Shanghai Archives of Psychiatry, 2012, Vol.24, No.1

• Forum •

Service availability, compulsion, and compulsory hospitalisation

Graham MELLSOP[1]*, Kate DIESFELD[2]

Legislation sometimes leads to social change, but more often it formalises evolutions in existing community views. China's draft Mental Health Act appears to have both elements. While the draft Act (the Act) has a significant emphasis on patients' rights, it also aims to improve and increase services for people who are mentally unwell in China.

Overall, the Act stresses the importance of improving the general environment so that people with mental illness obtain support and care. One of the Act's greatest strengths may be its aspirational value, aiming to influence attitudinal change and reduce discrimination. The Act's reach is broad, calling for the active participation of government agencies, local communities, educational institutions and employers in the promotion of mental health. Its primary goals also include the prevention and treatment of mental disorders, legislating the standardisation of services throughout the country. The government has the lead role in providing services and every relevant government department is required to fulfil its own specific responsibilities. Also, the Act includes specific civil and criminal penalties for non-compliance by individuals and relevant agencies. In this it is consistent in several ways with current international thinking[1].

The human rights orientation is apparent in many sections. Patients' rights specified within the Act include the right to dignity, safety, education, employment, medical services, privacy, assistance from the government, and support from society at large. More specifically, individual community members are required by the Act to respect, understand, and care for individuals with mental disorders. Furthermore, the Act stipulates that individuals shall not discriminate, insult or torture mentally ill individuals and that no one shall illegally limit the freedom of mentally ill individuals. After the legislation is enacted and implemented, clarification of these concepts and methods for applying these principles in daily life will emerge over time. Nevertheless, at this stage, it is apparent that China is committed to establishing a range of legal protections for people with mental illness.

China's Act appears to incorporate recent and evolving commitment to the engagement of patients in their health care decisions. In the last decade the term "recovery" has increasingly been referenced in the international mental health literature[2,3]. Historically, "recovery" in the broad health context meant clinical improvement and restoration of health. The present notion of "recovery" acknowledges that some people who are mentally unwell may not achieve a complete "cure", due to the chronicity of their illness or its sequelae. However, "recovery" acknowledges that people should be supported to the greatest extent possible to pursue their goals, given the limitations of their illness[2,4].

This recovery model has been described as a "blueprint for living well in the presence or absence of one's mental illness"[4]. It is founded on the principle that mental health law and mental health services should reflect the priorities identified by those who are subject to them. The recovery model emphasises the importance of hope, combined with personal and social responsibility, thereby acknowledging that people need to be actively involved in the process of their recovery. Also, the recovery philosophy promotes maximising individuals' rights and autonomy, to the greatest extent possible. Rather than championing total patient autonomy, it implies that degrees of autonomy exist. It is usually in the patients' interests to take as much responsibility as possible, which will in turn assist the therapeutic efforts of clinicians and supporters.

The recovery model has influenced mental health policy and practice in several countries. For example, since 1998 all mental health services in New Zealand have been required by government policy to use a recovery approach[4] and mental health professionals are expected to demonstrate competence in the recovery model. It highlights the importance of taking patients' views about their illness seriously, even about

doi: 10.3969/j.issn.1002-0829.2012.01.008

[1] Waikato Clinical School, University of Auckland, New Zealand

[2] Te Piringa-Faculty of Law, University of Waikato, Hamilton, New Zealand

* Correspondence: graham.mellsop@waikatodhb.health.nz

such central concepts as how to handle clinician-patient discussions of diagnosis[5,6].

The above analysis provides a context for our comments on the viewpoint of Professor Xie[7] who has expressed a number of concerns regarding the draft Act, including a concern that it may lead to less access to care for people with mental illness. For example, the Act will not allow family members to initiate or supervise involuntary admission of non-violent patients (currently at least 60% of psychiatric admissions in China are of this type) and there will be new obstacles to involuntary hospitalization (such as the right to a second or third opinion). Professor Xie predicts that less access to inpatient care combined with the very limited community-based services for the mentally ill will result in several undesirable consequences including increasing the burden on, and potential risk to, patients' family members.

Firstly, it appears to us that the Act expects family members to continue to have an important role in admission and treatment decisions even though, following current international practice[1], they will no longer make the ultimate decision about whether or not the patient will be involuntarily admitted. The Act places significant responsibilities upon family members and guardians; they are expected to bring family members with a mental illness to a medical facility for diagnosis and treatment, to provide information and opinions during the evaluation and registration of the patient, and to be informed about the patient's diagnosis and treatment.

Professor Xie's concerns regarding the limited community-based services are appropriate and consistent with the modern recovery philosophy that is predicated on an environment where a wide range of community mental health services are available[2]. To address this situation, the Act actively promotes the goal of increasing community-based services in China, although with a surprising emphasis on service provision by non-governmental organisations which may or may not be feasible. While it would be preferable for any compulsory treatment act to prioritise compulsory community-based treatment, most countries only adopted such provisions after some years of legislation focused on compulsory inpatient treatment, so it would probably be a premature step in China to initiate compulsory community-based treatment, particularly in the absence of a strong community-based service system. Perhaps the proposed legislation does not address compulsory community-care because the drafters envisioned a staged process of reform.

Thirdly, Professor Xie discusses the relatively low ratio of inpatient psychiatric beds to population in China. He anticipates that some people will not receive needed inpatient treatment due to the proposed reforms. However, given the limited beds available it would appear that there will always be sufficient demand to fill psychiatric hospitals. If some patients do not get involuntarily admitted due to the new legislation, it is likely that there will still be many others who would use the services voluntarily. So the Act is unlikely to reduce the total amount of mental health care delivered. With a focus on voluntary admissions the types of persons who receive inpatient care may change but the mental health care that is delivered will be delivered in a fashion that is more consistent with patients' rights and, thus, over time patients' and family members' respect and confidence in the mental health services should improve.

We believe that the aspirations of the Act, and many features of the reforms encoded in the Act, are very progressive. Coupled with increased access to community-based services and appropriate protections for patients' rights, we share the hope of Professor Xie that this new Act is "going to be a blessing" and believe that the negative outcomes he fears can be minimized or avoided altogether.

References

1. Mellsop G, Diesfeld K. Legal frameworks for compulsory treatment. Shanghai Arch Psychiatry, 2011, 23(1):53-54.
2. Schrank B, Slade M. Recovery in psychiatry. Psychiatr Bull R Coll Psychiatr, 2007, 31: 321-325.
3. Meehan TJ, King RJ, Beavis PH, Robinson JD. Recovery-based practice: do we know what we mean or mean what we know? Aust N Z J Psychiatry, 2008, 42(3): 177-182.
4. Mental Health Commission. Recovery competencies for New Zealand mental health workers. http://www.mhc.govt.nz/publications/recovery-competencies-new-zealand-mental-health-workers-0. [Accessed 01 January, 2012]
5. Moeke-Maxwell T, Wells D, Mellsop GW. Tangata whaiora/consumers' perspectives on current psychiatric classification systems. Int J Ment Health Syst, 2008, 2(1):7.
6. Mellsop GW, Clapham-Howard F. Meeting the needs and expectations of those we serve: how psychiatric diagnosis and formulation go hand-in-hand. Asian Pacific Psychiatry, 2011, 3:173-179.
7. Xie B. Where is the path to recovery when psychiatric hospitalization becomes too difficult? Shanghai Arch Psychiatry, 2012, 24(1): 38-40.