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# The 'forensication' of mental health care in Norway

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## PERSPECTIVES

STINE KILDEN

stine.kilden@ous-hf.no

Stine Kilden, MA in Management, special adviser at Centre for Research and Education in Forensic Psychiatry/SIFER at Oslo University Hospital  
The author has completed the ICMJE form and declares no conflicts of interest.

ØYVIND HOLST

Øyvind Holst PhD, Candidate of Law, special adviser at the Centre for Research and Education in Forensic Psychiatry/SIFER at Oslo University Hospital

The author has completed the ICMJE form and declares no conflicts of interest.

CECILIE BHANDARI HARTBERG

Cecilie Bhandari Hartberg PhD, specialist in psychiatry and head of the National Coordinating Unit of Forensic Psychiatry

The author has completed the ICMJE form and declares the following conflicts of interest: she receives book royalties from Gyldendal and has shares in RafX Technologies.

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**The justice sector is now a key driver of developments in mental health care, and an increasing share of healthcare resources is being diverted to meet the demands of the criminal justice system. As a result, the health service's influence over its own operations is diminishing.**

In 2002, the American psychologist Joe D. Alford (1952–2022) wrote about a rise in admissions in mental health care in the United States driven by the justice sector's need for crime prevention [\(1\)](#). He described this development as

'forensication'. A similar trend is now evident in Norway, where an increasing share of mental health service capacity is occupied by patients admitted for reasons of public protection (2-4).

*«An increasing share of mental health service capacity is occupied by patients admitted for reasons of public protection»*

When the special sanctions reform was introduced in 2002, comprising preventive detention, court-ordered compulsory care and court-ordered compulsory mental health care, it was estimated that no more than 160 people would be placed under compulsory mental health care. Today, that figure has surpassed 400, and projections indicate continued growth in the years ahead (4, 5). The consequences of the justice sector's encroachment into mental health care in Norway are now clearly visible: the boundary between the justice system and the health service is being steadily eroded (6).

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## Forensication in the Norwegian context

In his article 'The "Forensication" of Public Sector Mental Health', Alford describes a trend in which mental health services are increasingly tasked with managing society's forensic psychiatry dilemmas (1). The special sanctions reform of 2002 was also intended to address a long-standing dispute between the justice sector and the health service over who should be responsible for offenders deemed legally insane and posing a risk to others.

Until 2002, asylum sovereignty had functioned as a gatekeeping mechanism, shielding mental health institutions from forensic patients for over 150 years. Institutions themselves had the authority to decide who should be admitted and discharged. As part of the special sanctions reform, the justice sector gained the authority to decide on admissions, the duration of stays and to control the treatment of mentally ill offenders. Consequently, mental health services were required to prioritise crime prevention over therapeutic considerations, despite the fact that 'public protection' is not mentioned in the objects clause of the Mental Health Care Act.

This shift, in which mental health resources are increasingly devoted to meeting the justice sector's need for public protection, is what Alford terms 'forensication'. Here, we apply the term to the Norwegian context and contend that it should be adopted in Norwegian to denote this analogous development.

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## Failed projections

The special sanctions reform was premised on the expectation that the number of court-ordered patients would remain low enough for seamless integration into standard mental health services (7, 8). In other words, the reform was not intended to entail major changes for the health service. Early calculations suggested that the number of court-ordered patients would likely be lower than

those previously placed under preventive detention due to legal insanity (8), resulting in an estimated 20 new sentences per year and a minimum treatment duration of eight years. This would have created an equilibrium of around 160 court-ordered patients, with the number of new admissions matching discharges per year by 2010 (9). When the scheme was expanded to include time-limited sentences in 2016, projections were highly uncertain (10). The Ministry of Justice and Public Security estimated that only 1–10 people per year would meet the criteria for a time-limited special sanction.

For many years, the projection of 20 new sentences per year proved largely accurate, with an average of 18 each year between 2002 and 2016 (4). The projected equilibrium of 160 court-ordered patients was surpassed in 2015, five years later than anticipated. However, a turning point occurred in 2017: over the past eight years, the annual average has risen to 50 new sentences, and the number of people undergoing compulsory mental health care has more than doubled. This sharp increase likely has multiple causes. It partly reflects the 2016 expansion of criminal justice protections to include not only serious offences but also offences that are harmful to society or particularly bothersome, as well as amendments to the Penal Code's provisions on legal insanity and the Mental Health Care Act. What was intended as a narrow provision for admitting a small 'residual group' of offenders has become a widely used sanction in Norwegian criminal law.

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## Measures to address changing needs

From being a marginal part of the patient population at the start of the 2000s, forensic patients have become a defining feature of mental health services. The scope of this population primarily affects capacity and organisational structures, but challenges also arise in other areas, including the need for expertise in violence risk assessment and the expanded responsibilities associated with maintaining public protection. Reduced inpatient capacity further places pressure on municipal services, which already have limited resources to manage mentally ill offenders (11, 12).

*«The scope of this population primarily affects staffing levels and organisational structures, but challenges also arise in other areas»*

In recent years, the Ministry of Health and Care Services has acknowledged this trend and initiated processes to identify measures that could better equip the health service to address the challenges. Central to this effort is the National Plan for Forensic Psychiatry (3). So far, outcomes include a modest increase in inpatient capacity within hospital-based mental health services and the establishment of care pathways within what is known in Norway as 'security psychiatry'. This places a responsibility on psychiatric security units for a range of new functions both within and beyond the inpatient setting. The Ministry has approved a long-term increase of NOK 136 million to strengthen the service

provision in forensic psychiatry across the four regional health authorities (13). Questions remain, however, as to whether this funding is sufficient, timely, and whether these are the right measures to address the identified needs.

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## Consequences of the special sanctions reform

Both the 2002 special sanctions reform and its 2016 expansion were attempts to address highly complex societal challenges. In recent years, this has created rising expectations that the health service should take a greater role in crime prevention and public protection. The introduction of court-ordered compulsory mental health care placed a responsibility on the health service to treat mentally ill offenders considered not legally culpable for their crimes. As such, the reform represented the justice sector's 'retort' to the health service's lack of willingness and capacity to treat legally insane offenders, effectively extending the reach of the criminal justice system into traditional forensic psychiatry. Subsequent developments, however, have far surpassed the boundaries of forensic psychiatry. The reform now has implications for mental health services as well as primary care. In this context, three issues in particular warrant attention.

### **Justice sector's control over treatment capacity**

The 'forensication' of mental health services means that resources are not necessarily allocated to patients with the greatest potential to benefit from treatment. The main purpose of court-ordered compulsory mental health care is crime prevention, not treatment.

This tension is clearly highlighted in a 2007 letter from the Director of Public Prosecutions, which emphasises that 'the purpose of a sentence (...) to compulsory mental health care is primarily to protect society, not to ensure that the individual in question receives treatment' (14). Norway's National Plan for Forensic Psychiatry therefore notes that 'it is paradoxical that the justice sector has gained increased control over hospital treatment capacity, despite lacking the competence to assess the therapeutic benefit of a hospital stay for each patient' (3).

*«Admissions are increasingly determined by an actor for whom the provision of care is not the primary objective»*

The fact that a growing proportion of admissions are driven primarily by public protection needs suggests poor prioritisation of treatment capacity in an already pressured mental health system. However, there is no doubt that many forensic patients require proper treatment. The problem is that instead of admissions being based on clinical assessment or therapeutic need, they are increasingly determined by an actor for whom the provision of care is not the primary objective.

## **Displacement of civil patients**

Creating more formalised care pathways in forensic psychiatry risks drawing resources away from general psychiatric services, undermining their capacity to prevent poor mental health and to care for the broader patient group. The Ministry of Justice and Public Security warned of this back in 2017, noting that 'we need to be aware that those sentenced to compulsory mental health care may end up displacing other patients, including dangerous ones, who are admitted through civil procedures. Changes to the criteria for compulsory mental health care that are justified on the grounds of improved public protection should not have the unintended effect of diminishing public protection overall' (10).

Unfortunately, evidence strongly suggests that the measures now being implemented are insufficient to prevent forensic patients from displacing civil patients who have a greater clinical need for treatment. Reduced capacity for civil admissions increases the likelihood that people with severe mental illness will not receive the necessary care. The concern is that their condition may deteriorate to the point that they commit offences and are subsequently sentenced to compulsory mental health care. Forensication thus becomes a self-reinforcing cycle of forensic patients.

*«Reduced capacity for civil admissions increases the likelihood that people with severe mental illness will not receive the necessary care»*

## **Establishing a parallel system**

The introduction of care pathways in forensic psychiatry effectively marks a shift towards a parallel system, with forensic psychiatry on one track and general psychiatry on the other. This approach has both advantages and disadvantages. The National Plan for Forensic Psychiatry argues that a dedicated forensic psychiatric service will enable the implementation and enforcement of forensic psychiatry legislation that better safeguards patients with violent behaviour while addressing the need for public protection throughout the care pathway (3). Meanwhile, a parallel system could free up capacity within civil mental health services, allowing admissions to be based on clinical need.

A counterargument to such a division concerns the challenge of ensuring adequate access to the necessary expertise and sufficient staffing within the health services (3, 15). Neither approach is necessarily 'wrong'; the problem is that forensication is occurring without lawmakers having determined whether it is desirable.

Neither the scale of the forensic patient population nor the consequences for forensic psychiatry were anticipated at the time of the special sanctions reform. Against the backdrop of recent developments, expectations were high for the report by the Criminal Sanctions Committee. Unfortunately, the Official Norwegian Report on public protection and care (NOU 2025:2) provided only a limited opportunity to evaluate the current system (16). The Committee's

narrow interpretation of its mandate meant that a crucial opportunity to reconsider the overarching principles governing the division of responsibilities and the system for managing legally insane offenders was lost. Consequently, the health service also missed an opportunity to regain control of its own institutions.

Despite longstanding recognition of these adverse developments, legislators have so far only implemented remedial measures within the existing system, rather than addressing the continuation of the arrangement at a fundamental level. We believe it is essential to clarify whether the justice sector should continue to exert the same influence over mental health services as it has for the past 20 years. Should forensic care be allowed to continue eroding the boundary between the justice sector and the health service?

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