

# Making the most of Mental Healthcare Act 2017: Practitioners' perspective

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## ABSTRACT

The Mental Healthcare Act (MHCA) 2017, after parliamentary approval in 2017, came into effect from May 29, 2018. It is rights-based and empowers the patients to make their own choices unless they become incapacitous due to mental illness. There is much emphasis on the protection of human rights of persons with mental illness. The act provides a framework and regulation on how a person with mental illness should be treated. The experts, on multiple occasions, have debated on whether the act is a boon or a bane for the practitioners in India. The MHCA 2017 brings about more impetus on documentation, unlike the previous acts. With the act in place, clear documentation with reasons for decisions made and care given are important for good practice. Although this may potentially raise the cost of care, this will ensure a safer practice of psychiatry and will prove beneficial for the patients and the psychiatrists. To comply with the provisions of the act, one will have to modify the manner in which one carries out the day-to-day practice. Regular training through workshops is required to understand the practical implications of different provisions of the act. Furthermore, regular peer group meetings may give a sense of support and an opportunity to learn from one another and help find solutions to difficult aspects. Overall, following this and adapting to the new act may bring uniformity in practice. This article aims to explore ways to leverage the MHCA 2017 from the practitioner's perspective.

**Key words:** Legislation, Mental Healthcare Act 2017, mental illness, practitioners

## INTRODUCTION

The MHCA 2017,<sup>[1]</sup> received the President's assent and came into effect from May 29, 2018. MHCA 2017 is rights-based and more patient-oriented. Being a signatory to the UN Convention on Rights of Persons with Disabilities and its optional protocol in October 2007, Indian Government adapted its legislations to the UN standards, emphasizing on the protection of human rights of persons with mental illness during delivery of care. MHCA 2017 provides framework and regulation on how a person with mental illness (PMI) could be treated. When the bill was still evolving into an

act, concerned experts in the field, on multiple occasions, had debated whether this will be a boon or a bane for the practitioners in India.<sup>[2]</sup> The act is bringing an enormous change in the day-to-day practice, and therefore, posing challenges for the practitioners in getting accustomed to using it. Hence, the workshops and Continued Medical Education Programs are being conducted on this topic. This article aims to explore the ways to leverage MHCA 2017 from the practitioners' perspective.

## INFORMED CONSENT

Informed consent is central to MHCA 2017. In the Indian context, over the years, a well-structured informed consent

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was sought only in situations involving active interventions such as surgical procedures. Psychiatrists often treated patients on the basis of implicit consent, keeping in mind the best interest of the patient, with some exceptions like when electroconvulsive therapy (ECT) was being offered as treatment. Section 2(i) of the MHCA 2017 defines informed consent as "consent given for a specific intervention, without any force, undue influence, fraud, threat, mistake or misrepresentation, and obtained after disclosing to person adequate information, including risks and benefits of, and alternatives to, the specific intervention in a language and manner understood by the person." The number of psychiatrists in India is around 0.3/100000 population.<sup>[3]</sup> Informed consent as defined in the act is to be learned by all practitioners and to be adopted. Further, the act emphasizes more on capacity and consent, and it is imperative that the psychiatrist takes utmost care in obtaining comprehensive informed consent. Seeking explicit informed consent would not only be useful for the patients but also adopting it in their regular practice, including its documentation, would also be a safeguard for the practitioners from potential litigations. In addition, there could be a possibility of a better therapeutic relationship now, because the practitioners would have to spend more time discussing the pros and cons and asking the patient to choose from the options, in comparison to the paternalistic way of practice where patients were told about decisions made without involving them. Patients would feel their views are more heard or their opinions respected, and this can yield a healthier environment due to enhanced trust. Patients and family members may feel well informed, and thus, will be able to anticipate and follow the course of treatment. The overall working relationship between patients and practitioners may improve, though practitioners will have to adapt to this change.

### CAPACITY TO CONSENT

The MHCA 2017 empowers patients with the capacity to have control over the way in which they are treated. Chapter II, Section 4 mentions capacity assessment and the guidelines for the assessment of capacity. Capacity assessments will be central to all care- or treatment-related decisions for both independent and supported admissions. The law also mandates that a person admitted under the supported clause have periodic capacity assessments once in 7 days for consented patients admitted under Section 89 and once by the end of fortnight in consented patients under Section 90. Capacity assessments done by an independent psychiatrist other than the one treating will ensure objectivity in the assessments and more legal validity. From the patients' perspective, this would ensure that there are no violations of their autonomy and also warrants care when their capacity is lost. The decisions are to be made by the capacitous patient, and where the person is incapacitous, the decision would have to be made by the

patient's nominated representative (NR). A person who has the capacity to decide on care and treatment can decide to accept or refuse care and treatment. The assessment process, the discussion around the decision, and the basis of concluding whether a person have the capacity or not at the given time for particular issue have to be well documented. Patients, who are at risk of exacerbations in future, resulting in loss of capacity, are to be educated about the risk of taking a potentially harmful treatment decision. This has to be balanced with the freedom to choose the care they want. Since a set of guidelines are given in Section 4 of the MHCA 2017 about aspects such as understanding, weighing pros and cons, and retaining the information until they communicate the decision, it brings uniformity in the practice. Practitioners who follow these guidelines, along with reasonable documentation, would be at lower risk of facing indemnity or challenge by the patients or their relatives and can fall back and claim to have followed the MHCA. It is important to maintain documentation and to ensure that patient records are in order and audited regularly.

### ADVANCE DIRECTIVE

Chapter III discusses the advance directive (AD). Any person who is not a minor has the right to prepare an AD. This is a legal document developed by the patient which includes defining the way the person wants to be cared and treated for their mental illness, during the time the person loses the capacity to decide on treatment or care. In addition, the person can also specify the ways the person does not want to be cared for or treated. The AD is prepared by the PMI when he/she has the capacity. This would prove beneficial for the PMI who is at the risk of losing capacity due to multiple exacerbations of the illness. Rights, as well as responsibilities, are given to the individual. It would be good practice for the patients to discuss with the treating team and then prepare the AD, so the person can be well informed before making a choice. Having adequate information before preparing an AD is important, which means the practitioners have a role in providing this information to the patients, which can enhance rapport during the process. The onus is on the patient to make the AD document available in future consultations, including during emergency.

Consider a scenario where the patient wishes to provide the name of the hospital, name of the psychiatrists, and the modes of treatment in the AD. This section may advantage psychiatrists who have better rapport with their patients. This is also in keeping with the core of what psychiatric practice used to be, rapport with the patient being central to the practice. The patient may express a wish to be treated in the same hospital, under the same treating team, including the same psychiatrist. This can enhance the therapeutic relationship between the doctor and the patient and can be

of benefit in terms of treatment. This acts as an advantage for both the doctor and the patient because of the relapsing nature of some of the severe and enduring mental illnesses.

The section also authorizes the patient to choose an NR to make treatment related decisions on the patient's behalf when he/she is rendered as lacking capacity. Having a good therapeutic working relationship with the relatives of the patient may help to ensure care for the patients. If the patient is not willing to get admitted, the NR may decide to get the person admitted and treated in the hospital.

On the other hand, let us imagine another scenario where the patient has not liked the treatment provided, which occurs commonly with treatment in psychiatry. In such situations, he/she may refuse the same in future. This might go against the practitioners even if their treatment was working well. Some believe that if the treating psychiatrists follow the AD, the psychiatrists are less liable even if there are any unforeseen consequences. For example, when a competent patient had made a decision not to receive ECT, if the treating team follows this directive, then it is implied that the psychiatrist is at less risk of being questioned for following a valid AD as mandated by the law. Furthermore, the onus is on the patient to make the AD available to the psychiatrist and the team.

Caring for a PMI can be very stressful. The MHCA recognizes the need for treatment and involving family members and provides a framework to be followed, ensuring the individual rights of the PMI. The AD is one such provision in the act that ensures that the person understands the need to plan future treatment and take precautionary measures, balancing with the rights.

## **DISCHARGE PLANNING**

Chapter XII, Section 98 mandates that every patient admitted to a Mental Health Establishment (MHE) has a structured discharge planning. This is to ensure that the MHE to which the patient is being referred to, or the psychiatrist to whom the patient is referred to, take responsibility for the person's care and treatment. Discharge planning again could open up avenues to the psychiatrists just like informed consent, capacity assessments, and AD. When the law mandates certain procedures as compulsory, the treatment costs could go up. For a legally safe practice of psychiatry, the practicing psychiatrists will have to ensure that these steps are being followed. This will also make care transparent and ensure patient autonomy.

## **DECRIMINALIZATION OF SUICIDE**

Section 115 states that any person attempting suicide will be presumed to be under severe stress and shall not be punishable under Section 309 of the Indian Penal Code.

In addition, the appropriate government shall have a duty to care for, treat and rehabilitate the person attempting suicide, assuming that he/she is suffering from severe stress, to prevent the risk of further suicide attempts. The act recognizes the requirement for assessment and treatment of the persons who attempted suicide in terms of not only preventing such events in future but also in reducing the chance of completed suicide. This also serves as a way to screen and detect mental illness and offer intervention. The act seems to imply that persons attempting suicide and presenting to the General Practitioners/Specialists be provided care by a psychiatrist or other mental health professionals (MHPs). The act safeguards the person from the legalities by presuming severe stress and need for seeking treatment by the psychiatrist. This will improve access to mental health care from the patients' perspective; and from the practitioners' perspective, increase the number of referrals to the psychiatrists, in addition to providing a safety net for the patients from ensuring legalities. There is still a need for the general hospitals to register patient presenting with attempted suicide as a medico-legal case and intimate the police.

## **HEALTH INSURANCE COVERAGE**

Section 21 of MHCA 2017 discusses reducing the stigma by placing an obligation on the hospitals or health care providers to treat a PMI similarly as they would treat the persons with physical illness. More importantly, it says "Every insurer shall make provision for medical insurance for the treatment of mental illness on the same basis as is available for treatment of physical illness." The MHEs could tie-up with the insurance providers, and make sure that their hospitals are recognized for providing care under that particular insurance provider. This can be seen as an advantage for the patients as well as the hospitals. There were circumstances in the past where the patients could not afford inpatient care, but now, with the insurance provision, they will be able to receive treatment and hopefully without delay. The initiatives like Ayushman Bharat<sup>[4]</sup> covering persons with mental illness are steps in the right direction and will go a long way in making sure that mental health is a priority much like physical health.

## **REGISTRATION OF MENTAL HEALTH ESTABLISHMENTS**

Regulations are laid out in the MHCA 2017, in Chapter X, sections 65–72, on the mandatory registration of the MHE, and those minimum standards have to be maintained. The State Mental Health Authority has the power to grant or remove registration. This could potentially mean that establishments run by non-qualified people, rehabilitation centers with poor facilities, and hospitals not maintaining minimum standards are at high risk of closure. Those establishments which are appropriately staffed, maintain medical records, have an

appropriate number of psychiatrists available on duty, and follow protocol will be able to continue their registration. This also could be useful for the establishments, as in the process of following the guidelines, they would be able to audit their system regularly and maintain standards. The Mental Health Authority has the power to inspect the establishments and cancel the registration any time if they feel the establishment is not following the guidelines or maintaining minimum standards. This would help avoid the vulnerable patients and family from getting exploited and would improve the quality of care.

### **EMERGENCY TREATMENT**

Section 94 allows a medical practitioner to assess and treat, for a period of up to 72 h, a patient in whom there is reason to believe that there is a mental illness and that the person is at a high risk of harm to self or others, or to prevent the death or irreversible harm to self or others. This section helps a person with a severe illness to be assessed in the community or be transported to a nearby MHE. The person would benefit from being assessed and treated during this period under this section either in the community or in the emergency department. Whenever available, consent from the NR needs to be sought. This section allows the practitioner to assess for 72 h, against person's will, during which period, if an underlying mental illness is detected, further treatment can be planned. The law puts some obvious restrictions on ECT and psychosurgeries not to be used as an emergency treatment option. This 72 h period may provide ample time for the psychiatrists to assess such patients and identify persons with mental illness. The act safeguards the rights of the patient, but in times of emergency, the act makes sure that the person is suitably assessed and treated. This emergency section also indirectly safeguards the PMI as it provides an opportunity for the person to be assessed and treated, to prevent untoward incidents. This can also be seen as increased accessibility to care during the emergency period.

### **USE OF ELECTROCONVULSIVE THERAPY**

Section 95 of the MHCA 2017 prohibits the use of administration of ECT without the use of muscle relaxants and anesthesia. The established centers where modified ECTs are administered will not have to make any major changes, except that the act says it cannot be administered to a minor or when refused by a person who has the capacity to consent to treatment. This act emphasizes the safer administration of the procedure.

### **ACCESS TO MEDICAL RECORDS AND DOCUMENTATION**

Practitioners will have to give information to the patients and relatives and assist them to make decisions as much as possible. Documentation becomes the key. It may be

necessary to regularly assess the capacity of the individual to agree to remain in the hospital and accept treatment, and this information needs to be documented. Section 25 gives the right to the patient to access their medical records. However, the act mentions basic medical records and does not put the onus on the psychiatrist to provide entire medical records maintained by the hospital. Practitioners can withhold information if they believe that the PMI has a likelihood of risk to others or serious harm to self by knowing the particular piece of information. The practitioner will inform the patient that some information has been withheld, but the patient can still seek the information from the Mental Health Review Board (MHRB) if need be.

### **MENTAL HEALTH PROFESSIONALS**

The MHPs are granted powers, for instance, pertaining to admission under Section 89. Section 89 allows MHPs to make recommendations alongside a psychiatrist for admissions. Further, other MHPs would also be able to provide discharge planning for the patients. This would ensure that the patient gets formally assessed by >1 professional, considering the fewer number of psychiatrists available in India. This would indeed go a long way in providing effective care at possibly reasonable costs. Further, MHCA 2017 is a first of its kind act that brings MHPs under its ambit. This ensures accountability, unlike the previous acts where other MHPs were not covered under the ambit of the law.

### **MENTAL HEALTH REVIEW BOARDS**

Chapter XI of the MHCA 2017 outlines the MHRBs and its functions. The MHRBs are a quasi-judicial body set up by the State Mental Health Authority. The MHRB will hear any dispute in regard to the treatment of patients with mental illness. This would mean that the MHRB will now hear disputes which earlier directly went to the consumer courts, Human Rights Commission, and civil courts, etc. This seems to come as a kind of relief for the psychiatrists since the board already has a medical practitioner and a psychiatrist in its composition. A well-informed board will go a long way in ensuring justice to the patient as well as the treating psychiatrist.

### **RECOMMENDATIONS TO ALLAY APPREHENSION SURROUNDING THE ACT**

#### **Standard operating procedures**

Each MHE should prepare its own standard operating procedures (SOPs) about adhering to the provisions of MHCA 2017, which when followed bring uniformity and prepares a system in place.

#### **Audit**

Regular clinical audits and re-audits should be done in MHEs to check whether their practice is compliant to their own

SOPs. This approach would help the MHPs in identifying shortcomings or the areas that need to be improved and could safeguard them from liabilities or reduce their intensity.

### **Internal review boards**

Having internal review boards formed from professionals from different disciplines and regular reviews help examine and creates an opportunity to make amendments, and also provide greater validity for decisions pertaining to gray areas in practice. This would also help in ensuring better, legally valid decisions.

### **Training workshops**

It is important to attend training workshops conducted by experts in law and mental health to learn various case scenarios and to comply better with the MHCA 2017.

### **Role of professional bodies**

Professional Bodies should form legal advisory committees and help colleague member professionals to make decisions in times of difficult scenarios to comply with the act. It is also recommended that experts representing the professional bodies be at the behest to offer support through video consultations in situations demanding a legally valid decision.

### **Peer learning**

Learning from peers has been one of the best ways to enhance practice and regain confidence. All the difficult scenarios can be brought for discussion in a regularly occurring legal case conference, which can be held via teleconference.

### **Incorporating MHCA 2017 in the postgraduate curriculum**

The early career professionals need to be equipped to provide treatment in line with the MHCA 2017. This would help them come to terms with the challenges ahead better, at the same time, also help them leverage the act better.

## **CONCLUSION**

The MHCA 2017 is a step in the right direction and is in keeping with the international laws that stress the autonomy and rights of the persons with mental illness. When the law is at the interface of medicine, treatment decisions made in good faith often gets overlooked. Ethical and moral validity takes subsidence over legal validity. For

instance, consider a psychiatrist choosing to treat a person with schizophrenia on the basis of the emotional harm experienced by the family, in line with the Mental Health Act 1987, according to the requests by the family. This may be the right ethical and moral decision in such situations, aimed to reduce the suffering of the family members, in addition to treating the person against their will. However, with MHCA 2017, unless the patient is deemed to be lacking capacity and there is definitive evidence for risk on others or the self, the psychiatrist cannot treat the patient against the patient's wishes. This would ensure more legally valid decision. At the same time, one can question whether such decisions are ethically or morally valid. The MHCA 2017 brings more impetus on documentation, unlike the previous acts. Within the framework of new legislation, SOPs can be prepared to be followed that may bring uniformity in practice at the center. This may improve patient care along with respecting patients' autonomy and rights. Adhering to the new law and documenting the treatment decisions make the professional better prepared when challenged in an unfortunate untoward incident like suicide or harm to others. The psychiatrists may now be able to develop a system in their clinic or MHE and bring in changes in their practice to adapt to this legislation. During this transition, there needs to be regular peer group meetings to share experiences in the process of evolving a system that is feasible and less stressful. The group may become a platform for all to discuss difficulties and find simpler and workable solutions in the implementation of the act.

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There are no conflicts of interest.

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