

Court-Ordered Compulsory Psychiatric Care and the Prosecutor's Control Function

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1. Introduction

How should society protect itself from the risk of serious offences committed by persons with severe mental illness, and who are considered criminally insane? This question includes several difficult issues, among them the division of responsibility between two major sectors of society. As criminals they are the responsibility of the justice sector, whereas as patients they are the health sector's responsibility. In such cases, the issue of crime prevention offers challenges for the justice sector. Mentally ill criminals who are considered criminally insane cannot be held criminally responsible and subjected to punishment. This means that the justice sector cannot use imprisonment to protect against the risk that these persons commit new serious crimes. Society's need for protection against future crime must be sought by other means than punishment. This can be done in primarily two ways. The justice sector can establish its own secure psychiatric institutions, i.e., a kind of 'criminal justice hospital'; alternatively, crime protection can be left to the health sector's regular psychiatric health care institutions, in which case the health sector is attributed the role of an agent within the criminal justice system.

The Parliament in Norway has chosen the latter solution.¹ As we will return to, criminally insane offenders can be subjected to a special criminal sanction that is not

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¹ The Criminal Asylum in Trondheim was an exception. Between 1895 and 1961, the Ministry of Justice had the decision-making authority for confinements and expulsions for this asylum, see Dahl and Thomassen (2015), 'Om sikring og farlighetserklæringer – sikkerhetspsykiatrien etableres', *Tidsskrift for strafferett*, p. 42.

punishment and that consists in committal to compulsory psychiatric care. Although this is a type of criminal sanction, the responsibility for carrying it out rests on the regular psychiatric health care institutions. A question arises: is the health sector willing to take the role of an agent within the criminal justice system? Or more specifically: is the health sector willing to prioritise crime protection before health care? The Norwegian Parliament was in doubt about this, and so granted the prosecution authority a control function.

As a part of the Special Sanction Reform in 1997, the prosecution authority became the health sector's control body during the implementation of court-ordered compulsory psychiatric care.² Their legal instrument is the right to appeal specific decisions concerning crime protection. The core of the control function is to supervise the psychiatric health care system in terms of its responsibility for protection against future crimes. This article is about the control function. More specifically, the aim of this article is to explain the background of the control function and investigate specific issues related to the legislation.

In the following, the relevant rules will be given a brief presentation in section 2. The background of the control function is explained in section 3, while section 4 deals with the core of the control function: the legal regulation of the right to appeal. Section 5 rounds off with some concluding reflections about the control function.

2. The Relevant Rules in Brief

2.1 *A Special Penal Sanction: Court-Ordered Compulsory Psychiatric Care*

Court-ordered compulsory psychiatric care is not regarded as punishment, but as a special penal sanction with a specific purpose: to protect society against criminality. On the basis of section 62 in the Norwegian Penal Code 2005,³ the court may sentence a criminally insane offender to compulsory psychiatric treatment in cases where there is a risk of new serious crimes. This special penal sanction was enacted in 1997,⁴ implemented in 2002, and was introduced as a supplement to the civil system for compulsory psychiatric treatment based on the Mental Health Act 1999.⁵ Though both forms of compulsory psychiatric treatment have crime prevention as their purpose, they differ significantly in how they are established, implemented and terminated. In the following, the focus will be on the implementation of the special

² LOV-1997-01-17-11 om endringer i straffeloven m.v., see also recommendations made in NOU 1990:5, p. 97.

³ LOV-2005-05-20-28 om straff.

⁴ See footnote 2.

⁵ LOV-1999-07-02-62 om etablering og gjennomføring av psykisk helsevern.

penal sanction.⁶

The implementation of court-ordered psychiatric treatment is regulated in the Mental Health Act, and shares several provisions with the civil system for compulsory psychiatric treatment (section 5–1, first paragraph). The characteristics of court-ordered psychiatric treatment during implementation are regulated in section 5 of the Mental Health Act. Two distinctive features are to be highlighted here. According to the Mental Health Act section 5–3, second paragraph, the responsible physician or psychologist should pay consideration to both crime prevention and treatment, with particular emphasis on crime prevention. This is where the purpose of the special penal sanction is expressed. According to the Mental Health Act section 5–4, the prosecution authority has the right to appeal specific decisions concerning crime prevention. This is where the core of the prosecution authority's control function is expressed.

2.2 *The Control Function*

If we look more closely at the right of appeal described in section 5–4 in the Mental Health Act, the right of appeal relates to decisions on transfer. More specifically, decisions on the transfer of patients to and from fulltime stay at an institution, and decisions on the transfer of patients between fulltime stays at different institutions. This means that the right of appeal is linked to the change between inpatient and outpatient care, and the change of inpatient care at one institution to another. According to section 4–10, first paragraph, transfer between different departments within the same institution is excluded from the right of appeal.

Besides the prosecution authorities, other parties entitled to appeal are the convicted person, and his or her closest relatives (section 5–4, second paragraph). Appeals on transfer decisions (and most other decisions subject to the right of appeal) are judged by a supervisory commission, led by a lawyer, and consisting of a doctor and two other persons. Among the latter two, at least one should have experience as a patient or as a patient's relative. Every institution within the mental health care service is linked to a supervisory commission.

According to section 5–5, the prosecution authority may also request a change in the execution of the sentence. Such petitions appear to be of little importance in practice, and were not investigated by the group that evaluated court-ordered com-

⁶ Concerning the *terms* for establishing court-ordered compulsory psychiatric care, see Mindestrømmen (2019), 'Impending Danger: The Meaning of Danger as a Legal Requirement for Involuntary Psychiatric Treatment in the Norwegian Criminal Justice System', *Bergen Journal of Criminal Law and Criminal Justice*, 7(1) 2019, pp. 110-135

pulsory psychiatric care in 2008.⁷

Following a legislative amendment in 2019, the responsible physician or psychologist is required to consult the prosecution authority before the convicted person is transferred between different security levels within the same institution or is granted leave, if special considerations warrant it.⁸ The duty of consultation includes only changes which are of importance to the protection of society.⁹

In the next section, we will examine the background of the prosecutor's control function in order to better understand the purpose of the function.

3. The Development of the Control Function

3.1 *The Division of Responsibility*

In section one, it emerged that Norway has placed the responsibility for dealing with offenders with serious mental illness on the health sector's regular psychiatric health care institutions. In this section, we will take a closer look at the reasons for Norway's current legislation.

An adequate place to begin is the Mental Health Act of 1848.¹⁰ The Mental Health Act was based on an idea of asylums as medical institutions for persons with severe mental illness, led by medical staff.¹¹ One of the consequences of this idea was that asylums were protected from becoming a detention place for criminals. In line with this, section 20 of the Mental Health Act stated that insane patients must not be kept with criminals. The doctors themselves would decide who should be asylum patients and determine the duration of their stay. As such, the doctors together with the asylum's supervisory commission were sovereign in the decision on who should be admitted to the asylum and who should be discharged.¹² This system, called asylum sovereignty, met with criticism. Even though the justice sector had, for a period, its own secure psychiatric institution, it was clear—from the justice sectors point of view—that asylum sovereignty opened up the potential for the health services to re-

⁷ Report from an investigating group appointed by the Ministry of Justice and the Police, 18 May 2006 (Etterkontroll av reglene om strafferettslig utilregnelighet, strafferettslige særreaksjoner og forvaring), found at: <https://www.regjeringen.no/no/dokumenter/maland-utvalgets-rapport/id509546/> (Last accessed 9th September 2019).

⁸ The Mental Health Act, third paragraph in section 5–3, see LOV-2019-06-21-48 om endringer i straffeloven og straffeprosessloven mv. (skyldevne, samfunnsvern og sakkyndighet).

⁹ Prop. 154 L (2016-2017), p. 160.

¹⁰ Lov om Sindssyges Behandling og Forpleining (Sinnssykeloven) 1848.

¹¹ Skålevåg (2016), *Utilregnelighet - En historie om rett og medisin*, p. 67.

¹² NOU 1983: 5, p. 6. See also sections 9 and 12 of the Mental Health Act 1848.

fuse to take responsibility for offenders with severe mental illnesses.¹³

The Ministry of Justice initiated work towards a law reform in 1957.¹⁴ It would take decades of public investigations and resistance from the health sector before the legislative amendment finally came into place. As late as 1992, the Supreme Court noted that it was ‘highly unsatisfactory’ that the courts must accept people with severe mental illness being placed in jail instead of in hospital.¹⁵ The Supreme Court’s dissatisfaction clearly referred to the hospitals’ legal right to decide which patients they would be taking care of, i.e., asylum sovereignty. The justice sector finally addressed the system of asylum sovereignty with the Special Sanction Reform in 1997. The majority in the Parliamentary Justice Committee agreed that a restriction of asylum sovereignty was necessary to prevent patients from being subjected to ‘back and forth’ relocations between institutions.¹⁶ The reform included court-ordered compulsory psychiatric care, and with it a duty for the mental health service to take responsibility for the convicted patients. The reform also included a new control function for the prosecutor, which we shall look into in section 3.2.

3.2 The Background of the Prosecutor’s Control Function

A new control function for the prosecutor was mentioned already in the first proposal for a special sanction reform, in the Criminal Board’s review in 1974.¹⁷ The board proposed a special sanction—institutionalisation—for ‘the most dangerous group of criminally insane offenders’.¹⁸ The proposal was based on a duty for the health service to take responsibility for these convicted persons, with the addendum that the prosecution authority should be given the opportunity to pronounce a statement before discharge from the institution was ultimately decided by doctors. The purpose of the prosecutor’s right to make a statement was to emphasise that crime prevention is particularly important.¹⁹ The proposal for this new special sanction met strong resistance from the mental health care system and did not lead to legislative change.²⁰

The justice sector’s next review came in 1983.²¹ The Criminal Law Commission maintained the Criminal Board’s proposal for a new special sanction. The proposed right for the prosecution authority to make a statement was also maintained. The

¹³ See footnote 1.

¹⁴ NOU 1974: 17, p. 8.

¹⁵ Rt. 1992 p. 577.

¹⁶ Innst. O. nr. 34 (1996-1997), p. 13.

¹⁷ NOU 1974: 17.

¹⁸ *Idem*, p. 113.

¹⁹ *Idem*, p. 156.

²⁰ Ot. prop. nr. 87 (1994-1994), p. 10.

²¹ NOU 1983: 57

Commission believed that this would safeguard ‘public interests’ before discharge from an institution.²² The Criminal Law Commission’s proposal met the same resistance from the health service as the previous Criminal Board’s proposal had done.²³ In line with the idea of asylums as medical institutions led by a medical staff, the health sector’s counter-argument was that compulsory psychiatric treatment should only be established on medical grounds, and should not be ruled by a court as a result of a criminal offence, and on the grounds of society’s need for protection against dangerous offenders.²⁴

The justice sector’s third attempt for a legislative reform came with the 1990 NOU committee.²⁵ The committee’s mandate was characterised by the will to find a compromise that was acceptable both for the justice sector and the health sector.²⁶ They addressed a central question: Did the health sector lack the will or the ability to take responsibility for protecting society from the risk of serious crime committed by criminals with severe mental illness? If there was a lack of ability, legal reform in the civil system for compulsory psychiatric treatment was a relevant instrument. If there was a lack of will, a statutory duty to take responsibility was a relevant legal instrument. The committee found that authority granted to the health sector in the Mental Health Act was sufficient in itself, the problem was ‘significant restrictions’ when it came to the application of the law, i.e., there was a lack of will to use civil compulsory psychiatric treatment in order to protect society.²⁷ The civil compulsory psychiatric treatment legislation had to be supplemented with a criminal law form of compulsory psychiatric treatment.²⁸ The committee proposed a criminal law basis for the courts to sentence insane offenders to compulsory psychological health protection, with crime prevention as the primary purpose.²⁹

Still, the committee seems to have had doubts about the mental health care system’s willingness to protect society. The prosecutor’s right to pronounce a statement was not enough to ensure the protection of society. The committee strengthened the prosecutor’s legal instrument from a right to pronounce a statement, to a right to appeal against specific decisions made by mental health care authorities on the grounds of crime prevention. The committee had incorporated administrative law’s procedural rules in the implementation of court-ordered compulsory psychiatric care.³⁰ Ac-

²² NOU 1983: 57, p. 202.

²³ NOU 1990: 5, p. 68.

²⁴ Ibid.

²⁵ NOU 1990:5, often referred to as the special sanction committee.

²⁶ Ot. prp. nr. 87 (1993-1994), p. 10.

²⁷ NOU 1990: 5, p. 72.

²⁸ Ibid.

²⁹ Ibid.

³⁰ LOV-1967-02-10 Lov om behandlingsmåten i forvaltningssaker (forvaltningsloven), chapter IV–VI. See also NOU 1990:5, p. 93.

ording to the committee's opinion, some decisions were 'particularly intrusive both for the convicted, and for the society'.³¹ These decisions were pointed out as subject to appeal.

Which of the mental healthcare system's decisions were considered 'particularly intrusive', and therefore subject to appeal? Immediately there are three factors that seem relevant: considerations for the patients, considerations of crime prevention, and the need to maintain an efficient treatment regime. Due to efficiency considerations, it was found that most daily treatment decisions should not be subject to appeal.³² When it came to more significant decisions that should be eligible for appeal, the committee did not distinguish between considerations for the patients and considerations of crime prevention, even if these two considerations are unequal. They pointed out as eligible for appeal decisions on the transfer of patients to and from fulltime stay at institutions, and decisions on the transfer of patients between fulltime stays at different institutions. The patient and the patient's closest relatives were granted a right of appeal on behalf of the patient, and the prosecution was granted a right of appeal on behalf of society.³³ Parliament followed up the proposal, and the prosecutor's control function was established. The right to appeal was also made applicable to patients subjected to civil psychiatric treatment.³⁴

After a few years of implementation, actual practice of this right to appeal was found to have unfortunate consequences for the operation of the mental health institutions. The reason was that patients could not be transferred before the deadline for appeals was out, or the complaint case was resolved. Meanwhile, pending a decision, much needed treatment places could be left vacant and unused.³⁵ This is why the right to appeal today does not include transfer between different types of fulltime stay within the same institution.³⁶

In conclusion, both the need for a criminal law form of compulsory psychiatric treatment and the need for a control function must be seen in light of the lack of confidence in the mental health care system's willingness to take on responsibility for crime prevention.

4. The Content and Limits of the Control Function

In the previous section we saw that the Special Sanction Committee pointed out de-

³¹ NOU 1990: 5, p. 96.

³² Ibid.

³³ Idem, p. 97. The patient's closest relatives were given the right to appeal, because the patients were assumed often not to 'be able to safeguard their own interests'.

³⁴ Ot. prp. nr. 11 (1998-1999), p. 123, see also Mental Health Act 1999 section 4-10.

³⁵ Ot. prp. nr. 65 (2005-2006), p. 81.

³⁶ Mental Health Act 1999, section 4-10.

cisions that are ‘particularly intrusive both for the convicted, and for the society’ as subject to appeal. But the consideration of the patient’s interests and the consideration for prevention of crime are not necessarily coinciding considerations. Let us take a closer look at these two considerations in this context.

When it comes to secure psychiatric institutions, the transfer of patients usually has two key characteristics. First, the transfer may involve changes in the security level, and second, the transfer may involve changes in geographical location. From a patient perspective, both changes may be considered intrusive. From a crime prevention perspective, only security-level changes are relevant, and primarily changes that imply a reduction of security level. In the following, we will discuss the decisions subject to appeal primarily from a crime prevention perspective.

We will first look at transfers to and from fulltime stay at institutions. As mentioned in section 2.2, the right of appeal is linked to the change between inpatient and outpatient psychiatric care, which ensures the prosecutor’s right to appeal decisions concerning such transfers. Normally, transfers from fulltime stay to care without fulltime stay are relevant to the prosecution’s control function. Transfers to fulltime stay usually imply enhanced criminal protection, and thus are not as relevant to the prosecution authority’s control function. However, there may occur cases where the prosecutor does not consider the institution’s safety level on a fulltime stay basis to be satisfactory, and the main rule ensures the prosecutor’s right to appeal such decisions.

We will now look at transfers between different fulltime stays. Such transfers can occur either as transfers between different institutions, or as internal transfers within an institution. The main rule ensures the prosecutor’s right to appeal decisions about transfer between different institutions, irrespective of whether the transfer involves a strengthened or reduced security level. The exception rule for transfers within the same institution deprives the prosecutor the possibility to appeal decisions concerning internal transfers within an institution. The exception for such internal transfers raises questions about what is meant by the ‘same institution’. The problem is brought about by the fact that during recent years a number of health institutions in different geographical locations have been merged into major organisational units.³⁷ In its interpretation of what is meant by the ‘same institution’, the Directorate of Health has placed a decisive emphasis on the patient perspective:

‘Whether you have two different day care centers, or two departments within the same institution, must be assessed in concrete terms. The fact that the departments are part of one organisational unit is not decisive. The decisive factor must be the significance of the transfer for the patient in terms of breaking up from habitual surroundings, change of treatment environment, proximity to family, etc. A department may be regarded as a separate residential institution if it is geographically segregated or appears as an opera-

³⁷ NOU 2016: 25, p. 63.

*tional independent unit, depending on the circumstances of the case.*³⁸

As the Directorate of Health emphasises, changes in geographic location is a relevant criterion from a patient perspective. In a crime prevention perspective, changes in security level normally will be more important than changes in geographic location within the same security level. The Directorate of Health's interpretation does not seem to take into account that the interpretation does not only include civil compulsory psychiatric treatment, but also includes court-ordered psychiatric treatment, where the mental healthcare service is required by law to prioritise crime prevention. The interpretation also illustrates that the consideration of crime prevention was not considered when the exception rule was introduced.³⁹

The exception rule for internal transfers implies that a patient can be transferred from a closed fulltime stay department to an open fulltime stay department within the same institution, without the prosecution authority having the right to appeal these decisions. On the other hand, the main rule implies that the prosecution authority has the right to appeal decisions where a patient is transferred between the same level of security at different institutions, and even where the patient is transferred to a more stringent level of security at another institution. From a crime prevention perspective, the main rule and its exception imply that the prosecution authority have the right to appeal transfers that normally are not of importance to public protection, and are deprived of the right to appeal in some transfers that are of importance to public protection.

Finally, we will look at a form of non-statutory transfer that raises specific questions for the prosecution authority's control function. Gradual transfer from inpatient to outpatient psychiatric care involves a form of trial period, both from the perspective of the institution and of the patient. Such gradual transfers ensure that the institutions are able to quickly and informally change back to fulltime stay if necessary. Stays in the patient's home, which will normally increase in length during a gradual transfer, are considered as a form of leave. In some cases, these leaves may be protracted. The reasons are partly that the institutions need time to evaluate if the patient is prepared for a life outside the institution, and partly that some patients may consider it an advantage, or more secure, to keep the formal status of a fulltime stay patient during this transitional phase. From a patient perspective, gradual transfers are problematic only if they are mandatory. If so, the patient is deprived

³⁸ Directorate of Health, Regulations for mental health care with comments (*Helsedirektoratet, Psykisk helsevernforordningen med kommentarer*), author's translation of comment on section 12: 'Hvorvidt man har med to ulike døgninstitusjoner eller to avdelinger i samme institusjon å gjøre må vurderes konkret. Det at avdelingene inngår i én organisatorisk enhet er ikke avgjørende. Det avgjørende må være hvilken betydning overføring vil få for pasienten med hensyn til oppbrudd fra vante omgivelser, skifte av behandlingsmiljø, nærhet til familie mv. En avdeling vil etter forholdene kunne anses som en egen døgninstitusjon etter bestemmelsen her dersom den er geografisk atskilt eller fremtrer som en driftsmessig selvstendighet enhet.'

³⁹ Ot. prp. nr. 65 (2005-2006), p. 82.

the right to appeal until the transfer is formalised through a formal decision. From a crime prevention perspective, such gradual transfers mean, for the same reason, that the prosecution authority is deprived of the right to appeal until the transfer is formalised through a decision. These transfers which have ‘particularly intrusive’ impact for society, which justifies the prosecutor’s right to appeal, may have been in force for a long time before a formal decision is taken and the right to appeal arises.

This issue was not problematised in the legislative process before a review committee considered it.⁴⁰ In the public hearing that followed the review, central consultation bodies within the health service took a new position: they argued for a closer cooperation with the prosecution authority. The Norwegian Medical Association argued for the need to consider extended appeals or a more active role for prosecution authorities.⁴¹ The Directorate of Health argued in favour of strengthening the prosecutor’s role.⁴² The Ministry of Justice’s deliberations led to a bill proposing that the prosecutor should be consulted in decisions concerning internal transfers and leave, if the concern for crime prevention is justified.⁴³ As mentioned in section 2.2, the bill was passed by the parliament in the summer of 2019.⁴⁴ Although the amendment to the law means that the prosecution authority should be consulted in cases where the responsible physician or psychologist consider transfer from a closed fulltime stay department to an open fulltime stay department within the same institution, and in cases where leave challenges crime prevention, the prosecution authority still has no right of appeal if the decision goes against the prosecutor’s recommendation.

4. Concluding Reflections

This review shows that the prosecutor’s right to appeal does not include all decisions that fulfill one of the 1990 NOU committee’s criteria for complaints: the ‘particularly intrusive’ impact for society.

Nevertheless, the Supreme Court has assumed that the prosecution authority has a central role in reviewing significant changes during treatment. This ruling can be traced back to a circular from the Attorney General. Here it is stated that the prosecution authority ‘shall be notified of significant changes’, and in this regard have a right to appeal.⁴⁵ The courts, with the Supreme Court in the lead, adopted this interpretation of the prosecutor’s role. A number of judgements, concerning the choice between civil psychiatric treatment and court-ordered psychiatric treatment, are

⁴⁰ NOU 2014:10, p. 363.

⁴¹ Prop. 154 L (2016-2017), p. 156.

⁴² *Idem*, p. 157.

⁴³ *Idem*, p. 160.

⁴⁴ LOV-2019-06-21-48

⁴⁵ Attorney Generals circular nr. 4/2001.

based on the consideration that the prosecutor maintains a central role, i.e. have a right to appeal, with regard to significant changes in treatment.⁴⁶ This means that there is a marked discrepancy between the prosecutor's regulated right of appeal and the courts' perception of this right of appeal. Moreover, this discrepancy implies that there is reason to ask whether the courts actually has based the choice of sanction on a correct understanding of the prosecutor's control function.

At the same time, there is also reason to question the suitability of the prosecution authority as a control body. The legislative proposals show no discussion of the suitability of prosecutors, and this factor instead seems to be taken for granted. In the proposal for the 2019 law amendment, the Ministry of Justice emphasises the prosecution authority's experience:

*'Social security and criminal protection are usually core tasks for the prosecution authority, and prosecution authority are particularly experienced in assessing these matters.'*⁴⁷

Two considerations give reason to further question the suitability of the prosecutors, despite their experience in assessing risk of violence. First, the implementation of psychiatric treatment involves a medical treatment regime, which the prosecutors do not have the adequate prerequisites for assessing. Secondly, and closely related to the first, forensic psychiatry has developed instruments for risk assessments that go beyond the prosecution's experience-based assessments. The goal of modern violence risk assessments is described as follows:

*'The main challenge of violence risk work is not to preach a "context-free" decision about who will and who will not be violent in an unspecified period of time. Instead, the goal is to identify which management strategies are needed to minimise the individual's risk of violence.'*⁴⁸

The focus in psychiatric risk assessments has been changed from prediction to prevention. Against this background, a number of different risk instruments have been developed in forensic psychiatry, after the 1990 NOU committee gave the prosecution authority a control function. In psychiatric healthcare modern risk assessments have moved away from the dichotomy between dangerous or not dangerous. In the justice sector, this dichotomy is still widespread.⁴⁹ Their risk assessments still reflect the experience-based prediction that the 1990 NOU committee has built the

⁴⁶ Rt. 2002, p. 990, repeated in Rt. 2005, p. 1091, Rt. 2011, p. 385, etc.

⁴⁷ Prop. 154 L (2016-2017), p. 160, author's translation: 'Samfunnssikkerhet og samfunnsvern er normalt kjerneoppgaver for påtalemyndigheten, som myndigheten har en særlig erfaring med å vurdere.'

⁴⁸ NOU 2010:3, p. 96, author's translation: 'Hovedutfordringen ved voldsrisikoarbeid er ikke å predikere en «kontekstfri» beslutning om hvem som kommer til og hvem som ikke kommer til å gjøre voldshandlinger i løpet av et på forhånd uspesifisert tidsrom. Målet blir i stedet å utrede hvilke håndteringsstrategier som er nødvendige for at den enkeltes voldsrisiko skal bli lavest mulig.'

⁴⁹ See NOU 2014: 10, part 4.

court-ordered psychiatric treatment upon, and which forensic psychiatry has left behind. In such a light, the control body may prove to have less knowledge of risk assessments than the body to be controlled.

Both the lack of medical knowledge and modern violence risk assessments may indicate some caution on the part of the prosecutors when it comes to exercising the control function. Little is known about the number of complaints today, but a survey published in 2008 concluded that there were not many complaints about decisions on transfer, either from the prosecutors or the patients.⁵⁰

Despite the prosecutor's lack of both medical knowledge and modern violence risk assessment methods, there may still be reasons to maintain a control function for the prosecution authority. The Ministry of Justice, in its proposal for the 2019 law amendment, has emphasised the value of public confidence in the mental health care sector's ability to protect society from the risk of violence.⁵¹ At the same time, the Ministry has pointed out that the prosecution's control function should help to take account of 'all aspects' in the case.⁵² These diffuse 'all aspects' in the case might be the core of the control function. Although not all decisions that have 'particularly intrusive' impact for society are covered by the right of appeal, and even if the prosecutor does not have the prerequisites to be able to assess all decisions in the health service, and even though the right of appeal may hardly be used, the existence of a control function might satisfy a public sense of justice.

⁵⁰ See footnote 7.

⁵¹ Prop. 154 L (2016-2017), p. 158.

⁵² *Idem*, p. 159.