

## A History of Mental Health Laws in Taiwan

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*Taiwan Mental Health Act* with 52 articles was established in 1990. Based on the first edition of *Mental Health Act (MHA)*, it was intended to balance between the patients' rights and the society's harmony. Following a few minor modifications and a substantial revision in 2007, the revised version of the MHA was formally enacted on July 4, 2008. This *MHA Amendment* includes 7 chapters and 63 articles. Its aims are (A) to protect and prohibit discrimination against psychiatric patients; (B) to help patients and their families with recovery, as well as to help mental health providers and government in research and treatment decisions. (C) to ensure that the final decision on the compulsory admission of severe mental illness (SMI) patients should be approved by the Psychiatric Disease Mandatory Assessment and Community Care Review Committee (PDMACCRC); (D) to encourage patients to return and stay in the community; and (E) to enhance preventive psychiatric medicine for mental health promotion. One of the most important articles is procedure changes of compulsory treatment. Basically, it is to protect psychotic patients' rights and to encourage patients to return to community. After the 2007 *MHA Amendment* of Taiwan, patient with SMI who is dangerous to self or others and if he/she should receive compulsory psychiatric treatment which should be reviewed by the Psychiatric Illness Mandatory Appraisal and Community Treatment Review Panel (PIMACTRP), in addition to evaluation by two designed licensed psychiatrists. Otherwise, mandatory community treatment was established in this *MHA Amendment*. The alternative treatment offers another compulsory treatment with lower limitation for patient's freedom.

**Key words: Mental Health Act (MHA), severely mental illness (SMI), compulsory treatment, Psychiatric Illness Mandatory Appraisal and Community Treatment Review Panel (PIMACTRP)**

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## **General Description for Current Psychiatry in Taiwan**

Taiwan has a population of 23,552,470 as of June 2017, and the vast majority of individuals live in the low lands near the western coast of the main island. Taiwan, consisting of the island of Taiwan (an island located 160 km from the Asian mainland in the Pacific). Taiwan is a democratic country with relatively low levels of crime and unrest. The average income per capita is US\$19,626 (<https://www.dgbas.gov.tw/ct.asp?xItem=33338&ctNode=3099&mp=1>).

In Taiwan, psychiatry has developed rapidly since the 20th century. There were reported to be 1,329 psychiatrists in Taiwan in 2013, which corresponds to an average of one psychiatrist per 17,597 individuals. This proportion is higher than the global average, where there is only one psychiatrist per 200,000 or more people [1]. But this rate is still lower than in developed countries. By the end of the 20th century, the vast majority of psychiatrists still chose to work in an institution, while only a few chose to work in their own clinics.

In 2007, Handicapped Welfare Law was renamed the People with Disability Rights Protection Act. The amended act classified people with mental illness using internationally recognized diagnoses and environmental contexts [2]. The 2007 People with Disability Rights Protection Act is considered a civil rights landmark for persons with disabilities in Taiwan, as it states that the dignity, legal rights, and interests of people with disabilities shall be respected and guaranteed (Article 16). In Taiwan, 1,125,113 people are registered as having disabilities. Of these, 10% have been diagnosed as having mental disabilities ([www.mohw.gov.tw/cht/DOS/statistic.aphx](http://www.mohw.gov.tw/cht/DOS/statistic.aphx)).

Previously, psychiatrists had mainly been focused on treatments for hospitalized mental patients, including medication, social intervention, rehabilitation, and psychotherapy. Regarding community services, only traditional outpatient clinics, home visit treatment, half-way houses, and sheltered workplaces were available. On the other hand, it is known that patients with mental illnesses often fail to receive proper medical treatment if there is no sense of illness and if there are cognitive judgment impairments. In such cases, patients can harm themselves or others.

## **The Establishment of the Mental Health Act in Taiwan**

### ***The Birth of the First Edition of Mental Health Act***

Until the 1980s, the general public and the government did not have a strong understanding of mental health and chronic mental illness in Taiwan [3]. In 1981, the government commissioned a private mental health organization to develop a draft of the Mental Health Act, with the purpose of protecting the public and reducing the dangers from psychiatric patients. This new law stressed the need to balance the rights of the individuals with those of society [1]. Before 1990, people who were thought by the public or their family to exhibit mentally unstable and uncontrollable behavior were involuntarily admitted to mental care facilities or asylums without psychiatric evaluation upon the request of the family or police. Historically psychiatric patients were either in the community not receiving care or locked in a prison-like place. In 1970, Master Kaifeng Shi founded the Hall of Dragon Metamorphoses with a thatched building in Kaohsiung County for Buddhist practices. Shi took in the mentally ill and created his own folk therapy to take care of

them. Kaifeng Shi first tied a rope with the patient and stabilized the condition of the patient through the teaching of traditional aphoristic literature (sutras). The rope used was referred to as the “emotional chain” and later became the “metal chain.” This understandably raised serious human rights concerns. In the 1980s, those abuses by the Hall of Dragon Metamorphoses attracted the attention of the press and the public [4]. Then, after the occurrence of two high-profile social incidents involving assaults perpetrated by psychotic patients – one individual threw sulfuric acid on children at Ying-Qiao Elementary School, and another killed her government official husband out of acute paranoia – the Mental Health Act which had 52 articles was finally enacted in 1990. This Act emphasized that individuals with mental illness have the right to accept reasonable treatment [5]. The first article of the Act stated that we should work on the prevention and treatment of mental illnesses to protect patients’ rights, promote their physical and mental health, improve the mental health of the people, and safeguard a harmonious and peaceful society at the same time. Based on the first edition of *the MHA*, it seemed to balance between the patients’ rights and the society’s interests. But throughout the content of the MHA, there were numbers of sections asking the patient’s compliance with medication and left with few alternatives for them.

The first edition of *the MHA* allowed the protector to restrict the domicile of the severe patient for the purpose of medical treatment, rehabilitation, educational or occupational training (Article 24, 1990 *MHA*). But after increasing concerns about the improper management of patients at home or private non-professional institution, the 2007 *MHA Amendment* emphasize the right of the patient in choosing their treatment and rehabilitation modalities by themselves.

## Compulsory Admission

To protect the safety of both the patients and the people around them, the compulsory admission procedure was developed as an emergency measure. Therefore, “patients with severe mental illness (SMI)” and “who harm others or themselves or are in danger of causing harm” are the main reasons for the involuntary admission and treatment of mental illness patients in all countries.

## Evolution of the *Mental Health Act* in Taiwan

The original version of *the Mental Health Act* did not change much after two minor modifications in 2000 and 2002 to adjust the competent authority and to fit in with newly enacted administrative procedure law. The long waited substantial revision of *the Mental Health Act* finally passed in the congress of Taiwan in 2007, and the revised version was formally enacted on July 4, 2008. This *MHA Amendment* includes 7 chapters and 63 articles. Its primary aims are (A) to protect and prohibit discrimination against psychiatric patients; (B) to aid patients and their families with recovery and to help mental health providers and the police in research and treatment decisions; (C) to ensure that the final decision on the compulsory admission of SMI patients should be approved by the Psychiatric Disease Mandatory Assessment and Community Care Review Committee (PDMACCRC); (D) to encourage patients to return and stay in the community; and (E) to enhance preventive psychiatric medicine for mental health promotion [6]. Based on 2007 edition MHA, there are some changes and strategies following the establishment of *the MHA Amendment*.

### ***To protect and prohibit discrimination against psychiatric patients***

In the past, the patient must provide certification of recovery to the institutions or organizations to resume his/her post. This situation can be avoided now after the 2007 *MHA Amendment*. According to the Article 22 of *the MHA*, patients' personality and legitimate rights and interests shall be respected and protected, and may not be discriminated against. For patients under stable conditions, it is not permitted to refuse their access to schooling, examination, employment or implement any other unfair treatment for the reason that they have ever suffered from mental illnesses. Thus, no discrimination in employment toward the patients is allowed under stable condition.

Moreover, the Article 23 of *the MHA* clearly states that communication media may not use any discriminative addressing or descriptions related to mental illness. The 2007 edition gives a clear sign of progress of patient's rights and anti-discrimination policies.

### ***To aid patients and their families with recovery and to help mental health providers and the police in research and treatment decisions***

The 2007 *MHA Amendment* provides the source of law that the rights of the patients, their family and group to participate in policy formation and discussion based upon (article 13-15). The patients and their family are the most influenced population under mental health policies but in the meanwhile the less participated. After the 2007 *MHA Amendment*, the opinions of the patients under stable condition and their family (not less than 1/3) play an important rôle in participating in the public mental health policies, prevention of psychiatric diseases, resource planning,

specific treatment and right to access medical care. The 2007 *MHA Amendment* enables the "patient-centered" mental health system, and shapes the mutual partnership through encouraging patient empowerment and civic participation.

### ***To ensure that the final decision on the compulsory admission of SMI patients should be approved by the Psychiatric Disease Mandatory Assessment and Community Care Review Committee (PDMACCRC)***

#### **The definition of patient with severe mental illness (SMI)**

The transition of discourses about patients with SMI in Taiwan has moved on from exclusion to inclusion and from protection to respect for rights in the past three decades. *The MHA Amendment* is viewed to balance between the human rights and public safety concerns ([www.mentalhealthalliance.org.uk/mentalhealthbill/index.html](http://www.mentalhealthalliance.org.uk/mentalhealthbill/index.html)). Relating to *the MHA Amendment*, several majors debates were proposed in the legislative process. First of all, the criteria for the compulsory admission in *the MHA Amendment* became stricter than before. The greatest dispute was the concept of "quasi-patient" and whether it could be properly allied to *the MHA Amendment* ([www.lci.ly.gov.tw](http://www.lci.ly.gov.tw)).

#### **The changes of criteria of compulsory treatment**

Taiwan's Mental Health Act of 1990 also changed by stipulating that the compulsory admissions of psychiatric patients must be decided by two licensed psychiatrists agreeing on patient's symptoms and needs (Article 21 in the first edition). In fact, that act did not concern as much with a patient's legal right to liberty and privacy as it did to the risk of self-harm and community

endangerment, using a medical model to justify lawful detention. This act was also amended in 2007 to ensure that they not only received treatment, but their human rights were respected as well. There are different criteria to decide psychotic patients to be received compulsory admission in different countries. In Taiwan, according to the newly developed *Mental Health Act Admentment* (the 2007 version), in addition to an evaluation (Article 41) by two designated certificated psychiatrists (assigned by the local health department); compulsory hospitalization is primarily for SMI patients with the potential to hurt themselves or others. In addition, an emergency placement should be started during the evaluation phase (within two days) to protect the rights of the patients. Compulsory admission will also require the review and approval of a PDMACCRC within five days (including evaluation phase). This committee consists of several different specialists or representatives, including psychiatrists, registered psychiatric nurses, occupational therapists, clinical psychologists, psychiatric social workers, lawyers, relatives, and patient-rights protection representatives (usually the caregiver or a family-representative group). The rôle of this panel is to ensure that the criteria for compulsory admission are met [7]. The maximum length of compulsory hospitalization is 60 days (Article 42). If they are evaluated that they should be treated continued by two designed certified psychiatrists over 60 days, the procedure of compulsory admission should be conducted 2 weeks before the end of compulsory hospitalization.

### **The prominently decrease of compulsory admission after amendment in 2007**

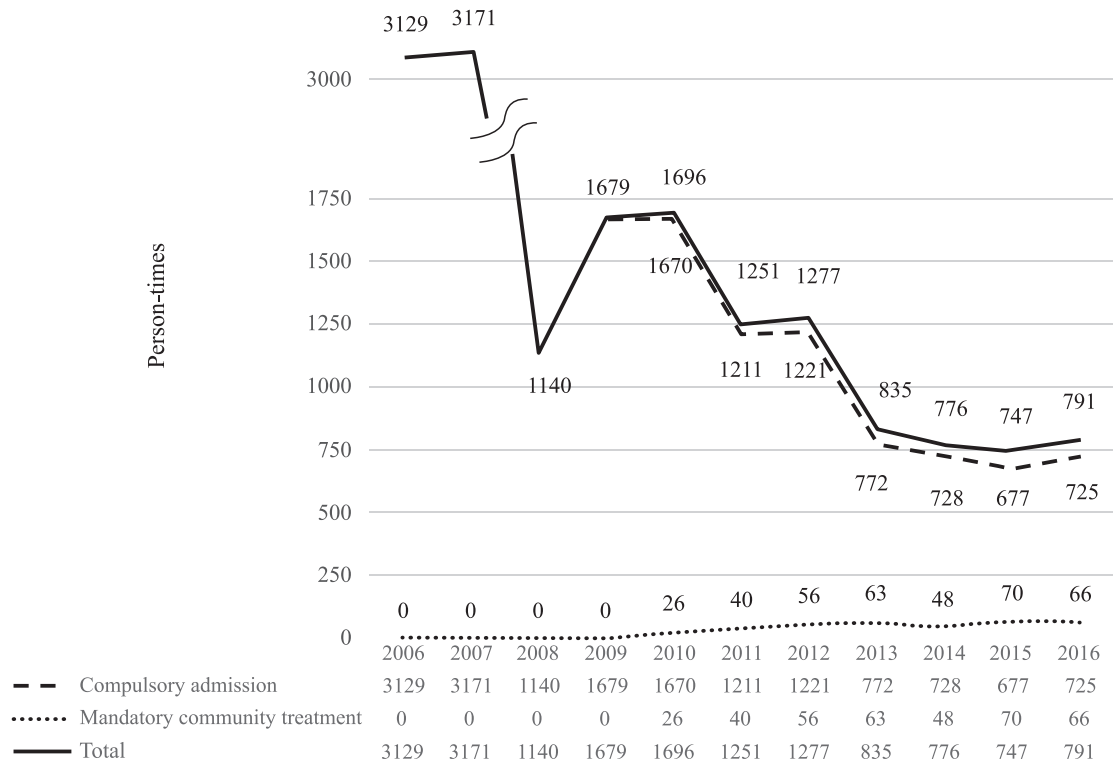
In Taiwan, since the 2007 *the Mental Health Act Admentment* was implemented, the number of the patients with compulsory admission has sig-

nificantly reduced by 83%, corresponding to a decrease from 3,129 patients in 2006, to 3,171 patients in 2007, to 728 patients in 2014 [1], to 677 patients in 2015 and to in 725 patients in 2016 (Figure 1). Although approximately 70,000 people consented to be hospitalized, only 0.96% of these individuals were compulsorily hospitalized, which is significantly lower than the 6%-58% who is compulsorily hospitalized in the United States and Europe [1,8].

### **Mandatory community treatment: an alternative compulsory admission fell short of the target**

Mandatory community treatment was established in this *MHA Admentment* that let Taiwan be the first country to establish mandatory community treatment in Asia. The alternative treatment offers another compulsory treatment with lower limitation for severe patient's freedom. The necessity of mandatory community treatment requires permission from PDMACCRC (Article 45). Mandatory community treatment services are provided by designated psychiatric institutions and include the items include (A) pharmaceutical therapy, (B) testing of pharmaceutical concentrations in blood or urine; (C) screening for alcohol or other addictive substances; (D) other measures that can prevent deterioration of illness conditions or can promote patients' life-adapting functions. Mandatory community treatment may be performed without informing the severe patients; and, if necessary, the police agencies or fire-fighting agencies may be contacted and asked for assistance in the execution (Article 46).

After 10 years of establishment of mandatory community treatment, it did not become daily practice for treatment of severe patients. Although the number of patients receiving compulsory admission was remarkably dropped from 1,670 patients



**Figure 1.** The trend of compulsory treatment (compulsory admission and mandatory community treatment during 2007-2016) (Data from Department of Oral and Mental Health, Ministry of Health and Welfare)

in 2010 to 725 patients in 2016, mandatory community treatment only increased marginally from 26 patients in 2010 to 66 patients in 2016 (Figure 1). This unproportional trend may point out the problems of inadequate resource distribution in Taiwanese community mental health system.

***To encourage patients to return and stay in the community***

Responding to the human rights-based approaches to health (HRBA) of WHO ([www.who.int/gender-equity-rights/knowledge/hrba/en/](http://www.who.int/gender-equity-rights/knowledge/hrba/en/)), the mental health policies of Taiwan are focused focused on enhancing availability, accessibility, and acceptability in the community. The 2007 *MHA*

*Admendment* promotes a major paradigm shift of mental health system from the medical and institutionalized system to community-based service model. The primary goal now is supporting the patients to live normally in the community.

The concept of Discharge Planning Committee is legislated in 2007 *MHA Amentment*. And the rehabilitation, placement and follow-up plans of the patients in the community are further regulated in written law. As the article 38 of 2007 *MHA Amentment* states: Before the discharge of patients, psychiatric institutions shall assist patients and their protectors in formulating concrete feasible plans for rehabilitation, referral, placement, and follow-up. Meanwhile, to fulfill the

needs of patients to live in community, the article 39 requires central competent authority shall award mental health related institutions and associations for their engagement in services of patients' community care, support, rehabilitation, and so on.

Two of the largest impacts to the psychiatric institutions from 2007 *MHA Amentent* are plans for community living and emergency placement. Especially, the discharge planning, including rehabilitation, placement and follow-up, is required for all kinds of the patients (not only severe patient) and has to be realistic and feasible. Thus, the various kinds of care or rehabilitation institution need to be designed for integration of a wide variety of specialties and rehabilitation solutions. Therefore, the discharge planning shall not only focus on accelerating discharge and enhancing medical compliance of the patient, but also includes the rehabilitation and referral planning in community.

Community mental health rehabilitation is defined as assisting patients to adapt to social life gradually. The rehabilitative treatments offered to patients in community include programs regarding to work ability, work attitude, psychological reconstruction, social skills, and ability to manage daily life, etc. (Article 3.5). Hence, the rehabilitation service includes:

**To integrate social resources, including labor, public health, social administration, or NGOs**

The psychiatric institutions are the provider of mental health services. However, linking to existing social resources is key to successful community rehabilitation. For example, employment need of mentally disabled, such as job transition and matching, can be assisted through employment service station. And the employment service

of the mentally disabled can be incorporated into the labor administration system.

**To construct the network of community and occupational support of the mentally disabled**

It is important to have specially-assigned persons (such as nurses, social worker, or occupational therapeutics) to bridge the hospital-based service and community after the chronic patients are discharged. Their services include reminding the patient to take medication, visiting outpatient clinics regularly, or providing assist of life and job searching. Such kinds of supports are the key point of successful community living.

**To provide assistance and consultation to the patient's family**

The family members are the main care takers of the patients in the community. The patients do not have many resources other than themselves or their family when facing difficulties. They may be desperately confused when family and community supports are lacking. Social stigma and discrimination further hinder their dream to lead a quite life. Therefore, psychiatric institution staff must consider thoroughly about the dwelling environment and provide necessary support to enhance the possibility of stable community living. In summary, realistic and feasible discharge plans are needed before their returning to community.

**To encourage community-based rehabilitation facilities**

The patients need accessible and available social support and rehabilitation service in the community. Hence, rehabilitation facilities should be built in the community and integrate into neighborhood. Besides, community-based rehabilitation facilities can suit for personalized need

of the patient better and can avoid the risk of institutionalized model owing to large amount of patients.

### ***To enhance preventive psychiatric medicine for mental health promotion***

Before the 2007 *MHA Amendment*, the municipality and county (city) competent authorities “may” set up community psychology health centers. But it became mandatory for these competent authorities to set up community psychology health centers in the *MHA Amendment* (Article 7), which clearly points out the rôles of community psychology health centers in primary prevention and these centers also provide some function of secondary prevention. Therefore, the major rôle of community psychology health centers is not treatment of the patients but conducting psychological health campaigns, education and training, counseling, referral and transfer services, resources networking. Treatment of suicide and substance abuse is also emphasized here.

Effective resource integration and referral are more important than directive service providence. The Internet also serves as an important information gate of psychoeducation. Besides, the current strategies of anti-drug campaign are cutting supply and reducing need. The tactics are seizing, refusing, and abstinence with the integration of government and civic/social organization resources. Methadone harm reduction program is the main focus of current policies. According to the forms and structure of government, public health agencies are responsible for abstinence. However, in the viewpoint of preventive medicine, public health agencies should invest more resources in refusing drug. Hence, psychological health centers will play an increasingly important rôle.

## **Conclusion**

The development of mental health law falls behind Western countries, especially the United States and European countries. Countries in East and Southeast Asia such as China, Indonesia, Japan, Malaysia, Mongolia, Myanmar, North Korea, Philippines, Singapore, South Korea, Taiwan, Thailand, and Philippines had passed written mental health law. However, the degree of family involvement is different from Western countries. For example, in Japan, China and South Korea, compulsory admission with family consent is legalized [9, 10].

In Taiwan, after the *MHA Amendment*, the protection of patient’s right and range of alternative treatment choice are more prominent than other Asian countries. Nevertheless, 10 years after the *MHA Amendment*, we still face the dilemma between human rights and social security. Some scholar and politician urge the broadening of emergency placement and compulsory admission after several homicidal cases related to mentally disabled suspects. And the stigmatization toward psychiatric diseases from mass media is still common. The below the mark number of mandatory community treatment is also an alarm for the efficiency to community care system. These practical problems are challenge and chance for Taiwan to further improve our mental health care system.

Being one of the leading countries in promoting rights of mental disabled patients, integration of mental health care system and resource allocation requires greater attention. The experience of finding balance between human rights and social security can serve as a valuable model to enhance mental health in Taiwan and neighboring countries.



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