

COMMENTS

Some ethical tradeoffs in mental health legislation and practice

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Abstract

An examination of the intersection of legal and medical discourses, particularly in the realm of mental health legislation, provides a rich opportunity to clarify fundamental ethical conflicts. This essay studies one such legal discourse, the draft amendments to the Mental Health Act (1987), to demonstrate that the realm of ethical decision-making is constrained not only by pragmatic administrative, training and financial issues but also by the very contradictions that are necessarily at the heart of any ethically conducted project, however well intentioned and reasoned.

This essay will discuss the ethical and conceptual tradeoffs required in policy-making and practice in legislation over mental health. While it is accepted that ethical concerns are central to all sides of the debate, tradeoffs are always necessary. This is because the ethical domain in itself, contains contradictions. As a starting point, the essay will use the draft prepared by Soumitra Pathare and Jaya Sagade of the Centre for Mental Health Law and Policy, Indian Law Society, Pune prepared on behalf of the Ministry of Health and Family Welfare, Government of India (1). Dated May 23, 2010, this document may be taken as a statement of the contemporary state of affairs. This author is less interested in taking sides or advocating particular reforms than in using the recommendations and the Act to raise larger questions on societal goals and ethical conundrums.

Bringing the patient into the fold of expert systems

Broadly speaking, the Indian Law Society's draft amendments call for more professionalisation, especially by giving greater weightage to legal capacity. There is an appeal for the balance to shift from the more loaded terms of illness ("psychiatry", "psychiatric hospital") to a framework based on rights, dignity, community housing and legal capacity. This would demand the Indian government recognise its deeper obligation to its citizenry, as well as to the international conventions that India has ratified. The tension in distinguishing between medical and legal definitions, priority, and authority, emerges early in the draft, in Section 2. The conflict is over whether the draft amendments should define mental illness on the basis of medical-diagnostic criteria, or in terms of "observable behaviours". The arguments for a behaviour-centred approach are that diagnostic criteria keep changing; that they are for clinical and research purposes rather than for legal ones; and that they are too specialised for non-psychiatrists. On the other

hand, the law better represents the family, the administration and the concerned individual herself.

This discussion in the draft amendments takes place in the context of substance abuse disorders, though the larger question of mental health as defined according to behaviour or diagnosis is clearly involved. The particular significance of the substance-abuse context is the ethical question of how to assign legal responsibility. For example, when judging penalties for crimes committed under the influence, does alcohol use diminish responsibility or enhance it? In some cases, this judgment may depend on the diagnosis; that is, if one commits a crime under the influence of alcohol, the punishment is enhanced unless it is proven that the agent has a history of substance abuse. In such a case, the clinical medical history might ameliorate the sentence. Other commentators have written of the limitations of the Act in parsing legal and medical jurisdictions under specific circumstances. For example, how does one tackle the problem of the transportation of an unwilling patient by agencies other than the police? What about the question of punishing relatives or officers who appear to have deliberately colluded in unnecessary detention (2:14)? And how does one engage with the right to refuse treatment, especially on the contested terrain of involuntary hospitalisation (3:237)? This is further complicated if the patient/client does not concede to being in "denial", but only claims that the facilities are not up to the standard to which she is entitled. Further, many mental health issues are sub-legal, and the connection to mental health is not clear – the entire terrain of personality disorders, for example (4).

Again, this essay is concerned with posing a generalisable ethical question on the contradictions that routinely appear in cases where there is a conflict between two indisputable ethical goods. Here, the problem may be formulated as: if a person under the influence commits a violent crime, how does one balance the ethical good of justice through punishment for causing injury versus respecting a person's civil rights and dignity, and not discriminating against – or, more positively, reacting with compassion and empathy to – a person with a substance abuse problem? Thus, according to one view, the person who commits such a crime must be given not only compassion but also respect for the autonomy of his life history which might have led him to commit a violent act. This autonomy must be granted to any agent as an ethical obligation.

When autonomy may be denied

However, this expansive definition of autonomy may be denied to those who do not have some accepted norm of cognitive ability. Hence, there was no dispute from the outset that “mental retardation” was beyond the scope of the legislation. It is thus admitted from the outset that all mental health subjects cannot be equally protected. Such exclusions are by no means obvious or self-evident. The criteria for labelling persons with mental retardation (often no more than some version of an extended IQ test) and denying them autonomy are bound to be fairly arbitrary; there is no reason that such persons cannot produce public goods worthy of their fellow citizens’ esteem. Indeed, much disability advocacy in the West has been about showing the creativity and insight of people thought to be cognitively or developmentally delayed (to use current terminology). If India ratifies treaties, and claims to be progressive, then it must revisit the exclusion of these people with mental retardation from legal process. In the Act and its critique, such exclusion is not explained or questioned. Such exclusions are the result of the contradictions that lie at the heart of legislation, however well-intentioned. They are conceptual contradictions and resolvable only at a pragmatic level. Such pragmatism is the substance of the everyday life of citizens’ justice. But they leave open questions of the ethical tradeoffs we unconsciously have to make every day. We have to learn how to debate on several levels—the everyday life of disability, the clinical life, the research life, and the legislative life. The demands of all these levels do not overlap so easily. Paradoxically, an acceptance of ethical contradictions may assure us of at least some of the ethical goods of understanding, namely compassion and tolerance of a multiplicity of demands.

The role of the advocate

This compassion and tolerance can moderate the rightful concern with societal safety. The problem of safety exists critically with regard to the question of other oft-excluded populations. Here, one can refer to prisoners and mental health conditions. At one extreme, one can argue that prisons intrinsically generate behaviour that would be considered criminally reprehensible. A similar problem exists for the homeless population, who may have no one to advocate for them – neither friends, nor family, nor a street community. In such cases, anyone willing to volunteer, including a person not necessarily involved in organisations working with the homeless, may be the advocate. The dangers of abuse and meagre resources in these cases are well understood – even self-appointed volunteers require oversight and training. However, in practice, it is no longer possible to argue that there is an intrinsic pathology of the institution of the prison and in homeless living – that appointing an advocate is not a solution to this situation. More discussion is invested in legal protection of the person afflicted with mental illness – and then too, only at the moment of the acute breakdown precipitated by that illness.

Within the Act referred to here, this chiefly devolves into the question of the nominated representative, and the process

of acquiring power of attorney. The immediate issue then concerns the circumstances of the appointment: should any person with a mental illness have to immediately appoint, be it as right or obligation, such an attorney. Or is the attorney empowered only in the instance of the “episodic state” of breakdown? The attorney’s chief function is ironically described as helping the afflicted person cope with the alienating demands of the mental healthcare system itself; the attorney then needs to further assume extra-legal roles in being involved in medical and social care and the decision-making process. This is another instance whereby, on the back of legal protection, the power of the nominated representative (typically family member or friend) may be at odds with the power of the normative medical fraternity.

It is recognised by the drafting team that, culturally in India at least, the power of the medical fraternity, especially with regard to mental health diagnosis and treatment, has been overwhelming, and at the cost of the other stakeholders. Thus the draft proposes that the person with mental illness be given the power of choosing someone s/he trusts to be attorney; the document also argues for increasing that person’s power in the decision-making process of treatment and protection. The ethical tradeoff here is explicitly cited to be between the medical establishment’s judgment of “best interest” and a complex of diverse and “supported decision making”. This tradeoff more generally may be said to involve the larger ethical tension between the perceived, immediate, and compassionate duty of the doctor (which might involve further the principles of “least harm,” or “minimising pain”) versus the perceived possible threat to the autonomy of the patient and her (nominated) agents. The cultural fact that in India most persons with mental health issues continue to live within families and in sub-professional settings also motivates the drafting team to give more importance to the lived experience of carers, both family and friends (and hence their right to prioritise decision-making requirements), than to medical expertise. This goes hand in hand with the earlier prioritisation of socially and culturally based behavioural judgments of mental health issues, rather than a purely medical diagnostic one.

The difficulty of trusting the socio-cultural context

However, all this is further complicated if one questions the basic assumption that the carer is always a benign entity. It is a fact that the family or friend may not act in the best interests of the person with mental illness, and that the person is often likely to be harmed or exploited by the family, whether out of self-interest or ignorance. Hence the team writing the draft amendments to the Mental Health Act has acknowledged that it is difficult to ascertain the reliability of this ideal of well-intentioned supported decision-making. The team refers to the health legislation of some countries whereby the patient must give voluntary consent to the healthcare service provider. The question of informed consent is a large and fertile field of inquiry; this is further complicated in the case of mental illness. Thus when expert medical service is being provided, there are three prioritised stakeholders – the patient, the

healthcare service provider, and, on a lower level of priority, the nominated representative. There would remain the inevitable ethical conflict between the immediacy of medical decision-making in an emergency situation and the longer-drawn-out and more complex process of consensual decision-making that the family or friends, and even the user/patient with mental illness, might prefer. Further, though the law is at pains to delegate responsibility to nominated representatives in certain circumstances, it equally reserves the right to withdraw that right if, in its judgment, the representative is acting in an "unsuitable" manner, or not in the best interests of the person with mental illness. In looking to appoint a suitable representative, it sets the bar rather high. It is also imprecise - it demands that the appointed representative be aware, among other things, of the "values and cultural background" of the concerned person.

This question of cultural values is perhaps the single largest window that opens the medico-legal constraints to the widest possible notion of community. In its maximalist form, this recommendation is impossible. Who can possibly adjudicate what cultural values are, and how they impinge on questions of care and cure? How might we even begin to coordinate the neutral word "culture" with the plethora of thorny questions of caste, religion, class, domestic patriarchy and such other social domains? Yet the draft must be commended for bringing this breadth of vision into full view, and as a necessary demand. It understands that without at least a gesture to this complex terrain, any attempt to solve questions within the narrower medico-legal domain will be frustrating and incomplete. The ethics lies if only in the gesture, and this in itself is heartening to the non-specialist, family and well-wisher of the afflicted person.

However, this brings with it one of the deeper conceptual dilemmas of the situation. On the one hand, there is the emphasis on ever deeper specialisation and domain knowledge. For example, it is not enough to be legally or medically aware; one must also be specifically trained in an ever smaller subset of specialisation within the medical and legal realms of mental health. On the other hand, there is the recognition that the final ethical resting place of this journey is beyond or outside technical specialisation. It resides in our experiences, our sense of cultural comfort and belongingness. Science and legality would not be able to achieve this final realm of cultural security. Yet the way to that final experiential, lived realm is paved through medico-legal procedure and guarantee. How is this impossibility to be achieved whereby the ladder has to be used, but then emphatically thrown away, where the end is uncontaminated by the journey? In other words, how is the integrity of the patient's cultural belongingness and satisfaction to be maintained at all costs against a medico-legal system which is not in the habit of stepping aside, and tamely yielding power to other forms of knowledge that are far more fuzzy?

Additional elements of "culture" include illiteracy and great unfamiliarity with urban and modern forms of knowledge

(medical, legal, police); the diverse and stark regional, linguistic, customary, penitentiary, and resource variations in the country; the legal judgment of "moral turpitude", a wide-ranging and unclear but favoured term in the lexicon; insolvency; and erstwhile imprisonment and/or conviction. It has also been suggested that such types of people - who represent large swathes of the population - should find representation in any governmental or medical commission itself, as they best understand it from the user's perspective.

Implications for practice

The pragmatic administrative questions also follow immediately. One field mediating individual cultural comfort and medico-legal knowledge systems is called, vaguely, "education" for all stakeholders - nurses, social workers, doctors and anyone involved in care. The question is muddled because, again, on the one hand it is understood that education is irreducible to simply medication or medical and legal services. On the other hand, such education cannot be given under the generic field of higher education, for the experience in India has been that nurses and social workers have often gone into the mental health field without any specific training or licensing in that field; indeed, there is no clear licensing policy in this field for counsellors and therapists, and the potential for abuse and lack of expertise has been high. The larger question of the legislative relation of the Persons with Disabilities (Equal Opportunities, Protection of Rights, and Full Participation) Act, 1995, to the Mental Health Act is itself unclear on what the demarcated and overlapping areas (for example, social justice and employment programmes, protection from abuse, and licensing of shared detainment facilities) of concern and relevance are.

The question of the larger, non-expert culture is also evoked in the recommendation that the hearings be public, and even open to the media. Here, at least, part of the ethical problem can be formulated as the conflict between confidentiality on the one hand (privacy, autonomy) and the need for accountability and transparency on the other. The question is only partly ameliorated by asking the "consent" of the person involved, as consent would then immediately be related back to "capacity to consent", which judgment and assessment would again devolve into a specialist question at the cost, putatively, of autonomy. A further complication is the meaningfulness of the public hearings if the patient is there involuntarily; in such a situation, the requirement that he or she consent to the public hearing would be actually quite nonsensical and even, insulting, and violative of the rights of the patient.

The matter at hand is also relevant to the more specific question of the autonomy of the patient. For example, in a divorce or property matter, the presence of mental illness affects the outcome in a manner that is unclear. How can one disentangle marital behaviour from its mental health origins, when the rights of at least two (more than two, if there are children or elderly dependents) people are involved? How can one speak of norms of appropriate marital behaviour if the local "culture" to which the spouse stakes a claim deviates from

acceptable governmental (and progressive) norms of gender relations? What about diverse, culturally based norms and models of treatment, measurement of outcomes and definitions of cure? Treatment cannot be a mystery to all but the medical establishment; it must be explainable at every level—from diagnosis to cure or amelioration. The very difficulties and adversities of that socio-cultural space may accelerate mental health difficulty. It is absurd then, if, after treatment, the person is expected to go back into the very society that pathologised or stigmatised him/her. Why would such a society be expected to magically turn compassionate, supportive and able to render the help required, appropriately and thoughtfully? After all, the Act (and even the critiques of the Act) does not ask for large-scale education of the community; indeed such an education would amount to a conversion.

It sometimes seems that the notion of the socio-cultural community is being sentimentalised as the ultimate repository of the wholeness that will finally restore the patient. But what if the practices of the community are generating the difficulties in the first place? We know this is likely, be it the many rural or urban or religious practices (sometimes with extreme practices like chaining the afflicted), or the more generic problem of how patriarchal households treat minors and women. How meaningful is “choice” in such a situation? What about the related, broader difficulties of ideas like “informed consent”, when there is such an asymmetry between the vulnerable, non-specialised patient and the entirety of specialised medical and legal systems? For the patient, the “choice” is between the isolating, unintelligible medico-legal system and an often judgmental and insufficiently-informed family and community. It is in this context that extreme caution must be urged against the rhetoric of “values”, and “cultural background” of the person or his or her community. Over-dependence on the notion of native community wisdom has often had severe negative repercussions in the past and seems unlikely to yield obvious benefit in the future.

Conclusion

This essay has tried to highlight legitimate ethical dilemmas where there are no easy answers. The opinions expressed here are therefore necessarily tentative—that a final horizon of good health governance would try and recognise the full variety of human vulnerability, from substance abuse to personality disorders to prisoner mental health exacerbated by the institution of the prison. Yet this widening of compassion can ill afford to belong exclusively to an ivory tower of reformers. For the reality is that in India, where most patients/users are in families, or homeless, we need to engage with popular community perceptions (including fear, disgust and denial) regarding the mentally afflicted. Of course the community is not going to sit back and be “educated”; it will likely resist, or turn indifferent, or hostile, or plead financial strain. Hence, resources must be allocated for this battle over accumulated religious, cultural and social perceptions. At any rate, it is folly to expect the simple return of the mentally afflicted to idealised notions of community or family. It is not yet clear if such idealised notions of “nurturing, welcoming communities” or family are the beginning of the problem or the beginning of the solution.

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