Mental health care bill – 2013: a clinician's perspective

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Mental health care bill 2013[1] is being looked at with suspicion by majority of psychiatrists and has given rise to several debates on how it would impact our clinical practice in a negative way.

Compared to earlier legislations, MHCB 2013 is rights based and follows the principles of the United Nations Convention on Rights of Persons with Disabilities which the Government of India ratified in 2007.The opinion has been divided among the psychiatrists across the country and majority are unhappy about it being legislated in the current form." The present bill would make every psychiatrist in this country quite uncomfortable, seeing the kind of measures it is bringing in, to control this group of medical professionals[2]". However very little can be done now as the bill is in parliament waiting to be passed.

Among the statement of Objects and Reasons are two important ones concerning the mental health professionals and their clinical practice. They are

1. Regulate the public and Private mental health sectors within the rights frame work to achieve the greatest public health good (2(a) v).
2. Promote the principles of equality, efficiency and active participation of all stakeholders in decision making (2(a) viii).

Thus it has become imperative on us that while delivering the services we need to follow certain rules and regulations framed by competent authorities and also take along the various stake holders. The attitude of omnipotence and "I know what is best for you" are no longer accepted in today's world. So it is necessary for us to be more conversant with the legal implications of our decisions and actions.

While discussing mental health care legislation, the important question that needs to be examined is 'Are we primarily concerned with ensuring that we are not inconvenienced and defending our own needs or do we commit ourselves to acting in the very best interests of our patients?'

Does the current MHCB in any way helps us to practise a better psychiatry or is it causing more inconvenience to psychiatrists and their patients? According to A.K Kala, 'In a country where families bear the total burden of mental illness, and constitute by far the largest manpower resource in treating mental illness in an otherwise resource strapped country, such a step would put families and patients on the opposite side of the legal fence, as adversaries and push a wedge between the two'[3].

The main stakeholders in mental health care are the patient, his relatives, community in which the patient is living, various participating NGOs in the community, and the mental health professional. When one looks at priorities and perceptions of each of the above groups though there are points of convergence, there are also areas of disagreement.

The patient wants to have his rights protected, ensure that his individual freedom is not infringed upon and that he is not coerced and no damage is done to him.

The caregiver or family would like to have their relative properly diagnosed, treated and free from suffering and illness.

The community would like to see that no one is harmed by a mentally ill person and the order of society is well maintained.

Owing to the fact that the mentally ill are a vulnerable section of society and are subjected to discrimination in our society, there are certain NGOs who work for this population.

To fulfil the goals and aspirations of all the above stakeholders the agency which all of them look up to is the Mental Health Professional.

However the mental health professional cannot enjoy unfettered freedom to choose his way of caring and delivery of mental health services, however much he might feel he is doing the right thing. Here comes the role of mental health legislation.

Does this legislation impact the way we practice psychiatry? Does it restrict our role? Does it cause impediment in delivery of care? Does it cause lot of inconvenience to the professional and the patient?

Both Indian Lunacy Act 1912 and MHA 1987 were never implemented nor followed by the psychiatrists in the right earnest. Because of this we could never enlighten the government or community about how bad those legislations were. Our empathy to our patients and their families made us circumvent the law to our convenience and patients family's convenience thereby presenting a rosy picture of care and made the government believe that majority of admissions in mental hospitals and psychiatry units of general hospital are voluntary (which is exactly the opposite), and that family and community are ready to receive and give comfort to the mentally ill. In the process we forgot the patient's views about his care and his rights. Though the family has the patient's welfare uppermost in their mind, their motives in certain situations can be suspect and this is where legislation gains importance.

Certain assumptions when incorporated into law become bottlenecks in proper implementation of the law. If we were to implement the above laws (ILA 1912 and MHA 1987) in letter and spirit, probably the judiciary, police and community would have been better sensitized to the needs of various stake holders and law makers would have kept the ground realities in mind while legislating. As debate on these issues is very lengthy, controversial and time consuming, I would refrain from any further elaboration on this issue.

To understand the impact of MHCB in our day to day practice we need to look at the context through which mental health care is delivered in India. The contexts and locations of care are as follows:

1. Practice in consultant's chamber.
2. Practice in a Poly Clinic.
3. Practice in a General Hospital without inpatient facilities for Psychiatry.
4. Practice in a general hospital with inpatient facilities.
5. Outpatient practice in a clinic and admission facilities in General Nursing Homes.
6. Psychiatric Hospitals and Psychiatric Nursing Homes.
7. De-addiction Centres, Rehabilitation Centres, Halfway-homes, and Day-Care Centres etc.
8. Long term care facilities.

Very often a single psychiatrist practises in several of above locations simultaneously and this is the ground reality of mental health care in India.

Practice locations 1, 2, and 3 do not come under the purview of MHCB while 4, 5, 6, 7and 8 are in the purview of MHCB.

What are the main areas of concern for a clinician in MHCB? They are

1. Advance Directives,
2. Nominated Representative,
3. Review Commission, Mental Health Authority, and the District Board,
4. Involuntary admissions,
5. Long term stay,
6. Community care,
7. Treatment Restrictions,
8. Research.

Advance Directives

It may take some time before the patients and their relatives see the utility or otherwise of this provision. In its present form there may not be much impact on routine practice.

It does not apply for emergency treatment. There is no liability on the part of psychiatrist if something unforeseen happens because of following an advance directive (sec.13 (1)).

Psychiatrist is not liable if he is not given a copy of valid advance directive (sec. 13(2)).

Nominated Representative

The practice of the relative bringing the patient is the commonest occurrence in our day to day practice and this can continue.

In those cases where a relative is not available, (e.g. wandering patient brought by police or any other NGO) section 14, sub section 4 (d) and 4 (e) are very helpful.

The role of Nominated Representative is taken over by the Government (Department Of Social Welfare) and the psychiatrist is absolved from taking any unilateral decision regarding admission, discharge or treatment. The nominated representative appointed by the Board is also responsible for discharge planning. The usefulness of this provision can be appreciated by those working in mental hospitals. This provision can also help in negating the popular opinion that Human Rights are not respected in mental hospitals.

Mental Health Establishments

The places which are included in this category are very clear and all such places come under the purview of MHCB. Compared to the Licensing Procedures of MHA 1987, registration of Mental Health Establishments has been made much simpler. There is scope to classify mental health establishments into different categories and also fix different standards for different categories keeping in view the needs of the local conditions (Sec.65 sub sec 5 a, b and c). Further after enactment 18 months time is given to specify standards for different categories of mental health establishments.

Definition of Mental Illness

The definition is more explicit without much ambiguity. Determination of mental illness is in accordance with internationally accepted medical standards --sec.3(1). Further the distinction between legal insanity and medical insanity is brought forth in sec.3(5) which states that the determination of persons mental illness shall alone not imply or be taken to mean that the person is of unsound mind unless he has been declared as such by a competent court. To understand the implications of definition, capacity to make mental health care and treatment decisions and the right to community living the section 19 should be read along with sections 2(r) and sec.4.

For a clinician, the Psychotic disorders and Dementia are the categories which come under the definition of mental illness as per the MHCB.

The Regulatory authorities for Mental Health Establishments are The central MH authority, State MH authority, MH review commission, MH review Board. In all these regulatory bodies the psychiatrist is included and this is a very positive and welcome step. This enables us to voice our opinion in the appropriate forum.

Among the four members of MH review commission one is a psychiatrist - sec. 74 and 75(3).

Central Mental Health authority comprises apart from other members Directors of Central Institutes of Mental Health and one mental health professional who can be a psychiatrist - sec 34(1).

State MH authority apart from other members comprises of Superintendent of mental hospital and one private psychiatrist - sec 46.

The state mental health authority develops quality and service provision norms for different types of mental health establishments in the state - sec.55.

Mental health review boards; one psychiatrist is a member of the board – sec.81(c). This acquires much more importance for the fact that all proceedings before the board shall be deemed to be judicial proceedings - sec.86

It is very clear that all the stakeholders have been given adequate representation in all the regulatory bodies and this need to be welcomed. This was wanting in the MHA 1987.

According to sec 90 (i), the commission shall appoint an expert committee to prepare a guidance document for medical practitioners and mental health professionals containing procedures for assessing when necessary or the capacity of the persons to make mental health care or treatment decisions and as per sec 90(2) everyone should comply with guidance document.

Most likely this expert committee will be comprising psychiatrists and here is an opportunity for us to formulate our views and express our opinions in a single voice. This will be a crucial document for the implementation of the act in the right perspective.

Involuntary admissions – Sec 98 deals with this and is more or less same as Sec 19 of MHA 1987 with which we are familiar with. However the duration of admission is only for 30 days. The other important component is that the admission has to be reported to the board within seven days. This provision should not be seen as restrictive. On the other hand it may help the govt to prioritize the needs of mentally ill. It also helps to sensitise the various stake holders, society and government of what exactly the care of mentally ill involves and may help in fine tuning the legislation.

The provision for admission under section 99 involves the role of two psychiatrists. This may pose a problem in places where only one psychiatrist is available. However it is not an insurmountable problem.

Long stay Homes for mentally ill - The guide lines are not very clear and probably some can be incorporated at the time of framing rules for different categories of care.

Treatment restrictions - Sections 104 and 105 deal with this aspect and are an irritant to the psychiatrist. Though it has been represented by psychiatrists probably no changes can be expected at this juncture. The only option is to invoke sec.135 at a later date.

Research - Section 108 deals with this aspect and gives a fair scope for conducting research in mentally ill persons and does not restrict case notes based research when the person is unable to give informed consent.

What is the way forward?

While conceptualizing the delivery of mental health care we need the experience and expertise of psychiatrists who have knowledge and preferably exposed to working in various contexts and who can appreciate the ground realities. Otherwise we will end up having rules framed (as it happened With MHA 1987) which cannot be implemented and which cause lot of inconvenience to the psychiatrist and to his patients.

The professional bodies like IPS and IAPP should be prepared to have certain guidelines ready when they are expected to be on the boards of regulatory bodies. Those representing psychiatrists should be able to voice the collective opinion convincingly and not go by their personal views; hence the need to start discussions and formulate concrete policies which can be implemented when the act comes into force. Instead of discussing and lobbying for changes in the bill at this juncture let us focus more on formulating the rules and regulations which can be brought to the notice of relevant authorities. We should also frame rules keeping in mind the ground realities of the respective regions and implore upon the State Mental Health authorities when they frame rules and regulations. The mistakes which were committed while drafting rules under MHA 1987 should not be repeated. Further, when the act comes into force, all of us should follow the rules and regulations in letter and spirit. Only then can we bring our concerns and difficulties in the implementation of the act to the notice of central govt which has powers under Sec.135 to remove difficulties under this act.

References

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