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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