China's New Mental Health Law: Reframing Involuntary Treatment

After 27 years of often contentious debate, China's first national mental health legislation was adopted by the Standing Committee of the National People's Congress on October 26, 2012, with the law taking effect on May 1, 2013 (1). Over the coming decades, this wide-ranging law will fundamentally transform the provision of mental health services in China.

How has this law come into being? From 1985 through 1999, 10 proposed versions of the law were primarily debated in academic circles, spearheaded by the efforts of Professor Xiehe Liu (2). After 1999, the responsibility for the development of the law was taken over by the Ministry of Health. Over the next decade, several large municipalities around the country adopted their own mental health regulations (3), gaining experience that helped in the formulation of the national statute (which will now supersede local regulations). Multiple versions of the national law were debated by expert committees convened by the Ministry. The members of these committees were primarily prominent psychiatrists, public health experts, and legal experts. Other professional groups, individuals with mental illnesses, and the families of the mentally ill had little role in the formulation of the law, although they were able to make comments on the law after the draft version was released for public comment in June 2011.

Why has the law passed now? As China's underlying economic conditions and the material well-being of its citizens have improved over the past two decades, there has been a gradual increase in the perceived importance of psychological well-being and a corresponding heightened awareness of the importance of mental illness to overall public health (4). Open debate of these issues in the media have moved mental health up the political agenda. The recent passage of the mental health law is one important indicator of this ongoing trajectory. Like all laws, the content of the law reflects the current status of underlying cultural values and of the relative power of different social institutions in the country. Cultural values and institutional relationships within China are changing rapidly, but they remain quite different from those in high-income countries, so it is not surprising that there are unique components to the law and that some parts of the law take approaches different from those of statues in other countries.

One of the most significant and controversial changes in the law is the requirement that psychiatric treatment be voluntary in the majority of circumstances (3, 5). Traditionally, families in China are responsible for the care of disabled family members, so the decision about whether or not an individual was treated for a mental disorder, particularly if it involved inpatient treatment, was usually made by family members, not by the individual or by the treating psychiatrist. As more treatment services have become available for less severe forms of mental disorders, increasing numbers of individuals have voluntarily sought outpatient services without the involvement of their families; but the majority of individuals with severe mental disorders who require inpatient treatment are still involuntarily admitted by their legal guardians, who are almost always family members (6).

Changing that long-standing practice to a largely voluntary admission system will increase the burden on families, because they are legally responsible for the care and management of patients who are living in the community and bear civil liability for the patients' behavior (3). Converting to a voluntary admission system will also greatly increase the need for community-based mental health services; these services are currently quite weak in most urban communities and absent in most rural communities.

One of the major goals of the law is to shift the focus of mental health care from specialized psychiatric hospitals—most of which are situated in urban areas—to general hospitals and community health clinics. But in order to ensure that persons with mental disorders receive appropriate care, the law also dictates that only physicians with psychiatric qualifications who work in certified health facilities are permitted to diagnose and treat mental disorders. The vast majority of general physicians do not have special training and certification in psychiatry, so they must refer persons with potential mental disorders to health facilities that have psychiatrists or other physicians with psychiatric certification. Counselors cannot diagnose or treat mental disorders, and clinical psychologists (a profession not yet clearly defined by the law) can provide psychotherapy only after an individual's mental disorder has been diagnosed by a physician with psychiatric qualifications. Thus, achieving the goal of comprehensive, community-based services will require a major increase in the number of psychiatrists working in nonpsychiatric settings or, alternatively, a great expansion in the numbers of general physicians with psychiatric qualifications. This challenge, which is faced by many countries, is not specifically addressed by the new legislation.

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There are two exceptions to the principle of voluntary admission. Persons who have a "severe mental disorder" as determined by a qualified psychiatrist and who are judged to be at risk of self-harm or of harming others may be involuntarily admitted. When a person with a severe mental disorder is at risk of self-harm but not a risk to others, the individual's legal guardian must agree to involuntary inpatient treatment. But in cases where an individual with a severe mental disorder is judged a danger to others, inpatient treatment can be required even without the approval of the legal guardian. In both of these instances, the individual and the guardian are empowered to require an independent review, by two qualified psychiatrists, of the diagnosis and of the need for inpatient treatment; if they disagree with the reevaluation, they can subsequently demand a formal medical certification by a legally accredited certification agency. With the exception of forensic cases (which are regulated according to China's revised Criminal Procedures Law [7]), the process of involuntary admission is not directly supervised by a court, but patients and family members are empowered to take the case to court if they believe the required procedures have been mismanaged. China's approach may be contrasted with that of countries that provide direct judicial review of all involuntary admissions and free legal representation (8).

Unlike many other jurisdictions (8), the duration of involuntary admission in China is not specified and there are no set intervals for reevaluation, but the law requires medical facilities to reevaluate involuntarily admitted patients whenever

their clinical status changes and to discharge them if they no longer meet the criteria for involuntary admission. The law strictly limits the use of restraints and seclusion in inpatient settings and makes it illegal to require patients to participate in labor or to limit their right to communicate with the outside. Unlike statutes in some other jurisdictions (9), the law does not give involuntary patients the right to refuse psychopharmacological treatment. Moreover, there is no form of mandatory outpatient treatment specified in the law, so it is not possible to require treatment in the "least restrictive environment" (10). Nevertheless, the provisions in the law constitute major changes to the current system of involuntary admission (11), so it will probably take several years of trial and error before the intent of the law is fully realized.

The law specifically makes it illegal to use psychiatric admission as a punishment or to enforce treatment of individuals who do not have mental illnesses, and it specifies penalties for institutions and individuals who do so. However, the definitions of "severe mental illness" and "being a danger to self or to others"—the two conditions that must be met to justify involuntary treatment—remain somewhat vague, so the likelihood of a wide interpretation will remain until these definitions are clarified in subsequent regulations. Will the law silence the most ardent critics of China's "abuse of psychiatry" (12)? Probably not. But the law does bring the issues of inappropriate psychiatric hospitalization and of the legal rights of persons with mental disorders into broad daylight and makes it possible to move the debate forward.

The law also addresses several other issues that will likely have a much greater effect on the mental health of the nation than the changed criteria for involuntary treatment. Different sections of the law discuss the prevention and rehabilitation of mental disorders, the financing and management of services, the provision of social welfare services for patients and their families, and the responsibilities different agencies and community members should assume in the mental health effort. There is a clear legislative intent to expand the role of nongovernment organizations in the provision of services, to promote scientific research, and to encourage international collaboration. Some of the stated provisions are more aspirational than practical (e.g., "Family members shall be concerned about each other, create a healthy and harmonious family environment, and improve their awareness of the prevention of mental disorders"), but the law provides a clear framework for the future that can be refined by the subsequent formulation of related regulations and revised over time as experience accrues during the law's implementation.

This new law is a high-water mark for Chinese psychiatry, and potentially for global mental health. At present, the central government has both the political will and the resources available to implement many of the changes required by the law. What is uncertain is whether or not the political will and resources will be sustained over the long run and, perhaps more importantly, the extent to which local agencies—particularly those in less affluent rural areas—have the motivation and resources needed to implement the required changes. It is also unclear whether the monitoring system put in place will be sufficiently comprehensive and of sufficient quality to accurately assess the effect of the law over time and, thus, to provide the information needed to make necessary midcourse corrections. Regardless of the eventual outcome, the lessons learned as China undertakes this transformation will be of potential value to the many other low- and middle-income countries that are starting the long process of closing the gap between the high burden of mental

illnesses and the very small proportion of societal resources being used to address these complicated problems. There will also be lessons for high-income countries as China tries new ways to resolve the universal problem faced by all nations: finding the right balance between care and control.

An annotated English translation of the law is available on the web site of the *Shanghai Archives of Psychiatry* (13), a journal that is encouraging ongoing debate and discussion from both Chinese and international observers about the many different components of the law.

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