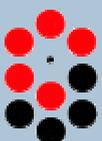


***COMPULSORY INTERVENTION
TOWARDS ADULT SUBSTANCE ABUSERS
AND MENTALLY DISABLED PEOPLE
IN SCANDINAVIAN SOCIAL LAW***

Even Nilssen

***Social policy and marginalization
Working Paper 19:2002***



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Socialforskningsinstituttet
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ABSTRACT

Compulsory interventions towards different social groups have a long history in the Scandinavian countries. Attitudes towards such controversial measures have changed during the last decades, and currently all three countries (Denmark, Norway and Sweden) emphasize individual autonomy and integrity as the basic principle in social law. This does not mean, however, that the use of coercive measures is removed from social law. In this paper our focus is on two social groups who historically have been the target of comprehensive compulsory interventions – adult substance abusers and mentally disabled people. On both these fields the legal development has been quite different in the three countries.

One important duality in the Welfare State is related to the tension between liberal ideas of freedom and legal protection on the one hand, and the possible dangers of paternalism and coercion following from the allocation of welfare resources on the other. The Welfare State may be described both as a project of liberty based on solidarity and justice, and as a powerful state apparatus controlling the lives of the citizens according to its own judgements, thus limiting the opportunities of individual freedom and self-determination. This tension becomes particularly visible when state action is enforced against the will of the receivers of certain “social benefits”. The paper discusses the legal foundation of compulsory measures in Scandinavian social law on the basis of three general principles of justice: The Liberal Principle of Autonomy, the Principle of Care and the Utilitarian Harm Principle. A critical approach towards the weighting of these principles in social law is elaborated.

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INTRODUCTION

Compulsory interventions towards different social groups have a long history in the Scandinavian countries. Attitudes towards such controversial measures have changed during the last decades, and currently all three countries (Denmark, Norway and Sweden) emphasize individual autonomy and integrity as the basic principle in social law. This does not mean, however, that the use of coercive measures is removed from social law. This paper focuses on two social groups who historically have been the target of comprehensive compulsory interventions – adult substance abusers and mentally disabled people. In both these fields the legal development has been quite different in Scandinavia. The Swedish Social Law legalizes an extensive use of coercion towards substance abusers, while such rules are almost absent in Denmark. In this country compulsory action towards drug addicts is based on voluntary retention. Norway occupies a position in the middle. Norway and Denmark have recently established legal rules regulating compulsory interventions towards mentally disabled people in their social laws. No such rules exist in Sweden.

One important duality in the welfare State embraces the tension between liberal ideas of freedom and legal protection on the one hand, and the possible dangers of paternalism and coercion following the allocation of welfare resources on the other (Nilssen & Lien 1999). The Welfare State may be described both as a project of liberty based on solidarity and justice, and as a powerful state apparatus controlling the lives of the citizens according to its own judgements, thus limiting the opportunities of individual freedom and self-determination (Rothstein 1994). This tension becomes particularly visible when state action is enforced against the will of the receivers of certain “social benefits”, and may be formulated as an ethical dilemma:

“the choice between neglecting to give any help or care for the needy and to violate the freedom of the fellow human beings – to deprive them of the protection of physical and mental integrity which we consider a basic good in liberal constitutional government” (Bernt 1993:160).

In principle, the use of coercive means in social policy is problematic, especially when such measures are implemented towards people of age. On the one hand, collective interventions may infringe a basic value of the Liberal Constitutional State (the *rechtsstaat*): the individual right of self-determination and integrity. On the other hand, a lack of interventions may neglect our collective ethical obligation to help people in need.

How is this dilemma solved in Scandinavian social law? To what extent do these laws protect the individual right of self-determination and how is compulsory interventions justified? In this

paper these questions are critically elucidated from a normative theoretical point of departure, focusing on the relationship between three general principles of justice: the Liberal Principle of Autonomy, the Principle of Care and a Utilitarian Harm Principle. The first principle constitutes a basic argument against coercion, while the other two provide different types of arguments in order to justify such measures. The actual weighting of these principles in Scandinavian social law is discussed in relation to an ideal model elaborated in the next section of the paper. The object of investigation is the founding ideas underlying the material rules of the relevant acts. Thus, our main concern is the relationship between social policy and justice, not to provide an account of valid legal practices based on legal dogmatic analyses.

1. JUSTIFYING COMPULSORY INTERVENTION

In liberal political thought the ability of the individual to make its own choices has been perceived as the basic founding of social freedom and moral responsibility. According to Kant every man has a moral right to make his own choices, a right derived from the fact that human beings possess the ability to make independent choices based on reason (Andersson 1994; Steinton 1994). From the basic moral imperative; “Act only on that maxim by which you can at the same time will that should be a universal law” (Rosen 1993 p 12) a liberal (Kantian) conception of justice can be formulated as “a condition in which each individual’s external freedom is restricted so as to make it consistent with the freedom of all others in the framework of a common law or systems of law” (Rosen op.cit. p 9). Freedom is an inviolable human right only limited by other persons’ right of freedom. An important normative argument for the value of freedom is that an individual who is not exposed to coercion is able to live his life according to his own goals and assessments, his own projects and conceptions of what is valuable – for instance different ethics (Kupfer 1990, Plant 1993, Rothstein 1994).

The *Liberal Principle of Autonomy* is founded on a value that does not express any substantial or ethical conceptions of “the Good Life”, but is rather seen as a general prerequisite for the existence of a plurality of such conceptions in society. While questions about “the Good Life” consider how an individual (or a group) wants to live his (or their) life according to his (or their) own values, the Principle of Autonomy deals with the relationship between people who have different conceptions of “the Good Life”, or to use a formulation by Kant: “Right is therefore the sum of the conditions under which the choice of one man can be united with the choice of another in accordance with a universal law of freedom” (Kant 1996 p 24).

In liberal political thought it is an important point that the autonomy of the citizens must be secured by the State (the Rechtsstaat). The central doctrine is that the main task of the State is to guarantee the freedom of the citizens from internal and external dangers. At the same time a powerful state is a potential threat to this freedom. The freedom of the citizens depends on the State’s own delimitation of its capability to harm the autonomy or integrity of the citizens (Hindess 1996). Thus, autonomy depends on the constitution of civil rights granting the individual a space of action not infringed by collective interventions. Such rights must be incorporated into the system of law in specific countries. In the same way as morality, the law is supposed to protect the autonomy of all people embraced by it (Habermas 1996).

The classical Principle of Autonomy emphasizes the moral aspects of the Liberal Constitutional State. However, the conception of legal security founded in this kind of reasoning is a purely formal one, expressed as the amount of protection each citizen possesses against any public

infringements of his/her freedom (Bernt & Doublet 1996). This is a protection of what Berlin (1958) termed “negative freedom”, i.e. autonomy is simply understood as absence from external coercion. From the perspective of negative freedom autonomy is only an opportunity to make individual choices, not something that is necessarily exercised (Taylor 1995). The liberal idea of freedom presupposes the existence of rational (in some way or another) and potentially autonomous individuals. However, man is not only a rational being, but also a vulnerable social being. Our ability to act is in many ways dependent on other people’s actions, and we are particularly vulnerable in different phases of our lives. For people with learning disabilities, suffering from dementia or other groups, any reference to the Principle of Autonomy may be problematic or irrelevant (O’Neill 1988) and the definition of our collective ethical obligations becomes crucial.

While the Principle of Autonomy is founded in a practical moral discourse of freedom (Habermas 1996), the *Principle of Care* is linked to an ethical discourse about our collective obligation towards those of our fellow citizens not capable (temporarily or permanently) to exercise their autonomy (cf. O’Neill 1996). Joseph Raz (1986) underlines in his discussion of the concept of autonomy that the role of the State cannot be limited to protect the individual against external harm or coercion: “Governments are subject to autonomy-based duties to provide the conditions of autonomy for people who lack them” (Raz 1986 p 415). Raz argues that not to fulfil a collective ethical obligation to improve the situation of a citizen often is the same as harming him/her. Following this perspective, justice is not primarily a question of protecting citizens against interventions from the State, but also a question about the allocation of resources necessary to enable the citizen to live a life in dignity.

By a principle of care we mean the distribution of any such resources when the motive of the allocation is to improve the situation of the recipient (Nilssen & Lien 1999). This principle may be justified from the idea of equal autonomy (cf. Weale 1983), but there is no indispensable link between the Principle of Care and the Principle of Autonomy. The Principle of Care may involve the use of paternalism in the distribution of welfare services because it involves assessments of individual needs, which again are often linked to decisions about “the Good Life”. Generally, paternalism may be defined as “interference with a person’s liberty of action by reasons referring exclusively to the welfare, good, happiness, needs, interests, or values of the person being coerced” (Dworkin 1972 p 65).

It is important, however, to make a distinction between a strong and a mild form of paternalism. As a point of departure we may claim that an autonomous person must possess a certain capacity to make voluntary choices based on a form of practical reason; they have to be “in the maturity of their faculties” to quote John Stuart Mill (1859/1989 p 13). By *mild paternalism* we mean

interventions towards persons who do not possess, permanently or temporarily, this capacity. Paternalism may be expressed in pure work of social caring, for example in the work with multi-handicapped persons. Paternalism may also be justified from the purpose of restoring the autonomy of a person temporarily unable to act autonomously, for example by different kinds of treatment such as psychiatric or medical services. The crucial point is that justifications of mild paternalism always have to be made by reference to the mental capacity of the individual to make independent choices and not to the content of these choices themselves (Dworkin 1988). Justifications based on assessments of the contents of individual choices will be termed *strong paternalism*. In these situations the reason for interventions are not a lack of mental capability to make independent choices, but that the interventionist does not accept that the choices made by a person are for his/her own good. This does not necessarily go beyond the value of life itself, but it may cover a more comprehensively substantial approach to the concept of “the Good Life”. We may find plausible reasons to set aside the Principle of Autonomy (for example in order to to save a person’s life), but welfare state efforts based on strong paternalism are often morally dubious because it “easily becomes a cloak for the imposition of our values on those who are coerced.” (Ten 1980 p 117). Public welfare based on strong paternalism may become a repressive instrument of normalisation, i.e. corrections of deviances based on other persons' conceptions of a normal life.

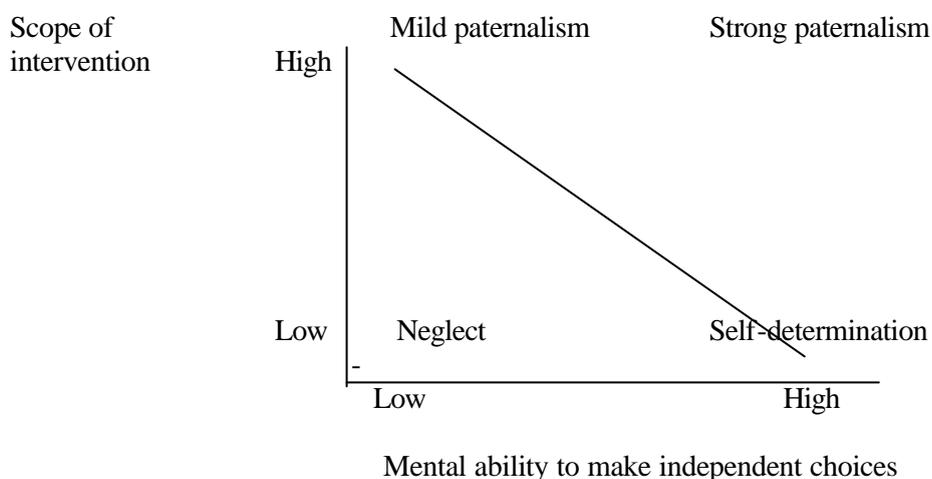
Arguments for compulsory interventions may also be based on utilitarian ethics. Normally this would mean that such measures are considered to increase the welfare, utility, happiness (or whatever) of a larger population, for instance the family, the local community or the whole society. While the Principle of Care places the interest of the individual above the interest of the collective, the Principle of Utility (understood as a political principle and not as a theoretical concept of individual utility maximization) does the opposite (Nilssen & Lien 1999). It is anchored in an aggregated concept of welfare and may thus come into conflict with the liberal concept of autonomy. The classical utilitarian dilemma originates in the fact that the autonomy of the individual may be set aside by the interest of others (Husak 1992).

Of particular relevance to our study is a justification of state-intervention according to a Millesian *harm principle*. In his work *On Liberty* John Stuart Mill (1855/1989) defended the liberal idea of autonomy and rejected any intervention towards people “in the maturity of their faculties” based on paternal arguments (strong paternalism). According to Mill an individual is not accountable to society for his actions as far as they only concern himself. A person should be allowed to follow his own opinions without interventions as far as the consequences of his actions are at his own expense. The only legitimate reason for collective intervention is to protect the interest of others from harm caused by the person’s actions. An individual is

accountable to society for his actions if they cause (severe) harm to the interests of other people and may thus be exposed to legal punishment. The Harm Principle is first and foremost an underlying foundation of criminal law. Nonetheless, the protection of the interests of others has historically played an important role in the justification of compulsory interventions in social law. Mill himself, for instance, argued that people who could not support a family (in certain situations) should be prohibited from getting married in order to prevent negative social consequences (for society or the children).

Utilitarian justifications of state interventions may be defined both positively (increasing total utility) and negatively (protection from harm) and the Harm Principle may both be used to justify the protection of individual persons or a collective such as a community or the entire society. Thus, utilitarian interventions in social law may infringe the individual right of self-determination and/or obscure the distinction between care and punishment.

The main purpose of this paper is to elucidate the founding principles of compulsory interventions towards adult substance abusers and mentally disabled people in Scandinavian social law. The following model will be used as a point of departure.



The model attempts to grasp the relationship between the institutional and individual dimensions of welfare interventions. Scope of intervention embraces the kind and amount of collective encroachments on the individual right of self-determination. In our work this means assessments about the use of coercion towards substance abusers and mentally disabled people founded in social law, i.e. the content (description) and justification of the law. Ideally, coercive measures ought to be considered in relation to the capacity to make autonomous choices of the person being coerced. The second dimension of the model comprises the demarcation line in our

distinction between mild and strong paternalism. Generally, the normative ideal line in this figure may be drawn between mild paternalism and self-determination (perfect adjustments between interventions and the Principle of Autonomy). Neglect and strong paternalism is thus interpreted as deviations from this ideal line.

A social policy based on the Principle of Autonomy emphasizes the self-determination of the receivers. In principle there should be a real situation of choice (alternative providers), but we will assert that social measures distributed as offers or rights which the citizen may (or may not) accept or claim, fulfil the Principle of Autonomy. However, we have seen that the Principle of Autonomy first and foremost is concerned with the negative freedom of the citizens (absence of external coercion). A social policy founded on such a principle will be in danger of *neglecting* those citizens who are not capable of exercising their self-determination in any reasonable way. For instance, to leave people with severe mental disabilities to their own choices, will decrease their welfare and many will probably end up in a life of misery.

In these kinds of situations compulsory interventions may be justified by the Principle of Care. By compulsory intervention we mean a transformation of the right of self-determination to others, for instance welfare professionals, based on coercive measures (force). The scope of such transformation should depend on the actual person's ability to make choices in different situations. Interventions may also be justified from an argument that such efforts will increase the capacity of the person to make independent choices, for example through treatment or education. Compulsory measures are based on what we called *mild paternalism*.

If the Principle of Care is applied to justify compulsory interventions towards people who are able to make their own decisions, these measures become more problematic. What happens is that autonomous individuals are exposed to the definitions of others of what should count as the "Good Life" for them. Social policy is based on what we called *strong paternalism*. To deprive a person of the right of self-determination is often an encroachment on his or her human worth (Tranøy 1993).

We may claim that welfare paternalism can be founded on a utilitarian harm principle (often in combination with the Principle of Care), but in the case of utilitarianism the person's ability to make independent decisions is considered more or less irrelevant. What counts is the consequences of a person's performed (or anticipated) actions on other people. Even if a person is capable of making his/her own choices, there may be due reasons to intervene if his/her actual choices will cause severe harm to others. Our point of departure is that the right of self-determination is a founding right in a liberal constitutional government, and that any encroachments on this right must be convincingly justified by (in our case) the State. As an example, it is easier to argue for compulsory intervention (in social law) towards a person if he

or she constitutes a serious risk to the life or health of others due to a mental illness or retardation, than if the purpose of the intervention is to remove social “deviants” from the local community (renovation). However, social policies based on the Harm Principle also raise important questions about the distinction between the Social Law and the Penal Code. Historically, the protection of others and punitive measures have been closely linked in Scandinavian social law.

2. COMPULSORY INTERVENTION IN THE FIELD OF SUBSTANCE ABUSE

2.1 Legal background

Alcoholics have constituted a core category within the group of “undeserving needy” and they have been the subjects of different kinds of public policies based on moralising, disciplining and punitive motives (Mathiesen & Heli 1982, Midré 1995, Kinnunen 1994). In the first part of the 20th century the amount of compulsory measures and institutions was about the same in these countries (Kinnunen 1994).

In Denmark a measure for prevention of intemperance, placement in work-homes and treatment institutions (sanatoriums) could be applied towards alcoholics at the beginning of the last century. The measure for prevention of intemperance could be used by a court of law when an infringement of the law had been committed under the influence of alcohol. Repeatedly criminal conduct could cause compulsory placement in work-homes (between 1 and 5 years). In 1933 The Public Assistance Act made it possible to place alcoholics in treatment institutions administratively without any decision from the court of law. In certain circumstances the Municipal Social Committees could request a person to be placed in an institution for maximum 1½ year. If he escaped from the institution or a new claim for compulsory placing was raised within one year after being discharged, the person could be institutionalised in a work-home from three months to two years. An important purpose of the law was to control alcoholics who neglected their duties towards their families. The Municipal Councils also had a legal opportunity to decide to force a person to work for maximum 2-3 months (in difficult cases 3-12 months). In 1960 a new Public Assistance Act was worked out. According to this act the Municipal Social Committees could request a person to subject himself to treatment if he abused alcohol and if there was an application for treatment from the family or other relatives, the police or another public authority or from a physician. The person could be detained in an institution, institutional department (for example in a psychiatric ward) for up to 6 months. If he sabotaged any outpatient treatment after being discharged from the institution, he could be institutionalised for another year. The same procedure could be followed if a family became dependent on public allowances due to a person’s drunkenness, or if the Child Care Council recommended treatment to prevent a child from being taken into public custody. This Act was unchanged until a new law of social assistance was implemented in 1976 (Kinnunen 1994). By this act legal rules for compulsory interventions towards alcohol abusers disappeared from Danish social law. Compulsory interventions could only be applied as a part of psychiatric treatment (which presupposes a situation of insanity).

In the first publication of the Social Reform Committee in 1969 (Betænkning 543/1969) it was suggested that the question of compulsory treatment should be discussed at a later time, but in their second report from 1972 (Betænkning 664/1972) this topic was not mentioned at all.

In Sweden an act concerning the treatment of alcoholics was implemented in 1916. This act exclusively regulated compulsory treatment of people “addicted to inebriety”. In resemblance with The Poor Law (1918) the Alcoholic Act was primarily an act of detention based on patriarchal traditions and work ethics (Kinnunen op.cit.). Compulsory efforts were first and foremost justified to protect others rather than the substance abuser himself – his family or others who could be harmed by his drinking. The Alcoholic Act was replaced by a new act on treatment of alcoholics in 1931. In opposition to the old law the new one emphasized individual care. It was, however, still a question of internment of the most serious cases. In the Swedish Temperance Act of 1954 the main focus was on voluntary preventive measures. Compulsory interventions should only be permitted when voluntary efforts were regarded insufficient. According to the main rule the time of compulsory placing in treatment was one year, but if a person was institutionalized once again within five years after being discharged, the duration of involuntary treatment was two years. The scope of the law was also widened compared with the old Alcoholic Act; it introduced to the Municipal Temperance Committees not only a right, but also a duty to intervene towards persons who were defined as alcoholics.

In Norway the Poor Law of 1863 contained rules about imprisonment and forced labour for alcohol abusers who did not have any income and thus were a burden to the local Poor Council. In 1900 a more general law of punishment for intoxicated persons who were disturbing the community, molesting their environment or causing dangers to their families or others, was effectuated (The Act on Vagabonding, Begging and Drunkenness) (Lien & Nilssen 2000). This act increased the public control of the “vagabonds” and alcohol abusers, although it was only the persons who disturbed “peace and order” who were taken care of (Seip 1994, Midré 1995). People who were imprisoned due to drunkenness could, according to the act, be placed by force in work-homes or institutions for a maximum of two years. In 1932 a new law, The Temperance Act, was implemented. According to this act a substance abuser could be placed under compulsory treatment for up to two years if, due to his abuse, he a) maltreats his wife or children or exposes the children to moral damage or neglect, b) fails in his duty to support his family according to existing laws, c) exposes himself to severe physical or mental damage, causes any danger to himself or others or repeatedly harms his surroundings, d) is a burden to the social services or his family or e) abuses or spoils his property, giving due causes to fear-straitened circumstances for himself or his family. The act intended first of all to protect the family and others from the abuser (Nilssen & Lien 1999). Protection was justified by the

possibility of physical, economic and moral harm. In 1957 the scope of the act was widened also to embrace drug abusers. The Temperance Act was valid until the revision of the Social Security Act in 1993.

2.2 Current legislation

The Danish law: Retention of drug abusers in treatment. According to Laursen (1992, 1999) the question of using coercion in the treatment of substance abusers came on the Danish public agenda as a result of a police action against drug addicts and traffickers in Copenhagen (Vesterbro) in 1991. The police in cooperation with a newly established treatment centre based on the Minnesota model (Egeborg), had criticized the local authorities for handling the city's drug abusers too softly. In the winter of 1991 the discussion of compulsory treatment was attached to the political process. After a meeting between the ministers of health, social affairs and justice it was decided to promote a bill based on contractual coercion, prepared by the Civil Service. The bill passed parliament in 1992 and was sustained in 1997 after some adjustments in relation to other changes in Danish social law.

The value of voluntariness can be traced at three different levels in this act. Firstly, it is up to each county council (or municipal councils if they are given the authority) to decide if they want to apply the act in principle. Secondly, a decision to offer the drug addict a contract of compulsory retention is needed in each specific case. Thirdly, the drug addict has to agree and give his/her consent if such a contract is offered.

In 1998 the act had never been applied and only three of the counties in Denmark had made a principal decision to use it (Socialministeriet 1998a). The main argument had been that the treatment of drug abusers should be voluntary and not based on coercion. In the guidelines from the ministry the Government agrees on this, but maintains that voluntary retention may be of support for the substance abuser in some of the potential crises occurring in the initial phases of the treatment process. However, it was important that the drug abuser himself wanted to be held back in certain specified situations, before the treatment starts. The act emphasizes that it is essential to assess the Principle of Self-determination (consent) in relation to the situation of the drug abuser at the time he enters into a contract. The client must not be subjected to any pressure in order to make him sign the contract, for example to declare that this is the last offer of treatment given to him/her. The person has to be in such a mental state that he comprehends what kind of treatment he enters into if he signs the contract. The contract should also contain information stating that the person may denounce the contract at any time as far as the conditions of retention are not fulfilled. The act warrants the use of necessary physical force to keep the client back if the conditions of the act are fulfilled. A contract of voluntary retention

can only be valid for 6 months (maximum). However, a single retention cannot endure for more than 14 days in a row and the total amount of retention must not exceed 2 month during this 6 months period of time.

The Swedish Act on ward for substance abusers in certain cases (LVM). In 1980 a new Social Service Act passed the Swedish Parliament. This law did not contain any legal foundation for real compulsory interventions. An important aspect of the act was that individual measures should be based on voluntariness and the right of self-determination (SOU 1981:7, p 7). However, the Parliament expressed a strong wish to elucidate the topic of coercion further, and in 1981 the Social Committee presented a proposal for a new bill (LVM) (SOU 1981:7). This proposal was introduced to the Parliament without any mayor changes (Prop 1981/82:8) and passed the Parliament in December 1981 (Rskr 91).

According to this act compulsory placing was permitted for 2 months with an opportunity to prolong the stay for another 2 months under certain circumstances. During this time it was important to motivate the substance abuser to accept further treatment on a voluntary basis. The conditions for compulsory interventions were attached to different kinds of dangers. Firstly, the health condition of the abuser and other kinds of serious dangers to him-/herself related to certain situations (for example risks of accidents or freezing to death). Secondly, possible risks related to the security of his family. The reason for this last condition was, according to the committee, that family members were not properly protected from domestic violence by the Penal Code. Due to loyalty and fear such cases were rarely reported to the police. Since substance abuse often was an important cause of such violence, the committee at the time found it adequate to regulate these kinds of problem in social law (SOU 1981:7).

In 1987 the Social Committee presented a proposition for a revision of the act (SOU 1987:22) that also lead to an extension of the foundation of compulsory intervention. The committee emphasized that the respect for the client as a person should not result in passivity concerning a previous heavy substance abuse. It could not be accepted that the social workers just waited for a client to change his/her motivation for treatment (op.cit. p 245). The Social Service had a duty to initiate an investigation to make sure that the substance abuser was given proper support and help. The co-operation between the Social Service and the police ought to be intensified. As a result of the committee's proposals the scope of time for compulsory placing was increased from 2 to 6 months. The reason was to give the substance abuser a realistic foundation to fulfil a long-range treatment program. In section 4 the word "can" was replaced by the word "shall", meaning that compulsory intervention had to be decided if the criteria of the law were fulfilled. The committee also discussed if the protection of the family should comprise an unborn child (foetus), but concluded that such an interpretation was not to be recommended. One main

argument was that this might scare the woman away from contacting the relevant public services and thus decrease the chances to help her by voluntary measures.

The revised act was effectuated the first of January 1989. Even though the respect for individual autonomy and integrity (as formulated in the Social Service Act) was emphasized as the founding principle in the care of substance abusers, the decisive factor of the LVM was the need of help related to substance abuse (Norström & Thunved 2001). The act does not request that voluntary treatment have to be tried (and failed) before compulsory interventions may be effectuated. Related to the health-criteria (serious risk of damaging mental or physical health) the committee had added a “social indication” which emphasized the risk of substance abusers to damage their lives more generally (related to work, education and “normal behaviour”). The reason for doing this was to enable the Social Service to intervene at an earlier stage, especially towards young adults (op.cit. p 246).

The Norwegian Social Service Act. As we have seen the old Temperance Act of 1932 authorized comprehensive use of coercion towards substance abusers and was permeated by utilitarian considerations and legal moralism. The Social Law Committee (SLC), who prepared the new Social Service Act (implemented in 1993), criticized the leitmotif of the Temperance Act from a more liberal point of view. Only in extreme circumstances, when the life or health of the individual is seriously at risk, could society interfere and prescribe any treatment against the will of the individual (NOU 1985:18, p 52). In line with this reasoning the committee suggested radical limitations in the use of compulsory actions towards substance abusers compared with the Temperance Act. According to the committee it was beyond the authority of the social services to interfere in order to protect other interests of society against infringements of person or property. These tasks belonged to the police and the criminal authorities. The old relation between social law and the Penal Code was broken (Andenæs & Olsen 1996). Even though the SLC emphasized the right of self-determination, this did not mean that compulsory intervention was removed from social law. Such measures were vindicated by the argument that addiction itself represents such a strong coercion that it would be ethically just to apply compulsory measures to sober up the substance abuser in order to restore his/her ability to make independent choices and to motivate him/her for further voluntary treatment (NOU 1985:18 p 21).

The Social Service Act stresses that voluntariness is the dominant principle in the treatment of substance abusers (§ 6-1). Decisions about compulsory intervention can only be made if voluntary efforts are shown to be insufficient. Only when such voluntary attempts have failed may § 6-2 be applied. The physical or mental health of the client must be seriously at risk due to extensive and lasting substance abuse, and the treatment institutions have to be professionally and materially able to provide sufficient help (Andenæs & Olsen 1996). The main intention of

the law is to initiate a process to motivate the abuser for further voluntary treatment. It does not, in principle, permit compulsory treatment as such. However, unlike the Swedish LVM, the act does not state that compulsory efforts have to be applied when all the criteria of the law are fulfilled.

The SLC proposed that the scope of compulsory placement should be limited to three weeks. The Department of Social Affairs disagreed and stated that this would not be enough to reach the intentions of the law – to motivate the substance abusers and prepare for long-range voluntary treatment (Ot.prp.No 29 (1990-91)). The scope of time was increased to 3 months.

§ 6-3 of the Social Service Act contains rules for voluntary retention in institutions. In certain instances a treatment institution may request a substance abuser to give his/her consent to be retained in the institution for a defined period of time. The conditions for such contracts are that retention is necessary for the purpose of the treatment and that it is not considered to be a disproportionate violation of the substance abuser's right of self-determination related to his/her actual situation. The maximum time of retention is three weeks from the time of hospitalization.

In long-range treatments (at least of three months duration) it may be contracted that the three weeks of retention shall be valid from the day the substance abuser withdraws his/her consent.

The legal section concerning compulsory placing of pregnant substance abusers (§ 6-2a) was included in the Social Service Act in 1996. This section contained a break with the principle stated by the SLC that compulsory interventions should only be based on the concern of the substance abusers themselves. In November 1994 the Parliament requested the minister of social affairs to present a bill that made it possible to institutionalize a pregnant substance abuser by force for the whole period of pregnancy. The result was § 6-2a which passed parliament 13th of June 1995. According to this section compulsory action may be enforced if there is every possibility to believe that the child will be born with damages due to the substance abuse of the mother, and voluntary efforts according to § 6-1 are not sufficient. The main objective of the rule is to prevent or limit such damages. Health personnel and the Child Care Service have an obligation to provide information to the Social Service if there are reasons to believe that a pregnant woman abuses intoxicating substances in such a way that § 6-2a may be applied (Ot.prp.No.48 1994-95). The other conditions of this section are congruent with § 6-2.

Some changes concerning compulsory interventions have been made in the Social Service Act. According to the view of the majority of the Parliament, the compulsory measures had been applied too rarely (Innst.S.No.180 1995-96). This started a process leading to some adjustments in the act in order to make it easier to apply the rules (Ot.prp.nr 78 (1997-98)). Of most importance was a new prescription obligating the Social Service to investigate a case if information of extensive substance abuse was provided by the family or near relatives. Further,

the Social Service no longer had an obligation to assess the professional and material quality of treatment institutions in each specific case.

2.3 Summary

In the area of the “social state” (Seip 1984) substance abuse was primarily interpreted as a deviance from normality and the institutionalization of social policy was closely attached to the principles of criminal law. Punishment, social control and discipline (correction of behaviour) were major objectives for compulsory interventions towards people defined as alcohol abusers. In the first part of the 20th century institutional treatment was first of all based on a general work ethic and compulsory placement, often meaning forced labour. Work was often considered the most powerful method of treatment (normalization). Different social laws were infused by utilitarian motives related to the economical, moral or social consequences of drunkenness. Repression and the protection of local communities (renovation) and the family were often of more importance than the care for the abuser him-/herself even though it was a shift in ideology in this field from work to real treatment institutions after the Second World War (Thorsen 1993).

From the mid 1970s the legal development in the Scandinavian countries have follow different paths. In Denmark compulsory measures towards substance abusers were removed from social law in 1976. Voluntary treatment and individual autonomy became the core principles in this field of social law. The new act on voluntary retention was also founded on the Principle of Autonomy even though compulsory measures were legalized on a contractual basis. In Denmark substance abusers cannot be placed in a treatment institution without consent. However, the act on voluntary retention does not provide any legal rights for the substance abusers except the possibility to accept or refuse to sign a contract offered to them by the Social Service. Such an offer presupposes that the County Council has accepted the law in principle. Legal rules for voluntary retention are also found in the Norwegian Social Law. The county councils have no similar right as in Denmark to assess the foundation of these rules. In Norway contractual offers of retention are primarily defined as a right for the treatment institutions and not as a right for the substance abusers. According to the Norwegian rules an institution may request a substance abuser to sign such a contract in order to receive treatment. This is prohibited in Denmark. The Swedish Social Law does not contain any rules of voluntary retention.

The Swedish Social Law deviates most profoundly from the Danish one in the field of substance abuse. Even if self-determination and integrity is underlined as the founding principle in Swedish social law (both in the Social Service Act and LVM) Sweden has constituted the most comprehensive legal rules warranting compulsory interventions towards adult substance abusers

compared with the other Scandinavian countries. The Swedish Welfare State has taken a “total responsibility” for substance abusers including compulsory measures based on the Principle of Care and utilitarian considerations.

In Norway compulsory placement of adult substance abusers was initially exclusively based on the Principle of Care. The Social Service Act stresses that voluntariness is the dominant principle in the treatment of substance abusers. Decisions about compulsory intervention can only be made if voluntary efforts are shown to be insufficient (the criterion of the least encroachment). Only in extreme situations, when the substance abuser’s health is seriously at risk due to lasting and extensive substance abuse, may the collective obligation of care justify compulsory intervention. However, only the Norwegian Social Law warrant a possibility to institutionalize pregnant substance abusers without consent in order to protect the foetus from damages caused by substance abuse. This is a deviance from the paternal foundation of § 6-2.

3. COMPULSORY INTERVENTION IN THE FIELD OF MENTAL DISABILITY

3.1 Legal background

The historical development of this field of social policy has been quite similar in the Scandinavian countries. After the Second World War there was an intensified build-up of big and centralized institutions for the mentally retarded, a process that had started before the war. Planning and centralization, sorting and segregation were key political concepts, and the founding idea of the segregation policy was to distinguish different groups from the normal society (and each other) and provide the necessary treatment according to their own abilities (Ericsson 1996; Seip 1994). During the 1960s and 1970s a new ideology of normalization and integration arose from a general critique of the impersonal and inhumane character of the segregated institutional forms of care (Söder 1992; Nilssen 2000). Normalization and integration came to mean de-institutionalization and decentralization of the services for the mentally disabled people. During the 1990s the old institutional care have disappeared in the Scandinavian countries.

Within the old institutional system in Norway special departments were established where the freedom of the individual was severely restrained and different kinds of compulsory treatment were applied (Ot.prp.No.58 (1994-95). Even if the institutional care in principle was founded on the consent of the resident or his/her parents, the life in the institution represented for many people an administrative infringement of their freedom. As certain scandals were exposed, molestations as part of the treatment of these clients were disclosed to the general public, leading to an intensified critique of institutional care and behavioural therapy. The Norwegian social law did not contain specific rules regulating the use of compulsory measures towards this group. The use of such efforts was primarily attached to the *jus necessitates* and an interpretation of the duty of care as formulated in the Penal Code. These rules contained a very weak legal foundation for the services to apply coercion and force in their treatment of mentally disabled people.

The first legal regulations of compulsory intervention (covering placing and retention) towards mentally disabled people in Denmark were formulated in an executive order (*bekendtgørelse*) No.505 the 19th of September 1977 (On the use of force etc). This was replaced by another government instruction the 1st of January 1980 (*Bekendtgørelse* 568 af 21.december 1979 (on the use of force in institutions)) which removed the legal foundation for compulsory placing or retention of mentally retarded persons over 18 years of age. The government instruction embraced cases where a person was held by force or lead to another room or place due to his/her abnormal/deviant behaviour. Fixation and physical force were commonly used in institutional

care at this time, and some guidelines concerning how such measures could be applied were given in the instruction (Socialministeriet 1998b). The rules could only be applied in institutional care, not in other forms of services (like group homes or in private homes). This meant that these rules were invalidated by the abolition of the concept of institutional care.

In Sweden the old Social Care Act of 1967 contained rules of compulsory placing and retention in institutions for the mentally retarded, but this act was repealed in 1985. The Act on Specific Care for Mentally Disabled People and others, which succeeded the old law, expressed a strong wish to remove compulsory rules from this kind of care (Lewin 1998). The need to apply coercion in the services was perceived to have decreased due to the early contact between the public care and the mentally disabled children (Hollander 1995). The Social Care Committee found no reason to continue an arrangement of compulsory interventions within this specific kind of care (op.cit. p 79). However, compulsory rules were not totally removed from the law. As a temporal arrangement § 35 in the old Social Care Act concerning the provision of care without consent remained until 1997 when the institutional care was abolished by law in Sweden. After 1997 the only valid rules for compulsory interventions are founded in the Penal Code (jus necessitates/self defence).

The Act on Support and Service to Certain Persons with Disability (LSS) from 1994 was worked out as an act of rights. People covered by this law (defined in § 1) may claim certain forms of help and resources defined by the act (§ 9) depending on certain conditions specified in § 7. Section eight is stating that the act lacks any rules of compulsory interventions (Hollander 1995). No measures can be decided against the will of the receiver.

The question about specific legal rules for compulsory measures in the care for mentally disabled people has aroused little debate in Sweden (Østenstad 2000). This is reflected by the fact that these problems are hardly mentioned in the juridical literature and public committee preparations.

3.2 Current legislation

The Norwegian Social Service Act, section 6A. In 1990 a new committee (Røkke-utvalget (RC) was established to assess the legal security of mentally disabled people in relation to compulsory measures in different kinds of situations. According to the RC (NOU 1991:20) the use of force in emergency situations should continue to have its legal foundation in the Penal Code. However, the committee emphasized that the duty of care to a certain extent legitimizes compulsory efforts in such situations and that the demarcation towards coercion for treatment and training purposes was vague and fluid. The RC made a distinction between compulsory interventions in emergency situations and in what they called systematic/methodical efforts. By

systematic efforts the RC meant professional service satisfying claims on propriety according to ethical, professional and legal standards. Such measures embraced treatment, training and professional work of care. Work of care was defined as “systematic efforts for the best of the receiver, conducted by a service provider, without any purpose of treatment, education or training” (NOU 1991:20, p 74). These distinctions became important in the further preparation of the law.

In 1994 the Ministry of social affairs presented a memorandum circulated for comments, containing a proposition for new legal rules for compulsory interventions towards mentally disabled people. In opposition to the RC the department stated that compulsory measures should not be limited to concerns of the situation of the receiver himself, but also aim to protect other persons and interests (beyond sheer situations of emergency). The ministry wanted to incorporate the use of force in states of emergency into social law in order to avoid a situation where social work had to be regulated by the Penal Code (Sosial og helsedepartementet 1994, p 34). The use of compulsory measures was primarily justified to prevent or limit “unacceptable injuries or disadvantages”. The proposition was based on a distinction between compulsory interventions in isolated situations (based on *jus neccessitates*/the right of self-defence) and planned efforts of behavioural modification or care. The use of force had to be professionally and ethically defensible. These concepts were not very thoroughly elucidated, and became a source of conflict throughout the process.

A bill was introduced to the Parliament in June 1995 (Ot.prp.no.58 1994-95). The conditions for compulsory action were mainly the same as in the memorandum. Professional defensibility was attached to the scientific status of the methods used in such interventions (for instance, documented effects and side effects). The basis for ethical assessments was the principles of self-determination and integrity, and the consequences of not conducting an intervention. The least radical form of intervention had to be chosen whenever possible. The justification of coercion to attain behaviour modifications was to effect on the causes of behavioural deviances in order to avoid such conduct in the future. In cases where this did not succeed, planned compulsory interventions based on the duty of care could be permitted. The ministry emphasized that this was congruent with prior interpretations of the duty of care. The proposition did also contain rules for “technical installations of warning”, so-called interventional alarm and warning systems (for example electronic warnings when a person leaves his bed or flat) and technical devises for observation in certain situations.

Due to some heavy critique from the Institute of Human Rights, among others, the Parliament did not handle the proposition but returned it to the ministry, instructing it to assess the proposals in relation to (primarily) the European Declaration of Human Rights. In a new

proposition presented in May 1996 (Ot.prp.no.57 1995-96) some changes had been made. For instance, the main condition for compulsory intervention was tightened up by a linguistic change from “unacceptable injuries or disadvantages” to “serious injuries” accepting a critique stating that the first expression may result in an extensive interpretation of the law in practice. The ministry also stated that the question of professional and ethical defensibility would be referred to in greater detail in legal precepts and guidelines. The majority of the Parliament accepted the act in principle, but they instructed the Government to submit these rules and guidelines to the Parliament before any formal decision was made (Innst.O.No.79 1995-96).

In this report (St.meld.no 26 1997-98) a prohibition against methods and means of treatment based on infringements of integrity and degrading punishment was formulated. (Bernt 2000). Professional defensibility had to be assessed according to the available knowledge at the time in question. The claim on professional defensible methods meant that it had to be based on professional knowledge and documented effects and side effects. The legal precepts state that thorough work have to be done in search of information on similar problems, as far as possible other professional milieus with relevant experience should be consulted, and it is important to find methods that do not imply the use of force. Alternative professional approaches must be accounted for (Kramås 1999). Ethical responsibility is understood as respect for individual autonomy and the protection of individual rights and some criteria are specified in the guidelines (I-41/98). Compulsory interventions must not extend what is necessary to attain the purpose of the effort. The prevention or limitation of injuries is a main condition of the law. The definition of injury could be distinguished into seven groups (Kramås 1999): 1) physical injury to the receiver him-/herself, 2) psychical injury to the receiver/obstruction of development, 3) social degrading behaviour, 4) physical injury to others, 5) infringements of the personal integrity of the staff, 6) material damage to ones own property and 7) material damage to the property of others.

The Danish Social Service Act. As we have seen the legal regulation of compulsory interventions towards mentally disabled people disappeared with the abolishment of institutional care. The effect of this development was elucidated by the parliamentary Social Committee as a part of a debate on a new bill of social service in 1997 (Betænkning 22.maj 1997). What kind of impact would the lack of legal rules have on the provision of necessary social-pedagogical treatment, training etc. against the will of the receiver? The Minister of Social Affairs had expressed that in her view such services could be provided in accordance with a general duty of care anchored in the fact that the public authorities already had undertaken the responsibility for mentally disabled people not capable of handling their own interests. The Ministry of Social Affairs found it necessary to clarify the legal position of the

mentally impaired in relation to compulsory treatment, and established a committee to assess this topic with the purpose of strengthening the legal security of people who are not able to act on the basis of reason due to psychological impairments (mentally retardation, senility and brain damages). The committee presented its proposals the 1st of January 1998 (Socialministeriet 1998b).

The committee referred to the legal statutes of the Social Service Act which impose a duty on the municipal or the county authorities to provide different kinds of services to people who are in need of them due to (temporarily or permanently) decreased physical or psychological functioning or specific social problems. For people with mental disabilities the purpose of the provisions is to make sure that they are stimulated in order to increase their own abilities and possibilities to handle their daily life, for example in relation to personal hygiene, eating, dressing, shopping etc. However, the committee pointed out that the duty of care did not warrant an admission for using physical force or fixation.

Three spheres in need of legal changes were identified: 1) regulating the use of force, 2) moving a person to a more suitable service situation, 3) elucidating the duty of care.

Ad 1: According to the proposal, closed doors or any other measures used in order to obstruct the service receiver from leaving a room, flat or building was not permitted. However, installations for alarming the service providers when a person leaves a building etc or to help tracing a resident who has left the building, should be allowed. The purpose of such systems was to enable the staff to lead the client back to a shared dayroom or his/her own habitation. Fulfilling this intention could imply the use of physical force (holding back and leading the client). A legal regulation of these situations should be considered as a supplement to the statutes of the penal code embracing states of necessity.

Ad 2: In certain situations, the committee maintained, it could be necessary to move the service receiver by force to another habitation in order to provide adequate care. The conditions for such interventions were negatively defined – to prevent injuries to the client or others and that no other less infringing solutions were found. Thus, it was not enough to argue that the intervention would improve the situation of the client. In the case of compulsory placing the service receiver should have a right to be represented by a lawyer.

Ad 3: The committee did not find it appropriate to regulate the duty of care more closely, but stated that the Social Service Act ought to make it clear that such an active obligation of care did exist. But the dependency of public service provisions did not imply that the client had renounced his right to autonomy and integrity, or that the staff could neglect the claim of voluntary consent. Services should be provided within the legal framework of coercive interventions proposed by the committee. The duty of care did not warrant compulsory

interventions. If the client did not express any kind of opposition (passivity) the duty of care (expressed in the Social Service Act) was the founding principle of service provision. In situations of resistance or opposition, the service provision had to be in line with the statutes regulating compulsory interventions.

The Minister of Social Affairs mainly endorsed the proposals of the committee, although a proposition to allow fixation was abandoned. The bill was unanimously approved by Parliament the 25th of May 1999 and implemented the 1st of January 2000.

The main principle of the Social Service Act is that coercive measures are not permitted. The individual right of autonomy and integrity is underlined. However, when an exception from this principle was approved in the law, the main reason was to prevent risks of personal injuries on the service receiver or others. The prevention of material damages was not included in the law as a condition for coercive intervention.

3.3 Summary

The development of services for mentally disabled people shows many similarities in the Scandinavian countries. Mental retardation was primarily interpreted along the line of the normality – deviance distinction and the development of public services followed the founding ideas of “organised modernity” (Wagner 1994) i.e. the belief in rational planning, centralized and differentiated institutional solutions to different social problems. For people with mentally impairments this came to mean a social policy based on an ideology of segregation and services provided by centralized institutions. During the last three decades of the 20th century the ideology of segregation was gradually exchanged by an ideology of normalization and integration (Söder 1992, Nilssen 2000). This process culminated with the abolishment of institutional care in all the Scandinavian countries during the 1990s. The use of coercive means in institutional care contained an important aspect of the critique of these services. Such measures had a very weak legal foundation and were primarily attached to a general interpretation of the duty of care or to the rules regulating states of necessity in the Penal Code (even though some specific rules regulating compulsory interventions were formulated in Sweden and Denmark). In Norway the use of behavioural therapeutic methods in the treatment of mentally disabled people has been an important source for the public critique of compulsory efforts in institutional care.

With the abolition of the concept of institutional care, the Scandinavian countries have followed different legal paths concerning the regulation of compulsory measures in the services. In Sweden no legal foundation for compulsory measures are given in the Social Law. Services for mentally disabled people are solely formulated as positive rights warranted in the LSS.

Denmark and Norway have incorporated new statutes regulating the use of force in their social service acts.

4. FINAL DISCUSSION

There are both similarities and differences in the content of compulsory interventions towards substance abusers and mentally disabled people in social law. In the field of substance abuse coercion is closely attached to the concept of hospitalization, i.e. compulsory placement in an institution for a given period of time. After such a stay the client has in principle regained his/her autonomy and may lead his/her life as he/she wants (within the frame of the law). Due to their mental abilities and continuous dependency on social care this is not the case for people with severe mental handicaps. After the abolition of institutional care compulsory interventions take place in their own homes. Coercion may be a more integrated and enduring part of their daily lives. However, for both groups compulsory measures may include placing, retention and treatment (including training and education). As we have seen the scope of interventions vary profoundly within the Scandinavian countries. In this last section of the paper we will elaborate these differences further in relation to the general model presented in section 1. The main focus of this work has been to describe the content of the actual legal statutes and how different principles are weighted in these acts. Theoretically we have argued that the use of coercive measures in social policy must be seen in relation to the mental ability of the receiver to make his/her own choices. As a point of departure for the final analysis, we will present some comments on this second dimension of our model.

4.1 The mental ability of the receiver to make independent choices

We have argued that compulsory interventions towards people who do not have the mental capacity to act autonomously may be easier to justify than interventions towards people “in the maturity of their faculties”. In practice, however, this line of demarcation is not always easy to draw. A person’s capacity to make autonomous choices is not dichotomous (yes or no) but often vague and varying from one situation to another. Nonetheless, this dimension is important in the justification of coercive measures in social law and the basic line of the distinction between mild and strong paternalism.

Coercive efforts do not, according to the Norwegian and Danish social law, embrace all people with mental disabilities. As formulated in the Danish act, the group covered by chapter 21 consist of persons with comprehensive and enduring reductions in their mental capabilities, who are unable to act on the basis of reason or to anticipate the consequences of their actions. In Norway the title of § 6A was changed from the use of force and compulsion towards “...people with mental disabilities” to “...some people with mental disabilities” which underlines that the target group was people with severe reductions in their mental capability to act on the basis of

reason. The diagnosis of mental disability is itself attached to such reductions. ICD-10 provides the following definition: “Mental retardation is a condition of arrested or incomplete development of mind (...) which contribute to the overall level of intelligence i.e. cognitive, language, motor and social abilities” (quoted from Gonnæs 2000). Although it may be difficult to assess the capacity to make independent choices in different situations and the demarcation is based on diagnoses and professional discretion, it should be uncontroversial to claim that the target group of the legal statutes can be placed on the negative side of the dimension of mental capability in our general model.

This is much more problematic when the target group is adult substance abusers. An explicit argument for compulsory interventions towards adult substance abusers in the preparation of the Norwegian Social Law (§ 6-2) was that comprehensive and lasting substance abuse in itself results in a loss of capacity to act autonomously (Nilssen 2001). The main argument is that dependency of intoxicating substances leads to a loss of control due to the problem of withdrawal (physical and mental symptoms of abstinence). The substance abuser then becomes coercively dominated by his/her dependency and loses the capability to make independent choices. However, the claim that substance abuse implies a loss of autonomy rests on some kind of empirical scientific evidence (medical/psychological) which seems very difficult to substantiate (Husak 1992; Patison, Sobell & Sobell 1977, Bergmark & Oscarsson 1985, 1987).

Based on a study of empirical documentation in the field of drug abuse, Husak concludes:

“Chief among these difficulties is that the pain of withdrawal from even the most highly addictive drugs is insufficient to support the judgement that the addict has no choice but to continue using drugs” (Husak 1992 p 116)

Waal and Mørland (1999 p 45) underline such a view: “Addicts are not people without willpower or people driven to act without making choices”.

In proving the “loss of capability thesis” it is not sufficient to show that substance dependency may result in what most people would consider “irrational” behaviour, for instance conduct leading to a loss of welfare. To use a deviation from an idealized standard of rationality as a proof of a decrease in the ability of self-determination is circular, because the standard itself has to be based on external interpretations (Nilssen 2001). This is not the same as to claim that dependency does not exist or that it is easy for a substance abuser to withdraw from his abuse, but only that he does not find himself in a situation of coercion where no other choices can be made (for instance to apply for voluntary treatment) but to continue using intoxicating substances. This leads to the conclusion that the target group of the legal statutes in this field of social law have to be placed on the positive side of the dimension of mental capability in our general model.

Following this line of reasoning the Danish legal rules are in line with the ideal model. Compulsory interventions are accepted towards people who are not “in the maturity of their faculties” while the use of coercive measures towards autonomous people are based on voluntary consent. Sweden deviates most extensively from this, allowing comprehensive use of coercion towards substance abusers while services for the mentally handicapped are based on voluntariness and social rights. The Norwegian Social Law may be placed somewhere in between warranting compulsory intervention towards adult substance abusers. However, this is nothing but a formal conclusion. We now turn to the more substantial aspects of the legal justification of coercive measures.

4.2 Utilitarian considerations and the Harm Principle

In the Scandinavian countries “treatment” of substance abusers (alcoholics) have primarily been a question of social control, punishment and correction of behaviour (normalization) implemented through forced labour. Such efforts were founded on the Utilitarian Harm Principle attached to the protection of the local community (peace and order), the family (from physical, social, moral and economical harm) and the public social services (from the economical burden). Although the normative foundation of compulsory intervention has changed, the protection of others still occurs as arguments in the justification of such efforts in Norway and Sweden. However, these arguments are very different indeed.

In Norway utilitarian justifications based on the Harm Principle was initially abandoned by the Social Law Committee and plays no part in the justification of compulsory interventions towards adult non-pregnant substance abusers (§§ 6-2, 6-3). The protection of other people’s interests (such as family members or close relatives) ought to be handled by the Penal Code and the criminal authorities, not by social law and the social services. This established a more clear-cut distinction between care and punishment and broke the historical relationship between social law and criminal law. In Sweden this relation has not been broken - incorporating the protection of near relatives as a criterion for compulsory interventions towards substance abusers in social law, was in fact seen as an extension of the Penal Code. The main argument was that the Penal Code did not protect the nearest relatives from domestic violence and that it may be easier for family members to ask the Social Service for help (treatment) than to report to the police in such cases (due to loyalty or fear). Thus, in Sweden compulsory treatment of substance abusers may be used as a substitute for punitive measures founded in the legal system of criminal law.

In Norwegian social law the Harm Principle is solely used to protect a foetus from injuries caused by the substance abuse of the mother. Although these cases also concern the relationship between the substance abuser’s self-determination and other people’s right to protection, the

relevance of the Penal Code was regarded more dubious due to the vulnerability of an unborn child and the fatal consequences of a potential “crime”. In Sweden the main argument against compulsory interventions were primarily pragmatic; that this will be dysfunctional, scaring away the mother from contacting the relevant public services. Another argument mentioned was that the prognostic relationship between the substance abuse and the injuries to be prevented was too difficult to establish.

The Harm Principle plays a more general (although complementary) role in the justification of compulsory efforts towards people with severe mental disabilities. The less controversial rules are those regulating states of necessity (*jus necessitates*) originally founded in the Penal Code. Such rules are valid in all the Scandinavian countries. In Norway and Denmark compulsory interventions in specific situations are to a large extent incorporated in social law while this is not the case in Sweden. In Denmark all statutes warranting coercive measures are partly justified by the Harm Principle. The only relevant criteria are attached to personal injuries (primarily physical) to others. In Norway this is extended to include material harm (on the property of others).

What are the criteria for incorporating the protection of others in social law (and not leave it to criminal law)? For people with severe mental disabilities the obvious answer is that these people are not able to act on the basis of reason and therefore are not (legally) responsible for their actions. The argument is similar to the justification of compulsory interventions based on mild paternalism. For substance abusers the justification of the Harm Principle cannot be based on a lack of legal responsibility. Here the interests of others are seen to set aside the right of self-determination of the substance abuser. In Denmark and Norway (except for pregnant substance abusers) the protection of others is left to the police and the criminal authorities.

The justification of interventions towards pregnant substance abusers is founded on the vulnerability of the foetus. As a part of another person’s body an unborn child is not a fully developed legal person and thus inadequately protected by the Penal Code. Normatively this seems less dubious than compulsory treatment of adult substance abusers in relation to domestic violence (protection of legal subjects embraced by the Penal Code). There are good reasons to argue, as Søvig (1999:119) does, that the self-determination of the woman should not include a right for her to intoxicate herself in such a way that the foetus is exposed to serious damages. The main arguments against coercive measures may be, as we have seen, of a pragmatic rather than normative nature. However, as far as compulsory intervention fulfil the objective of preventing damages (an empirical question), it may be convincingly vindicated. In our view the Swedish inclusion of the Harm Principle in relation to domestic violence, represents a historical heritage blurring the distinction between care and punishment in social law.

Nonetheless, the utilitarian and punitive aspects of social law in the Scandinavian countries are severely limited compared with earlier laws. Renovation (removing deviants from the local community, segregation) and punishment are no longer founding elements in these fields of social policy. Protection of others has a more limited meaning than before. We may conclude that there has been an individualization of the Harm Principle, from a general protection of collectives such as the society, the local community, the Social Service or the family, towards the protection of specific individuals from mental or physical damages. The main exception is the inclusion of material harm in the Norwegian § 6A.

4.3 The Principle of Care and the problem of paternalism

The most important aspects of the legal development in the actual fields of social policy in the Scandinavian countries are: 1) the increased significance of the Principle of Autonomy and integrity in social law and 2) an increased importance of the Principle of Care in the justification of compulsory interventions towards different groups of “deviants”. Legal security, voluntary treatment and care, de-institutionalization and integration have all been important concepts in this development. However, these principles have been weighted quite differently in the Scandinavian countries leading from a situation of similarity towards a more differentiated Scandinavian “model” of social policy.

Although autonomy and voluntariness are the core features of the social policies towards substance abusers in all the Scandinavian countries, Norway and Sweden have established legal rules founded on what we called strong paternalism. This conceptualization is based on the following presuppositions: a) that the target group of compulsory interventions have a mental ability to make autonomous choices and b) that the justification of such interventions is build on assessments of what is best for the person being coerced him-/herself. We will take the first assumption as given (cf. above) and concentrate on the second one.

§ 6-2 in the Norwegian Social Service Act is solely vindicated by the Principle of Care. Interventions are limited to considerations about the physical and mental consequences of the substance abuse on the abusers themselves. In the Swedish law the foundation of strong paternalism is broader, including a “social indication” embracing the risks of more general negative social consequences of substance abuse. This involves a more comprehensive interpretation of normalization not limited to medical damages. To a larger extent than in the Norwegian law, correction of behaviour is seen as adjustments to the common values of society (work, education and “normal behaviour”).

One important objective of both the Norwegian and the Swedish law is to motivate the substance abusers for further treatment on a voluntary basis. Ødegård (1995) has conceptualized

such efforts as power of preferences, i.e. to manipulate individual preferences. It is not considered sufficient to restore the ability of the substance abuser to make independent choices (cf. “the loss of capability thesis), the choices themselves have to be worked on. The problematic part is not the motivation itself, but that the process takes place within a framework of coercion. This underlines the interpretation of the legal rules as based on strong paternalism. We may, however, conclude that the Swedish law, with its idea of “total responsibility”, represents the strongest paternal legal framework for compulsory interventions towards substance abusers in Scandinavia. The legal criteria are broader defined than in Norway, the Social Service has a duty to recommend coercive efforts if the criteria of the act are fulfilled, the period of time for compulsory placements is longer and the law permits coercive treatment in special institutions. Thus, the amount of coercive interventions implemented in Sweden has been profoundly higher than in Norway (Nilssen & Lien 1999).

In opposition to Norway and Sweden, the Danish policy towards substance abusers is solely based on the Principle of Autonomy. Even the regulation of compulsory efforts has such a foundation. The act of voluntary retention is anchored in a “Homerian principle” (Gerdner 1988). As Odysseus temporarily surrendered his freedom in order to escape the potential destruction following from the alluring song of the Sirens, the substance abuser gives a prior consent to be held back in an institution against his will in order to avoid the temptation of intoxication. Voluntary retention may be understood as a way of correcting future actions founded on “a weakness of the will” or imperfect rationality (Elster 1984). However, the most important point, distinguishing such efforts from the incorrect idea of mild paternalism, is that the “idealized norm of rationality” in fact is formulated or accepted by the substance abusers him-/herself on a voluntary basis (consent). Persons, who do not feel that voluntary treatment is sufficient, may surrender their freedom for a limited period of time in order to be able to change their conduct. The voluntary foundation of such measures is most explicitly formulated in the Danish Social Law. In the Norwegian § 6-3 this is more obscured due to the fact that the claim for voluntary retention is formulated as a right for the treatment institutions rather than the substance abusers. In Denmark the individual right of such efforts is limited by the peculiar structure of the act – the formulation of a triple kind of voluntariness (and it only concerns drug abusers). Most Danish counties have not accepted to apply the law at all. On a normative level, however, it is our conclusion that these kinds of legal measures are much easier to justify than those based on strong paternalism.

Legal security and individual rights of autonomy and integrity have been important considerations in the reorganization of the public services for mentally disabled people in the Scandinavian countries. After the abolition of the concept of institutional care an important

question has been how to combine these considerations with a general duty of care for people who are dependent on the help of others due to severe mental retardation. In all the countries interpretations of the duty of care have traditionally constituted a legal foundation for the use of coercion in institutional care. Nonetheless, the current legal situation varies a lot among the Scandinavian countries.

In Norway and Denmark there exists an underlying assumption in social law that the duty of care in some way or another implies the use of coercive measures. The key arguments for compulsory efforts are based on mild paternalism: people who lack the mental capability to act on the basis of reason may have to be protected by coercive means. The absence of such interventions may lead to situations of neglect. However, as we have seen, the contents of the necessary interventions are interpreted differently in the two countries. In general the relationship between care and coercion is most widely defined in the Norwegian Social Law. Firstly, in opposition to the Danish law the Principle of Care embraces not only protection from physical or psychical injuries, but also from social degrading behaviour. Even though the law underlines that this criterion has to be interpreted very strictly, this does imply broader assessments about the distinction between normality and deviance in relation to coercive interventions. Secondly, and more importantly, the Norwegian law warrants the use of systematic coercive measures in the provision of care and in behavioural modification efforts (training and treatment) if these measures are considered ethically and professionally defensible (according to the criteria settled in the act or the precepts). The space left for professional discretion has been an important target for the critics of the act; especially legal professionals. For instance, the Norwegian member of the European Commission of Human Rights, Gro Hillestad Thune, wrote to the leader of the parliamentary Social Committee:

“The bill maintains professional defensibility as a criterion for the use of coercion. (...) There is a major [professional] discord about the defensibility and legitimacy of systematic training by the means of physical force and coercion. (...) If the bill is passed without any form of delimitation by the highest authority of the country, the situation will still be equally uncertain and nobody will know where to set the limit. (...) The ministry is in fact extending the right of the professionals to use coercive measures” (quoted from Innst.O.nr.79 1995-96, p 12).

The application of coercion in order to modify a person's behaviour (training) is the most controversial part of these legal statutes. This reflects a potential tension between professional interpretations of the Principle of Care and considerations about the legal security of the service receivers. Social law is both an instrument for professional workers and a formal regulation “censoring” this work according to basic legal principles of justice (Graver 1986).

In the Danish social service act, the duty of care does not presuppose an actual consent from the receiver, care can be provided for in situations of passivity. However, in situations of active resistance the legal rules warranting coercive measures are more specific and narrowly defined than in the Norwegian law. No rules permitting systematic use of coercion in behavioural modification efforts are given.

The Swedish Social Law is based on the opposite assumption than the Norwegian and the Danish laws; that sufficient care can be provided for people with severe mental disabilities without using any form of coercion extending the *jus necessitates*. This is of course an argument resting on empirical evidence. However if it is, for instance, correct that care without coercion is a question of professional methods, resources and/or organization, then the Norwegian and the Danish laws are unjust both from a normative and a legal (internal) point of view (both acts are based on the principle of the least encroachment). If the argument is incorrect, mentally disabled people in Sweden may suffer some sort of neglect of care due to the fact that they are unable to anticipate the consequences of their actions. Another, and perhaps more likely, possibility is that compulsory measures unregulated by law will be applied in the daily work with severe mentally disabled people.

4.4 Final remarks

In all the Scandinavian countries voluntariness is the founding principle of social policy. Normally, services for substance abusers and mentally disabled people are provided according to rights warranted in the general social service acts, or as in Sweden and Denmark specific statutes concerning people with reduced physical or psychical functional abilities. The use of compulsory interventions is seen, in principle, as an exception from this rule. Thus, social “deviants” have increasingly been embraced by the Principle of Autonomy and integrity in Scandinavian social law, reflecting a general development towards an “extended liberal modernity” (Wagner 1994). At the same time there has been a legal development from similarity towards difference in these fields of social policy in the Scandinavian countries.

The Danish Social Law is most in line with the justification of compulsory intervention following from our general model. Coercive measures towards people lacking the mental capacity to make independent choices are justified by the Harm Principle and the Principle of Care (mild paternalism), while interventions towards substance abusers are founded on the Principle of Autonomy. The Swedish case contains a paradox, justifying extensive compulsory interventions towards substance abusers based on both utilitarian considerations and the Principle of Care (strong paternalism), while no legal rules are founded in social law warranting coercive interventions towards mentally disabled people. The Norwegian law is somewhere in

between. On the field of substance abuse compulsory interventions are based on voluntary retention (as in Denmark) and strong paternalism (as in Sweden). The scope of intervention is however more limited than in the Swedish law even though the Norwegian law more explicitly embraces interventions towards pregnant substance abusers. As in Denmark coercive efforts towards mentally disabled people founded in the Principle of Care and the Harm Principle, are legalized in Norway. However, the scope of intervention is generally broader than in the Danish Social Law. This may be due to the strong tradition of using behavioural therapeutic methods in this field of social care in Norway (Gomnæs 2000).

Generally we may conclude that the Principle of Care plays the most important role in the justification of compulsory intervention towards adult substance abusers and people with severe mental disabilities, and that it represents both a strong (substance abuse) and a mild (disability) kind of paternalism. For substance abusers coercive measures in social law may be interpreted as infringements of their right of self-determination (autonomy) based on the values of others (cf. Nilssen 2001), while the main legal question concerning people who do not have the ability to act autonomously, is to protect their right of integrity. The concept of autonomy directs our attention towards individual choices, which of course presuppose a mental ability to choose. "Integrity" is a wider concept, more generally attached to values concerning human worth and dignity. Integrity concerns the human inviolability in general while autonomy covers the right of self-determination. People who are not able to make their own choices due to mental impairments also have a claim on integrity and must be protected against physical and mental harm and damages. This means that integrity and paternalism of care are less antagonistic than paternalism and autonomy (a question of degree), but also that a person who is dependent on others has a right to legal protection of her or his integrity.

In principle it is easier to criticize the strong paternalism of the Norwegian § 6-2 and the even stronger paternalism of the Swedish LVM, than the mild paternalism of the law embracing mentally disabled people in Norway and Denmark. Concerning the differences between these countries and Sweden, the main question is whether voluntary service provision is sufficient to fulfil the collective obligation of care towards people suffering from severe mental impairments or not. The distinctive feature of the Swedish law is that it does not contain any rules warranting coercive actions if the person opposes to receiving certain kinds of services or care. For people who lack the capability to make independent choices, this is primarily not a question about choosing between mild paternalism and self-determination (others have to make the decisions for them), but about what kind of coercive measures the law legalizes in the provision of service/care. Voluntariness is interpreted as a lack of resistance, which also includes situations of passive consumption. On a general normative level of analysis, however, we have pointed out

two possible conclusions which depend on empirical evidence: If the assumption of the Swedish law proves right (i.e. voluntary service/care is sufficient to fulfil the principle of care), the use of force towards this group both in Norway and Denmark should be considered an encroachment on their autonomy and/or integrity, and thus unjust. If it proves wrong, the Swedish law may be interpreted as a violation of our collective ethical obligation of care.

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