

# Severe mental disorder as a basic commitment criterion for minors

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## Abstract

Since 1991, commitment to involuntary psychiatric care has been allowed in Finland for minors in broader terms than for adults. While in adults mental illness has to be diagnosable before involuntary treatment can be imposed, minors can be committed to and detained in involuntary psychiatric treatment if they suffer from “severe mental disorders”, and fulfil the further commitment criteria defined in the Mental Health Act. The first years of the new mental health legislation showed an increase in involuntary treatment of minors in Finland. Concerns were raised about the imprecise nature of the commitment criterion “severe mental illness”. This study set out to find out whether Finnish child and adolescent psychiatrists are in agreement on how to define severe mental illness and whether their interpretations are sufficiently similar to ensure the equality of minors in commitment to psychiatric care as prescribed by the Mental Health Act. Semi-structured, reflexive dyadic interviews were carried out with 44 psychiatrists working with children and adolescents. The data was analysed using qualitative content analysis. There was general agreement about what constitutes a “severe mental disorder” justifying the involuntary psychiatric treatment of minors. The child and adolescent psychiatrists were of the opinion that involuntary treatment of minors should not be tied to specific diagnostic categories. Which disorders are severe enough to justify commitment should rather be considered through developmental and functional impairment and interactions between a minor and her/his environment.

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## 1. Introduction

Although self-determination is a highly appreciated value in modern Western health care ethics, involuntary psychiatric treatment is generally allowed in Western countries (Appelbaum, 1997; Salize, Dressing, & Peitz, 2005; Salize & Dressing, 2004a,b), but being a controversial issue juxtaposing the right to self-determination and the right to receive good care, it is carefully controlled in mental health legislation. The mental health acts in various countries vary as to what conditions are considered severe enough to justify compulsory treatment (basic criterion), and as to what additional criteria must be fulfilled before involuntary treatment can be initiated. The additional criteria usually include

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various combinations of need for treatment, being a danger to self, and being a danger to others (Appelbaum, 1997; Salize et al., 2005).

In Finland, the *Act on the Status and Rights of Patients (1992/785)* stipulates a patient's right to decide about her/his own treatment, and a right to refuse recommended treatment, as do Patients' rights acts, for example, in the other Nordic countries (Fallberg, 2000). In specific situations related to mental disorders, mental handicap, substance abuse and certain infectious diseases, involuntary treatment can be imposed, and it is regulated by the respective laws (Kaltiala-Heino & Välimäki, 2001). Of these, involuntary psychiatric treatment is by far the most important, and compulsory care under the other acts is very rare (Kaltiala-Heino & Välimäki, 2001).

The theoretical justification for imposing involuntary treatment in psychiatry is that mental disorders are seen to impair a patient's competence so that s/he is no longer able to make decisions serving her/his own best interests according to her/his own long-standing values (Appelbaum & Grisso, 1988; Grisso & Appelbaum, 1995). Competency includes the capacity to understand information, to appreciate it as related to oneself, to consider the consequences of different choices, and to communicate a choice. Adults are basically assumed to be competent, but mental disorders are considered to potentially impair an adult's competence so much that it may be justifiable for others to intervene. Children and adolescents are generally deemed not fully competent, which is illustrated in the variety of legal provisions restricting their rights or compelling their compliance in a number of issues including education, economic issues, guardianship, child welfare etc. The Finnish Act on the Status and Rights of Patients states that children and adolescents have a right to participate in decision-making about their health care to the extent it is appropriate given their age and developmental level.

In Finland, the *Mental Health Act of 1991 (1990/1116)* introduced broader criteria for the involuntary treatment of minors than of adults. While the committed adult has to be mentally ill (psychotic), the basic criterion for the involuntary treatment of minors is "severe mental disorder". In addition, the legislation requires that the person, due to her/his mental illness (adults) or severe mental disorder (minors) is in need of treatment to the extent that not treating would result in serious deterioration of the condition, or in serious harm to the patient her/himself or to others, and that other treatment options are inadequate. Minors committed to psychiatric care have to be treated separately from adults.

In general, European mental health legislation reforms in recent decades have attempted to reduce involuntary treatment and to protect the civil rights of the patients (Salize & Dressing, 2004a). The revised Finnish Mental Health Act was seen to protect minors from developmentally harmful refusal of treatment, but concerns were also raised that the concept of "severe mental illness" may be too vague to ensure the legal protection of minors. A progressive major increase in involuntary commitment of minors was observed after the Act was passed (Kaivosoja, 1999; Kaltiala-Heino, 2004). There is also a considerable regional variation in commitment figures for minors (Kaltiala-Heino, 2004). Due to these concerns, several attempts were made in the 1990's by the Ministry of Social Affairs and Health to define the concept of "severe mental disorder" more clearly, using surveys among professionals and committee work. In 2001, the first author was appointed by the Ministry to carry out the necessary research to arrive at guidelines for interpreting the concept of severe mental disorder as stated in the Mental Health Act as the basic commitment criterion for minors.

We are aware of very scarce scientific literature on the involuntary treatment of minors. Most of the papers dealing with self-determination, competence and informed consent in minors are theoretical or single case presentations (Batten, 1996; Billick, Edwards, Burgert, Serlen, & Bruni, 1998; Blondeau, 1995; Brody & Waldon, 2000; Casimir & Billick, 1994; Kluge, 1995; Koren, Carmeli, Carmeli, & Haslam, 1993; Susman, Dorn, & Fletcher, 1992). The literature on the use of coercive measures within the psychiatric inpatient treatment of minors concentrates on alternatives in aggression management (Bath, 1994; Delaney, 2001; Earle & Forquer, 1995; Barnett, Dosreis, & Riddle, 2002; Finke, 2001; Mohr & Anderson, 2001). The literature on the treatment of juvenile delinquents has addressed the confinement of minors in prisons, particularly the ethical and social learning aspects of confining minors among adults and the question of an appropriate balance between treatment needs and punishment, as well as whether separate juvenile court processes protect or compromise the rights of minors (Fox, 1977; Lerman, 1984; Nesburg et al., 1971; Ryerson, 1996). There is a lack of research on the ethical and legal aspects of involuntary commitment to psychiatric care of minors. No international comparisons of criteria of commitment in minors are available. Information on the process and criteria for the commitment of minors is needed as a starting point for research analysing the complex balance between minor's rights to protection and the self-determination, and as a basis for comparing the extent of the involuntary treatment of minors across countries.

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