MENTAL HEALTH LAW PROFILES

Mental health law profiles

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In this issue, for the Mental Health Law Profiles we move to two economically developed Scandinavian countries, Denmark and Finland. Some may find it surprising how strongly Finnish legislation implies a degree of trust in medical professionalism as the guarantor of patient welfare. This difference from not only Danish but more broadly civil rights-based approaches, including Anglo-Saxon approaches, to mental health law probably reflects the social cohesion and experience of social solidarity in Finland, as the authors suggest.

Do different approaches to mental health law perhaps reflect the different histories of medicine and psychiatric practice in different countries, some generating more trust than others, or do they simply reflect and emphasise the importance of different cultural factors in general to core psychiatric practice? Do such different approaches lead to different patient experiences and outcomes in different countries? In an era rightly characterised by outcomes-based planning it would be useful to know.

MENTAL HEALTH LAW PROFILE

Mental health law in Denmark

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In Denmark, the parliament passed the first Mental Health Act (MHA) in 1938. A new Act was passed in 1989, based on a thorough report from the Ministry of Justice. The 1989 Act emphasised the protection of citizens' legal rights in relation to compulsory admission, detention and treatment in psychiatric hospitals. That Act is still in operation, although it has been amended several times. In 2006 the definition of 'compulsion' was changed, and a 2010 amendment introduced compulsory treatment in the community for a trial period of 4 years.

How mental disorder is defined in law

The Danish MHA (available at http://www.retsinformation.dk) applies the concept of 'insane or a condition entirely equivalent to this' to define the kinds of mental disorders for which compulsory measures can be used. In current psychiatric nomenclature 'insanity' is regarded as more or less equivalent to 'psychosis'. Several problems have arisen in consequence, as the current diagnostic system (ICD-10) does not include 'psychosis' but only 'psychotic symptoms'. Appendix 1 of the Danish edition of ICD-10 states which mental disorders should be considered equivalent to 'insane in a legal sense'; however, a number of Danish psychiatrists share the opinion that the concept of psychosis and insanity has narrowed since 1994, when ICD-10 was introduced in Denmark. This in turn influences the way the MHA is used in daily clinical practice and might eventually pose a risk that adherence to one of the core intentions of the Act – to secure the treatment of persons with severe mental disorders – diminishes over time.

Grounds for compulsion

In Denmark, the only medical specialty allowed to use compulsion is psychiatry. Only hospitalised patients can be subject to compulsory measures, with the exception of compulsory treatment in the community.

The first criterion for compulsory admission or detention is that the patient is insane or in an entirely equivalent condition. Second, it should be regarded irresponsible *not* to deprive that person of his or her liberty because:

- the prospect of restoring or at least improving health will otherwise be seriously compromised (the 'treatment indication') *or*
- the patient presents an obvious and considerable danger to him- or herself or others (the 'danger indication').

The 'treatment indication' is the more widely used.

The Danish MHA provides detailed descriptions of the various compulsory measures (Box 1). According to the Act, each compulsory measure must be decided individually. It does not automatically follow from compulsory admission or detention that the patient will also receive compulsory medical treatment.

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Box 1

Compulsory measures detailed by the Danish Mental Health Act

(1) Compulsory admission to psychiatric hospital
(2) Compulsory detention in psychiatric hospital
(3) Compulsory medical treatment:
  - psychopharmacological treatment
  - electroconvulsive therapy
  - nourishment (e.g. for patients with severe anorexia nervosa, if necessary by gavage)
(4) Compulsory medical treatment of life-threatening somatic conditions
(5) Compulsory restraint
  - physical restraint (staff holding the patient)
  - mechanical restraint (belt, straps, gloves)
(6) Compulsory treatment in the community
(7) Constant surveillance performed by staff members (with the purpose of protecting the patient)

Generally, only medical doctors who are specialists in psychiatry (senior consultants) are authorised to decide upon the use of compulsory measures. However, a decision to initiate compulsory admission (item 1 in Box 1) or physical restraint (item 5) can be made by all physicians/medical doctors. In the former case, it will often be a general practitioner (GP) who makes the decision. The physician fills in a special application form, which is then delivered to the police in order to ensure that the formal conditions for compulsory admission obtain. The police in turn contact the senior consultant psychiatrist at the institution to which the patient is to be admitted, in order to obtain final approval. Item 2, compulsory detention, can follow compulsory admission but can also apply to voluntarily admitted patients. In both cases, the detention must be authorised by the senior consultant.

Regarding compulsory medical treatment (items 3, 4 and 6), the same prerequisites as for admission and detention must be fulfilled. For a decision regarding item 4, authorisation must obtained from both a senior consultant psychiatrist and a senior consultant within the actual medical specialty involved. An amendment to the MHA in 2006 made compulsory treatment with electroconvulsive therapy (ECT) possible only if the patient's life is in threat. The same is the case for coercive somatic treatment (item 4).

Physical and mechanical restraint (item 5) can be decided upon by all physicians or even by nursing staff in emergencies. It is not mandatory that the patient is insane. Instead, one of the following conditions must be fulfilled:

- there is obvious danger to the patient him- or herself or to others
- the patient is grossly molesting other patients
- there is substantial damage to property.

The removal of all compulsory measures apart from item 5 relies solely on the senior consultant.

Specific administrative forms exist for each compulsory measure, providing the basis for the mandatory reporting to the Danish Health and Medicines Authority.

A person's family should call upon a medical doctor if it is believed that the person is insane and is not him- or herself seeking necessary medical assistance. Apart from this, the family has no role in relation to compulsory admission or treatment in Denmark.

The balance between protecting the public and protecting the human rights of people with mental disorder

The main concern of the Danish MHA is the protection of the legal and human rights of persons who are mentally ill. Only second to this comes protection of the public.

The MHA applies equally to non-offender patients and mentally disturbed offenders under a psychiatric treatment order. The only compulsory measures allowed under a treatment order are admission and detention. No other compulsory measures can be applied unless the general conditions mentioned above are present for the individual. This sometimes creates clinical dilemmas, as up to 30% of patients under a psychiatric treatment order are considered non-psychotic.

Mental capacity

According to the Danish Health Act, no treatment can take place without the informed consent of the patient. General exceptions, apart from the ones given in the MHA, are:

- children below 15 years, in which case the parents must consent
- emergency cases where immediate treatment is necessary and the patient temporarily lacks the ability to consent
- persons permanently lacking the ability to make decisions on their own behalf.

The last group primarily comprises persons with moderate to severe dementia, although some persons with intellectual disability and acquired brain damage may also qualify.

Traditionally, persons with other mental disorders, no matter the kind or severity, are considered to have the capacity to decide for themselves regarding medical treatment.

In Denmark, there is no specific law on a person's mental capacity with regard to consent to medical treatment. However, there is a law describing when a citizen can be subject to guardianship. The main issues of this law are lack of capacity to decide on economic or personal dispositions. Nevertheless, an appointed guardian can consent to medical treatment, including mental health treatment, on behalf of the patient. However, if the person 'in words or action' clearly refuses the treatment, it cannot be carried out, according to the Health Act.

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In this case, a psychiatry specialist should evaluate whether it is relevant and legal to carry through the treatment involuntarily according to the MHA. Overall, there is agreement among Danish mental health professionals that patients with psychotic states (i.e. who are 'insane') should *not* be classified as 'persons permanently lacking the ability to make decisions on their own behalf'.

Rights to complain

If a patient is subject to compulsory measures, a patient counsellor will always be appointed. The counsellor is obliged to visit the patient within 24 hours and to assist if the patient wishes to complain. For healthcare services, Denmark is divided into five regions. Each has a regional state administration that arranges complaint boards for the settling of psychiatric patients' complaints concerning compulsory measures under the MHA. The tribunal of a complaint board comprises three members: the director of the regional state administration, presiding; an appointee of the Danish Medical Association, not necessarily with psychiatric expertise; and an appointee of the Disabled People's Organisation. If the tribunal approves the compulsory measure, the patient has the right to appeal to a court. If the tribunal disallows it, the hospital is given the right of appeal, but only in cases concerning medical treatment, not those concerning deprivation of liberty.

The MHA does not specify time limits for compulsory detention or treatment. However, in appeal cases it has been stated that if no improvement occurs within 6 months the patient should not be kept any longer for a 'treatment indication'. The MHA has been frequently amended in order to reduce the use of mechanical restraint, especially of long duration (i.e. days, weeks and in rare cases even months). Since 2006, the physician must examine a restrained patient four times every 24 hours, and this must be documented. Further, a second opinion from an external consultant psychiatrist is mandatory after 48 hours of continuous use of mechanical restraint.

Compulsory treatment in the community

Compulsory treatment in the community (CTC) has only recently been introduced. An intense debate took place over several years. Those opposing claimed that research was sparse and no evidence existed to prove its effectiveness, while the introduction of such far-reaching restrictions on personal freedom should presuppose a high degree of certainty that it will work better than measures already used. Supporters claimed that CTC was in the best interests of patients with the most severe mental illness, and that not to introduce such measures might count as malpractice and lack of care.

The criteria for the use of CTC are strict: three instances of compulsory detention during the previous 3 years and the failure of both the discharge contract and assertive community treatment. CTC can last for a maximum of 1 year, during which it must be renewed every third month.

The introduction of CTC has allowed the compulsory first-line use of long-acting antipsychotic drugs, thus disregarding the expressed opinion of the complaint boards that oral antipsychotics should be regarded a less radical compulsory measure. Few patients are in fact subject to CTC (between 10 and 20 persons a year in a population of 5.5 million). Patients under a psychiatric treatment order cannot be subject to CTC.

The Danish Health and Medicines Authority has closely followed the trial of CTC and in 2014/15 parliament will decide whether it shall continue.

National regulation and statistics

Involuntary detentions take place only in psychiatric hospitals. In the case of compulsory somatic treatment administered on medical wards, the patient is technically registered as a psychiatric in-patient, but will actually seldom come to the psychiatric ward.

Each single compulsory measure must be reported to the Danish Health and Medicines Authority, which closely monitors the situation both nationally and regionally. Annual statistics on the use of compulsory measures (as listed in Box 1) are published and accessible on the home page (http://www.SST.dk) of the Authority in the form of a register, which is both detailed and regarded as very accurate. Mental health services in Denmark are provided almost entirely within the public sector and exhibit a very high degree of cooperation with instructions from parliament and the Danish Health and Medicines Authority. Another feature facilitating the accuracy of the register is the Danish identification system of all citizens – a unique ten-digit personal number – which is applied every time a citizen is in contact with a public authority, including being subject to compulsory psychiatric measures.

Despite the efforts to reduce the frequency of use of compulsory measures, the results do not seem satisfactory. The use of such measures in psychiatry is continuously subject to debate among politicians and the public, and in the media. This probably reflects the fundamental challenge of balancing the right to personal freedom and situations where this should temporarily be suspended.

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