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Current Legislation on Admission of Mentally Ill Patients in China

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Abstract

Objective—To date, there is no systematic analysis of mental health laws and their implementation across the People's Republic of China. This article aims to describe and analyze current legal frameworks for voluntary and involuntary admissions of mentally ill patients in the five cities of China that currently have municipal mental health regulations.

Methods—Information on the legislation and practice of involuntary admission in the five cities was gathered and assessed using the "WHO Checklist on Mental Health Legislation." The checklist was completed for each city by a group of psychiatrists trained in mental health legislation.

Results—Although the mental health regulations in these five cities cover the basic principles needed to meet international standards of mental health legislation, some defects in the legislation remain. In particular, these regulations lack detail in specifying procedures for dealing with admission and treatment and lack oversight and review mechanisms and procedures for appeal of involuntary admission and treatment.

Conclusions—A more comprehensive and enforceable national mental health act is needed in order to ensure the rights of persons suffering mental illness in terms of admission and treatment procedures. In addition, more research is needed to understand how the current municipal regulations of mental health services in these cities are implemented in routine practice.

The psychiatric service system of China is institutionally complex. It is uncertain how many administrative systems (*Xi Tong*) have their own psychiatric facilities, but the great mass of mental health services are provide by four departments. The largest mental health service system is governed by the Ministry of Health and its local bureaus. Nationally, these public psychiatric hospitals are accessible to urban and rural citizens who have health insurance, which covers their medical costs. The second largest system is managed by local departments of the Ministry of Civil Affairs. There facilities mainly serve those who are jobless or homeless and those whose families are otherwise too poor to pay for their care. The third largest system belongs to the military. Hospitals within the military's system operate primarily for military personnel and their families. In recent years a number of these hospitals have begun providing care on a fee-for-service basis to local citizens. Finally, there is a system managed by the provincial or municipal departments of public security, called "Ankang Hospitals." These

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hospitals provide care for mentally ill criminal offenders. The level and modality of care throughout these institutions has varied greatly, and overall it is safe to say that the professional standards and level of services have not been high.

To improve mental health services within these different systems and to protect the rights of mentally ill persons, China began passing a series of mental health reform laws in 1985 (Liu, 1998). These laws have seen limited success, and there remains much room for improvement. When in 2005, 78% of countries, and 69% of the population, were covered by mental health laws, China was still no existing mental health legislation at the national level (WHO, 2005a). Three factors help account for why such improvement remains elusive. First, there still lingers a longstanding stigma against mental illness, with the popular assumption being that mentally ill persons pose a threat to the social order (Park, Xiao, & Worth, 2005). As a result, there is a long history of legislation leaning more toward the ensuring of public safety than the guaranteeing of patients' rights. This asymmetry has been exacerbated by the fact that mental health policy has traditionally not been viewed as a high priority issue. Second, mental health services have historically been unequally provisioned throughout the country, with rural areas and poorer urban areas offering fewer opportunities for care (Yip, 2006; Hu, Higgins, & Higgins, 2006). Since it is the local governments who must pay to implement services once those services are mandated at the national level, such mandates can comprise a huge burden for China's less-developed municipalities and regions. The western provinces in particular experience significant financial difficulty in meeting requirements to improve care. Third, the national government is often hesitant to take on problems that are controversial or institute programs that are perceived as being experimental. In such instances, the national government will often pass responsibility for managing the problem or testing the program down to the local level, and will then adopt a wait-and-see attitude before instituting national level legislation. This mode of mixing national level goals with local level projects is common in China, and it has characterized mental health policy for years.

One example of such mixing is Shanghai's 2002 law entitled "Shanghai Municipality Regulations on Mental Health." During the process of drafting the law, opinions from legal experts, mental health providers, representatives from patient advocacy organizations, and patients themselves were solicited, with the result being a law that was collectively drafted and supported by a number of stakeholders. Since then, several other cities – Ningbo (2006), Beijing (2007), Hangzhou (2007), and Wuxi (2007) – have used a similar methodology to draft their own local mental health laws. These cities are in a position to pave the way regarding mental health reform in large part because of their being located in coastal regions that enjoy levels of high economic development. If these cities' new laws are successful, it is likely that they will serve as models both for other cities and for the national government as well (Hu, Higgins, & Higgins, 2006).

Each of these cities' new laws focuses on protecting patients' rights to receive adequate medical treatment and services and on prohibiting discrimination on the basis of mental illness. However, it is difficult to assess the degree to which these laws are being enforced. As is the case with most of China's mental health care facilities, external review is difficult to achieve.

To promote efforts toward better internal and external review of China's national and local mental health care services, this article will describe and evaluate the legal framework and provisions within Chinese mental health legislation regarding voluntary and involuntary admissions. Given that policies governing involuntary admission constitute one of the most fundamental components of any nation's mental health care system, and given that calls for reforming China's policies regarding involuntary admission continue to be voiced, the authors hope to contribute to the discussion as to what direction policies should be steered and also

how to most effectively implement such policies without causing undue financial burdens on cities and regions ill-equipped to invest in additional medical infrastructure.[1]

This article will also review the progress that is manifested collectively in the recent efforts by the five cities mentioned above to enact their own mental health reforms. By calling attention to these cities' efforts in this article, we aim to point out those areas of the legislation that, to us, are most relevant for improving care and guaranteeing patients' rights. We also aim to point out those areas within the legislation that are still problematic.

Given that China is now in the process of using globally accepted standards in its efforts to improve mental health care, it is incumbent upon researchers and policy-makers to 1) obtain data on the state of mental health care throughout the diverse regions of the country, 2) recognize the local level legislative efforts recently undertaken, and 3) examine the effect that these legislative efforts are having. In so doing, policy-makers at the national level will be in a stronger position to take the best of each city's laws and programs and apply them throughout the country. We aim to contribute to this process by comparing key sections of the five cities' new legislation (focusing particularly on that of Shanghai, given that Shanghai was the first to draft such legislation and that the other four cities followed Shanghai's model closely in the drafting of their own legislations) with international standards. Cognate work had already done by Watchirs in Australia that using a Rights Analysis Instrument to evaluate weather mental health legislation was compliance with the UN Principles for The Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (Watchirs, 2000; 2005). In this article, we chose the WHO Checklist on Mental Health Legislation (WHO, 2005b). Because the WHO Checklist is respected around the globe as a tool for assessing any country's mental health care laws, we have endeavored to assess the degree to which these five cities' new laws uphold international standards.

Methods

Data on the legislation and practice of mental health admissions in five cities with recently-enacted mental health laws – Shangai, Ningbo, Beijing, Hangzhou, and Wuxi – were analyzed using the WHO Checklist. This checklist was designed by the World Health Organization to help countries assess whether or not key components of internationally-accepted mental health care standards have been included in local legislation. The analysis was undertaken by a group of psychiatrists who have been trained in evaluating mental health care systems. In particular, we compared the sections on admissions from the WHO Checklist with corresponding components of the five cities' new legislation so as to assess the degree to which the municipal laws aligned with WHO guidelines. Those sections focused on the following components: 1) Voluntary Admission; 2) Non-protesting Patients; 3) Involuntary Admission; 4) Oversight and Review Mechanisms; and 5) Police Responsibilities. The remainder of the paper will review each of these sections in turn.

Results

1) Voluntary Admission

According to the World Health Organization, autonomy and informed consent should form the basis of the treatment and rehabilitation of people with mental disorders (WHO, 2005b). According to the *WHO Checklist*, there are five questions that should be asked in evaluating the degree to which a law governing voluntary admissions guarantees patients' autonomy and right to informed consent:

[1]Given that procedures governing forensic psychiatry in China are regulated by criminal law and not considered part of the mental health care system proper, forensic psychiatry will not be discussed in this article.

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1. Does the law promote voluntary admission and treatment as a preferred alternative to involuntary admission and treatment?
2. Does the law state that all voluntary patients can only be treated after obtaining informed consent?
3. Does the law state that people admitted as voluntary mental health users should be cared for in a way that is equitable with patients with physical health problems?
4. Does the law state that voluntary admission and treatment also implies the right to voluntary discharge/refusal of treatment?
5. Does the law state that voluntary patients should be informed at the time of admission that they may only be denied the right to leave if they meet the conditions for involuntary care? (WHO, 2005b, p. 130).

According to our evaluation, with the exception of Hangzhou, the municipal mental health laws of the cities under consideration here have each satisfied the first four conditions. The Hangzhou laws do address conditions for involuntary hospitalization and treatment, and state that competent patients have the right to refuse admission and treatment according to his/her own will.

Sometimes patients who lack the capacity to consent are "voluntarily" admitted to a hospital simply because they do not protest against admission. The Shanghai Regulations use the phrase "competency of insight" (*Article 47: …the ability of knowing, understanding and making proper presentation of one's abnormal mental state and morbid acts"*) as the precondition for voluntary hospitalization and treatment. Other cities just prescribe the criteria for "involuntary mental health care," and in other situations stipulate the use of "voluntary hospitalization and treatment." These regulations thus reflect the view that competency to provide informed consent is an important factor in the rights of voluntary admission and treatment. But in these regulations, the determination of such competency basically depends on the perceived mental condition of the patient, particularly with regard to the patient's "insight," instead of on legal considerations or procedures. If a certified psychiatrist considers that a patient meets the criteria for "lack of insight about his/her mental state," the patient will be seen as incompetent and the rights of informed consent for admission and treatment will be transferred to a close relative or guardian of the patient. Using "insight" as a proxy in mental health review proceedings can also be found in western developed countries. Although the application of insight appears problematic in these decisions, it is used as a bridge between legal and clinical discourses (Diesfeld, 2007). Since 2003, some researchers (Pan, Xie & Bian, 2005) have developed more objective instruments for evaluating the competence of informed consent in daily practice, based on nationally and internationally accepted standards. These efforts have been considered in the draft national mental health legislation.

Other than acknowledging the importance of competence, the legislation of these cities does not prescribe detailed procedures for voluntary admission, only providing "the rights of free discharge from mental hospital" for voluntary patients.

2. Non-protesting patients

The WHO checklist suggests that provisions be made for patients who are incapable of making informed decisions about admission or treatment but who do not refuse admission or treatment. These patients are referred to as "non-protesting patients." The reasons for WHO's establishing "non-protesting patients" as a separate category is to account for those patients who are in an in-between space: their condition renders them incapable of consenting to voluntary treatment, yet their willingness to be treated obviates the need for an "involuntarily" admission. The "non-protesting patient" status allows patients to obtain much-needed treatment without their

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obtaining an involuntary admission on their clinical (and perhaps legal) record (Freeman & Pathare 2005: 45-46).

Although as noted above, there are patients who fall into this category, there are no provisions in China's legislation for "non-protesting patients." If some one is incapable of giving consent because of mental illness, it will be a close relative's or a guardian's responsibility to apply for mental health care, whether the patient agrees to treatment or not. Such hospitalization is classified as "medical protection hospitalization," one of forms of involuntary admissions and treatments in a broad sense. The neglect of the 'non-protesting' patients, for example, the 'Bournewood Gap' in the U.K (the absence of clear legal safeguards for informal patients lacking capacity to consent) has meant that many other patients have received treatment without the presence of formal checks (Larkin, Clifton, & Visse, 2009).

3. Involuntary admission

In the WHO checklist, the criteria for involuntary admission and treatment include: 1) evidence of a mental disorder of specified severity; 2) serious likelihood of doing harm to self or others and/or substantial likelihood of serious deterioration in the patient's condition if treatment is not given; 3) admission is for a therapeutic purpose.

In China, a basic form of involuntary admission is called "medical protection hospitalization." Such hospitalization requires a specific and confirmed mental disorder diagnosed according to China's diagnostic system (CCMD-3) or diagnostic criteria adopted internationally (ICD-10).

The Chinese regulations do not specify harm to self or other or likelihood of serious deterioration in the patient's condition, or admission for a therapeutic purpose, as necessary for this category of involuntary admission. However, additional criteria for involuntary hospitalization are provided, which vary in the five cities. Shanghai's guidelines stipulate that patients must have *"totally or partially lost competence or the capacity for insight (the ability to know, understand and make a proper assessment of ones abnormal mental state and morbid behavior"*). Beijing's and Wuxi's guidelines stipulate that patients demonstrate *"grave impairment in mental activities such that ones state of being or external reality cannot be fully identified or that ones behavior cannot be controlled."* Hangzhou's and Ningbo's guidelines stipulate that a patient "cannot recognize, evaluate, or control his/her own behavior." Thus, all five cities use "lack of insight," "impairment of judgment," or comparable language as additional criteria required for the determination of a "medical protection hospitalization."

Other criteria enumerated in the five cities' new laws include the following. 1) Involuntary admission requires clinicians with an "accredited mental health care practitioners certificate"; 2) Only an accredited facility can admit patients involuntarily; 3) The principle of the least restrictive environment must apply to involuntary admissions; 4) Patients, families and legal representatives are required to be informed of the reasons for admission and of their rights of appeal; 5) There exists the rights to appeal an involuntary admission; 6) Patients must be discharged from involuntary admission as soon as they no longer fulfill criteria for involuntary admission.

In the procedure specified for a "Medical Protection Hospitalization," a certified psychiatrist's duty is only to advise that the patient be admitted; the patient's family member or guardian has the right to decide whether accept the advice or not, and when to finish or withdraw from the hospitalization and treatment. Such kind of practice is very similar with the laws in Japan (Nakatani, 2000). For example, the Shanghai regulations state:

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> Article 30: A certified psychiatrist with the title of Attending Physician or higher and who consider that a person is suffering from a mental disorder and is totally or partially without insight and should be hospitalized shall put forward the medical proposal of hospitalization for medical protection. The guardians of the person with the mental disorder shall go through hospitalization procedures on behalf of or in assistance to such person.
>
> Medical institutions shall make diagnostic checks as required for persons with mental disorders hospitalized for medical protection.

Several items on the WHO checklist are not covered by most of the five cities' regulations. These include: 1) the existence of an independent authority to authorize all involuntary admissions; 2) speedy time frames lay down within which the independent authority must make a decision; and 3) time-bound periodic reviews of admission by an independent authority (WHO 2005, p. 133). The one exception is Shanghai, whose regulations do stipulate periodic review. Article 32 states that *"Medical institutions shall make appraisals of mental state at least once every month for mental inpatients."* These regulations do not describe a formal procedure for a patient to be reclassified from involuntary to voluntary admission. Involuntary admission and involuntary treatment are not distinguished. Thus, once patients are admitted involuntarily, they may be treated involuntarily without having to undertake a separate procedure for sanctioning treatment.

4. Emergency Situations

According to the WHO checklist, emergency admission and treatment should be limited to situations in which there is a high probability of immediate and imminent harm to self and/or others (WHO 2005, p. 136). All of the five cities' regulations use such criterion. For example, Shanghai's legislation allows emergency admission for *"persons with mental disorders or possible mental disorders who have conducted acts of self-injury, have hurt others, or have behaved in a way dangerous to the public."* (Article 31)

The WHO checklist also recommends: 1) a clear procedure for admission and treatment in emergency situations; 2) that only qualified and accredited medical or mental health practitioners should admit and treat emergency cases; and 3) that procedures for involuntary admission and treatment are initiated, if needed, as soon as possible after the emergency situation has ended. All the five cities have covered these. For example, the Shanghai regulations state:

> "Article 31. If persons with mental disorders or possible with mental disorders have conducted acts of self-injury, hurt others or have dangerous behavior to the public, their guardians, next of kin, …… or the police at the scene should send them to a mental health medical institution.
>
> With the diagnosis made by at least two certified psychiatrists, one of whom has the technical title of Attending Physician, and with the two considering hospitalization necessary for observation, mental health medical institutions shall exercise emergency hospitalization observation of the persons with mental disorders or possible mental disorders, and notify their guardians or next of kin at the same time. Mental health medical institutions shall make a diagnostic conclusion within 72 hours after carrying out emergency hospitalization observation."

In most cities, the application for emergency admission will be only made by police and/or the patient's family member or guardian. Other people or organizations can only report to the police that there is an emergency in process. But in Shanghai's case, the procedure also can be started by *"guardians, next of kin, affiliated units, Neighborhood Committees or Villager's Committees where they reside, or the public security department at the scene."* (Article 31)

The level of training/certification required to order an emergency admission is higher than that required to recommend a "medical protection hospitalization." Additionally, in most cities, whereas only a single psychiatrist can recommend a "medical protection hospitalization," two psychiatrists at the "attending" level or above are needed to order an emergency admission. (Shanghai differs from this by requiring that only one of the two psychiatrists be at the attending level or above.)

Most cities' regulations do not specify a time limit for an emergency admission. Although all cities require thorough assessments by psychiatrists as soon as a patient is admitted, only Shanghai states that this assessment should be conducted within 72 hours. If such people are found not to be suffering from a mental disorder, they should be released within those 72 hours.

Another area of concern is that there are in all cities' regulations inadequate provisions governing the kinds of therapy that can and cannot be used in emergency hospitalizations. However, each city does have provisions prohibiting the use of psychosurgery, experimental procedures, or participation in clinical trials unless the family gives additional written consent concerning the procedure or trial in question. For example, it is stated in Article 23 of the Shanghai regulations that:

> When there is a need to conduct psychosurgery on persons with mental disorders for treatment, medical institutions shall organize the consultation of at least three certified psychiatrists with technical title of Chief Physician, notify the persons with mental disorders or their guardians of the consequences that the surgical treatment may bring about, and obtain the written consent of such persons themselves or their guardians.

The mandatory notification of relatives or other persons in case of a compulsory admission is a basic civil right guaranteed in each city's regulations. In all five cities, notification is a mandatory part of the admissions procedure. But the cities do not stipulate that patients and/or their family members have the right to appeal the emergency admission. This kind of litigation is usually undertaken on the basis of national legislation, the Regulation on Handling Medical Malpractice.

5. Oversight and Review Mechanisms

In order to reduce the discretion of physicians and limit medical paternalism, many countries have enacted laws transferring the authority to order an involuntary admission from physicians to non-medical authorities (Dressing, & Salize, 2004). However, in China, this shift has not been implemented. Officially, the psychiatrist's role is limited to providing medical recommendations, and the ultimate decision is left to family members (under the "medical protection hospitalization" protocol) or to the police (under the "emergency hospitalization" protocol).

The mental health regulations of most of these cities do not mention clearly how to set up an independent oversight and review mechanisms for involuntary hospitalization or treatment. Only the Shanghai regulations state that *"Persons with mental disorders or their guardians, who doubt the conclusions of diagnostic reviews or the conclusions of the diagnostic consultation of certified psychiatrists, may apply for evaluation to the Municipal Expert Committee of Forensic Psychiatric Expertise."* Nonetheless, patients and their family members can appeal involuntary admission and treatment directly to the local health bureau or to the court, according to the Regulations on Handling Medical Malpractices, requesting negotiation, mediation, or even civil litigation (Harris, & Wu, 2005).

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6. Police Responsibilities

According to the WHO checklist, laws governing the police's role in mental health admissions should include the following: 1) place restrictions on the activities of the police to ensure that person with mental disorders are protected against unlawful arrest and detention, and are directed towards the appropriate health care services; 2) allow family members, carers or health professionals to obtain police assistance in situations where a patient is highly aggressive or is showing out-of-control behavior; 3) require that persons arrested for criminal acts, and in police custody, be promptly assessed for mental disorder if there is suspicion of mental disorder; 4) make provision for the police to assist in taking a person to a mental health facility who has been involuntarily admitted to the facility; and 5) make provision for the police to find an involuntarily committed person who has absconded and return him/her to the mental health facility (WHO, p. 146-147).

In China, forensic evaluation of persons arrested for criminal acts and of those in police custody is regulated through the Criminal Procedure Law. In the five Chinese cities, the responsibility of police is restricted only to "emergency hospitalization" procedures. In other situations, police may become involved only when the patient's family member or guardian or the hospital request help. For example, the Shanghai regulations include the following:

> Article 20. Guardians bearing medical protection duty have the right to ask the public security department for help.
>
> Article 34. Not knowing the whereabouts of the person with mental disorder, the medical institution shall report to the local public security department within 24 hours.
>
> ……the public security department, when finding the person with mental disorder who absconded from hospital, shall notify the medical institution where the person with mental disorder is hospitalized, and help to send him/her back.

All of these cities' regulations discuss the role of the judiciary in providing counseling to those in prison. For example, *"Judiciary administrative departments shall create conditions to provide mental health counseling services to the persons serving their terms in prison" (Shanghai Regulation Article 13).*

Discussion

Our overall findings are that the legal regulations on detaining mentally ill persons are similar in the five cities of China and in general these laws do adhere to international standards. These regulations emphasize voluntary hospitalization and treatment as the first-line treatment; they require informed consent from the patient or the family member or guardian; and they restrict the use of involuntary treatment. Thus, these regulations basically cover the principals in the WHO Guidelines for the Promotion of Human Rights of Persons with Mental Disorders (WHO, 1996), the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (UN, 1991), and the UN Convention on the Rights of Persons with Disabilities (UN, 2006). But since patterns of hospitalization are affected by a society's social policies and by cultural and attitudinal characteristics of a particular society, not only by the clinical status of the patients (Bauer, Rosca, & Grinshpoon, et al., 2007), these social and cultural characteristics can also be seen as manifest in the mental health legislation in China.

In the past, voluntary hospitalization and treatment of persons with mental illness was not the norm. According to a national survey covering 17 cities of China in 2002 (Pan, Xie, & Zheng, 2003), the proportion of voluntary hospitalization in mental health hospitals was only 18.5%. The low rate of voluntary hospitalization stemmed not only from a lack of legislative support but also from a longstanding hesitancy, borne of stigma, for family members and guardians to grant psychiatric patients the right of informed consent. According to a recent survey by Li,

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Liu and Ma (2006), 60.8% of schizophrenia patients were sent to hospital by their guardians without those patients being informed beforehand. This also reflects a broad pattern of giving far more priority to the role of the family in making decisions about the mentally ill in China, in contrast to societies that give more priority to the autonomy of the individual patient.

By emphasizing voluntary hospitalization and treatment as the preferred choice and by restricting the criteria for involuntary care, these cities' new regulations have had a positive impact on the standardization of psychiatric admissions procedures and on increasing the level of respect for the autonomy of patients. Traditionally, hospitals had the right to take patients from their homes and forcibly admit them merely at the request of the patients' relatives. Though this kind of practice can indeed help some patients get much-needed treatment promptly, it has the potential for doing harm. Sometimes people who did not meet the criteria for involuntary admission were taken into hospital unjustly. But as a result of these five cities instituting reforms, admissions procedures in those jurisdictions have become more standardized, informed consent has become legally-mandated, and as a result many of the "traditional" habits governing hospitalization have been prohibited.

Although there are some minor differences in the criteria for "medical protection hospitalization" in the five cities, each of the guidelines for this mode of admission agrees on the need to determine that 1) the person's judgment has been impaired because of mental illness, and that 2) the person needs medical treatment. These are in line with internationally-endorsed principles for involuntary admission and treatment (UN, 1991).

These criteria are less stringent than the "danger to self or others" criterion required for an "emergency hospitalization" admission. When this risk of posing danger to self or others is not present, involuntary treatment in the best interest of patients' health is controversial in Europe. It is possible under English legislation, but in Germany it would depend on the patients' inability to give informed consent, and in Austria it would not be possible (Zinkler, & Priebe, 2002). Under the regulations of each of the five cities under consideration here, this type of admission, i.e., involuntary treatment in the best interest of the patient's health but without the requirement of posing a danger to self or others, is allowed. The Chinese criteria for "medical protection hospitalization" make it possible for patients who are unable to give informed consent, but who require treatment and admission for their (mental) health, to receive necessary care even if they are not a safety risk to themselves or others. At the same time, the stricter procedures required for "emergency hospitalization" can protect patients from being forced into the hospital without clear indications.

One issue deserving clarification is that concerning the range of parties allowed to take part in the "emergency hospitalization" admissions procedure. The Shanghai regulations allow the "guardians, next of kin, affiliated units, Neighborhood Committees or Villager's Committees where they reside" to take part in "emergency hospitalization." This is because in this city, all of these have been actively involved in the "Three-tiered Community Based Prevention Program." For many years, the patient's workplace, Neighborhood Committees, and Villager's Committees played an important role in a patient's community rehabilitation project. In cases in which a person has no close relatives or guardian, these organizations served as a guardian (Zhang, Yan, & Phillips, 1994). This kind of system served a useful purpose in the past. It helped those mentally ill patients without caregivers get help. However, with the economic and social changes in China today, this kind of system is not as effective as before.

We have indicated that involuntary hospitalization includes involuntary treatment. This does not imply, however, that the patient and family members play no role in the treatment plan. According to these cities' regulations, persons with mental disorders and/or their guardians have the right to know the state of the illness, the diagnosis, the treatment plans, and the possible

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consequences of treatment. Furthermore, some special procedures and therapies, such as ECT, require additional informed consent.

Involuntary outpatient treatment as a follow-up to an involuntary inpatient episode is considered by some to enhance the continuity of treatment as well as public safety. However, there is still not enough scientific evidence for the efficacy of coercive outpatient treatment to recommend this policy (Steadman, Grounis, & Dennis, 2001; Swartz, Swanson, & Hiday, 2001). Even in the European Union, only five Member States include an option for this modality in their laws (Dressing, & Salize, 2004). In China, because of the underdevelopment of community-based mental health services, involuntary community treatment would require some time to be implemented. The regulations in these five cities all include articles promoting community-based rehabilitation and occupational therapies and training. Although Chinese mental health policy is increasingly emphasizing community-based care over institutionalized care, the actual development of community services in nearly all of China is still in the initial stage of development.

Chinese mental health policy, as elsewhere in East Asia, gives strong primacy to the family of a patient. Accordingly, Chinese mental health regulations allow family members, rather than third parties, to take on the responsibility of protecting patients' rights and offering consent for admission and treatment when necessary. Traditionally, the Chinese family has been at the base of all social support networks; this remains largely true today. The main responsibility for seeking health services, providing support and care to a person who is diabled, and paying for health care for those who are mentally or physically ill rests with the family (Hu, Higgins, & Higgins, 2006). Thus, it is often not the individual who is consulted about his admission, but his or her family (Pearson, 1992). The family often takes primacy over an individual patient's autonomy in medical ethics and in mental health policy and procedures. Thus, the consent of patients themselves has only become a serious issue recently.

In China, a person's "guardian" is determined by procedures indicated in the "General Provisions of Civil Law of the People's Republic of China." The provisions stipulate that the guardian is usually the spouse, parent, son/heir, or sibling. Generally the determination as to which of those individuals becomes the guardian is based on an informal negotiations among family members. If the family members cannot come to an agreement, then a representative from the Neighborhood Committee or Villager's Committee will mediate. In case a determination still cannot be made, the court may become involved. Since there may be a conflict of interest between family members and the patient, all the five cities instituted regulations stating that family members or guardians "causing damage to persons with mental disorders shall bear civil liability according to law" as a safeguard.

These regulations also do not direct other non-medical authorities to play a role in involuntary admission and treatment. While some have argued that limiting physicians' discretion is a means to reduce the frequency of involuntary admissions (Hoyer, 2000), others have found that compulsory admission rates or quotas are not significantly lower in countries with non-medical authorities deciding on compulsory admission (Dressing, & Salize, 2004).

Our review of the mental health legislation in the five cities of China indicates that the lack of detailed procedures regarding the implementation of admission and treatment remains an important shortcoming. Although the policies stipulate that patients should be given the reasons for their confinement, explicit guidelines on precisely how the cause for confinement is to be communicated, how to get informed consent, how to appeal an admissions or treatment decision, as well as mechanisms for getting legal representation involved in the process of admission or appeal, are not included in the legislation. As a result, the articles of these legislations articles read more like general statements of goals or principles than procedures

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to be operationalized or mandates which can be enforced. The lack of specificity in these articles will allow the aim of protecting patients' rights to remain more at the level of theory than practice. Thus, we suggest that more detailed operational guidelines for mental health care in these cities should be developed.

Another shortcoming our research has identified is the lack of oversight and review mechanisms regarding the appeal of involuntary admissions and treatment. Although a patient can appeal to the public health authorities or the courts according to the Regulation on the Handling of Medical Malpractice (State Council, 2002), there are still no mechanisms – aside from malpractice claims – for ensuring that hospitals abide by the new regulations. Thus, the draft of National Mental Health Law mandates setting up an independent ethical committee to review ethical and procedural issues related to involuntary admission or treatment and other violations of patients' human rights. It mandates that such a committee should be composed of at least one legal practitioner, a health care practitioner, and representatives of the patient's family.

Many of the shortcomings of the mental health regulations in the five cities we have reviewed reflect a longstanding bias which prioritizes the patient's right to receive treatment over the patient's rights and autonomy. This has been a source of criticism of Chinese mental health policy. Current drafts of the National Mental Health Law recognize this and place new emphasis on patient rights.

Although so many defects exist in these legislations, what we want to argue is that there has been progress at the level of legislation; and by highlighting this progress, we hope to encourage wider, national level, legislative reforms as well as increased efforts to actually bring the new legislation from formality to reality. We are not naive enough to believe that legislation alone is the answer. Many good laws go unenforced. But in the case of China at least, we consider that the formalization of reform in municipal legislation marks a very positive step in the wider effort to improve mental health care, and it is for this reason that we feel it important to call attention to the praiseworthy components of the new municipal laws, as well as call attention to those areas that, in our opinion, warrant further review.

Conclusions

Mental health legislation continues to progress in China. However, much remains to be done. National mental health legislation should be more comprehensive and specify procedures for directly, with the overall goal of strengthening the protection of patients' rights, especially as they relate to admissions and treatment procedures. Continued research on the influence of recently-enacted municipal regulations on mental health services in different cities, in particular of how these policies are actually put into practice, may contribute to the development of a more effective national mental health policy for China.

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