

The Legal Criteria and Trend of Compulsory Psychiatric Admission: A Mini-review and Implications for Taiwan

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The stipulations and practices of mental health law have been various globally. But human rights protection is the trend. Haunting Taiwan, recent episodes of indiscriminate killing have regenerated the debate on broadening practices of compulsory psychiatric admission. Now is the best timing to examine the legal criteria and trend of compulsory psychiatric admission around the world and its implication for Taiwan. Using keywords, we retrieved literature addressing criteria and trend of compulsory psychiatric admission in different countries from digital literature databanks. From the Taiwan Ministry of Health and Welfare, the authors also retrieved the annual numbers of compulsory psychiatric admission and the psychiatric admission covered by national health insurance (NHI) in 2005-2014. Rates of compulsory admission over NHI admission per year were calculated to observe the trend. Contrary to the U.S., in East Asian countries including Taiwan, decisions on compulsory psychiatric admissions are not made through court procedures. However, adopting soft paternalism, the 2007 Taiwan Mental Health Act ranks high in human rights protection. Furthermore, the numbers and rates of compulsory psychiatric admission had decreased by five times from 2005 to 2014. In contrast to many Western countries, Taiwan has had a recent decreasing trend of compulsory psychiatric admission which might be induced by its 2007 legislation reform. The 2007 Taiwan Mental Health Act has served the purpose of human rights protection well when compared to its counterparts of other countries. In the future, it is important, to explore whether there are significant hidden coercion practices in voluntary admission in Taiwan.

Key words: mental health act, compulsory psychiatric admission, human rights, mental capacity, Trend

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Introduction

Promulgated in 2007, the newly revised mental health act in Taiwan came into force in July 2008. The 2007 Taiwan Mental Health Act is the first mental health act in East Asian countries to adopt mandatory community treatment [1]. Differing dramatically from the old act, the 2007 Act enhances the procedural protection in compulsory psychiatric admission and mandatory community treatment. Only the severe mentally ill patient, who lacks the competence to handle his or her own affairs, can be admitted compulsorily or put under emergent placement (up to 5 days) when meeting the criterion of dangerousness to self or others (Article 3, Article 41). If suggested by two designated board certified psychiatrists (could be one in smaller islands), the designated hospital may apply for compulsory admission for the above mentally ill. The review committee set up in the Department of Health (now Ministry of Health and Welfare) is in charge of examining and deciding on the application (Article 15, Article 41). Furthermore, if the severe mentally ill patient or his/her protector opposes to emergent placement or compulsory psychiatric admission, they can petition to family courts for determining whether the compulsory measures should be terminated (Article 42). Periodic review by the review committee every two months is mandated to determine the necessity of continuing compulsory admission (Article 42).

Unfortunately, in recent decade, Taiwan has been haunted by rare but frightening indiscriminate or random killing incidents. There have been arguments for loosening the criteria of compulsory psychiatric admission to detain and treat those potential killers to reduce the risk. In addition, as the newly revised Habeas Corpus Act came into

force in 2014 in Taiwan, it seems the procedural efficiency would improve if the courts could hear petitions on compulsory psychiatric measures all at once. Furthermore, as more and more scholars are addressing the compatibility of current mental health legislations with the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) [2, 3], it is now good timing to review the provisions and the trend of compulsory psychiatric admissions in different countries as well as their implications for the 2007 Taiwan Mental Health Act.

Methods

Compulsory psychiatric admission in different countries

Using keywords to search in literature databanks, we conducted a literature review of the institutions of compulsory psychiatric admissions in the mental health acts in different countries. We also surveyed the WHO MiNDbank (www.mindbank.info/collection/country) to locate mental health acts of Japan and South Korea. Due to the limitation of the space of the review and the emphasis on East Asian countries, we did not make a country-by-country description of the findings in countries with Western cultural origins.

Trend of compulsory psychiatric admission in Taiwan

The data of the annual numbers of psychiatric admission covered by Taiwan's national health insurance (NHI) were retrieved from the reports and documents through the links on the website of the Department of Statistics, Ministry of Health and Welfare (MOHW) (<http://www.mohw.gov.tw/cht/DOS/>). The annual numbers of compulsory admission were obtained from the annual administrative report by the MOHW min-

ister in 2015. The ratio of the annual numbers of compulsory admission over those of the NHI admission was calculated for observing the trend of compulsory admission. Using Stata/SE 13.1, the Cochran-Armitage test was conducted to evaluate whether the two kinds of admissions have the same trend.

Results

Compulsory psychiatric admission in Japan

In Japan [4, 5], three main types of compulsory admission exist. In the first type, the persistent compulsory admission is ordered by prefectural governors to handle the mentally ill after at least two designated physicians confirm that the said mentally ill person is likely to harm himself, herself or others due to the mental illness unless admitted (Article 29). In the second type, the admission is based on the mentally ill's need for medical care and protection when applied by the person responsible for the mentally ill's protection and approved by the administrator of the mental hospital under the recommendation of the examining designated physician (Article 33). In the third type, the emergency admission (not longer than 72 hours) may be ordered by the prefectural governor when the said mentally ill person is excessively likely to harm self or others yet arranging examinations by designated physicians in time is not feasible (Article 29-2); in addition, if a mentally ill is in need of emergent medical care and protection whereas consent from the person responsible for protection is not available, the prefectural governor may order the admission (no longer than 72 hours) based on the recommendations of the examining designated physician (Article 33-4 and Article 34). Incompetence to make decisions of the mentally

ill is not an explicit criterion for compulsory admission [4, 5].

Comprising at least 2 members with expertise in medical care of the mentally ill, one in jurisprudence and one in other disciplines, a 5-membered psychiatric review board is established to review cases of compulsory psychiatric admission (Articles 12, 13, 38-2, 38-3). After the psychiatric review board deems the compulsory admission unnecessary, the governors must order the release of the said mentally ill person [4, 5]. For the time being, there is no literature addressing the trend of compulsory psychiatric admissions in Japan.

Compulsory psychiatric admission in South Korea

South Korea revised its provisions regarding psychiatric admission extensively in 2008 (<https://www.mindbank.info/collection/country/korea>). Lack of mental capacity of the mentally ill is not a required condition for compulsory psychiatric admission. In the first type of compulsory psychiatric admission, if a person with mental illness is noted to be in danger of harming self or others by a psychiatrist, the head of a local authority may order the admission of the said person for up to two weeks and then order the hospitalized treatment following the consensus of two or more psychiatrists (Article 25). In the second type, under the written consent of two (one, if there is only one qualified) persons responsible for protecting the mentally ill persons (according to South Korean civil act), the director of a mental institution may hospitalize a mentally ill person (perhaps against his will) for up to six months with the possibility of extension if a psychiatrist judges that hospitalization is necessary to meet the mentally ill person's need for treatment, or for health and safety of the mentally ill's self or the safety of others (Article 24). In the third type, in the urgent

case of a person suspected to have mental illness with substantial risk of harming self or others, the said person may be hospitalized for no longer than 72 hours with the consent of a doctor and a police officer. When longer compulsory admission is necessary, the procedures for the previous two types shall take over (Article 26).

Upon requests by the mentally ill person compulsorily admitted or the person in charge of his/her protection, the compulsory admission could be reviewed and determined first by the basic mental health deliberative committee and, if for re-examination, by the metropolitan mental health deliberative committee. The head of the local authority shall issue orders regarding compulsory admission according to the committee report. The original or continuous compulsory admission ordered by the head of the local authority may not exceed three months, unless upon review danger of harming self or others due to mental illness continues to exist (Articles 28-36).

Unfortunately, no current literature addresses the impact of the legislative reform on South Korean trend of compulsory psychiatric admission.

Compulsory psychiatric admission in the People's Republic of China

The People's Republic of China (PRC) promulgated its mental health act in 2012, which came into force in May 2013 [6, 7]. Guardians are designated according to the 2012 act or the Common Principles of Civil Act. Perhaps this means that the PRC mental health act presumes that a diagnosis of mental illness implies lack of capacity [6]. But, only the severely mentally ill, who lack full knowledge of their health problem or reality or are unable to handle their own business (Article 83), could be qualified for compulsory admission (Articles 30-32).

Based on Article 28 paragraph 2 of the act, if the suspected mentally ill person harms self or others or shows risk of such harm, his/her next of kin, his/her workplace authority, or the police shall take immediate measures to stop such behavior and take the said person to the medical care institution for mental impairment diagnosis. Article 29 paragraph 2 stipulates that medical care facilities, upon receiving the said person in Article 28 paragraph 2, shall detain the said person and designate psychiatric practitioners to make the diagnostic conclusion in time. Since there is no upper limit of detention time in this paragraph, the potential of abuse is worrisome.

Article 30 paragraph 2 stipulates that after mental evaluation, those who are diagnosed to suffer severe mental disorder and have behavior of harming self or others or showing such danger shall be admitted. Consent of the severe mentally ill patient's guardian is required only for compulsory psychiatric admission to manage the patient's behavior or danger of suicide (Article 31) [6, 7]. According to Article 32, the reviews of compulsory psychiatric admission cases with behavior or danger of harming others are handled by mental health professionals. There is no review committee or legal court playing the role of examining the legitimacy of the medical care facility's decision on compulsory admission [6, 8]. For the time being, no literature addresses the trend of compulsory psychiatric admission in the PRC.

Mental Health legislation and trend of compulsory admission in Western countries

Based on a survey in 15 European countries, five countries stipulated mental illness and dangerousness as the conditions of compulsory psychiatric admissions; three countries combined mental illness and need for treatment as the condi-

tions; and six countries accepted both above condition sets [9]. In a review of the mental health acts of 32 Commonwealth countries, the institution of an automatic review of the compulsory psychiatric admission did not exist in a significant minority of the countries [10]. For example, in the 1983 Mental Health Act of England and Wales, a tribunal review need to be initiated by applications; furthermore, only 25% of the patients compulsorily admitted made such application [11]. It was argued that the dangerousness criteria for compulsory psychiatric admission could set a high enough barrier to reduce the over-paternalistic psychiatric admission. However, according to a review, no significant difference in the practices of compulsory psychiatric admission was observed in the European countries no matter from the perspectives of rate (numbers over 100,000 population) or quota (percentage of all psychiatric admissions in the same year) [12].

In ten countries, the deciding authorities for compulsory admission were non-medical personnel such as judges, prosecutors, majors or social workers. In the remaining five, psychiatrists had the authority to determine compulsory admission. However, there was no correlation between the deciding authority and the increased compulsory admission rates or quotas [9]. In Denmark, the diagnosis of those subjecting to compulsory admission should be always psychosis. For the remaining 14 countries, the definition is either wide or non-existing. The deciding authorities had a broad leeway to implement compulsory admission. In six countries, the criteria for compulsory admissions were mental illness and dangerousness; in another six, mental illness plus dangerousness or need for treatment; in the remaining three, mental illness and need for treatment [9].

In the U.S. states, before the 1960s, psychiatrists had the power to determine admission.

The usual criteria for compulsory psychiatric admission were mental illness and the need for treatment. In the 1960s, with the advance of anti-psychiatry, promotion of community treatment, emphasis of human rights and the increased expenditure of psychiatric admission, the criteria of compulsory psychiatric admission were shifted to the more restricted combination of mental illness and dangerousness to others or self (including inability to meet basic needs) [11, 13]. Basically, the legalistic criteria of psychiatric compulsory admission may comprise dangerousness, grave disability and/or the need of treatment [13, 14]. Although sometimes psychiatrists have the authorities to place the mentally ill patients temporarily [15], the courts should decide on compulsory admissions. In many states, incompetence to refuse treatment is necessary for the state to implement coercive treatment for the mentally ill patients who are admitted compulsorily [15].

In general, the trend of compulsory psychiatric admission was not related to the criteria or decision authority of compulsory psychiatric admission [11]. On the one hand, in some countries, even if there was a short term downturn of the rate of compulsory psychiatric admission, the rate would return gradually. On the other hand, the continuous decrease of the psychiatric bed numbers may be an alternative explanation for the trend [11].

The 2007 Taiwan Mental Health Act and human rights protection

According to Principle 16 of the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991), after the examination by “a qualified mental health practitioner authorized by the law,” a person diagnosed to have a mental ill-

ness and fulfilling either one of the two following criteria, can be admitted involuntarily:

That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or that, in the case of a person whose mental illness is severe and whose judgement 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 in accordance with the principle of the least restrictive alternative.

According to Article 41 of the 2007 Act, only the incompetent severely mentally ill patients (infra, severe patients) with the behavior or danger of harming oneself or others could be admitted involuntarily. The causal relationship between mental illness and the behavior or danger of harm is implied in the legal text. Also, based on Article 3, only a designated board certified psychiatrist could make a diagnosis of severe patient. If not for the lack of the wordings of “immediate” or “imminent” harm, the 2007 Act actually could meet the UN convention’s requirement completely.

Furthermore, according to Principle 17 of the UN Principles, “[t]he review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law.” As the review committee stipulated in the 2007 Act comprises 7 professional categories of disciplines (including psychiatrists) and functions independently and impartially, it actually meets the above requirements.

Although the word “court” is mentioned in Article 5 section 4 of the European Conventions

of Human Rights (ECHR) in determining compulsory psychiatric admission, according to the interpretation of the European Court of Human Rights and some scholars, “the courts” are never meant to be the “formal legal courts” [16]. It will suffice if the review body is independent and impartial in a judicial sense. Accordingly, composed of a legal professional, a psychiatric professional and a lay person, the mental health tribunal in the 1983 Mental Health Act of England and Wales actually meets the requirement in Principle 17 of the UN Principles and Article 5 of the ECHR [17]. Modeling the mental health tribunal, the review committee in the Taiwan 2007 Act also meets “the court” requirement.

Not only matching the requirements of the international treaties, the Taiwan 2007 Act is also constitutional from the perspective of domestic law. Scholars in Taiwan have argued that the board certified psychiatrists in the old act or the review committee in the Taiwan 2007 Act could be interpreted to be the broadly defined “police authority”. Thus, the decision to deprive the liberty of the severe patients according to the mental health act was constitutional according Article 8 of the Taiwan Constitutional Law [18]. Furthermore, the Judicial Yuan, the highest judicial authority in Taiwan, is not enthusiastic in taking the place of the review committee to determine issues related to emergency placement and compulsory psychiatric admission. Its representatives have been humble in opining that the judges do not have the expertise in determining issues related to emergency placement and compulsory psychiatric admissions (personal communication). If the performance of the review committee is acceptable, it seems that based on pragmatic and theoretic considerations it is not necessary that legal courts take over the decision making power from the review committee.

Mental capacity, compulsory admission and treatment in 2007 Taiwan Mental Health Act

As regards whether the mentally ill have the rights to refuse psychiatric treatments, there are three combinations between mental capacity and compulsory psychiatric admissions. In the first type, like in the provisions of some states in the U.S., the patient can be involuntarily admitted, but only when the patient has no competence in determining psychiatric treatment can the patient receive compulsory treatment [15]. In the second type, mental capacity is not related to compulsory admissions or treatment. For example, in the 2007 Mental Health Act of the UK, for the persons with dangerous and severe personality disorder it is their treatability that is at issue not their mental capacity [19, 20]. In the third type, only those mentally ill without mental capacity can be compulsorily admitted and treated. The rationale underlying the second type is called strong paternalism and the third soft paternalism [21].

Some scholars for the so-called fusion law proposal have argued that the patients' mental capacity to make treatment decisions is what matters not whether they suffer from mental or physical disorders [22]. In Taiwan, according to articles 63 and 64 in the Medical Care Act, the "compulsory" treatment could be implied to be acceptable if the substitute decision-makers agree to certain treatment when the patients lose competency to make treatment decisions [23]. According to Article 3 of the Taiwan Mental Health Act, severe patients do not have the capacity to handle their own affairs, which include treatment decisions. Thus, based on Taiwan's relevant laws, there is no separation of compulsory admission and compulsory treatment no matter in physical or mental disorders. It would not result in the awkward situation in the above first type that a person is compulsorily admitted

for long time because he or she does not receive any treatment reciprocally due to his competence to refuse treatment [15, 24]. In addition, since in the fusion law design mental disability is not always a fixed requirement for compulsory treatment, the stipulations of the use of coercive measures in Taiwan 2007 act actually can pass the muster of the CRPD as described by scholars [2].

Trend of compulsory admission in Taiwan

As shown in Table 1, the annual number of NHI psychiatric admission has been increasing gradually. However, the annual number of compulsory psychiatric admission has been decreasing. Especially dramatic, are the steep decreases of the numbers in 2007-2008 (from 3171 to 1140) and in 2012-2013 (from 1221 to 772). In 2005-2014, there was a five times decrease in the annual number of compulsory psychiatric admission. Also, the ratio of the compulsory admission over NHI admission each year has been decreasing up to five times. The Cochran-Armitage test revealed that the trend of compulsory psychiatric admissions is different from that of the NHI psychiatric admission ($p < 0.0001$).

Discussion

International comparison of criteria and procedure of compulsory psychiatric admission

Based on the World Health Organization guidelines and the Council of Europe recommendations, Fistein et al. proposed a framework to assess the extent of human rights protection in mental health legislation of different countries [10]. The framework is comprised of five axes – diagnosis (plus exclusion criteria), therapeutic aim, risk, capacity (for admission and for treatment), and review process. According to them, recent

Table 1. Trend of national health insurance (NHI) and compulsory psychiatric admissions in Taiwan

Year	Compulsory admission number	NHI admission number	Ratio (%)
2005	3,565	11,4451	3.1
2006	3,129	11,3814	2.7
2007	3,171	11,4892	2.8
2008	1,140	11,4838	1.0
2009	1,679	11,7821	1.4
2010	1,696	12,3941	1.4
2011	1,211	12,6326	1.0
2012	1,221	12,7508	1.0
2013	772	12,6444	0.6
2014	718	12,7521	0.6

Parts of the data in this table are based on FHC Chou's work [25]

mental health legislations of developed countries tended to get higher “autonomy scores” (minimum = 6 and maximum = 30). The highest two in the ranking were Northern Territory of Australia (score = 25) and Scotland (score = 22) [10]. Actually, according to the framework, the 2007 Taiwan Mental Health Act could get the score of around 20-22 based on whether the criteria were interpreted strictly or not. Also, from the perspectives of human rights protection and fusion law, the criteria and procedure of compulsory psychiatric admission of the 2007 Taiwan Act are ranked higher than other East Asian countries and most of the Western countries.

Implication of the trend of the compulsory admission in Taiwan

In an editorial, Chou showed in figure the decreasing numbers of compulsory psychiatric admission since 2008 [25]. But, he did not consider the possibility that the numbers of compulsory psychiatric admission just reflected the trend of overall psychiatric admission. As shown by our analysis (Table 1), it is clear that the trend of the annual numbers of compulsory admission did not

follow that of the NHI one. As the annual numbers of the NHI admission have been slowly increasing, the annual numbers of the compulsory admission have been decreasing; further, the difference of the ratios of compulsory admission over NHI admission is up to 5 times between 2005 and 2014. Thus, the revision ratios in the Taiwan 2007 Act did have impact on the practice of compulsory admission. However, there are two major components of the revision, one in the definition of severe patients as incompetent and the other in the establishment of review committee to examine the application of compulsory admission. It is still not clear which component is the more important determinant. But, in addition to the sharp decrease of the annual number of compulsory admission in 2008, there was another sharp drop in 2013, when stricter requirements were first implemented for the preparation of the compulsory admission application forms and the operation of the review committee.

Therefore, contrary to the observation of some scholars that the change of the compulsory admission criteria had no impact on the practice of compulsory admission [11], the implementation

the Taiwan 2007 Act did exert influence on the practice. The question is what the appropriate ratio of compulsory admission over NHI voluntary admission is. If we follow the principlism of biomedical ethics, for respecting patients' autonomy, the best scenario is that the patient consents to admission voluntarily all the time [26]. Then, the dramatic decrease of the annual numbers and ratios of compulsory admission over NHI admission are both good signs of better practice of biomedical ethics. Of course, there is possibility that psychiatrists in Taiwan just forwent compulsory admission due to cumbersome procedural requirements. Or, many severe patients were made to "consent" to their admissions through some coercive or manipulative measures [27]. To solve the questions, further exploration through mixed methods approach is needed to see whether many people still felt coerced during their "voluntary" admissions. If that is so, the government should have paid more attention to the substantial coercion in the procedure of voluntary psychiatric rather than instead merely to the formal or nominal parts of voluntary admissions [28].

Literature has shown that sometimes the change of the trend of compulsory psychiatric admissions did not follow the intended direction of mental health legislation reform. The practitioners still have leeway to interpret the law as they would like to reach their clinical purposes [15].

The practice of compulsory psychiatric admission as law in society is different from the law in the text of the relevant statutes. If that is a reason of under-protection of human rights, the third party monitor or petition systems should exert stronger examinations of the practice of compulsory psychiatric admission. The ideal result will be the law in the text finally changes the law as culture in society [29]. Many psychiatrists in Western countries still interpret the statutes of the

mental health acts to fit their clinical purposes and rendered the trend of compulsory psychiatric admission unlinked to the revision of mental health acts [11]. Based on this perspective, the mental health acts in Japan and South Korea reflected their cultural practices more than those in Western countries. On the other hand, if the above covered coercion is not a severe problem in Taiwan, then the 2007 Taiwan Mental Health Act is actually transforming the coercive culture in mental health practices gradually.

Currently in Taiwan, events of indiscriminate killing have aroused arguments for revising mental health law to allow the detention and treatment of people with the risk of harming others. Actually, in quite a few such incidences, the offenders were not severe patients at all. The return to older-time practices of treating competent people against their wills carries higher risks of violating human rights than maintaining the current soft-paternalism ones. Therefore, it is important to open a public risk communication forum and facilitate understandings of whether the suggested older-time practices really could reduce the incidence of indiscriminate killing. As has been shown in a review of cases of indiscriminate killing by the Japanese Ministry of Justice, measures both at the social and individual levels by different disciplines are needed to provide a network that may reduce the incidence of indiscriminate killing (www.moj.go.jp/housouken/housouken03_00068.html). Since the base rate of indiscriminate killing is very low, we may never know who benefits from the new protection and support network. Revision of mental health law to broaden the practices of coercion could create more harm than benefit and at the same time infringe on people's autonomy. Law in the text and law in society are always in dynamic intermingling relationship. How to enhance their merging through effective

communication and transparency in policy making is very important in a democratic society [30].

Conclusion

The mental health legislation in Taiwan is now facing its evolution watershed. The international treaties have been pushing the mental health legislation towards individualism and human rights protection. But the communitarian tradition and the social unrest due to indiscriminate killing in Taiwan are pulling in the opposite direction. As shown by the data at the ecological level, the current compulsory psychiatric admission institution in Taiwan is doing a good enough job in the continuous decrease in the annual numbers of compulsory psychiatric admission. Embracing the legal idea of soft paternalism, the review committee could mingle liberalism and communitarianism in its interpretations of relevant statutes, which the courts respect almost all the time [31]. Human rights and communitarianism are not conflicting with each other if human rights protection is part of social good.

As rare events, indiscriminate killings should not be the determining impetus for mental health legislation reform. They should be handled by multi-disciplines at multi-levels including risk communication to the public. Only equipped with information from legal impact assessment, public attitude, other social safety network designs, and up-to-date legal theories, can the mental health legislation be effective, rights-protective and culturally sensitive at the same time [32].

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