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Compulsory psychiatric detention and treatment in Finland

Despite efforts to integrate and harmonise legislation across the member states of the European Union (EU), mental health legislation, including legislation for the detention and treatment of offenders with mental disorders, differs widely across Europe. With changes to the Mental Health Act 1983 in the UK currently underway, investigating the different approaches to compulsory psychiatric care in other countries can be a stimulating and worthwhile exercise. We explored the Finnish mental health law with regard to compulsory admission and treatment and forensic care. Relevant differences between the Finnish approach and legislation in other European countries will be discussed.

Finland has a population of approximately 5 255 580; a total of 4.3 million Finns (82.3%) live in urban communities, and Finland's economic structure is that of a typical urbanised country. Primary production is now a source of employment for only 6% of the population, 27% work in industry and construction and 66% in trade and services. Unemployment rates have been high, between 10 and 15%, in the past 10 years (see <http://virtual.finland.fi>).

Civil patients

The main law regulating the compulsory admission of psychiatric patients to hospital in Finland is the Mental Health Act 1990/1116, which was passed in 1991 and amended in 2002. The following account refers to adults only. Provisions for children under 18 years of age differ slightly and will not be considered here.

The current Finnish Mental Health Act stipulates the following criteria for compulsory admission:

- a person should be found to have a psychotic illness, and
- because of this psychosis, they are
 - in need of psychiatric care as their condition would otherwise worsen, or
 - a danger to their own health or welfare, or
 - a danger to the health or welfare of others
- no other mental health services are suitable or adequate.

'Psychotic illness' in the context of this legislation is understood to include the diagnoses of delirium, severe forms of dementia, all types of schizophrenia and other psychoses, organic and other delusional disorders, major depressive disorder with psychotic features and bipolar disorder. These diagnostic criteria are comparatively restrictive and can cause practical difficulties in some situations, for example if suicidal patients clearly pose a risk to themselves but do not clearly fulfil criteria for admission because of the absence of psychotic symptoms. The dangerousness criteria on the other hand

are interpreted in a rather broad way and can include risk to one's own health as a result of poor standards of personal care, as well as endangering the development of one's children.

The process of detention is initiated by a referral for observation (known as MII), which can be written by any physician if they consider it likely that the criteria for involuntary admission are fulfilled. In hospital, the patient is then examined by a second doctor who must be a psychiatrist. At this stage the patient can be admitted on a voluntary basis, or indeed not at all, if the psychiatrist does not consider the criteria for detention to be fulfilled. If compulsory admission is recommended by the psychiatrist, a written statement (MII) describing the patient's condition, detention criteria, as well as the patient's own views, has to be produced on the fourth day after initial admission at the latest. A third recommendation, MIII, the final decision, is then required by the psychiatrist in charge at the hospital to which the patient is admitted. This completes the procedure; the detention is then valid for 3 months. In Finland, involuntary admission of a psychiatric patient is therefore dependent on the opinion of three independent doctors but does not involve other professionals. Compared with other European countries this is a minority position only shared by Denmark, Sweden, Ireland and Luxemburg (Salize *et al*, 2002). The majority of EU member states require non-medical authorities (most commonly judges) to be part of the decision-making process or to make the final decision on compulsory detention.

If at the end of the 3-month period it is considered likely that detention criteria are still fulfilled, new recommendations MIII and MIII are filed and the renewed detention is then valid for 6 months. However, this second period of detention has to be immediately confirmed by a local administrative court. After this 9-month period, if the patient needs further compulsory treatment the process has to start anew with a MI referral which can be initiated by any doctor outside the hospital at which the patient is currently treated.

There is no legislative distinction made between involuntary placement and treatment in Finnish mental health law. Medication and other treatments can be given against the patient's will if the advantages clearly outweigh the disadvantages, and the treatment of the patient's illness or their safety, or that of others, necessitates it. This includes electroconvulsive therapy which can be administered in an emergency (e.g. in a catatonic state, as a life-saving measure) but would not otherwise be given compulsorily to a non-consenting patient. There are, however, no specific safeguards such as the requirement of a court order or a second opinion in relation to any compulsory treatments. However, every restriction has to be clearly documented and filed, and



the patient can file a complaint to the chief executive officer of the hospital, to the courts, or even to the parliamentary ombudsman. However, restrictions of other liberties are regulated in much detail, and the law makes specific reference to restricting patient's possessions, limiting contacts, seclusion and restraint. Every case of seclusion and mechanical restraint has to be documented and reported to the responsible authorities (the state provincial office). Compulsory out-patient treatment is not presently permitted in Finland.

Patients can appeal against their detention at a local administrative court within 14 days of notification of their compulsory admission (MIII). Decisions by the local administrative court can be appealed against at the Supreme Administrative Court. In appeals cases independent psychiatric reports are commissioned. Appeals can also be lodged with the medical director of the detaining hospital.

Patients with intellectual disability

Separate legislation is in place for people with intellectual disability (Statute on Special Welfare for the Mentally Handicapped 1977/988). These can usually only be detained in a psychiatric hospital if they have a psychotic disorder. Exceptions apply if the care cannot be otherwise provided and if there is a risk to the patient's own safety or health, or that of others. Applications to that effect are dealt with by a commission appointed by the local social services department; a decision to detain has to be confirmed by the local administrative court and is in force for a maximum period of 6 months.

Patients with substance misuse disorders

Patients with substance misuse disorders are also dealt with under separate legislation, specifically the Act on Welfare for Substance Misusers (1986/41). This Act makes provisions for involuntary admission if there is a serious health risk to the person concerned or a risk to others. The health risk criterion mainly applies to the treatment of physical conditions rather than to the substance use disorder. This is reflected in the high threshold of risk specified, which has to be an 'imminent danger of life' or a 'severe acute damage'. The Act is rarely used in practice.

Forensic patients

The assessment and treatment of offenders with mental illness is mainly regulated by two laws: the Finnish Mental Health Act 1990/1116 and the Criminal Law on Forensic Psychiatric Evaluations (1889). The Finnish criminal law recognises three categories of criminal responsibility:

- 'full responsibility',
- 'diminished responsibility',
- 'no criminal responsibility'.

The level of responsibility depicts the evaluated mental state of the offender at the time of the crime; the concept can be applied regardless of the type of offence. The court makes the decision of criminal responsibility, and in 99% of cases the perpetrators are considered fully

responsible. The court decides whether or not a psychiatric examination is required to assess the criminal responsibility of the perpetrator. The examination can be ordered if the criminal offence can lead to at least a 1-year prison sentence. In practice, the more serious the crime, the more likely that the offender will undergo a forensic psychiatric assessment. The court may also ask the National Authority for Medicolegal Affairs, a division of the Ministry of Social Affairs and Health, for an assessment of the need for treatment in cases where no forensic psychiatric examination took place. Criteria for a finding of no criminal responsibility are that the offender, owing to severe mental illness, mental retardation or another severe mental disorder, did not understand the true nature of the act, or its unlawfulness, or was unable to control their behaviour. The sentencing court plays no further part in the case after the finding of no criminal responsibility.

In 2004, 168 forensic psychiatric assessments were made; 82% of the offenders had committed homicide or another serious violent offence (excluding arson), 14% were women and 2% under 18 years of age (Terveydenhuollon Oikeusturvakeskus, 2005). Forensic psychiatric examinations are arranged by the National Authority of Medicolegal Affairs, and are carried out on an in-patient basis in a special hospital or in prison. During a 2-month period, a thorough assessment is conducted, which includes extensive information gathered from various sources, standardised psychological tests, physical examinations, laboratory tests, behavioural observation and repeated interviews by a forensic psychiatrist and the multidisciplinary team. The final forensic psychiatric report includes an opinion on the level of criminal responsibility, a psychiatric diagnosis according to ICD-10 criteria (World Health Organization, 1992) and an assessment as to whether the offender fulfils criteria for involuntary psychiatric care. The National Authority of Medicolegal Affairs prepares an independent statement for the court and in most cases recommendations are found to be in agreement with the forensic psychiatric report.

In 2004 (Terveydenhuollon Oikeusturvakeskus, 2005), 63% of offenders who had undergone a forensic psychiatric assessment were found to be fully responsible and were therefore sentenced in the usual way. In cases of diminished responsibility the prison sentence can be lowered by 25% at the court's discretion (until recently this reduction was mandatory). Offenders in this category may have serious psychiatric disorders, but not psychoses, or may have intellectual disability. They are dealt with by the criminal justice system without conditions of psychiatric treatment imposed. Substance use and personality disorders are not generally considered sufficient to warrant diminished responsibility. Offenders deemed to have no criminal responsibility are not sentenced but are usually committed to a psychiatric hospital (Eronen *et al*, 2000); in 2004 about 18% of offenders fell into this group. These patients can only be admitted to hospital if they fulfil the criteria for detention as discussed above. The National Authority of Medicolegal Affairs decides on the admission, and the need for treatment is reassessed every 6 months; this decision must be reinforced by the local court similar to the



process adopted with civil patients. Patients can also appeal to the local administrative court.

There are two state hospitals in Finland dedicated primarily to the care of offenders with mental illness (although they also admit other patients who cannot be treated anywhere else): Vanha Vaasa Hospital, Vaasa and Niuvanniemi Hospital, Kuopio. The former has 147 beds, the latter 296. The average length of treatment for the discharged criminal patient is 5 years (Niuvanniemi Hospital, 2005). The decision of where the treatment of the offender with mental illness initially takes place lies with the National Authority of Medicolegal Affairs. Most patients in these two hospitals have schizophrenia or schizoaffective disorder (82%); other diagnoses include other psychoses (10%) and bipolar disorder (2%) (information from Vanha Vaasa Hospital website; <http://www.vvs.fi/statsfin.html> PÄÄDIAGNOOSIT). After 6 months in a forensic hospital, local psychiatric services can take patients back into their care if this is regarded as safe, which is rarely the case in practice. Patients are rehabilitated gradually through less secure wards and rehabilitation units (which may include local psychiatric services), before being reintegrated into the community. After discharge from in-patient treatment, patients are supervised for 6 months during which they are regularly seen by a psychiatrist. If necessary, this period can be extended and the patient can also be recalled to hospital. Final discharge from supervision is decided by the National Authority of Medicolegal Affairs.

Discussion

Finnish mental health legislation takes a medical approach to compulsory measures, emphasising the need for treatment of psychiatric patients over civil liberties concerns. Consequently no non-medical professionals are involved in the decision of involuntary admission – although a court has to reinforce the decision at a later time – and no distinction is made in legislation between admission and treatment. On the other hand, diagnostic criteria for detention are strict, thereby assuring that only patients with severe illness are subjected to coercive measures, which are needed for their well-being. Finland has the highest rates of detention per 100 000 inhabitants, about 214 compared with 93 in the UK and 11 in Italy (Salize *et al*, 2002; Zinkler & Priebe, 2002). A high percentage of compulsory admission relative to all psychiatric admissions (21.6%) has also been described by Salize *et al* (2002). One could speculate that these figures may be partly a consequence of a medically orientated approach to detention of those with mental illness.

Standards of forensic assessment and care are high in Finland. Unlike in the UK, the concept of criminal responsibility is applied to all offences and its assessment is one of the main purposes of the forensic examination. Access to forensic psychiatric care is restricted to those patients who are found to lack criminal responsibility (i.e. having mental illness at the time of the crime, and needing care for ongoing psychotic illness. It is not surprising therefore that a larger number of offenders are found to

lack responsibility compared with the UK where this is not one of the admission requirements for forensic care.

Finnish mental health law is generally seen to work well in practice. It has been suggested, however, that clearer definitions regarding psychiatric disorders in relation to different levels of criminal responsibility are needed. Other problems are the perceived need for involuntary out-patient care to better prevent recidivism of criminal patients, and inequality of care received depending on where patients live. A multi-professional group was set up at the beginning of 2004 to review current legislation in relation to forensic patients. This expert committee presented its final recommendations in 2006 (Lankinen *et al*, 2006). These include a revision of the Mental Health Act so that offenders with a personality disorder found criminally irresponsible can also be compulsorily admitted for psychiatric treatment. Furthermore, compulsory out-patient treatment was recommended for mentally disordered offenders.

Conclusion

Mental health legislation differs widely across Europe. Finland takes a medical approach to compulsory detentions of psychiatric patients, emphasising the need for treatment in the best interest of the patient. The decision for compulsory admission is based on the assessment of medical professionals only. Separate regulations apply to patients with substance use disorders or intellectual disability. Forensic psychiatric assessments are comprehensive and conducted on an in-patient basis. The concepts of 'diminished responsibility' and 'no criminal responsibility' can be applied to any offence. In persons found to be not criminally responsible, the involvement of the criminal justice system ceases. Criteria for involuntary psychiatric admission for these patients are the same as for civil patients.

Declaration of interest

None.

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