

# Mental Healthcare Act 2017: Liberal in Principles, Let Down in Provisions

## INTRODUCTION

The Indian Mental Healthcare Act 2017 received presidential assent on April 7<sup>th</sup>, 2017 and replaced the 1987 Act.<sup>[1]</sup> The new act intends to align and harmonize existing laws with the Convention on Rights of Persons with Disabilities and its optional protocol which India ratified in 2007.<sup>[2]</sup> The act is hailed both as a revolutionary legislation as well as a hindrance to appropriate patient care.<sup>[3,4]</sup> It is true that the bill is a big leap in principles, and it has the rights of the mentally ill at its heart. The bill has several positive aspects such as introducing proxy decision-making options and including opportunities to make advance directives (AD); aspiring to establish parity with physical disorders; regulating all facilities that provide psychiatric care irrespective of systems of medicine practiced or nature of service provider; setting up systems to ensure due process when personal liberties are restricted; regulatory monitoring of restraints and seclusions; banning practices that are widely considered as inhumane; defining the role of police in ensuring patient safety; bringing informed consent to the core of practice; minimizing the role of magistrates in mental health care; instructing insurance providers not to discriminate against mental illness; and decriminalizing suicide.

There is a shift in focus from custodial care which was emphasized in the repealed 1987 act; this is evident in the principles described in chapter 12. The language of the new act is also an indicator of this shift. The word “detention” appeared 32 times in the old act; this word is not mentioned in the new act even though more patients are brought under the purview of the new act. The word “consent” appears 40 times in the new act whereas only three of the 11 appearances in the old act relate to patient consent. The word “compulsion” does not appear in the new act even though sections 89 and 90 are in fact compulsory admissions. The new phrase “supported admission” appears to be wishful thinking – as if a change in language would somehow allow the reality of compulsory detention to be perceived differently. This does make one sceptical as to how much of the act will remain meaningless words that mask realities and thus offer a false sense of progress.

There are major limitations to this act. Some of these limitations are in fact contradictory to the stated principles of the act. The limitations may hinder the meaningful realization of the revolutionary principles in this act. There are glaring gaps and omissions, and several compromises have been made in the name of adapting global principles to the Indian context. There is a lack of determination to set up robust systems which will provide adequate resources to implement the human rights agenda supposedly enshrined in the new act.

## REGULATION OF INFORMAL ADMISSIONS IS DISCRIMINATION AGAINST MENTAL ILLNESS

The act upholds the idea that all citizens, including those with mental illness, have a right to equality and nondiscrimination. Section 21 (1) states that “every person with mental illness shall be treated as equal to persons with physical illness in the provision of all healthcare.” Contrary to these declared principles of parity with physical illness, the act has brought all voluntary admissions of adult persons with mental illness under its purview.

### Case example

Mr. A is a person with chest pain and is seeking admission to a hospital. Usually, the doctor and the patient would collaboratively decide the best course of action which may include admission. It is not necessary for a patient to have a diagnosis to be admitted. Admission could be to rule out a diagnosis or to further investigate a known diagnosis. It could also be to treat a particular condition or merely for observation and reassurance. An adult individual like Mr. A has the full capacity to make such decisions with his doctor. There is no physical health care act that compels Mr. A's doctor to provide proof of diagnosis before admission or to establish that all other nonadmission options have been exhausted. Unfortunately, a mentally unwell adult with full capacity to make decisions about his or her care cannot easily access an inpatient bed. The act requires that the medical officer (MO) has to be satisfied that the patient has a mental illness of a severity requiring admission and that the patient is

likely to benefit from admission and treatment. MO also needs to establish that the patient made this decision with free will and under no duress. In contrast to physical health conditions, a doctor who wishes to admit a patient for a mental illness will now need to make a diagnosis using the international classification system as described in Chapter 11 (Section 3) of the new act. There are various situations where the nature of the illness is unclear until further assessment and observations are carried out. Admission might be a preferred option in many nonsevere disorders. It appears that the state is overstepping beyond the rules usually applicable for such decisions and interfering with what should have been a normal health-care transaction between adults with capacity and their doctor. By bringing voluntary admission of mental health-care patients under the regulatory gaze, the state is infringing on the principles of equality and nondiscrimination described in section 21 of the act.

### **THE STATE AVOIDING STATUTORY RESPONSIBILITY**

When the state limits the freedom of an individual, it is expected that the state also takes responsibility to look after the needs of the individual for the period of time such restrictions are in place. For example, if a person is quarantined for physical health reasons, the state is limiting the person's fundamental freedoms for the benefit of the larger society. It is only natural justice that all costs attached to the quarantine period are borne, in such cases, by the state. For individuals admitted for the safety of others (under section 89 or 90), the state should provide all required care. The new act has brought all mental health establishments (MHE), private and public, under its purview. The previous act required the MO (defined as gazetted MO in the service of Government) to be a party to compulsory admissions; this made compulsory admissions possible only in public facilities. The new act has allowed the MO in charge of MHE's to make decisions on compulsory admission in consultation with others as the case may be. It appears that the state clearly wants private sector providers to step in to care for patients under "supported admissions." However, the act does not specify how the state is going to fulfill its moral and ethical responsibility of bearing the cost of such treatments and the aftercare, as is prevalent in many modern societies.<sup>[5]</sup> The principles of equality, nondiscrimination, and a modern human rights approach are described eloquently in various sections of the new act. However, the new act also enables the state to avoid taking responsibility when it matters the most.

### **SHIFTING RESPONSIBILITY TO FAMILIES**

While welcoming the enhanced and empowering involvement of relatives and caregivers as endorsed by the new act, one cannot be blind to the burden it is covertly imposing upon them. Patients can appoint nominated representatives (NR) who act as proxy decision makers. A simple statement can make a nomination valid. There are no requirements to check that the nomination is made with free will or to verify that the patient has the capacity to make such a nomination unless it is made as part of an AD. The act stipulates that without an application from NR, a patient cannot be admitted to the hospital against his or her wish. Making such a decision, i.e., to apply and be responsible for compulsory admission to the hospital against the patients' stated wish, may lead to resentment, anger, and even vengeance toward the NR. Families already struggling with an unfortunate illness are now burdened with the responsibility of all important decisions such as compulsory admission, many of which may not be accepted by the patient. This makes families the direct target of the patient's anger and resentment. Families wish to be involved in caring for and supporting the patient, but not in the role of enforcers. Families taking on such roles could strain relationships beyond repair and may contribute to future relapse of the illness. Such roles should not be forcefully thrust on the family and should be optional instead. In countries like the UK, proxy decision-making is carried out by professionals, including specially trained social workers, who act as independent professionals and may make applications for compulsory admissions. The Government of India, through the new act, has decided not to shoulder these responsibilities and instead impose a heavy emotional burden on family members.

### **DISCRIMINATION AGAINST SINGLE INDIVIDUALS LIVING WITHOUT FAMILY**

Single persons living with no family or caregivers would struggle to get appropriate care in an MHE if their capacity is limited, even temporarily, by a mental disorder. Without an NR, MHE would not be able to admit them. The only option available is for the MO to request the district review board (DRB) to appoint an NR. This would take 7 days. Until then, such patients, who may be at risk of suicide, would remain in limbo. The act, though very vocal about individual rights, has avoided guaranteeing a single person equal access to appropriate and speedy mental health care. This could have been avoided if the act had granted immediate proxy decision-making powers in such situations to designated local self-government representative or clinical professionals by the discretion of the MO.

The act has adopted a dimensional model for capacity and encourages family members to support the patient in making decisions with a view to promote independent admissions. Individuals without family members would be at a disadvantage here as well and are more likely to be declared as having no decision-making capacity for independent admission.

## **NO SAFEGUARDS IN THE NOMINATED REPRESENTATIVES SYSTEM**

In its haste to avoid responsibility for the care of mentally ill, the new act has left huge uncertainties and many unanswered questions. If an NR is not acting in the best interests of a patient, the NR should ideally be removed. A patient who lacks capacity cannot remove an existing NR. Even while having capacity, they may not have the courage or financial freedom to remove a family member as NR. Any such removal can unsettle family relationships. A procedure to remove the NR (like DRB review) could have been included in the act to deal with instances where the MO desires to do so in the best interests of the patient. As of now, the DRB can revoke a minor's NR and a board-appointed NR. There would be many situations such as illness, inability, and unavailability that would necessitate the removal or change of an NR. The act, as it stands now, states that only the patient can revoke or change the NR. Unfortunately, the patient can do so only if they have the capacity, and if they had the capacity, they would not have needed an NR in the first place.

## **ADVANCE DIRECTIVE THAT CAN BACKFIRE**

In physical healthcare, valid AD does play a significant role as in most situations; it is possible to foresee the options in advance.

### **Case example**

Consider Mr. E, a patient with a severe psychotic disorder, who is admitted (under section 89) to an MHE. He has an AD stating that he does not want to take any antipsychotic medication when he becomes unwell with psychosis. The very idea of the AD is to express how one would like to be treated when one has no capacity. Mr. E has no capacity currently and his AD has to be respected. Wouldn't that mean he would deteriorate and even risk his life? If he is admitted under section 89/90, the very fact that he is admitted against his wish for treatment should mean that the requirement of getting him better would override the AD. If no treatment purpose was there, he should not have been admitted against his wish. Giving absolute power to AD could be, as shown above, detrimental in many cases.

The MO can appeal to the DRB to amend or cancel the AD. It is possible that the DRB would also be helpless if it can be shown that at the time of making the AD Mr. E had capacity to do so and was sufficiently well-informed to make that decision and that he anticipated the current situation. In essence, no one, not even the DRB, can overrule a valid AD. This would mean that Mr. E would remain in a hospital without being treated for the illness for which he was admitted.

In many mental health laws, involuntary admission (like section 89/90) overrides the absolute nature of the AD. Good practice would still require that doctors work with patients and make decisions taking into consideration the wishes expressed in the AD. Doctors need to show valid reasons to do so.

The AD permits a patient to declare in advance the way he/she wishes to be cared for and treated for a mental illness and also to specify the treatments he or she does not want to receive in the future. It would be interesting to see how the MO in a public health facility or the DRB would consider a valid AD declaring a preference to be treated in a private facility. Will the DRB refuse such an expressed wish? In the UK, the capacity act is clear about this: "People can only make advance decisions to refuse treatment. Nobody has the legal right to demand specific treatment, either at the time or in advance." In addition, in the UK, a compulsory admission (i.e., like 89/90 in India) would automatically override any AD except one refusing electroconvulsive therapy (ECT).

## **CAPACITY CONUNDRUM AND TREATMENT REFUSAL WHILE UNDER 89**

Informed consent for a medical intervention is a cornerstone of the doctor-patient relationship. In mental disorders, many countries have taken a deliberately slow route to incorporate the capacity criteria for admission and treatment. This is because, in contrast to a physical disorder, in mental health, there are many situations where a patient with full capacity would require compulsory treatment.

Consider Mr. F, a patient admitted under section 89. Mr. F is refusing medications. As per the new act, the MO has to obtain informed consent from the patient. The MO may use the support of the NR to get the informed consent. However, informed consent can only be given by an individual with the full capacity to do so. Therefore, the MO must check the patient's ability to understand, retain, and consider the information regarding the treatment. If Mr. F fails any of the criteria listed above, he is deemed to lack capacity. In such

situations, the NR as the proxy decision-maker can provide consent. If the NR refuses, the MO cannot proceed with treatment. If Mr. F had capacity (which many patients with mental disorders including psychosis may have) and is refusing treatment, the MO is helpless and cannot proceed. Mr. F is admitted against his wish because he has met the legal criteria for compulsory admission. Therefore, it makes sense that such compulsory admission should have allowed the MO to overrule the patient's wish and proceed with treatment. However, the act, in its eagerness to uphold patient rights, failed to see the unfortunate consequence – treatment refusal in instances where the patient cannot either decide for themselves or shouldn't be allowed to decide for themselves.

Unlike physical disorders, in mental disorders, the consideration is about the risk to oneself and others due to the illness. In such situations, the patient's preference to accept or refuse one or all treatments should not prevent the patient from receiving appropriate treatment, even if such treatment is against the patient's wishes. One purpose of sections 89 and 90 is to provide treatment when a person with a severe mental disorder is a risk to themselves or others. However, the act does not give the MO the power to appropriately treat the admitted patient if the treatment contravenes the patient's previous wishes (AD), the patient refuses the treatment (while having capacity to do so), or the NR (for a person with no capacity) refuses the proposed treatment. There is also the possibility that a patient admitted under section 89/90 could refuse treatment once he regains capacity. This would mean that a patient who meets the criteria for involuntary admission can remain in a hospital without receiving any treatment.<sup>[6]</sup> This would completely defeat the purpose of involuntary admission and have a paralyzing effect on the MHE.

### **NEGLECT OF THE NEED FOR COMPREHENSIVE CAPACITY CLAUSES**

Mr. T is admitted under section 89. On examination, the psychiatrist concludes that Mr. T does not need 100% support from his NR to make treatment decisions. The psychiatrist decides to go ahead with the treatment without getting explicit consent from the NR. However, section 89 (7) states that NR's consent is required if the patient needs nearly 100% support in taking decisions. Therefore, Mr. T can sue the psychiatrist in the future for treating him without a legally valid consent. For an informed consent to be legally valid, the patient needs to have full capacity to make decisions. In this case, Mr. T required support (though not nearing 100%) to make decisions. It could then be argued that Mr. T had no legal capacity to make decisions on his own.

Laws in the UK, the US, and Canada require that the stated wishes of patients be respected unless the patient can be shown not to be legally competent.<sup>[7]</sup> Although mental capacity is a continuous quality that may be present to a greater or lesser extent, legal competence cannot be present to a greater or lesser extent. A person is either entitled or not entitled, as per law, to have their wishes respected regarding treatment.<sup>[8]</sup> The idea of percentages of support needed suggest that the new act is shying away from this legal definition of capacity. The dimensional idea of capacity adopted in the act could come in to conflict with the dichotomous nature of legal capacity. If a medical practitioner attempts to treat a person without valid consent, he or she will be liable under both tort and criminal law. There is a possibility of being sued for negligence and being prosecuted for assault or battery. Indian contract law states that consent of any party (in this case, from the patient) that is obtained by coercion, undue influence, mistake, misrepresentation, or fraud will render the agreement, i.e., consent, invalid. Section 120 of the new act states that the provisions of the act shall override other laws and instruments even if such other laws and instruments have provisions that may be inconsistent with the new act. The guidance notes on capacity assessment will be produced by the government in due course. This will decide whether we will follow the dimensional clinical model of capacity adopted in the act, even though this model appears to contradict the generally accepted legal definition (i.e., a categorical concept) of capacity.<sup>[8]</sup>

### **REJECTING THE LIFESAVING EFFECT OF ELECTROCONVULSIVE THERAPY**

Section 94 describes the 72 h emergency treatment option where any MO can administer all treatments that are immediately necessary to prevent death or irreversible harm to the health of the patient or stop the patient from inflicting serious harm to self or others. ECT is a well-established, lifesaving treatment for individuals with severe depression, especially those at high risk of suicide.<sup>[9]</sup> In such situations, when the patient lacks capacity, psychiatrists should have been allowed to administer ECT (subject to additional safeguards) as a lifesaving measure. This practice is currently allowed in many countries including England and many Australian states (Western Australia, Northern Territory, Queensland, and South Australia).

### **UNREALISTIC EXPECTATIONS**

Mental health professional (MHP) status is given to nurses, psychologists, and social workers working in MHE. Professionals in such roles make an independent

judgement of the individuals' mental health and determine whether they meet the admission criteria. This is an extremely complex task and would require these professionals to have extensive training. Even in countries where nurses working in MHE have mental health nursing degrees and years of independent professional experience, this role is not given until they take further training and demonstrate specific skills and competencies to deliver this independent role. The new act does not specify any mandatory requirements or accreditation process for the professionals involved in such complex procedures. In the absence of comprehensive training requirements, the role of MHP as independent assessors is unlikely to be effective in practice. In the UK for example, even psychiatrists are not given the authority to make recommendation for compulsory admissions until they complete specific mandatory training and get approval from the secretary of state. From the new act, it appears that the state prefers to not invest in creating a competent workforce to implement this act effectively.

## PERSISTING PATERNALISTIC VIEWS

Admission of minors to MHE is another example of discrimination against mentally ill. A 16-year-old with abdominal pain can go to a physical health facility with their parents and get admitted even if it is just to rule out any illness. The doctor and the parent of the minor must agree to the admission. The same minor, if suffering from an eating disorder or abdominal pain of nonphysical origin, would not get access to a psychiatric facility unless the parent makes an application to the MO. Following this application, a psychiatrist and another MHP (or two psychiatrists) will need to decide, after independent examinations, if the minor has a serious mental disorder. They will also need to demonstrate that all options in the community are exhausted. This would mean that MOs would have to make a diagnosis at admission even though the purpose of admission is to assess the patient. Unlike in physical health conditions, this admission has to be reported to DRB within 72 h. The minor, if a female, cannot have a male carer, including her father, as the sole person staying with her. The professionals in the MHE are normally expected to make appropriate decisions when they suspect that a particular parent is not suitable to stay with a minor. However, the state has prejudged the male parent and endorses an extremely paternalistic position. The state, in this act, has made an assumption that it is unacceptable for a father to stay alone with his minor female child. A father of a child admitted for a physical health condition does not have to face this restriction. It is also worth pointing out that a minor admitted with parental decision is not under any detention or compulsion; they can

take discharge whenever the parent wishes to do so. Section 91 also includes granting of leave for minors. Granting leave would mean that they are otherwise not allowed to leave the MHE. This could be seen as undeclared detention. To satisfy its paternalistic intentions, the state has covertly converted voluntary admissions (where parental consent alone is needed) into a state-monitored process.

A similar approach is expressed in section 100. At present, the state can remove a person wandering in a public place if it has reason to believe that the individual is mentally ill and is incapable of looking after themselves. However, the new act also empowers the state to enter a private residence (without a magistrate's approval) if the police have reason to believe that a person in the residence is mentally ill and is incapable of taking care of themselves. The police have to present such a person to a health facility for assessment, within 24 h. There is no mention of using ambulances, instead of police vehicles, to transport such patients. The police merely need a "reason to believe" that an individual is ill and at risk; this entitles them to forcefully enter a private home and remove and hold a suspected patient for 24 h. A mental health crisis in the community is thus considered to be solely a law and order problem. The act does not ensure that community patients who are in various stages of crisis or illness and are not willingly accepting care are assessed in the least restrictive way possible. The act instead chooses to "forcefully transport" them to hospitals. A mental health assessment in the community, with police support and assistance if needed, and subsequent transfer (in an ambulance) to a hospital would have been the best method to uphold the principles enshrined in this act. The transfer, even in such cases, could have been processed under section 89/section 94.

## FORGOTTEN SETTINGS AND UNSEEN GAPS

Miss G is admitted to a physical health facility. While being treated for a physical illness, Miss G develops a psychotic state. Miss G also has no or limited capacity. The doctor in charge of her treatment is unsure of options. Does this act provide clear directions or ensure that Miss G's mental health care needs are addressed?

The act confines itself to MHE. If the hospital to which Miss G is admitted is not considered as an MHE (as per the definition in the act), there is not much care to offer her. The act conveniently avoids the reality that many patients receiving treatment in physical health facilities could also have serious mental health issues that may need immediate treatment, sometimes against

their wishes. If the act put forth a system of having approved psychiatrists, the doctor in the situation described above could have sought the help of an approved psychiatrist and if needed, have placed the patient under section 89 after an assessment. However, in the absence of such options, the patient can be treated only for 72 h against his/her wish and that too with the consent of the NR. The doctor would need to demonstrate that such treatment is being given to prevent imminent harm/deterioration.

Mr. H is receiving treatment from a community clinic for his psychosis. He is unwell and lacks the capacity to consent to recommended treatment. Mr. H can be managed at home, but he refuses to take medication. Can the psychiatrist carry on with treatment even if she knows that the family is forcing Mr. H to take medications at home?

The principles in the act, if applied to this situation, appear to suggest that since Mr. H is incapable of giving valid consent, there should ideally be a legally approved procedure to continue with the treatment. Unfortunately, since the act does not provide a clear procedure to deal with this situation, the psychiatrist is now at risk of colluding with the coercion at home. The act has restricted itself to regulations around admission to MHE. It fails to provide clear procedures and guidelines to assist doctors trapped in situations like the one described above.

Mrs. I is a patient with psychosis and is being treated under section 90. She is gradually getting better in the hospital. The doctor decides to test this recovery by granting a few days of home leave; Mrs. I's family supports the decision. After the granted leave expires, Mrs. I refuses to return and has stopped the medications. The patient is now a serious risk to others. The MO is now helpless as the act does not provide a mechanism to bring in a patient who refuses to return from leave. There is no option to revoke the leave or instruct the police to enforce section 89/90. The act provides that option only for patients under section 103, i.e., mentally ill prisoners.

The practice of psychiatry has advanced much in many states in India. Care in the community has spread widely.<sup>[10]</sup> Many facilities offer admissions and assessments for various mental health problems regardless of the severity of the illness. Admission is dependent on the personal preferences of the patient and the services available at the facility. Many patients are now proactively and voluntarily seeking help for mental health problems. The dark shadows from the past seem to cripple the act from seeing this positive change. The act seems to be stuck in the archaic asylum/institutional

care era. The act seems to emphasize the idea that admission to mental health institutions should be avoided at any cost and that even voluntary admissions must be under state supervision. One could argue that though positive in principles, there are aspects that propagate a stigma about mental illness. The marked dissociation between principle and procedures shows the inherent disparity in our attitudes toward the mentally ill. Without clear budgetary commitments, the promise of uplifting mental health care to new modern and humane standards will remain a pipe dream. After describing that appropriate government shall take measures to ensure adequate budget, the act proceeds to define adequacy as "in terms of how much is enough to offset inflation." Therefore, apart from inflation-related adjustments to a preexisting and meagre mental health care budget, there is no guaranteed funding to bring about parity with physical health or implement the principles which the act expounds. Without persistent action from the mental health profession and the people, this act is likely to end as an empty promise.

## CONCLUSIONS

There is no doubt that, in its scope, the new act is a big leap from the 1987 act. It is an attempt to absorb progressive views and principles that are now endorsed by the global community. The new act has set out some principles that mental health professionals will embrace and embed in practice. However, the new act is also a deliberate attempt by the state to shirk its responsibilities and shift the burden to families. This is likely to result in numerous unintended and mostly negative consequences. Breaching its own stated principles of equality, the act ends up discriminating against the mentally ill. There is a paucity of comprehensive rules and regulations to cover all the settings. The resolve to implement the principles underlying the act appears weak, given the avoidance of ring-fenced resources beyond inflationary adjustments.

**Manoj Therayil Kumar<sup>1,2</sup>**

<sup>1</sup>Director, Institute for Mind and Brain, INMIND, Thrissur, Kerala, India, <sup>2</sup>Hon. Senior Lecturer in Psychiatry, Keele University, Keele, Newcastle, UK  
E-mail: manojtherayil@gmail.com

## REFERENCES

1. Ministry of Law and Justice. The Mental Healthcare Act; 2017. Available from: <http://www.egazette.nic.in/WriteReadData/2017/175248.pdf>. [Last accessed on 2018 Feb 16].
2. United Nations. Convention on the Rights of Persons with Disabilities (CRPD); 2017. Available from: <https://www.un.org/development/desa/disabilities/>