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·Review·

Involuntary admission and treatment of patients with mental disorder

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Despite the efforts of the World Health Organization to internationally standardize strategies for mental-health care delivery, the rules and regulations for involuntary admission and treatment of patients with mental disorder still differ markedly across countries. This review was undertaken to describe the regulations and mental-health laws from diverse countries and districts of Europe (UK, Austria, Denmark, France, Germany, Italy, Ireland, and Norway), the Americas (Canada, USA, and Brazil), Australasia (Australia and New Zealand), and Asia (Japan and China). We outline the criteria and procedures for involuntary admission to psychiatric hospitals and to community services, illustrate the key features of laws related to these issues, and discuss their implications for contemporary psychiatric practice. This review may help to standardize the introduction of legislation that allows involuntary admission and treatment of patients with mental disorders in the mainland of China, and contribute to improved mental-health care. In this review, involuntary admission or treatment does not include the placement of mentally-ill offenders, or any other aspect of forensic psychiatry.

Keywords: involuntary admission; involuntary treatment; mental-health legislation; compulsory admission; commitment criteria

Introduction

From an ethical perspective, the involuntary admission and treatment of patients with mental disorders are often discussed from the perspective of personal liberty. However, influenced by an increasing emphasis on individual rights, the autonomy of patients with mental disorders has been growing in importance. This viewpoint may undermine the original purpose of involuntary admission and treatment, which is to provide adequate mental-health care to those individuals whose mental disorders interfere with their rational ability to consent or decline treatment. The United Nations Convention on the Rights of Persons with Disabilities adds a new perspective on non-discrimination and equality. Given this context, the legal framework for involuntary admission and treatment, and/or commitment laws pertaining to persons with mental disorder has been reformed in many countries[1, 2].

Involuntary admission and treatment generally have been accepted as a necessary measure to protect patients, others, and society. However, it remains a controversial and complex ethical and legal issue, and sometimes it is difficult to balance the rights of patients with the rights of the public. A number of international human rights documents are available to provide context and guidance. These include the Principles for the Protection of Persons with Mental Illness (or MI Principles, 1991), the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950), The Declaration of Hawaii

(1983), and the Ten Basic Principles for Mental Health Law published by the World Health Organization (WHO)[3]. Many countries also stipulate a number of relevant provisions for involuntary admission and treatment that govern their national or regional mental-health care systems. The principles and procedures of involuntary admission and treatment vary among countries because of different cultures, traditions, economies, and human resources.

Criteria for Involuntary Admission

The formulation of a clear criterion for involuntary admission or treatment is a complex and cumbersome process. According to the checklist for Involuntary Admission and Treatment developed by the WHO, the criteria for detention in most countries include similar conditions: the patient must be suffering from a severe mental disorder; and compulsory treatment is necessary in the interest of the patient's health or safety, or the protection of other persons. However, these criteria are not included in all legal frameworks (Table 1).

It is worth noting that there is a difference in procedures for involuntary placement in France: the need for treatment criteria being present only in the HDT (Hospitalisation à la Demande d'un Tiers) procedure, but not in the HO (Hospitalisation d'Office) procedure[2]. According to Norwegian legislation (the Mental Health Care act of 1999 and its precursors), involuntary admission of a patient may be conducted when a patient who suffers from a psychotic disorder is a danger to himself/herself or others and/or there is a need to admit the patient to ensure that he or she receives necessary treatment. Paragraph 5 of the Danish law concerning the involuntary criteria stipulates that besides being psychotic, a patient has to be either dangerous to himself/herself or others or have a prospect of recovery if treated involuntarily.

Presence of A Mental Disorder

The basic requirement in all countries is that the patient

Table 1. Criteria or conditions for involuntary admission

Region	Country/District	Mental disorder +Danger	Mental disorder +Need for treatment	Mental disorder +Danger/mental disorder+Need for treatment	Mental disorder +Danger+Need for treatment
Europe	UK			Yes	
	Austria	Yes			
	Denmark			Yes	
	France	Yes			
	Germany	Yes			
	Italy		Yes		
	Ireland			Yes	
	Norway				Yes
Americas	Canada				Yes
	USA	Yes			
	Brazil			Yes	
Australasia	Australia			Yes	
	New Zealand			Yes	
Asia	Japan	Yes			
	The mainland of China	Yes			
	Taiwan region				Yes
	Hong Kong Special Administrative Region			Yes	

suffers from a mental disorder[4-6], but the type and severity of mental disorder that qualify a person for involuntary admission vary across jurisdictions. Some countries allow involuntary admission only for "severe mental disorder (illness)"; others stipulate specific mental disorders, such as "psychotic illness"; while the remaining countries use a broader definition of mental disorder. Thus, despite the availability of detailed international classification systems (e.g., the ICD-10 or DSM-5), the definition of "mental disorder" varies across jurisdictions. A specific ICD-10 diagnosis is rarely required, but words that cover a variety of psychiatric phenomena, mostly related to the broad concept of psychosis, are used. Whether the criteria should include mental retardation, substance abuse, or personality disorders is often contentious[7].

As described in Table 2, the 2007 Mental Health Act of the UK defines mental disorder as “any disorder or disability of the mind”. However, the Royal College of Psychiatrists of the UK has opposed having a personality disorder, in and of itself, as a criterion for involuntary admission, largely because of the unresponsiveness to available treatments. The laws of Austria, Germany, and the UK use broad concepts, but mental deficiency without psychotic symptoms, noncompliance, substance abuse, sexual promiscuity, and sexual psychological disorders are excluded from the criteria[8]. In Norway, the term "serious mental disorder", as stipulated by the Supreme Court's interpretation, includes active psychosis or deviant states of mental deficiency where the reduction in functioning is as substantial as that seen in psychosis.

In Canada, a “person with a mental disorder” means a person who has a disorder of the mind that requires treatment and seriously impairs the person’s ability to react appropriately to their environment, or to associate with others. For example, in British Columbia, involuntary admission and treatment require that the person has a disorder of the mind that causes serious impairment of the person’s ability to react appropriately to their environment, and requires care, supervision, and control in, or by, a designated facility to prevent substantial mental or physical deterioration, or for the protection of the person or others. In the Mental Health Act amendment of 1998, mental retardation was removed from the definition of mental disorder. In the USA, the state must prove that the person

Table 2. Psychiatric diagnoses for involuntary admission

Region	Country/District	Definition of psychiatric/medical diagnosis
Europe	UK	Any disorder or disability of the mind
	Austria	Not defined
	Denmark	Psychosis
	France	Not defined
	Germany	Wide diagnostic criteria
	Italy	Not defined
	Ireland	Mental illness, severe dementia, significant intellectual disability
	Norway	Serious mental disorder
Americas	Canada	Mental disorder
	USA	Not defined
	Brazil	Not defined
Australasia	Australia	Wide diagnostic or serious mental disorder
	New Zealand	Severe mental disorder
Asia	Japan	Not defined
	The mainland of China	Severe mental disorder
	Taiwan region	Severely ill
	Hong Kong Special Administrative Region	Not defined

suffers from a mental illness or disorder, which is often defined as a substantial disorder of emotional processes, thought, or cognition that grossly impairs judgment, behavior, or the capacity to recognize reality. Detention or involuntary commitment might be permitted for persons with any kind of mental retardation, epilepsy, alcoholism, or harmful drug addiction.

In Australia, involuntary inpatient treatment requires the presence of a mental illness/disorder as defined in the relevant state legislation. There are state differences in the name, specificity, severity, consequences of symptoms, and exclusions. Most Australian jurisdictions use the term "mental illness". In the majority of jurisdictions the definitions of the terms are detailed and similar to that of New South Wales where mental illness is a "condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterized by the presence of (a) delusions; (b) hallucinations; (c) serious disorder of thought form; (d) a severe disturbance of mood; (e) sustained or repeated irrational behavior indicating the presence of any one or more of the above… symptoms "(according to the Mental Health Act 2007, S.4). Some South Australian jurisdictions use the term "serious mental disorder". In New Zealand, Section 2 of the Mental Health (Compulsory Assessment and Treatment) Act (1992) defines mental disorder as "an abnormal state of mind (whether of continuous or intermittent nature)" characterized by delusions or disorders of mood, perception, volition, or cognition. The criteria appear to exclude persons with only a personality disorder[9].

Japan's Mental Health and Welfare Law (1995) and Hong Kong's Mental Health (Amendment) Ordinance (1997) do not define specified diagnostic categories for involuntary admission. In Hong Kong Special Administrative Region, the "mentally incapacitated person (MIP) who does not demonstrate mental illness plus abnormally aggressive or seriously irresponsible conduct cannot be detained in a mental hospital or correctional services department (CSD) psychiatric centre"[10].

In the mainland of China, a "severe mental disorder" requires severe symptoms that result in serious impairments in social adaptation (or other types of functioning) and awareness of objective reality or of one's medical condition, or result in an inability to deal with one's own affairs[11]. In the Taiwan region, only those persons whose disoriented and unusual thoughts and behavior render them unable to manage their own affairs, or who are clearly likely to injure others or themselves, can be subjects of involuntary admission. Also included in the class of severely ill are those who, due to disoriented and unusual thought and behavior, have actually injured others or themselves

Serious Likelihood of Immediate or Imminent Danger

Generally, preventing harm to oneself or to others is an important requirement of mental-health legislation[3]. The "dangerousness criterion" (threatened or actual danger to oneself or to others) is the most common additional criterion, while in some laws it is the only criterion justifying or permitting someone to be treated involuntarily[12]. However, this is not an essential prerequisite in all the jurisdictions reviewed here. Table 3 summarizes the diversity of dangerousness criteria for involuntary admission to mental-health care.

The dangerousness criteria are sufficient on its own for involuntary admission in Finland, Greece, Ireland, Portugal, and the UK, though it is not the only essential prerequisite in the UK, Denmark, Ireland, Australia, New Zealand, or Hong Kong Special Administrative Region. In the above countries or regions, the need for treatment is stipulated as an alternative criterion. And in Italy, Spain and Sweden, danger to oneself or to others is not considered as a criterion. In addition, in some countries such as Iceland, Portugal, and Spain, a lack of insight by the patient is a requirement[12].

In some Canadian jurisdictions, the dangerousness criterion is offered as an alternative, but in other jurisdictions there is a deterioration criterion. Four jurisdictions (Ontario, Nunavut, Northwest Territories, and Quebec) continue to limit danger to physical or bodily harm. In British Columbia, the word "dangerous" is not mentioned in the involuntary admission criteria, which include the need for care, supervision, and control in or by a designated facility to "prevent the person's...substantial mental or physical deterioration" or "for the protection of the person...or the protection of others". Since California adopted a standard in 1969 stipulating that a person had to be dangerous to self or to others to be considered for involuntary commitment,

Table 3. Dangerousness criteria for involuntary admission

Region	Country/ District	Danger level specified	Danger to oneself	Danger to others	Danger to oneself or to others
Europe	UK	No			Yes
	Austria	Yes			Yes
	Denmark	Yes			Yes
	France	Yes			Yes
	Germany	Yes			Yes
	Italy	No	No	No	No
	Ireland	Yes			Yes
	Norway	Yes			Yes
Americas	Canada	Yes			Yes
	USA	Yes			Yes
	Brazil	Yes		Yes	
Australasia	Australia	Yes			Yes
	New Zealand	Yes			Yes
Asia	Japan	Yes			Yes
	The mainland of China	Yes		Yes	
	Taiwan region	Yes			Yes
	Hong Kong Special Administrative Region	No			Yes

most states in the USA have passed similar acts. Some states even specify suicidal behavior, harmful attacks, *etc*., and provide clear time-frames for such behavior. Hence, the presentation of a risk of harm "as a result of mental illness" is essential for involuntary admission. To be a candidate for involuntary civil commitment in Florida, a person must be deemed at risk of inflicting serious bodily harm on another person in the near future, as evidenced by recent behaviors causing, attempting, or threatening such harm.

All the Australasian jurisdictions have a broad harm/ danger criterion; for example, in South Australia, "the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others". Harm is not limited to physical or bodily harm. In addition, most Australian states have a deterioration alternative — for example, Queensland requires a risk that the person may (a) cause harm to himself or herself or someone else; or (b) suffer serious mental or physical deterioration.

Section 2 of the mental-health code of New Zealand requires the person to have an abnormal state of mind posing a serious danger to the health or safety of oneself or of others, or the capacity of that person to take care of himself or herself is seriously diminished. Thus, the involuntary criteria do not only rely on measures of "dangerousness", but have provisions for those persons with mental disorders who have no ability to care for themselves in the community[9].

Japan's Mental Health and Welfare Law (1995) introduced two types of involuntary psychiatric admissions: compulsory admission by two or more designated physicians and admission for medical care and protection; only the former requires the patient to be likely to cause danger to themselves or others unless admitted to a hospital. Such a person shall be admitted to a national or prefectural mental hospital or other designated institution[13]. The Article 30(2) of China's 2012 Mental Health Law also provides two legal conditions for involuntary admission: the

patient has already injured himself/herself or others, or has the potential to commit the said act[14]. "Dangerousness" as an alternative condition for involuntary admission in the Taiwan region, has a definition similar to that in the mainland of China, as is only to be implemented when a severely ill person is "clearly likely to injure" others or self, or who has already acted injuriously.

Need for Treatment

Prior to 1969, most legal frameworks stipulated a specific need for treatment as a standard criterion for compulsory admission[2]. The MI Principles (Principle 16) of the WHO Resource Book on Mental Health, Human Rights and Legislation, states that involuntary admission may be considered "in the case of a person whose mental illness is severe and whose judgment is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility…"[7].

In Europe, there have been many objections to this by organizations, individuals, and mental-health services users. In Italy, if a person needs urgent treatment and the treatment cannot be provided outside the hospital, involuntary hospitalization is authorized. This is very different from the dangerousness criteria used in most other jurisdictions. The 2007 Mental Health Act in the UK has a requirement that the patient cannot be detained for treatment unless appropriate treatment is available. Italy, Spain, and Sweden also stipulate the need for treatment as a criterion.

In North America, five Canadian jurisdictions (British Columbia, Saskatchewan, Manitoba, Nova Scotia, and Newfoundland and Labrador) have a specific need for treatment requirement, but eight do not, including the two largest provinces, Ontario and Quebec[15]. In the USA there is a strong tendency to replace "need for treatment" with a "dangerousness criterion".

In Australasia, most Australian jurisdictions have a requirement that psychiatric treatment is needed before a person can be involuntarily admitted. In Western Australia, the individual must have a mental illness requiring treatment.

In Asia, Japan's Mental Health and Welfare Law (1995) stipulates that family members can initiate involuntary admission if the need for treatment can be demonstrated[13]. In the mainland of China, Article 30(2) of Mental Health Law does not mention the need for treatment, but is ambiguous about the enforceability of hospitalization when there is no appropriate medical treatment available[14]. The Mental Health Law in the Taiwan region expressly requires that the person needs full-time hospitalization[16, 17].

Procedure for Involuntary Admission

Mental-health legislation usually specifies the procedure for involuntary admission. Although these procedures are heterogeneous, they all include the following sections (see Tables 4–6).

Who Should Make the Application?

Who should make the application for involuntary admission is a matter of debate. The person may be a family member, a close relative or guardian, a mental-health practitioner, or another state-appointed person (e.g., a social worker in the UK). In some countries, family members are not involved in the application at all. These differences may be affected by different cultures and processes[7].

Required Qualifications and Numbers of Assessors for the Applicability of Involuntary Admission Criteria

As an additional safeguard to protect the rights of those being detained involuntarily, the issues of who and how many assessors should determine the psychiatric/medical criteria for involuntary admission or treatment are important. The MI Principles of the WHO recommend that two medical practitioners conduct the assessment separately and independently. Generally, multiple assessments by additional qualified assessors are likely to decrease the possibility of abuse and provide the greatest protection for patients. In some countries, the clinicians who make the evaluation (such as psychiatric social workers, psychiatric nurses, and psychologists) need to be specifically trained and accredited. However, this is not possible or practical in low-income countries with a shortage of psychiatrists and general medical professionals[7].

All member states of the European Union (EU) require psychiatrists to perform the assessment upon patient admission to a psychiatric facility, although regulations for preliminary assessment or emergency assessment

Table 4. Psychiatric /medical assessment for involuntary admission

Region	Country/ District	Psychiatrist mandatory for initial assessment	Number of assessor	Deciding authority
Europe	UK	Yes	2	Med
	Austria	Yes	2	Non-Med
	Denmark	No	1	Med
	France	No	2	Non-Med
	Germany	No	1	Non-Med
	Italy	No	2	Non-Med
	Ireland	Yes	2	Med
	Norway	No	1	Non-Med
Americas	Canada	Yes	2	Med
	USA	Yes	2	Med
	Brazil	No	1	Non-Med
Australasia	Australia	Yes	2	Med
	New Zealand	No	2	Non-Med
Asia	Japan	Yes	1–2	Non-Med
	The mainland of China	Yes	1	Med
	Taiwan region	No	At least 2	Non-Med
	Hong Kong Special Administrative Region	Yes	1	Non-Med

Non-Med, non-medical; Med, medical.

differ. For example, only Austria, Greece, Ireland, the Netherlands, Portugal, Spain, and the UK require the initial assessor to be a trained psychiatrist. In the HO-procedure of France and some Federal States of Germany, any physician is allowed to make the psychiatric assessment[17].

In Norway, general practitioners or other physicians not working in a psychiatric hospital may conduct the assessment for involuntary commitment; however, a psychiatrist (or a physician and clinical psychologist approved for this) finally decides whether the patient's admission should be voluntary or involuntary after the patient arrives at the acute psychiatric unit[18].

Most EU countries require more than one expert to make the decision. However, in Belgium, Denmark, Germany, and the Netherlands, only one expert is required[17].

In most Canadian provinces, a physician in the community can authorize a short-term (24–72 h) admission. For example, in British Columbia, a person may be admitted involuntarily and treatment may commence based on a Mental Health Act certificate from a physician that is approved by the Director of a hospital, but a second certificate must be completed by a psychiatrist within 48 h.

In Brazil, a physician needs to be duly authorized for assessment by the Regional Medical Board (CRM) in which the facility is situated.

Section 8 of the 1992 Mental Health (Compulsory Assessment and Treatment) Act of New Zealand allows any medical practitioner to examine the person, assess if the person may be suffering from a mental disorder, and issue a certificate which initiates a more demanding process. Then a psychiatrist approved by the Director of Area Mental Health Services performs a more definitive assessment of the person.

In the Taiwan region, at least two specialist physicians are required to check the diagnosis of a severely ill person for involuntary diagnostic criteria. In the mainland of China, the diagnostic assessment can be conducted only by a

Table 5. Procedural regulations for involuntary admission (1)

Region	Country/District	Involuntary admission and treatment legally defined as different modalities	Detailed regulation of coercive measures	Compulsory outpatient treatment possible	Mandatory inclusion of patient counsel
Europe	UK	Yes	No	No	No
	Austria	Yes	Yes	No	Yes
	Denmark	Yes	Yes	No	Yes
	France	No	No	No	No
	Germany	Yes	Yes	No	No
	Italy	No	No	No	No
	Ireland	No	No	No	Yes
	Norway	No	Yes	Yes	Yes
Americas	Canada	No	Yes	No	No
	USA	No	Yes	Yes	Yes
Australasia	Australia	Yes	Yes	Yes	No
	New Zealand	Yes	Yes	Yes	Yes
Asia	Japan	No	Yes	No	No
	The mainland of China	No	Yes	No	No
	Taiwan region	No	Yes	Yes	No
	Hong Kong Special Administrative Region	No	No	No	No

registered psychiatrist[11].

Independent Authority and Periodical Review

In order to improve the physical and mental health of psychiatric patients, the 17th Principle for the Protection of Persons with Mental Illness and the Improvement of Mental Health suggests setting up an independent agency as a review mechanism. Such a mechanism could include medical, psychiatric, and other professional expertise to confirm the appropriateness of involuntary admission. The independent authority would make decisions to admit or retain a person as an involuntary patient according to the procedures designated by the relevant law, and to review all the patients at reasonable intervals.

Involuntary patients could apply to such a review body for release or review of their voluntary status within a reasonable time as specified by the relevant domestic legislation. A patient or his/her personal representative unsatisfied with the result would have the right to lodge a complaint in a higher court [according to Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, 1991 (General Assembly resolution)].

In Europe, to restrict the physicians' discretion and medical paternalism, many countries require that the final decision of involuntary placement be transferred to a non-medical authority, such as a judge, prosecutor, or other representative of the legal or medical systems, or another agency that is independent of the medical system[12]. The 2007 Mental Health Act of the UK empowers the Mental Health Review Tribunal (MHRT) to safeguard patient interests by reviewing hospital decisions involving involuntary commitment and the current discretionary time-limit for review, and to permit automatic referral by hospital managers to the MHRT.

Other EU member states confer these rights on psychiatrists or other health care professionals. Legislated time intervals for re-evaluation or re-decision differ considerably.

Table 6. Procedural regulations for involuntary admission (2)

Region	Country/ District	Maximum between psychiatric assessment and involuntary admission	Maximum of short-term detention	Decision-making authorities for short-term detention	Maximum length of initial placement	Re-approval
Europe	UK	14 days	72 h	Police or physician plus social worker	Assessment order: 28 days; Treatment order: 6 months	28 days; 6 months
	Austria	4 days	48 h	Psychiatrist	3 months	3 months
	Denmark	24 h (D) 7 days (T)	Not separately defined	Psychiatrist	Not defined	3, 10, 20, 30 days, then monthly
	France	24 h (HO-procedure)	48 h	Mayor (Paris: police)	Not defined	HDT-procedure: 15 days, then monthly HO-procedure: 1, 3, 6 months
	Germany	24 h–14 days	24 h (15 Federal States) 3 days (1 Federal State)	Municipal public affairs office or psychiatrist	Preliminary detention: 6 weeks; regular placement: 1 year, in obvious cases 2 years	Preliminary detention: 6 weeks;regular placement: 6 months (defined by Federal State of Saarland only)
	Italy	2 days	48 h	Public health department	7 days	7 days
	Ireland	24 h	Not separately defined	Psychiatrist	21 days	21 days, 3, 6, 12 months
	Norway	3 days	Not separately defined	Psychiatrist	3 months	Every 3 months
Americas	Canada	14 days	48 h	Psychiatrist	30 days	30 days × 2, then 90 days, then every 180 days
	USA	15 days	90 days	Local court	Temporary: 90 days Not defined: more than 90 days	Temporary: not defined Not defined: annually
Australasia	Australia	24 h	72 h	Judge	Less than 3 months	8 weeks; then annually
	New Zealand	14 days	Not available	Judge	14 days	5 days
Asia	Japan	Not defined	Emergency: 72 h Temporary: 1 week	Prefecture governor	4 weeks	Not defined
	The mainland of China	Not defined	Not defined	Psychiatrist	Not defined	Not defined
	Taiwan region	2 days	5 days	Mayor	60 days	60 days
	Hong Kong Special Administrative Region	7 days	7 days	Judge	28 days	Not defined

In Norway, a patient can complain to the Supervisory Commission about involuntary admission. This commission usually consists of a lawyer (acting as a judge), a physician (not affiliated with the hospital), and two other members (who have received psychiatric treatment, or are relatives of the patients) to fully represent the interests of the patient. If the Commission finds that a patient does not meet the involuntary admission standards, it can overthrow the involuntary admission decision made by psychiatrists[18].

In British Columbia (Canada), a Review Panel composed of three or more people determines whether patients meet the standards for involuntary admission, has decision-making powers to decertify or to continue involuntary hospitalization, and determines if a person younger than 16 continues to meet the criteria set out in the Act for a "person with a mental disorder", which includes the need for psychiatric treatment.

The Review Panel consists of a medical practitioner, a lawyer, and some other person(s) who is not a medical or legal professional, with the lawyer being the chairman of the panel. A patient or anyone on behalf of the patient can apply for a hearing.

Usually review panels make a decision directly after the hearing, or within 48 h. If the majority of the panel members are of the opinion that the involuntary admission standards specified in the law are not met, the panel must cancel the patient's involuntary hospitalization.

In most states of the USA, it is a judge who decides, but there are also many states that allow the respondent to request a jury trial. Except for temporary admission without a hearing, “not sure hospital” reviews must be conducted at least annually.

In Brazil, the patient's family members or legal representative may apply to the State Prosecutor upon mandatory hospitalization. State Prosecutors convene a multi-disciplinary team that includes a medical professional, preferably a psychiatrist, to conduct a mental-health assessment to decide whether there is a need to continue the involuntary admission.

In New Zealand, a District Court Judge must decide whether there is a mandatory medical situation within 14 days after a lawsuit filed by a patient. According to the New Zealand Mental Health legislation, patients may challenge their compulsory status through a variety of means, including judicial review, and appeal to a Mental Health Review Tribunal. This Tribunal consists of a lawyer, a psychiatrist, and a lay community member. At every step, a person challenging their compulsory treatment order is entitled to free legal representation. Under this Act, compulsory assessment of a person proceeds in a stepwise process with the initial period of compulsory assessment being only 5 days prior to the completion of a reassessment. Then, before a family court judge determines whether a compulsory treatment order should be made, there are two further periods of 14 days of compulsory assessment prior to a hearing, which is reviewed on a 6-month basis prior to an indefinite order being considered. Any compulsory treatment order made under the Act is deemed to be an order for compulsory assessment or treatment in the community, unless a case can be made to the presiding judge that such assessment or treatment can only be effectively undertaken as an inpatient. Section 4 of the Mental Health (Compulsory Assessment and Treatment) Act (1992) is clearly intended to exclude persons with personality disorders from compulsory treatment under the Act[9].

Every county in Japan has its own Psychiatric Review Board. The prefectural governor appoints the members of the board of directors, including the designated physicians, jurists, and other learned and experienced persons. The board of directors has two main functions. First, to evaluate the necessity for mandatory admission, and second, to give full consideration to patient and guardian requests for discharge and improvements in medication and treatment, so as to decide whether to continue medication or how to improve treatment[13].

In the mainland of China, according to Article 32 of the law, reassessment is conducted by the original medical facility or another medical institution with the appropriate legal qualifications within three days of receiving the results of the original diagnostic assessment. If the assessment was done by another medical institution, two registered psychiatrists have to be appointed to a face-to-face assessment of the patient. The medical institution must release its evaluation immediately[11].

Maximum Length of a Compulsory Admission

There are no clear rules about the maximum duration for (initial) involuntary admission in Denmark, France,

Portugal, and Spain. In the rest of the EU countries, the first-time compulsory treatment duration varies from 7 days to 2 years[17].

In Norway, the referring physician must have seen the patient in person within 10 days prior to the compulsory hospitalization. After a patient arrives in a hospital's acute ward, a psychiatrist (or a physician and a clinical psychologist approved for Mental Health Act decision-making) is required to evaluate, within 24 h, the necessity for compulsory hospitalization[18].

In British Columbia, an initial Medical Certificate, completed within the past 14 days, gives authority for 48-h mandatory psychiatric care. A second Medical Certificate must be completed within 48 h of admission. If the second certificate confirms the need for involuntary hospital care, the treatment period is extended for 30 days from the date of hospital admission. The treating psychiatrist reviews the need for compulsory treatment after 30 days and the first Renewal Certificate stipulates treatment for an additional one month. A second Renewal Certificate can extend compulsory treatment in a hospital for an additional three months. A third or subsequent Renewal Certificate can extend compulsory psychiatric treatment for an additional six months. All initial and renewal certificates are subject to appeal by patients or their representative.

In Brazil, the period a patient can be confined in a hospital, based upon the judgment of a mental-health expert submitting a report to a prosecutor, is 72 h. The procedure also applies when patients are discharged from hospital.

In the mainland of China, according to Article 44, the law does not specify the duration of mandatory treatment or the time interval for re-evaluations. It only regulates that if medical institutions think patients no longer meet the compulsory medical conditions, patients shall be discharged from the hospital[19].

Emergency Admission

Some jurisdictions provide for emergency, short-term detention (from 24 to 72 h), immediately, at night, or during weekends. For example, Belgium allows for ten days, whereas some EU member countries have emergency short-term detention standards that are different from those governing normal involuntary admission.

The laws of almost all EU member countries distinguish between emergency short-term detention and regular compulsory detention. Only in Denmark, Finland, and Ireland, do the laws make no distinction. The duration of emergency short-term detention varies from 24 h to 10 days[2].

Mental-health legislation may combine involuntary admission and treatment into one procedure, or treat them separately. Under the "combined approach", patients admitted involuntarily may be treated without their consent. Under a fully "separate" approach, the treatment of an involuntarily admitted patient requires a separate procedure for determining if such treatment is necessary[7]. This distinction is partly due to the influence of the international human rights standards: "Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental-health Care" [17].

The legal frameworks of Austria, Denmark, Germany, the UK, Sweden, the Netherlands, and Luxembourg define involuntary commitment and involuntary treatment as distinct modalities.

A number of Canadian jurisdictions allow involuntary patients to refuse treatment. For example, in Ontario, even a patient who is judged to be incompetent may refuse treatment. Refusal is considered to be in the best interest of the patient if there is no prior wish for treatment. In addition, in British Columbia the Mental Health Act (Appendix 14) states that the aim of an involuntary admission is to treat a patient’s mental disorder. Treatment is defined in the Act as "safe and effective psychiatric treatment and includes any procedure necessarily related to the provision of psychiatric treatment".

Canadian jurisdictions authorize (usually by the treating physician) involuntary treatment for the involuntarily admitted patient. British Columbia, Saskatchewan, and Newfoundland and Labrador, like all Canadian jurisdictions, do not allow patients admitted involuntarily to refuse treatment. However, patients in British Columbia may request a second opinion regarding the appropriateness of treatment. It is noteworthy that Section 31 of the Mental Health Act of British Columbia states that any person admitted to a psychiatric hospital for court-ordered treatment (those found by the courts to be unfit to stand

trial, or not criminally responsible for a criminal act) is deemed to have consented to treatment, with no further certification required to compel treatment. Other provinces do allow treatment refusal but it can be overruled. Persons who have a mental illness (whether or not they are competent) and are thought to pose a risk of harm to themselves or others can be treated without consent[20]. In New Zealand, committed patients can refuse treatment in some circumstances. This can be over-ridden by a second (psychiatrist's) opinion.

In the mainland of China, the new mental-health legislation does not allow involuntary patients to refuse psychopharmacological treatment. Moreover, there is no form of mandatory outpatient treatment specified in the law[21].

Involuntary Treatment in the Community

Involuntary or compulsory treatment in the community is a mechanism by which treatment is delivered in the "least restrictive environment"[22]. Early involuntary community programs were seen as a means to provide a less restrictive alternative to hospitalization and to increase individual autonomy. It is not clear if community compulsory care offers advantages or disadvantages in terms of outcomes, such as subsequent service use, social functioning, quality of life, or cost-effectiveness[23].

In England and Wales, Community Treatment Orders (CTOs) are included in the 2007 revision of the act. The legislation has a provision for conditional discharge, which requires the service user, still defined as an inpatient, to accept treatment in the community for extended periods[24].

In Norway, Community Care with Special Provisions (CCC) was permitted in 1961 under the law, but it can only be initiated following compulsory treatment in a hospital until 2001 when revisions were made to allow initiation of CCC without a prior hospital stay. So far, we consider CCCs to be "a least restrictive form" of coercive care.

Among the 13 Canadian jurisdictions, nine have some form of compulsory community treatment. These include six jurisdictions that have Community Treatment Orders (CTOs) provisions, two others that have conditional leave, and Quebec where court-ordered treatment can continue after discharge.

In the USA, CCC was introduced because of the enactment of "Kendra's law" in New York in 1999. Now, 42 states allow for CCC; in some jurisdictions, a compulsory order can only be issued after a period of hospitalization, in some cases after several hospitalizations[25]. All Australian jurisdictions have CTO provisions. New Zealand is one of the few jurisdictions in which a compulsory CTO can be made without the person first being admitted to a hospital.

In Japan, community support services are not mandatory, and the government has not taken the initiative to remove economic and social obstacles to the development of community support services. In the mainland of China, the mental-health law mandates that different levels of government develop and support community-based mental-health services.

Conclusion

There are many different ways of approaching involuntary admission and treatment, and they are part of modern psychiatry all over the world. Since the commitment law came into force, the involuntary commitment rate (annual number of compulsory admissions per 100 000 population) has increased, but the involuntary placement quotas (percentage of all psychiatric admissions) have remained more or less stable during the past decades, or have even decreased in some countries with financial austerity and a limited number of hospital beds[12]. While decreases are seen across Europe, the general number of psychiatric beds has increased in the mainland of China[26].

Some researchers have reported a positive correlation between rates of involuntary admission and the number of psychiatric beds, whereas areas that give priority to comprehensive outpatient care have less frequent involuntary commitments. A range of factors, such as gender, age, employment status, poverty, perceived dangerousness, and attitudes may be important in determining the manner by which jurisdictions utilize involuntary admission and coercion[27-34] .

Involuntary admission and treatment have advantages and disadvantages. In general, there is no doubt that the legislation of involuntary placement pays more attention to the psychiatric patients' right. This will prevent unnecessary involuntary admission and treatment. On

the basis of the law, the independent authority is obliged to review the patient's status at regular intervals. On the other hand, many countries have devoted much effort to minimizing the potential side effects of involuntary admission and treatment[34] . This was followed by an increasing shift from inpatient to outpatient psychiatric care. A diagnosed psychiatric disorder, imminent danger to self or to others, a causal link between the disorder and the danger, and the need for treatment, are the most frequently used determinants set out by the legal requirements for compulsory disposition. For example, according to the general trend towards evidence-based or guideline-supported procedures in mental-health care, the inclusion of standardized risk assessments could improve the assessment of the danger criterion. However, few countries currently stipulate the application of standardized risk assessment procedures as a mandatory part of a psychiatric examination. Ambiguities and lack of specificity of some provisions of the law create practical difficulties for implementation.

The mental-health legislation of the mainland of China, without detailed related administrative enactments, came into effect on May 1, 2013. This wide-ranging mental-health law on involuntary admission and compulsory treatment reformulated the key principles of the WHO. The main advantage offered by this law is to legalize the involuntary placement process, and provide suitable treatment to psychiatry patients. Meanwhile, there are some disadvantages, such as the operational problems that the introduction of a new law always entail. Besides, the regulation of involuntary admission and treatment detailedly stipulates the dangerous criterion, but with a lack of standard strategy and procedure to assess the risk of patients. Whether or not it may face challenges in practice, national data on involuntary admission and treatment will be collected to more precisely determine both the patterns and the types of diagnoses that are most commonly used in cases of involuntary placement. This wide-ranging law will fundamentally transform the provision of mental-health services in the mainland of China. Even after contentious debate, it still has the above problems and is far from satisfactory in being able to protect the legal rights and interests of involuntary patients. Like all nations, China still has a long way to go before finding the right balance between protection and control.

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