. Some said that the services were not tailored to help people overcome this fear around receiving services.

When people did not receive sufficient support, carers felt that they had to take a lot of responsibility for their loved ones. Many said this was stressful at times, and they could get exhausted as their loved ones' mental health deteriorated. According to the carers, there was little, if any, service approach or support for them as carers to help them manage these situations.

Insufficient Adaptation of Services Provided

As seen in **Figure 1**, the category *insufficient adaptation of services provided* represents characteristics emphasizing how the provision of essential services for people with SMI was not sufficiently tailored to individuals' needs. Many individuals who received mental health services prior to a referral to involuntary admission had done so for long periods, often years. Some received multiple services, and from both the primary and secondary care levels. Nonetheless, many participants experienced that the long-term follow-up from mental health services, both prior to and during their path toward referral to involuntary admission, often lacked the degree of continuity people with SMI needed.

Professional participants from primary mental health services said they sometimes tried preventive measures when an individual showed early signs of deterioration. For instance, when an individual receives ambulant services, some professionals said they could try to increase follow-up and come by the individual's home several times a week in critical periods. However, several participants felt that this flexibility was hampered by the lack of resources, service organization, and knowledge. A few professional participants said that people with SMI at risk of involuntary admissions had crisis plans that guided the measures to implement, although the majority explained that the use of crisis plans varied greatly and were often neither established nor actively used. Poor collaboration among services, both at the primary level and between the primary and secondary levels, was highlighted by participants in all stakeholder groups as affecting adaptation of services. Many of the professionals working in mental health services experienced difficulties in collaboration with GPs, and collaboration between primary and secondary mental health services was also often experienced as poor or absent. Many participants mentioned that good collaboration depended on the people and was not part of a systemic approach.

> *Many services were involved—our service [primary mental health service], the activity center, an outpatient psychologist from the secondary mental health service, and the GP. In addition, his carers were there. But in my experience, the services did not collaborate much. One service did not know what another service did. The help provided was concurrent and not complementary, and coordination between the primary and secondary services were lacking. To my perception, a general lack of clarity in the division of tasks and responsibilities in this municipality is not good for individuals with severe mental illness, who often need multiple services and individual adaptation.* (Staff, primary mental health service)

Many professionals from primary mental health services said they lacked the right competence and tools to divert individuals' paths from ending in referral to involuntary admission. This was echoed by many GPs and professionals from secondary services.

> *I am not sure if this is a group of people that the primary mental health services are capable of handling. At least, it appears like they have too little knowledge in how to handle aggression and agitation, and it also seems like the ones working there get anxious in situations like that. Then the working routine might end up with the staff calling the police as soon as the slightest indication of conflict appears, instead of being able to help them calm down. And you know, in a supportive housing there can be many situations that potentially can cause conflicts, like shortage of cigarettes, money, or a drugged neighbour frightening you.* (Staff, secondary mental health service)

Furthermore, several participants revealed insufficient access to voluntary inpatient treatment at a secondary mental health care facility prior to an individual's deterioration becoming so severe that referral to involuntary admission was deemed necessary. In the experience of several GPs and primary mental health professionals, the threshold for people to be voluntarily admitted at secondary mental health inpatient services was often too high. A lack of beds (capacity) at the secondary care level was mentioned as a possible explanation.

> *When I really needed and wanted to be admitted, it was rejected. And I know how sick I can get! But it just did not happen! Psychiatry is a very rigid system.* (Individual with lived experience)

When Things Get Acute

As seen in **Figure 1**, the category *when things get acute* represents characteristics experienced as being present when the deterioration has become so severe that a referral to involuntary admission is on the cards. People from four stakeholder groups were typically the ones who contacted GPs to express their concern: (1) carers, private network, or others from the community; (2) professionals working in primary health services; (3) the police; and (4) professionals working in secondary mental health services. Sometimes the individual's GP received the concern, but in most cases those with a concern contacted the primary emergency medical service. Occasionally, carers directed their concern to the chief municipal medical officer; this mostly involved "revolving door patients," where the individual and carers knew the chief municipal officer from previous admissions. Chief municipal officers were also contacted by others from the community when they were concerned for an individual's mental health; examples of these were neighbors, animal welfare inspectors, and the fire brigade. In addition, some participants said that carers could express their concern with a primary mental health service if the individual received follow-up from this service. In situations where individuals with SMI did not give any response or let anyone in, GPs had to contact the chief municipal officer, who could decide on an involuntary medical examination.

> *We heard about the concern through a friend of the woman when she had not collected her mail for a while. The women did not answer the phone and did not open the door when we went to her home to make contact. This was a woman we had known for a long time, and we knew she had a severe mental illness. We contacted her GP, who contacted the chief municipal officer, who decided on an involuntary medical examination. The GP called on the police to break into the woman's home. There, we—the police, GP, and me—found her in bed in a state where she appeared to be very psychotic. She denied that she was ill and refused to be admitted. The GP referred her to involuntary admission, and the police had to escort her by force out to their car to drive her to the hospital. I think that when the police need to be involved in these situations,*

> *it makes the situation appear very dramatic. I think about how it must appear to the neighbors or others passing by.* (Staff, primary mental health service)

The participants shared that sometimes the police were the first ones in contact with people in acute situations. This could occur when an individual acted out in public or stood on a bridge and seemed prepared to commit suicide. In these situations, the participants said the police were the ones who brought the individual to the GP for medical assessment. According to the police participants, they were mostly involved in such cases outside their regular office hours. They said they did not know who to call in other services when they were faced with an acute psychiatric crisis. Consequently, the medical emergency service became the primary available place where they shared their concern. In the participants' experience, a few referrals to involuntary admissions occurred solely within secondary mental health care; typically, this happened if an individual was placed under a community treatment order. In these situations, the participants explained that professionals from outpatient secondary mental health services could direct their concern directly to their inpatient unit, and involvement from others besides secondary mental health services and police could be absent.

When a GP conducted a medical assessment to see whether a referral was warranted, they typically performed it either at the GP's office or in the individual's home. However, most referrals were described as happening outside of regular office hours. As a result, assessments were often conducted by GPs at emergency medical services. This meant that the doctor conducting the assessment had no or limited knowledge of the individual involved. Participants from all stakeholder groups expressed that, in their experience, the GPs had inadequate knowledge of SMI. Furthermore, they felt that GPs lacked knowledge about less restrictive alternatives at the primary care level. As mentioned in the category *insufficient adaptation of services provided*, professional participants also said they often did not have an available, updated crisis plan that could guide them on which measures to implement. Consequently, involuntary admission became the only option considered in acute situations.

> *When an individual comes to the medical emergency service with mental health and addiction problems, I often just refer them to the secondary services. I do not contact the primary services because I simply do not know enough about them.* (GP, emergency medical service)

In addition, several GPs said that other service alternatives were limited in an acute situation. For instance, primary mental health services were not available outside of regular office hours. In addition, the services could have intake time that was incompatible with the acuteness of the situation, and characteristic symptoms for this target group often prevented them from using the acute inpatient beds in primary health care. Another circumstance said to make involuntary admission the "only" option was that medical practitioners had too little time for individual consultations.

> *The medical emergency service has to take it all! We are the only service that has to deal with all kinds of problems and illnesses, arrange it all, fix it all. Often it is hectic and time is limited, and we quickly have to find a solution for a critical situation. At that point, the easiest alternative is to refer people further into the health system, and in these situations, this means referring them to involuntary admission at the [name of the acute ward at the secondary mental health inpatient unit]. The police, carers, or those who have brought the individual to the medical emergency service, typically at night or on the weekends, also want us to request an involuntary admission. They stand here waiting, and at the same time many others with different problems and illnesses are waiting too. So, the quickest and simplest solution might be to send them with the police to [name of acute ward]. Referral to involuntary admission often becomes the solution, because significantly longer time is needed to find any primary services that could be an alternative.* (GP, emergency medical service)

Also, participants with lived experience mentioned that GPs often had to little time at consultations.

> *GPs have to little time. It is important that the GP takes his time when meeting us. It is important that they know you. If you are heard and understood you can get more appropriate help.* (Individual with lived experience)

Several participants perceived that the police were often involved in one way or another in this phase. Participants said the police were typically called to assist with transport if an individual was assessed as aggressive, violent, or affected by noticeable intoxication, or if they had to break into an individual's home to enable access for health staff. The approach of the police varied. For instance, some described how the police used rough methods when breaking into homes or used force when escorting individuals from public places. Others had experienced the police's approach as caring and helpful, and they described how the police took their time and talked with the individual or let the individual perform their morning routine or put on make-up before they were brought away.

DISCUSSION

A conceptualized model based on multiple stakeholders' experiences and displaying categories and characteristics of individuals' paths toward referral to involuntary admission was developed from the results (**Figure 1**). Typically, multiple characteristics were present, and most paths started prior to the acute situation that resulted in a referral to involuntary admission. The clinical and socioeconomic characteristics described by participants in the current study generally match what is known in the literature as factors associated with involuntary admissions (11, 16). Consequently, the discussion will instead focus on some of the shortages in service provision appearing within such trajectories, including difficulties in accessing and adapting services, insufficient assessment of possibilities to use, and lack of less restrictive service alternatives, before implications for practice are highlighted.

"It was like there was nothing between no help and coercion" was a statement that is illustrative of many carers' experiences. Both individuals with lived experience and carers said it was difficult to get help in an early phase of an individual's mental health deterioration. Many GPs had a medical focus and lacked knowledge of primary mental health services. Individuals with SMI who received long-term mental health services often experienced service limitations, inadequate individual adaptation, and limited possibilities to act upon individuals' shifting needs. In addition, insufficient collaboration between services was revealed. Jankovic et al. (19) also found that carers perceived that services responded to crises rather than prevented them. This implies a potential to prevent some involuntary admissions, if services can be provided at an earlier stage of an individual's deterioration. Potential may be found especially in the phase where people make contact with their GP or other services asking for help. "*There is too much focus on just illness and too little focus on the fact that life consists of more than just illness*" was a statement from a participant with lived experience. If a medical perspective dominates, assessment of the individual's overall situation might be limited, and thus access to services that focus more on personal and social recovery in an early phase of deterioration will not be provided. Furthermore, factors that can hamper individual service adaptation include limited resources within services, budget cuts, rigid allocation systems, heavy caseloads, no or arbitrary use of crisis plans, and limited opportunities for voluntary admissions prior to the situation becoming acute (17, 20). Lack of alternatives due to a narrow range of housing, activity, and employment opportunities for people with SMI can negatively affect personal recovery and services' ability to reverse individuals' paths toward referral to involuntary admission (12, 17, 21).

Reducing referrals to involuntary admission cannot be taken separately from the provision of other services. The results in the current study indicate that acute situations are characterized by a lack of less restrictive care alternatives. Furthermore, even when potential alternatives were present, they were not always assessed as an option. For instance, busy medical emergency services with no or limited knowledge of the individual led GPs to choose referral to involuntary admissions instead of taking on the more time-consuming work of arranging other alternatives. In addition, the GPs' knowledge of current primary mental health services that provide alternatives were perceived as insufficient. Mental health legislation requires that options for voluntary engagement have been exhausted (22); therefore, it is important to question whether some individuals might experience unlawful referrals to involuntary admissions, if services for this group are organized in such a way that the time-consuming nature of considering voluntary alternatives in an acute situation sometimes becomes the rationale for referral to involuntary admission. A recent review of initiatives to reduce coercion in mental health clearly state that facilitating voluntary support requires a range of community services from which service users can choose (23). Unavailability of less restrictive care alternatives has been found to predict decisions of referral to involuntary admission (24, 25). In fact, a lack of alternatives has been found to be more significant than mental disorder, dangerousness, or individuals' refusal of care (24). In Norway, a discrepancy between referrals to involuntary admission and psychiatrists' decisions to involuntarily admit have been seen in about one-third of the cases (10, 16). This strengthens the notion of insufficient provision of or access to less restrictive service alternatives for this target group.

Furthermore, these paths might bring about ethical challenges for the professionals involved. In situations where professionals must choose between an individual's right to autonomy and their right to health care (26) when less restrictive alternatives are lacking, the health care organization influences this choice. Professionals are then left with a different ethical dilemma: to choose between involuntary admission and neglect. Consequently, involuntary admission might become the only moral choice to safeguard the individual, and the rationale and justification of the involuntary admission are potentially left unchallenged. Floyd (27) found that most professionals were comfortable or totally comfortable with cases they had handled wherein people were involuntarily admitted. This indicates that provision of less restrictive service alternatives, and services' capability to adapt according to individuals' shifting needs, might be influenced by mental health professionals' attitudes toward involuntary admissions. In Norway, the health government's directives to reduce involuntary admissions have formally addressed the secondary health care level (28). Without this being on the agenda at all care levels, professionals at the primary care level might simply continue their former ways of doing things (15), leaving involuntary admissions unquestioned with regard to the organization and provision of services between care levels. A lack of systematic focus in primary mental health services on reducing involuntary admissions (17) might indicate that professionals' attitudes toward involuntary admissions have not been particularly challenged at this care level.

Strengths and Limitations

The results of the current study represent the experiences of multiple stakeholders in five Norwegian municipalities. Thus, they may not be representative elsewhere. However, the high number of participants from several municipalities and from multiple stakeholder groups strengthens the possibility of generalization across settings. Including multiple stakeholders and stakeholder groups moderated personification and strengthened external validity. The results represent the participants' experiences with individuals' paths toward referral to involuntary admission and are limited to situations that end with such a referral (and, subsequently, an involuntary admission). The focus groups recruited through the advocacy organization Mental Health Norway included both participants with lived experience and carers. This might have limited disagreements in the discussions between these stakeholder groups. This study was part of a larger project that sought to develop and test an intervention at the primary mental health care level, aiming to reduce the use of involuntary admissions; this could have affected the experiences and examples the participants shared, potentially making them more inclined to describe cases where they thought referral to involuntary admission could have been avoided. However, our impression was that we obtained a mix of different experiences, including those where participants perceived that such referrals could not have been avoided. A multidisciplinary research group with three researchers (including a peer researcher) performing interviews, and an additional extended research group participating in the analysis process, strengthen the internal validity of the results.

Implications for Practice and Research

The conceptual model *"Between no help and coercion: Toward referral to involuntary psychiatric admission"* developed in this study indicates a gap in current practice between, on the one hand, the policies to reduce involuntary admissions and, on the other hand, the provision of, access to, and individual adaptation of less restrictive service alternatives for adults with SMI at risk of referral to involuntary admission. Given these perspectives, we recommend that further service development and research aim to facilitate:

- Easy access to services in early phases of deterioration.
- Individualized adaptation of service provision, housing, and activities.
- Systematic use of joint crisis plans.
- Enough consultation time and flexibility in service provision.
- Collaboration among services facilitating complementary and comprehensive treatment and care.
- Knowledge in primary health care on SMI, involuntary admissions, and alternatives to involuntary admissions.
- Access to less restrictive service alternatives in acute situations.

CONCLUSION

The aim of this study was to explore the characteristics of the paths toward referral to involuntary psychiatric admission of adults with SMI. Based on the personal experiences of multiple stakeholders in five Norwegian municipalities, the four main categories of deterioration and deprivation, difficult to get help, insufficient adaptation of services provided, and when things get acute are illustrated in a conceptual model displaying the characteristics of such paths. The model demonstrates the complexity of individuals' paths and underlines the importance of comprehensive approaches, along with the flexibility to tailor service delivery to individual needs, in working to prevent involuntary admissions. Furthermore, the results in this study indicate a gap in current practice between, on the one hand, the policies to reduce involuntary admissions and, on the other hand, access to, adaptation of, and provision of less restrictive services for adults with SMI at risk of involuntary admission. Further research is needed on effective measures and interventions at the primary care level.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable for the datasets generated in this study due to their containing information that could compromise the privacy of research participants, further inquiries can be directed to the corresponding author.

AUTHOR CONTRIBUTIONS

IW, TLH, SHHK, and TH developed the interview guides, recruited participants, conducted the interviews, and performed constant comparison and preliminary analyses. SHHK had a particular focus on the experiences of participants with lived experience and of carers. The writing of the manuscript was led by IW. TH, SHHK, JR, TLH, and MBR participated in the critical review of several drafts. All authors participated in final analyses and discussions of how the results were related to existing literature, contributed to planning the study, and revised and approved the final manuscript.

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PAPER 2

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RESEARCH **Open Access**

Professionals' perspectives on factors within primary mental health services that can affect pathways to involuntary psychiatric admissions

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Abstract

Background: Reducing involuntary psychiatric admissions has beenon the international human rights and health policy agenda for years. Despitethe last decades' shift towards more services for adults with severe mentalillness being provided in the community, most research on how to reduce involuntaryadmissions has been conducted at secondary health care level. Research from the primary health care level is largely lacking. Theaim of this study was to explore mental health professionals' experiences withfactors within primary mental health services that might increase the risk of involuntarypsychiatric admissions of adults, and their views on how such admissions mightbe avoided.

Methods: Qualitative semi-structured interviews with thirty-twomental health professionals from five Norwegian municipalities. Data were analysedaccording to the Systematic Text Condensation method.

Results: Within primary mental health care professionals experienced that a number of factors could increase the risk of involuntary psychiatric admissions. Insufficient time and flexibility in long-term follow-up, limited resources, none or arbitrary use of crisis plans, lack of tailored housing, few employment opportunities, little diversity in activities offered, limited opportunities for voluntary admissions, inadequate collaboration between services and lack of competence were some of the factors mentioned to increase the risk of involuntary psychiatric admissions. Several suggestions on how involuntary psychiatric admissions might be avoided were put forward.

Conclusions: Mental health professionals within primary mentalhealth care experienced that their services might play an active part inpreventing the use of involuntary psychiatric admissions, suggesting potentialto facilitate a reduction by intervening at this service level. Healthauthorities' incentives to reduce involuntary psychiatric admissions should toa greater extent incorporate the primary health care level. Further research isneeded on effective interventions and comprehensive models adapted for thiscare level.

Keywords: Primary mental health care, Mental health services, Involuntary admission, Mental health recovery, Mental health, Psychiatry

Background

Involuntary admission of adults to psychiatric hospitals has obvious implications for people's autonomy and liberty, is ethically and professionally controversial and expensive for services and the wider society [1]. The use of involuntary admissions can also be traumatic for both the person in question and their relatives [1]. The United

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Nations Convention of the Rights of Persons with Disabilities from 2006 severely restricts the use of involuntary care towards persons with severe mental illness (SMI), and clarify their human rights to liberty, autonomy and free choice in matters of health and treatment [2].

In Norway, as well as internationally, reducing involuntary admissions within mental health care has been on the policy agenda for many years [3–6]. Despite the policy to reduce involuntary admissions, rates in many countries have increased or been close to constant over the last decades [7]. The rates vary greatly between countries. For instance, in 2015 Italy and Austria reported rates of 14.5 and 282 per 100 K people, respectively [7]. Norway reports numbers at the high end compared to other Western countries [8] with a rate of 186 per 100 K person 16 years and older in 2018 [9].

Very few studies have investigated interventions to reduce involuntary admissions. A systematic review only found 13 eligible RCTs [10]. The meta-analysis found that only advance statements, including advance directives and crisis plans, contributed to reduction of involuntary admissions. This is supported by other studies [1, 11, 12], although evidence is somewhat mixed [13, 14]. Other studies report that self-management [12], having alternatives additional to hospital services [15], contact with multiple services [16] and regular outpatient contacts [17] are associated with reduced involuntary admissions. Evaluations of the Trieste Model, where psychiatric hospitals were replaced by a network of Community Mental Health Centres that applied a framework of personal recovery and social inclusion, found that its effectiveness in keeping the rate of involuntary admissions low was achieved through a "whole system" approach, rather than the effectiveness of individual interventions [18].

Persons with SMI often use services from both primary and secondary health care level. Typically, acute mental health crisis services and involuntary admissions and treatment are the responsibility of secondary mental health care level, while primary mental health care provide non-acute services and general support [19]. This means that mental health professionals at the primary care level are frequently in contact with adults with SMI at a point when relapse occurs and therefore in position of detecting early signs. Primary health professionals also serves as gatekeepers to involuntary admissions, as most referrals come from General Practitioners (GPs) or out of hours medical emergency services [20]. This suggests that intervention at the primary health care level might facilitate or prevent pathways leading towards involuntary admissions. So far, research on service development aimed to reduce involuntary admissions has almost exclusively been conducted at the secondary level, and research on primary health care level is lacking. Of 121 studies identified in a broad scoping review concerned with efforts to prevent and reduce multiple forms of coercion and compulsion in the mental health context, only 10 were referred to under the category of community-based strategies, and most were from services provided at secondary health care level [19]. A review of studies focusing on involuntary admissions with data from Norway included 74 articles, none of which examined factors within primary mental health services or ways in which these might affect pathways to involuntary admissions [8]. There are also few qualitative studies on how to reduce involuntary admissions in the literature [19]. Strategies to reduce involuntary admissions involve practices in complex contexts. Detailed information on current practice, including factors contributing to or preventing involuntary admissions, is needed to investigate the potential for primary mental health services to impact, or reduce, involuntary admissions. To address this gap in the literature, the aim of this study was to explore mental health professionals' experiences with factors within primary mental health services that might increase the risk of involuntary psychiatric admissions of adults, and their views on how such admissions might be avoided.

Methods

Given the limited research in this field, we conducted a descriptive qualitative study, exploring research participants' experiences and views through semi-structured individual interviews.

Study setting

The current study was the first stage of a larger project that will develop and test, through a cluster randomized controlled trial, a primary care level intervention to reduce involuntary admissions (ClinicalTrials.gov, NCT03989765). The intervention arm consists of five Norwegian municipalities, in which the present interview study was conducted.

Norway has a publicly funded health care system, where primary mental health services are funded through the municipalities and secondary mental health services through the regional health trusts.

In Norway, involuntary psychiatric admissions are regulated in the Norwegian Mental Health Care Act §§3-2 and 3-3 [21], and they are effectuated at the secondary care level. Secondary mental health care is delivered through Regional Psychiatric Hospitals and their Community Mental Health Centres that provide community-based inpatient and outpatient treatment, including ambulant treatment. National health policies and directives to reduce the use of coercion has appointed the responsibility to reduce the use of involuntary psychiatric admissions to the secondary care level [22]. In the following, 'involuntary admissions' refers to involuntary psychiatric admissions of adults at the secondary mental health care level.

The 356 Norwegian municipalities are responsible for meeting its populations' primary care needs. Primary mental health care often provides services to persons with SMI over long periods of time, commonly for years. Services provided can include everything from sheltered housing, day-care facilities, and therapeutic conversations, to helping with practical tasks in the house, transport to doctor's appointments, handling medication, and assisting with leisure activities. GPs and out of hours medical emergency services are provided at the primary health care level. In addition, municipalities provide social care, (un)employment services and housing services. Many municipalities, including the five intervention municipalities, operate with a purchaser-provider split for allocation of their services, and this includes primary mental health services. A municipal Purchaser Office makes assessments based on individual needs, and issue decision letters that specify what services and extent of support an individual should get from primary mental health care.

Participants and recruitment

Research participants were recruited from the five intervention municipalities. Eligible participants were professionals currently working within the municipality's primary mental health services and who had supported someone who had been involuntary admitted. They were strategically recruited to get informants representing both managers and staff, and a variety of primary mental health services like sheltered housing, ambulant services, and activity/day care centres. Potential participants were identified by service managers in each municipality.

Data collection

Data was collected through semi-structured individual interviews. The interview guide was structured around two overarching themes; (1) exploring pathways to involuntary admissions within current practice, and (2) exploring potential to prevent involuntary admissions. Interviewees were asked to describe one or two of the last incidents where they had been involved, directly or indirectly, in which someone was referred for involuntary admission. Managers were in addition asked some contextual questions on service organization, resources, and numbers of staff. The interview guides were developed by IW and TLH in collaboration with the research group of the larger project, which includes a peer researcher. IW and TLH carried out the interviews. In the first municipality they conducted them jointly, after which reflections on the functionality of the interview guide lead to no revisions. The rest of the interviews were performed separately by IW and TLH in two municipalities each. The interviews were carried out in meeting rooms at the municipality's town hall or the relevant service's location. The interviews lasted between 35 and 69 min, were audio recorded and transcribed verbatim.

Data analysis

In line with the descriptive and explorative design of the study, data analysis followed the Systematic Text Condensation method [23, 24]. Analysis was performed in four steps. First, all transcripts were read in full by IW in order to form a total impression of the data material. Six preliminary themes were identified; (1) numbers unknown, (2) relationship, time, and stability, (3) individual adaption of activity, employment, and housing, (4) bureaucracy vs. flexibility, (5) collaboration with other services and (6) competence needed. The analytical software NVivo 12 pro was used in the second analytical step (QSR International). Here, IW systematically examined all transcripts and identified elements of text that elaborated the participants' experiences of factors that could increase the risk of involuntary admissions and their suggestions of potential improvements that could facilitate a reduction. Malterud [24] calls such text fragments meaning units. On the basis of the preliminary themes the meaning units were coded and sorted. Corresponding codes within and across transcripts was gather into code groups. Thereafter, all authors read two randomly chosen transcripts and in agreement consolidated the code groups and their associated subgroups. Code groups were also reviewed within the context of previous research and theory. In the third analytical step IW represented the meaning content as written condensates, one for each subgroup. Participant quotes illustrating the meaning content of each subgroup were also identified. In the fourth analytical step, condensates and quotations were synthesized into an analytical description of the results. Results were written up by IW and the other authors contributed with reflections and critical revision. The final analytical code groups and subgroups are presented in Fig. 1. To complete step four, IW read eight randomly chosen original transcripts to assess whether the results reflected the data, which they did.

Below we illustrate our findings with direct quotations from participants. These were translated into English by the authors, and, to protect anonymity, are identified only with unique participant numbers, gender, and unique municipality numbers.

Table 1 Description of the research participants

Variable	Informants (N = 32)	Percent
Sex		
Male	10	31.3
Female	22	68.7
Position		
Manager	14	43.8
Staff	18	56.2
Age group		
25–39	10	31.2
40–49	11	34.4
50–59	7	21.9
60–69	4	12.5
Level of education		
Vocational education training	1	3.1
3 years higher professional education	7	21.9
> 3 years higher professional education	24	75.0
Work experience within mental health services		
1–5 years	3	9.4
5–10 years	7	21.9
> 10 years	22	68.7
Work experience within present municipality		
< 1 year	5	15.6
1–5 years	8	25.0
5–10 years	4	12.5
> 10 years	15	46.9

Results

A total of 32 mental health professionals took part in the study, 14 managers and 18 staff from the five municipalities. Different primary mental health services were represented, including ambulant services, home care services, sheltered houses, and day care/activity centres. All the research participants had at least one year of experience working within mental health services, 23 had more than ten years' experience. All but one participant had at least three years of higher professional training within health or social science. Information about the participants is described in Table 1.

Before describing the main results, two findings related to the study aim, form a backdrop. Firstly, the participants stated that their municipality in general provided good services to people with SMI. Secondly, during the interviews it became clear that while a few working in sheltered housing could recollect an estimated number of involuntary admissions within their service during the last year, none had the overview over the extent of involuntary admissions in their municipality nor the number of persons involuntarily admitted each year. This information forms an important part of the background on which to interpret the participant's experiences.

The main results comprise the participants' experiences with factors within current service provision that could increase the risk for involuntary psychiatric admissions, and their suggestions of how such admissions might be avoided. The results are presented according to the code groups as presented in Fig. 1.

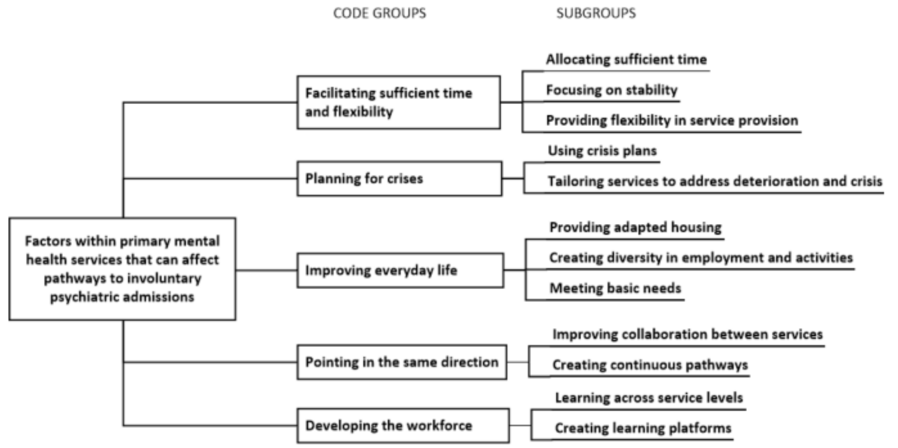

Fig. 1 Final analytical code groups and subgroups

Facilitating sufficient time and flexibility

According to the participants, relationships and trust between them and the persons with SMI receiving their services were important to be able to prevent involuntary admissions. In their experience, there was no quick fix to establish a good relationship and trust with adults with SMI. Stability and sufficient time in their service provision were mentioned by the participants as important to prevent involuntary admissions. Over time this could potentially put them in a position to identify deterioration at an early stage, when easier to reverse. Many experienced that a factor in current practice that could increase the risk of involuntary admissions was lack of time. Budget cuts due to poor economy in the municipality, increased focus on efficiency and more people in need of help from primary mental health care, meant there was too little time to follow up each person, and made it harder to build good relationships and trust in the long run. One research participant described this as being caught in the "quantity vs. quality trap". Political and health service management's will to prioritize services towards this group of people was highlighted as a premise for sufficient resource allocation.

In addition, participants described the flexibility to act upon people's shifting needs as important to be able to prevent involuntary admissions. In some municipalities the system for service allocation was mentioned as a factor that could increase the risk of involuntary admissions. This was highlighted by participants who experienced decisions made by the municipal Purchaser Office as rigidly controlling the amount of time they could spend with an individual. According to these participants, the service allocation hindered flexibility, left little time to act upon peoples shifting needs and were sometimes even contradictory to the participants' professional assessment. That new measures to meet emerging needs could be delayed by the time it took for the Purchaser Office to process a request, was experienced to increase the risk of involuntary admissions. The participants who, when observing a person in deterioration, experienced having authority to spend some of their time more flexibly perceived this flexibility to be preventive.

> *"I'm not very happy about these decision letters [from the Purchasing Office]. [...] if you're supposed to be one hour here, one hour there, one hour there, then I think your work won't get any focus. I'm not happy about not being able to get that. And there is something about, - in a way I do get it, that you need these decisions, but I just wish they weren't so rigid about the hours." (ID 51, female, municipality 5)*

Another factor mentioned in some municipalities, was that lack of time and flexibility within their practice hindered assertive work towards people who did not yet have a decision for a particular service, but still had obvious needs. Some of the participants said they knew people who had SMI, but did not seek or want help, and who sometimes were involuntary admitted.

Some participants mentioned that more staff and resources were needed to get sufficient time to provide adequate care and facilitate flexibility in service provision. Others expressed that such improvements could be reached by prioritizing current resources within primary mental health care differently. Another potential improvement suggested by the participants was to organize allocation of service provision differently. A concrete suggestion was to categorize the decisions into "small", "medium" and "large" amounts of time instead of specific number of hours. They argued that less rigid decisions could enable them to up- and down-scale service delivery according to a person's present needs and thus give the flexibility in service provision needed to potentially prevent involuntary admissions. Allocating a proportion of time within the mental health services that the professionals could use in a flexible manner, was also mentioned as a possibility. Some argued that this could ensure that they had the time to work assertively to motivate persons without individual decisions to receive help.

Planning for crises

Many participants described situations where people ended up in "revolving door patterns" of repeated involuntary admissions. Service development preventing such patterns were described as potentially contributing the most to reduce involuntary admissions. According to several of the participants, crisis plans could be a good measure to avoid this. In their experience, crisis plans made collaboration with the unwell person during crises easier, which could reduce the risk of involuntary admissions. Many of the participants experienced that a person's stable periods were windows of opportunity to work together on an active, updated and functional crisis plan.

> *"And about coercion, I mean, that you get things imposed on you. Because many of ours [service users] have had kind of revolving door admissions, I mean in and out and in and out, over many years. And then there are those crisis plans, coping strategies. And I do see that we can prevent admissions too because we are involved. And I believe that's important, at least for this group of users, because many of them have been admitted a lot and that is traumatic, I mean that is an additional burden. Simple as." (ID 24, female, municipality 3)*

The participants described great variation in how crisis plans were used, ranging from extensive, active and systematic use in some services, to others that hardly ever used such plans. In municipalities where the participants described no or more arbitrary use of crisis plans, this was expected to increase the risk of involuntary admissions. Different factors were mentioned including that services lacked routine to make, actively use and review crisis plans, that many persons declined when offered to make crisis plans, or that they said no to the measures in their crisis plan when they experienced a crisis.

Another factor within current practice mentioned by some was that crisis plans made by secondary health services during admissions were not always adapted to life outside the hospital setting. This was said to potentially increase the risk of repeated involuntary admissions. In some services, participants described that they used crisis plans more as the professionals' plans for risk assessment. Such plans were made by staff without involving the person in question, and participants did not experience this use of crisis plans to have potential to reduce involuntary admissions.

Participants experienced it as sometimes difficult to get voluntary hospital admissions when someone was at an early stage of deterioration. They said that such referrals often were rejected, and that the situation had to be severe or even acute before a person got admitted, and at this point this frequently ended up as an involuntary admission. Some participants mentioned that in current practice the primary mental health care sometimes ended up passively watching further deterioration to the point where people got so unwell they got involuntary admitted, as the participants experienced the primary mental health services had no alternatives left that could help.

In line with the variation described in current practice, some participants indicated more potential than others in reducing involuntary admissions through improved use of crisis plans. Working out routines that secured structured and active use of crisis plans to all persons that could benefit from having one, was mentioned as a potential improvement measure. Another potential improvement mentioned was that better use of crisis plans could make GPs and out of hours emergency services aware of other options for persons in crises, and thereby prevent GPs and out of hours emergency services from assessing involuntary admission as the only option. Several participants suggested ways in which primary mental health care could reorganize services to be better able to prevent people from deteriorating to the point where involuntary admission became the solution. This included self-referral beds to persons in need of a short period of treatment, which could be established within or in connection with one of the housing facilities with round the clock staff. Other measures suggested was multidisciplinary teams working intensively towards persons during and after crises, increased availability of primary mental health care 24/7, and improved knowledge in GPs of what services the primary mental health care could offer persons when in crises.

Improving everyday life

Making improvements to people's everyday life was, according to the participants, one of the aims for primary mental health services. In some municipalities, the participants experienced lack of suitable housing alternatives for persons with SMI as a factor that could increase the risk of involuntary admissions. Narrow shelters, tight quarters in turbulent neighbourhoods, several persons with severe challenges living in the same place, limited protection against factors that could trigger relapses, and frequent drug use among neighbours, were described as environmental factors that made it difficult to de-escalate aggression or make worried persons feel safe. In one municipality participants had experienced that providing housing better adapted to a person's circumstances and challenges had stopped her revolving door pattern of involuntary admissions.

> *"I do think there are cases where we can reduce the use of coercion too. Thinking of someone in supported housing for example [...] So that too, differentiated accommodation, is extremely important, for some, to give them the opportunity to live on their own [i.e. independently] [...] So that was important too, in a preventative view, as regards why that lady, for example [refers back to detailed discussion of accommodation tailored to individual needs], hasn't [been involuntary admitted] as much as before. I am sure that had she lived at her previous accommodation there would've been so many trigger points that there would have been much, much more [involuntary admissions]." (ID 15, female, municipality 3)*

Another factor mentioned in most of the municipalities was the lack of diversity in activities for persons with SMI. Lack of employment opportunities offered to persons with SMI were also mentioned.

> *"I think that if you'd managed to tailor support by means of activities... That's why I think the collaboration that exists between Social Services and the municipality at the moment with IPS [Individual Placement and Support], individually tailored employment support, I think that's a good entry, yeah, to prevent things. I believe so. At least for those at the starting line, I mean, who are about to build a mental disorder. That's what I think. To get people to have self-worth, or to feel useful, you know. I think*

> *that is important. But, of course, there are those with severe disorders, where I also think that it's about activity. And I'm saying that from what I see that some of them achieve, despite how really unwell they are." (ID 30, male, municipality 2)*

According to the participants, getting more diverse and adapted housing for people with SMI depended on this being a priority of the municipality's housing services, as residential development is costly and demand resources. Some of the participants mentioned that providing the service model Individual Placement and Support could be an improvement to get persons with SMI employment. This was thought to potentially facilitate recovery and thus reduce involuntary admissions. In regard to activities the participants mentioned establishing more diversity in activities offered at the primary mental health care's activity centres, better utilization of already existing activities, collaboration with voluntary organizations, increased use of human service assistants and transport assistance to go to activities, as potential measures to improve people's possibility to engage in individual adapted activities. In municipalities where participants experienced that they offered a lot of activity opportunities, further improvements in diversity and individual adaption was still emphasized, as they still experienced people that did not engage in what they currently offered.

Pointing in the same direction

Good collaboration between different services involved in an individual case was mentioned by the participants as important to be able to facilitate comprehensive treatment and coherence in service provision to persons with SMI. Collaboration with other services was, in many cases, seen as insufficient or lacking. Poor collaboration with GPs and secondary mental health services was considered to be a factor that could increase the risk of involuntary admissions. Collaboration with GPs was particularly emphasized, as they were the medical authority, within the primary health care level, on a person's treatment and medication. The participants said that collaboration depended on the personal attitude and working preferences of the individual GP. They also mentioned that many GPs lacked knowledge about the services that the primary mental health care could offer. Collaboration with the secondary mental health services was also said to vary. Many participants mentioned that sometimes primary mental health care was not involved prior to a discharge and that this could result in people not getting adequate help as they returned home. Poor collaboration was described as potentially leading to lack of coordination between services from primary and secondary services, providing services in parallel rather that giving complementary support.

Another factor mentioned to affect collaboration between primary and secondary mental health care services in some municipalities, was that the primary and secondary service level held different professional perspectives. In the municipalities where this was mentioned to be a factor, the participants experienced that professionals at the secondary mental health services devalued the primary mental health care's professional knowledge. This made it difficult to collaborate and agree on what was the right help to offer a person at transitions between care levels.

> *"Because the hospital and the specialist services often lecture us on what we should be doing and often have a shopping list for us when the service user gets out [of hospital]. And I think that specialist services, I mean, we see thing a bit different, they see the diagnosis and they see medication and they see treatment. And perhaps we see everyday opportunities more, and that you create a life, you must live life. You're not supposed to be admitted and sort of not be, you're not the illness, you know, you are something other than that. So, we have a bit different view on what is necessary when they get out." (ID 2, male, municipality 1)*

A general improvement mentioned by the participants was the primary mental health care's collaboration with other services. Regular collaboration meetings between the primary and secondary mental health services, drawing up better routines for collaboration, and working up collaboration relations with staff in other services, were examples of suggested measures of potential improvement at an organizational level. At an individual level, collaboration meetings before discharge, deciding which service is responsible for what, and collaborating to make crisis plans, were some of the measures mentioned to improve collaboration between the services in their direct contact with the persons. Further, a joint understanding where both primary mental health care's psychosocial recovery orientation and secondary mental health care's more medical orientation was integrated in comprehensive service provision to persons with SMI, was mentioned as something to strive for. Some suggested establishing integrated multidisciplinary teams with staff from both service levels as a new measure that potentially could reduce involuntary admissions. A specific service model suggested was Flexible Assertive Community Treatment.

Developing the workforce

Many participants experienced that a lack of competence to prevent involuntary admissions within their services could increase the risk of such admissions. A few of the participants mentioned that, particularly in supported housing services for people with SMI, some of the staff did not have relevant training. Some participants who had prior experience of working in acute wards in secondary mental health care said that employees there were trained to have the specialist competence needed to prevent crises and aggression from escalating. In their current practice within primary mental health care, on the other hand, they experienced a lack of such competence being provided to employees.

> *"What I feel I need is supervision and training courses and more competency, more spot on [...] I have an impression that maybe it can be a bit like that, that if we all are better drilled, trained, supervised, that there will be more confidence and [...] I think that could have an effect." (ID 32, female, municipality 2)*

Several of the participants mentioned that mental health professionals in primary mental health services should get more relevant knowledge on special areas related to this target group. Which potential improvements the participants described varied, both between the participants, the different services, and between the municipalities, but included knowledge on legislation regulating compulsion, evaluation of a person's capacity to give informed consent, risk assessment, assessment of suicide risk, de-escalation techniques, personal recovery as framework for service provision, psychosis, tools to handle aggression, and medication. Here they suggested different measures to enhance the competence within the primary mental health services. Formal education or training courses, thematic tuition at internal staff meetings, staff reflection groups, and guidance from professionals form secondary mental health care level, including feedback on current practice were among the suggested measures. Joint professional development among staff from different services, exchange programs across service levels, and more guidance from secondary to primary mental health services, was also suggested.

Discussion

Participants' starting point was the primary mental health care in their municipality provided good services to people with SMI. Nevertheless, they described a number of factors that, in their experience, could increase the risk of involuntary admissions. Insufficient time and flexibility in long-term follow-up, limited resources, lack of or arbitrary use of crisis plans, lack of tailored housing, few employment opportunities, little diversity in activities offered, limited opportunities for voluntary admissions, inadequate collaboration between services, and lack of competence are examples of factors the participants mentioned. They suggested several improvements that potentially could be implemented to facilitate a reduction of involuntary admissions. Another finding was that none of the mental health professionals participating in the current study knew the extent of involuntary admissions of adults in their municipality.

Putting involuntary admissions on the agenda

Our results showed that many participants experienced organisational factors that challenged prevention of involuntary admissions. Budget cuts, increased focus on efficiency, repeated reorganizations and rigid allocation systems for service provision were said to affect essential factors like stability, continuity, relationship, sufficient time to care and flexibility in their follow-up of persons with SMI. This is remarkably similar to what is reported from secondary care. Belling et al. [25] found that inadequate staffing levels, financial pressure, time pressure, heavy caseloads and models of decision making could give less patient contact time, more user discharge and have negative effect on continuity. This is also supported by other studies, where higher continuity of care in outpatient setting were associated with fewer hospitalizations and improved health outcomes for persons with SMI [26, 27]. Puntis et al. [28] argue that services need to focus both on continuity and flexibility because regular contacts (linear continuity) might fail to meet the fluctuating needs of those with SMI. Given these findings from secondary health care level, it might be reasonable to assume that organisational improvements facilitating factors like relationship, stability, continuity, sufficient time and flexibility in the primary mental health care's long-term follow-up of persons with SMI, can potentially contribute to reduce involuntary admissions. For primary care to contribute in this regard the reduction of involuntary admissions needs to be put on the agenda and prioritised in the development of primary mental health care. None of the participants in our study, including the managers, were aware of the level of involuntary admissions within their municipality. This might imply that reducing involuntary admissions has not been systematically addressed, at least not within these municipalities. To monitor the numbers will allow the primary mental health care to evaluate questions like; Who are the persons that become involuntarily admitted in our municipality; Where do they live; and What mental health services do they receive. Likewise, they will be able to detect patterns of high use of involuntary admissions and endeavour to change them.

Preventing revolving door patterns

In some municipalities and services, the participants experienced a lack of planning for crises as a factor that could increase the risk of involuntary admissions when crises appeared. Although the participants experienced crisis plans as an effective measure to reduce involuntary admissions, the use of such plans varied greatly. The potential to prevent revolving door patterns was emphasized in the participants' suggestion to improve the use of crisis plans. According to Claassen and Priebe [29] revolving door patterns is a phenomenon that have followed the deinstitutionalization of mental health care. Recent reviews have found that crisis plans is one of the few measures shown to reduce involuntary (re) admissions [1, 11, 12], although the evidence is mixed as Thornicroft et al. [13] found no effect. As most existing research was conducted at secondary health care level, further research is needed to assess the effectiveness of crisis plans within primary mental health care. Although a crisis plan is a tool for crisis management it must, according to the participants, be prepared and actively addressed when the person for whom it is for is stable. This implies that one needs to take a long-term view, allowing sufficient time and stability in follow-up. This relates back to the organizational factors mentioned above: to be able to improve the use of crisis plans it might be necessary to address factors that can lead to insufficient time, stability, and flexibility in long-term care provision.

Facilitating inclusion and personal recovery

The participants in our study experienced that lack of appropriate housing, employment, and activity opportunities for persons with SMI could increase the risk of involuntary admissions. That such everyday life contexts are of importance to personal recovery for those with SMI, is well acknowledged [30]. Ådnanes et al. [26] found that unmet needs for activity centre/day centre, meeting places, social services, and individual support contact, have negative effect on quality of life. Furthermore, recovery oriented treatment models like Housing First and Individual Placement and Support that provides help with housing and employment concurrently with mental health treatment, have demonstrated a positive effect on personal recovery and quality of life [31, 32]. Moreover, the tendency in European countries to create new 'hospital-like' living contexts within communities, clustering persons with SMI in the same facility and joint activities, has been criticized [29]. It can lead to exclusion and stigmatization and impede personal recovery [29]. Providing all those with SMI with adapted solutions within housing, employment and activities, requires access to a great variety of such facilities in the municipalities. This goes beyond the remit of primary mental health care and would involve reorganisation and redistribution of budgets in other municipal services such as social care, housing office, land planning, voluntary organizations offering activities and public and private workplaces. Thus, a call for reducing involuntary admissions needs to be put on the agenda across multiple sectors within the primary service level.

Joining efforts across care levels

Persons with SMI often receive services from both primary and secondary mental health care, and health professionals at both level may share many of the same views and experiences regarding how best to provide support to avoid involuntary admissions. Collaboration across care levels might thus be a particularly important aspect as it could be of benefit not only to those using services but also to bot levels of care. In some municipalities in the current study, participants experienced that a complicating factor to such collaboration was that primary and secondary mental health services had a different perspective stemming from their different responsibilities and clinical focus. The participants experienced a knowledge hierarchy between primary and secondary mental health services, secondary care considering themselves as being on top. Participants suggested that combining resources and competency in a complementary manner could be a helpful way forward. Primary mental health participants could benefit from professional guidance from the secondary mental health care on specific issues regarding the target group, and better integration of the perspectives of primary care into secondary care could facilitate service provision, at both levels, better adapted to prevent involuntary admissions in individual cases.

As shown above, the participants experienced that the level of current collaboration with secondary mental health services varied. Lack of or poor collaboration was mentioned as a factor that potentially could be a risk for people ending up with involuntary admissions. Previous studies in Norway confirm that lack of collaboration between health services can lead to fragmented service provision and discontinuity in care [33]. One can thus assume that measures to improve collaboration across care levels can facilitate continuity in care and better coherence in service provision. Collaboration can also lead to joint efforts from mental health services at both care levels to provide voluntary alternatives, and thus facilitate a reduction of involuntary admissions. The participants described how services sometimes were provided in parallel rather than complementary support, showing that many of the themes from the results in the current study may be common to both primary and secondary mental health care level. Integrated multidisciplinary teams with staff from both service levels was suggested to avoid this. Flexible Assertive Community Treatment teams, which in a recent Norwegian evaluation showed reduction in involuntary admissions [34], was specifically mentioned.

Funding mechanisms and allocation of resources affect mental health service provision and thus might be factors affecting collaboration between care levels [35]. For instance, when health services are funded through fee-for-service, collaborative work might be given a lower priority because it does not release fees and thus represent a disadvantage to business [35]. With public funding of mental health services at primary and secondary care level, like in the setting of this study, the experience of limited funding and resources might give a 'push' effect where services try to disclaim responsibility in the follow up of persons with SMI instead of establishing a collaborative fellowship across care levels. Counteracting such effects is important to prevent persons with SMI ending up without the support they need from either care level.

Furthermore, if collaboration across care levels is good, reduction of involuntary admissions can be put on the agenda within both primary and secondary mental health care. National strategies and actions-plans place the responsibility to reduce involuntary admissions at the secondary health care level [4, 22]. The facilitation of such a reduction is expected to be done in partnership with the primary health care level. Improving the collaboration between care levels can thus help facilitate increased contributions from the primary mental health care level to the policy aim of reducing involuntary admissions.

Strengths and limitations

The current study was limited to exploring mental health professionals' experiences. Persons receiving primary mental health services, family and network, other services and relevant stakeholders might have different experiences. That managers in the municipalities held a "gatekeeper" role identifying potential participants could imply a bias in research participants. However, the service managers' overview of the different services was helpful to identify eligible potential participants according to the recruitment strategy. This provided a sample with representation of both managers and staff, from a variety of services, and with many years of experience from primary mental health care. This gave data material characterized by thorough experience with current practice. All authors participated in the analysing process. This secured different perspectives and strengthened the results. The study was conducted in five Norwegian municipalities and the results are not necessarily generalizable to other contexts. Norway is a welfare state where health care is provided through well-developed publicly funded services. In this context the participants' experiences are influenced by their expectations of such a health system, including long term follow up from health services. Results might have been different in other settings where health care services are structured or funded differently. Mental health services being organised in different care levels might have affected the participants' views on factors affecting collaboration across services. Other factors might appear in contexts where mental health services are differently organised. Nevertheless, the fact that Norway face many of the same issues as other countries when it comes to involuntary admissions [8] implies relevance across contexts. The results were, with a few distinctions, recognizable across the included municipalities. Thus, it is likely that the experiences of participants in the current study is recognizable to other professionals working within similar services.

Implications for practice

Based on the current study, there seems to be potential for primary mental health services to prevent some involuntary admissions. As such, for national policy to reduce involuntary admissions to be successful, the topic should find its place on the agenda of primary mental health care and form part of future service development at this service level. Specifically, primary mental health care should assess the need to improve the use of crisis plans and facilitate greater diversity in recovery-oriented service provision like housing, employment, and activities. In addition, competence to facilitate prevention of involuntary admissions should be improved at this service level. Further research is needed to explore other stakeholders' perspectives, including persons with lived experience and their families. Furthermore, strategies adapted for primary mental health care level should be developed and tested to find effective measures for this care level. Finally, health authorities should to a greater extent incorporate primary mental health care in directives and incentives intended to reduce involuntary admissions.

Conclusions

Professionals in primary mental health care experienced multiple factors in their service delivery and organization that could increase the risk of involuntary admissions. This could suggest that service improvements at this level potentially can facilitate a reduction of involuntary psychiatric admissions. Involuntary admission is the end-product of a process starting outside the hospital, implying this is where one should intervene when aiming to reduce use of involuntary admissions. The policy aimed to reduce involuntary admissions should therefore include primary mental health care service development. Continuity in service provision to adults at risk of involuntary admissions, diversity in recovery-oriented measures like housing, employment and activities for people with SMI, collaboration with other services provided to adults with SMI, and competence on prevention of involuntary admissions, needs to be prioritized within primary mental health care. Health authorities' incentives to reduce involuntary admissions should incorporate the primary mental health care level to a greater extent. Further research is needed on effective interventions and comprehensive models aimed at reducing involuntary admissions adapted for this care level.

Abbreviations

SMI: Severe mental illness; GP: General practitioner.

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Authors' contributions

IW and TLH made the interview guides and conducted interviews. IW performed the analysis and wrote the manuscript. TLH, JR and MBR contributed to the analysis and participated in revision of the manuscript. All authors read and approved the final manuscript.

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Availability of data and materials

The datasets generated and analysed during the current study are not publicly available.

Ethics approval and consent to participate

The Regional Committees for Medical and Health Research Ethics in Norway (REC) considered the study outside their remit (REC reference number 2018/2382 C) and the study was approved by the Norwegian Centre for Research Data (NSD reference number 743586). Informed written consent in accordance with GDPR was obtained from all research participants. All names and personal identification were removed during transcription. Information about the participants and services in dissemination of results is held to a minimum to secure anonymity.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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