

Commentary: Civil Commitment and Its Reform

Alexander I. F. Simpson, MB, ChB, BMedSci

Internationally, civil commitment laws have gone through substantial reforms in the past 50 years. Discernible shifts from the medically paternalistic to the excessively legalistic may be giving way to a blending of legislative intent under the rubric of therapeutic jurisprudence. In the light of those international movements, Shao and Xie describe how China's new mental health law shows the impact of these international and local influences on the development and practice of mental health law in China. The new Law was passed in 2012. It sets a broad vision for mental health services and mental health promotion in Chinese society as well as providing the legal framework for civil commitment. Practicalities of implementation may be highly significant in the success of the legislation.

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Civil commitment is, among other things, a health technology.¹ Its fundamental purpose is to set in place a system of procedures, appeals, and protections that allow for the treatment of people who have competency-lowering mental disorders and present a risk of self-harm or self-neglect or harm to others. The aim of civil commitment is to ensure due process protections so that the person can be restored to a state of safety and competence to make decisions for themselves.² Only those rights or freedoms necessary to maintain safety should be removed, to ensure clinical and personal progress.

In maintaining personal and public safety, the state has two ethics-related bases for intervention in the lives of citizens: the *parens patriae* duty to protect the vulnerable among us and the police powers to protect others if safety concerns arise from the conduct of a mentally ill person. Civil commitment should primarily serve a *parens patriae* function. The police powers function should usually be subsidiary to the need to restore the person's capacity. Treating the illness increases competence and stability, and thereby achieves public safety. The clinical purpose

of the intervention is not primarily the safety of the public. Occasionally, civil commitment may be corrupted for other purposes, such as the civil commitment of sexual offenders. This use of civil commitment may have been found to be constitutional,³ but that does not remove the ethically dubious nature of such detention for what is really a criminal justice or public safety intervention.

Winick³ describes civil commitment law as having gone through three stages of development. The first was a medical model marked by paternalistic deference to psychiatrists in making decisions about the detention and treatment of patients. The criteria for such detentions were poorly defined, and few appeals and protective mechanisms were available to the patient. This technology allowed detention for treatment, but at the cost of abuse of the patient's rights, and it ignored the needs for respect and inclusion. The second stage was the legalistic one, where the balance shifted from control by the psychiatrist to a radical curtailment of powers to detain and treat mentally ill persons. This stage was highly respectful of the patient's negative rights (e.g., the right to refuse treatment) but at the cost of positive rights (e.g., the right to treatment and the right to social inclusion, such as the right to work and to be a parent and a family member). The patient's rights might be respected but one's ability to function and be successful in one's life was lost (the dying-with-one's-rights-on argument). What are the dangers in these stages of

Dr. Simpson is Chief of Forensic Psychiatry, Centre for Addiction and Mental Health, and Associate Professor and Head of the Division of Forensic Psychiatry, Department of Psychiatry, University of Toronto, Ontario, Canada. Address correspondence to: Alexander I. F. Simpson, MB, ChB, BMedSci, Unit 3, Centre for Addiction and Mental Health, 1001 Queen Street West, Toronto M6J 1H4, Canada. E-mail: sandy.simpson@camh.ca.

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mental health law development? Overly lax laws that are deferential to medical practitioners are prone to abuse and neglect of patient rights with excessive or inappropriate detention and treatment. Excessively tight legislation that is overly legalized and difficult to implement may delay or deny treatment^{4,5} or contribute to adverse outcomes in the community.⁶

The final stage of development that Winick³ envisaged was a model of civil commitment built on therapeutic jurisprudence: a recognition embodied in the law that people who have a mental illness need both treatment (to restore their capacity and to keep themselves and others safe) and legal protection during this most vulnerable period in their lives.

The other major shift in civil commitment in recent decades has been the development of community treatment orders or involuntary outpatient treatment (IOT). As the location of care for mentally ill persons was deinstitutionalized, so too was the location where coercive care could take place. Although controversy continues regarding the efficacy of IOT, having both inpatient and community arms in civil commitment laws is now commonplace.

If health technology is to serve the purpose for which it was designed, it must be able to achieve its initial aims and be affordable and deliverable in its local context. It must respect local values and mores. Civil commitment requires a clear definition of mental abnormalities that qualify for it. Illness, of itself, is not sufficient. The person must also be a risk to self (either because of the possibility of self-harm or the incapacity to care for himself) or to others. Civil commitment requires robust decision-making, defining who initiates the processes of compulsory assessment and treatment, including stipulation of how orders are made and the appeal and protection mechanisms, which must be available and timely. It should ensure the least restriction necessary to achieve maximum safety and therapeutic and functional gains for the patient. We have learned a little about how to deliver compulsory treatment in a recovery-based manner⁷ through reducing experiences that contribute to the patient's feeling coerced and through enhancing principles of procedural justice (having a sense of voice, being fully informed, and being treated with respect).⁸

Review of the Chinese Approach to Involuntary Admission

Given the above, how do we view the new mental health legislation implemented in the People's Republic of China, so well described by Shao and Xie⁹? The English translation available through the Shanghai School of Medicine makes fascinating reading.¹⁰ The Mental Health Law of the People's Republic of China (2012) was enacted on May 1, 2013. Unlike much mental health legislation in the Western world, which is confined to compulsory care and its regulation, the first two chapters of the Chinese Law are devoted to setting out policy surrounding mental health in general. Article 2 states that the Law aims to promote the "maintenance and improvement of citizens' psychological well-being, the prevention and treatment of mental disorders, and the rehabilitation of persons with mental disorders" (Ref. 10, p 305). To mention but a few areas, this extends to prevention (Article 3), promotion of social inclusion, destigmatization (Article 5), and protection of the rights and liberties of persons with mental disorders (Article 4). The Law sets out to base care within scientific medicine, but encourages linkage with traditional Chinese and ethnic medicine (Article 11). Chapter 2 describes the community prevention and health promotion objectives, as well as the requirements of communities, workplaces, and places of detention to provide services for people with mental disorders (Articles 18–20).

The Law was 27 years in the making.¹¹ The scope of this law is clearly aspirational, rather than current,¹² but the legislation is intended to direct policy and to describe how compulsory care should be applied and administered. It has a bias toward voluntarism. Treatment of mental disorders, both voluntary and compulsory, and the responsibilities of the many players in this process are set out in Chapters 3 through 7.

Shao and Xie⁹ describe the origin of the legislation and its predecessors in particular parts of China. They note that there have been increasingly stringent legal conditions regulating how patients may be detained in some parts of China. There was diversity in the terms used in pre-existing legislation, much of which was not in line with international principles of protecting the rights of person with mental illness. They describe that there was still a need to make the legislation effective by supporting the institutions of

family and community that are seen as having a strong guardianship role in Chinese society. The new legislation had to strike a balance between the competing rights and interests of those involved. Some factors that shaped the policy formation, such as the inappropriate detention of people who were misdiagnosed, have a familiar international ring to them. The need for medical, legal, and social perspectives to be woven into the new legislation shares common themes with international mental health reform.

Notably also, some flexibility in how the legislation will be implemented is allowed, given the great variation in local contexts across the country. This will influence how the Law is implemented. Shao and Xie⁹ focus on the aspects of the legislation that provide for involuntary admission. Of interest, the legislation differentiates processes for those persons whose commitment is required for risk to themselves or an incapacity to care for themselves, referred to as medical protective admission, from the processes governing those who are deemed a risk to others, which is referred to as an emergency admission. The former is applied for by the family or guardian, the latter by police authorities. Differentiation of risks and defining different rights and procedures in this way is, to my knowledge, unique in international civil mental health law.

The definition of serious mental disorder as applied to compulsory admission is stated in Article 83 as:

Conditions considered severe mental disorders in this law are mental disorders characterized by severe symptoms that result in serious impairments in social adaptation or in other types of functioning, in impaired awareness of objective reality or of one's medical condition, or in an inability to deal with one's own affairs" [Ref. 10, p 316].

The risk criterion of the legislation is stated in Article 30 as:

If the result of the psychiatric evaluation indicates that a person has a severe mental disorder, the medical facility may impose inpatient treatment if the individual meets one of the following conditions:

- self-harm in the immediate past or current risk of self-harm;
- behavior that harmed others or endangered the safety of others in the immediate past or current risk to the safety of others [Ref. 10, p 309].

The risk-to-others criterion is of great importance. Shao and Xie⁹ point out that the definition of risk to others currently involves disturbing the public order. Many were concerned that this definition is too broad and open to abuse. The definition has been

tightened to wording very similar to international standards, reflecting a shift in the public's desire to ensure the protection and support of individual liberties and the intent to reduce the chances of inappropriate use of involuntary hospitalization by the state. This is an important step.

While appeal and protective mechanisms are extensive, one of the troubling gaps in the legislation is the lack of mandatory review periods once the initial emergency admission is past. There is clear stipulation of the requirement for regular review of compulsory orders, but its nature and timing are not defined, opening up the possibility of failure to review a person's detention with adequate timeliness.

Shao and Xie⁹ state that the Law does not govern areas of forensic psychiatry, although clearly it sets forth an expectation of mental health care for persons in prisons, envisaging that correctional psychiatry will be provided. Forensic psychiatry appears to be governed by the Criminal Code.

The Law supports community-based services (Chapter 4) but does not explicitly reference involuntary outpatient treatment. However, Article 55 states that:

Urban community health centers, rural township health centers and rural village health clinics shall establish a health registry for persons with severe mental disorders, periodically follow up persons with severe mental disorders who live at home, instruct patients about the use of medication and about rehabilitation, and educate guardians about mental health and about the supervision of the mentally ill [Ref. 10, p 312].

The role of guardian is defined according to general civil law (Article 84), suggesting that some degree of supervision and guardianship is needed in the community over the lives of some persons with serious mental disorders.

Intrusive interventions such as seclusion and restraint are regulated, and there are requirements for information and respect for the person's rights throughout the law. It appears that, in its scope, the principles of procedural justice are supported. How this is delivered in practice may be very much dependent on other factors. The workforce implications are considerable. Many components of the legislation require psychiatrists or medical practitioners with knowledge of mental health care to perform key assessments, but Shao and Xie⁹ point out that, with only about 20,000 psychiatrists, China has a major difficulty in coverage. Many of the processes and protections in the legislation will require the presence of

both medical and legal practitioners to assist with the delivery of care as stipulated. How far these provisions are able to influence mental health care in so large and diverse a country as China will be very interesting to watch. There is much to be done in developing practice standards and guidelines to operationalize the principles established by the Law. The provisions may not be an operable health technology in the absence of practitioners and adequate resourcing of services.

Final Reflections

Has China's new law found the right balance? Only time will tell. There is often a major difference between the vision of the legal reformers and the day-to-day reality of the application of mental health law in the hands of real-world practitioners.¹³ In favor of this legislation's improving care is that the crafting of the Law has been protracted and careful, and it contains many of the features that mental health legislation requires according to international standards. It is also clearly part of a broader movement for modern and forward-looking public attitudes and responsibilities regarding the social inclusion of people with mental disorders in the People's Republic of China.

Successful mental health systems require good laws, policies, coordination, and resources (in terms of both staff and total budgets¹⁴). Developing a successful mental health system for China clearly has stepped forward with this new legislation, both as better law, and better policy. There will be many

challenges yet, and most likely a need for further refinement as it is implemented.

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