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REVIEW ARTICLE

Mental Healthcare Act (MHCA 2017)–A review from Forensic perspective

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Abstract

Various laws have been implemented and amended for safeguarding the individuals suffering from mental ailments. The latest addition is the Mental Healthcare Act 2017 which tries to answer several lacunas in previous editions. The act tries to give legal solicitude with much needed precedence to rights of such patients. This review article is an attempt to go through the MHCA 2017 and its predecessor act, the Mental Health Act 1987 to discuss different modifications incorporated. This article tries to simply discuss the practical aspects of this act and the medicolegal perspective which is very much important for a practicing physician.

Keywords

MHCA 2017; Mental illness; Advance directive; Nominated representative; Forensic

Introduction

The field of medicine is very much related to the legal system. A doctor is required to know the legal system and laws of land followed by his society while practicing medicine. Mental illness is a disease where the patient might not be fit enough for decision making. Thus, the patients with mental illness become the perfect victim for any exploitation. The exploitations might vary from negligence during medical treatment to voluntarily causing harm to the person. This could be done by anyone from family members to a total stranger for any reason ranging from having fun to hate crimes. In such patients with mental illness, the doctor is required to follow the guidelines based on the central legislation regarding mental healthcare, so that there won't be any negligence.

In pre-independent India, in 1858 the Indian Lunatic Asylum Act was introduced. Later on, in 1912, this was repealed by Indian Lunacy Act.[1] In 1987, after Independence came an act with lot of changes, the Mental Health Act.[2] Still there were much more lacunas and gaps in the Mental Health Act which led to the constitution of The Mental Healthcare act 2017 which came into implementation on 29th May 2018 after presidential assent. The provisions in the act guide in catering of mental healthcare services to persons with mental illness (PMI/ PWMI). This act also helps in protecting the rights of such persons during delivery of mental healthcare services.[3] In India, the burden of mental illness is huge owing to the socioeconomic status, illiteracy and unemployment. There are large number of such persons not able to avail the mental health care services. The number of mentally ill patients getting treatment was much less proportionate to the statistics of total number of such patients for various reasons like social stigma, availability of a smaller number of trained mental healthcare professionals, a smaller number of institutions for such patients, inability to afford quality treatment etc. Indian government and legislature are trying to address these problems through implementation of different legislatures.

United Nations had started an international human rights treaty, the CRPD (Convention on the Rights of Persons with Disabilities) to protect the rights and dignity of people with mental illness.[4] In this, mental illness is also added as a disability. So CRPD is applicable for mental illness just like any other physical disability. This meant the mental illnesses pounding on the personal and professional life of majority got a voice of compassion and empathy. This convention and treaty demanded changes in existing legislatures all around the world. The treaty was put forward on 13th of December in year 2006 and India signed the same on 1st April 2007. Now since the CRPD was signed, there raised a need for a much stronger and up to date legislature to address the legalities of care in a mentally ill and to circumvent the three-decade old The Mental Health Act, 1987. The MHA 1987 was not found fully compliant with the UNCRPD resolution. To comply with it, the 2017 edition of mental health act was passed by parliament on April 2017. In 1987 Mental Health Act, here we are comparing the Mental Health Act 1987 with the latest Mental Healthcare Act 2017.

1987 Mental Health Act

The act was passed in year 1987 and came into force by April 1993. The definition of act says "An act to consolidate and amend the law relating to the treatment and care of mentally ill persons, to make better provision with respect to their property and affairs and for matters connected therewith or incidental

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thereto." The act has 10 Chapters and 98 sections. One of the important things the act did was cancelling the use of some terms which were offensive but used officially and provided some new terms. Like the term 'lunatic' was changed to 'mentally ill person'. 'Asylum' was changed to 'Psychiatric Hospital' and it introduced terminologies such as Reception order. The act established authorities to give license after stringent legal formalities and quality control. The act also made provision for treatment of minor ailment on outpatient basis, thus reducing detentions. Simple and easy guidelines were to be followed for both admission and discharge. Research on subjects with mental illness was prohibited without proper consent from the guardian.

Even though this act was a stepping stone at the time period when this was implemented, there were lots of shortcomings to this act. Most of them came out during practice and later were used as the lacunas in legal system. Even though the mandatory licensing came into existence, the licensing authorities lacked presence of a doctor who would have been in a better position to evaluate the amenities and services provided by these centers. In a developing country like India, concept of establishing new hospitals appear to be a costly affair and new establishments will require more motivation. This might negatively affect the population of our country already suffering due to lower number of mental healthcare establishments. The timely licensing and frequent inspection of such establishments by licensing authority will put extra burden on health budget of both Central and State government. No mention is made to incorporate general hospitals and centers as mental health care facilities in this act. The vast majority of population with lesser degree of mental illness comes to general clinics and hospitals for other ailments and there if they are diagnosed with any minor mental illness then proper care could be given there only. The hospitals which are already established in public healthcare, if taken along for treating minor mental ailment also could have been much beneficial for providing better mental health care. As no provisions are made for home treatment, much stress is laid on hospital admission and treatment which subsequently makes the health care costlier. This act does not provide much for the rehabilitation of patients or caretaker or about care of patients after discharge. It is not mentioned anywhere in the act about the protocol or guidelines to be followed if there are no caretakers available or if available, whether they are willing to take care of the patient after discharge. If discharged who will take care of the patient since some of the patients won't be able to take care of themselves. And if the patient still needs to be treated, there are no guidelines as to who will take care of the expenses incurred and for how long. Though the act prohibits any research on mentally ill patients without consent from guardian; there might be cases where the guardian may not act in the best interest of the patient. This might lead to human rights violation of the mentally ill. The act doesn't mention about the penalty for anyone who forcefully detains someone out of vested interests in home or in mental health establishments. The patient who is on treatment cannot say anything about his treatment in this act. Either the doctor or the legal guardian is given full power to take any decision. This could lead to conflict of interests which can affect the wellbeing of the patient. The act doesn't address the social stigma towards a mentally ill patient other than theoretically changing some terms which were previously used. There could have been provisions for reducing social stigma such as educating the public by various means.[5]

Mental Healthcare Act 2017

Even though this act was put forward for complying with CRPD, attention has been given to update the lacunas present in Mental Health Act 1987. This act is much more elaborate with 16 chapters and 126 individual sections. One of the main changes in chapter one itself is redefinition of mental health professional (MHP) where post graduate doctors in AYUSH are also included. This improves choices of patient and increases the much essential work force which is required to tackle large number of patients. Mental health establishments (MHE) are much more clearly defined by this act and includes AYUSH establishments and rehabilitation centers. This gives more focus on the social and vocational rehabilitation of patients. Another major inclusion in this chapter is that of personality disorder and addiction problems inside the definition of 'mental illness'. But it does not include mental retardation.[6]

Admission and discharge: Voluntary admission is changed as independent admission. This refers to admission of PMI who requires very minimum support in taking decision and PMI who has severe mental illness that requires admission and is likely to understand the need and nature of such admission or a PMI who capable of taking decisions on his treatment choices and mental health care. Informed consent is the essential part. In cases when a PMI is not taking the treatment due to his inability to understand the nature and purpose of treatment and also not able to take care of himself or if the PMI is violent, then the PMI should be admitted as Supported admission. (Section 89 of MHC act 2017) This is done after the application given by NR (Nominated representative). Police officer can take a wandering PMI or the one who is not able to take his own care under its protection. Such persons may be produced before public health establishment for admission after informing NR.[7]

Advance Directive (AD): Chapter three deals with AD. Any person can make an advance directive in writing provided he is not a minor, It is his right which empowers the patient to choose his treatment and to nominate a representative (NR) to make treatment related decisions on the patient's behalf when he/she

is rendered as lacking capacity.[8] For minors, care giver/ legal guardian will act as representative. The Advance directive has to be followed by healthcare personnel unless in case of Emergency treatment. If caregiver/ Mental Healthcare professional (MHP) are unsatisfied with Advance Directive, they can put up an application at Review Board to alter or cancel it. It is essential to document care at each step, as the courts presume that care was not provided if there is lack of documentation.[9]

Nominated Representative (NR): Guidelines in choosing Nominated Representative is given in Chapter 4. NR can give valid consent, seek information about diagnosis, admission, treatments and can help in decisions related to discharge planning, rehabilitation etc. Any individual who is not a minor, shall have a right to appoint a nominated representative. If NR is not appointed, then individual appointed in Advance Directive, a relative, care giver, person appointed by board or its designated representative shall be deemed to be a NR.

Human rights: Mental HealthCare Act 2017 provides for PMI to have a dignified life and protection from cruel treatment. The act also has sections for the right to self-hygiene, privacy, appropriate clothing, salary for work, community living, enough food, no compulsion to wear uniforms. The act also describes right for emergency and ambulance services in time of need, mobile/ e-mail facilities for PMI when admitted and free legal services when required. It also includes health insurance for mental disorders and treating the PMI according to international guidelines. There are provisions in the act for a woman and child below 3 years of age to be together. If the woman is suspected to harm the child and if separation for more than 30 days is essential, competent authority should approve it. The other measures included in the act are to conduct programs for preventing suicide and stigma against PMI.[4] The significant and serious issue of unemployment in persons with mental disabilities is not given importance in this act.[7,8]

Decriminalization of suicide: The MHC act 2017 effectively decriminalizes any attempted Suicide. Section 115 MHCA 2017 accepts that any person who is attempting suicide will be presumed to be under severe stress. Since the decision of Suicide has been taken under immense stress, the MHC act suggests not to punish the survivor under Section 309 of the Indian Penal Code. But this does not mean that Section 309 IPC is null and void. Now if a person has to be tried under Section 309 IPC, burden of proof that the person was not under any immense mental stress is up to prosecution and not on the defendant. The act safeguards from the legalities by presuming severe stress and need for seeking treatment by the psychiatrist instead of putting unwarranted legal burden on already ailing patient.[8,9]

Central mental health authority and state mental health authority**:** Chapter XI of the MHCA 2017 outlines the MHRBs and its functions. MHRB (Mental health review board) will now hear disputes which earlier directly went to the consumer courts, Human Rights Commission, and civil courts etc. Mostly in every district mental health review board will be set up and it will be for a term of 5 years.

The rights of PWMI construe into the moral aspects of psychiatric care. The ethics of psychiatric care are mainly related to the 4 main ethical principles i.e., autonomy (respect for patient's right to self-determination), beneficence (duty to do good), non-maleficence (duty to not do bad), and justice (treat all people equally and equitably). It also includes confidentiality (and disclosure), boundary violations, informed consent including involuntary treatment etc.

All doctors including a psychiatrist have the basic responsibility of keeping sensitive information regarding their patients confidential. On request from PWMI who wants the information regarding diagnosis to be disclosed, the treating doctor can disclose the same to the caregivers. The doctor should essentially obtain written informed consent from the spouse, including permission as to how much can be disclosed. This should be documented in the patient's notes. Such written document from the patient could protect the psychiatrist from any future litigation in the Court of Law. When a patient is admitted to a tertiary care hospital through intervention of Honorable courts, it's difficult to obtain adequate history since the relatives/caregivers are either unwilling to discuss or untraceable.

Psychiatrist appearing in the Court: Many doctors get their training in General Hospitals with Psychiatry Units without any direct exposure to forensic aspects which is usually dealt with at specialized forensic psychiatry units. They may be undertrained in legal aspects of patient care. In such cases the consultants should involve the resident doctors who are posted in such facilities to actively indulge in the legal aspect of patient care. This involves exposure to medical boards, discharge committee meetings, certification, etc. Outcome of insanity pleas: The treating psychiatrist of an accused may be summoned to court of law, if accused has a proof that he was under his psychiatry treatment prior to the crime committed. PWMI who committed crime if has documentary evidence of mental illness, then chance of acquittal on the grounds of mental illness is high. Absconding behavior in patients with mental illness: It's found mostly in males, especially diagnosed with schizophrenia or mood disorder with history of substance abuse. Absconding behavior in PMI admitted involuntarily without care givers poses more “responsibility” on the hospital authorities.[10]

Recommendations

The treating psychiatrist should be competent with court evidence and legal procedures to avoid unwanted hiccups.[10] The Mental Healthcare Act is giving much needed balance to the patient and caregivers which could increase the number of law suits against treating doctors and mental health institutions. Most of the forensic textbooks still mention the outdated Mental Health Act 1987. We would suggest the forensic medical fraternity to include the new MHCA2017 act since it's the most updated and useful information for any medical practitioner.

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