Ethical aspects of public health legislation: The Mental Health Care Bill, 2011

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Abstract

A legal framework is essential to promote and safeguard the interests of persons with mental illness. Since the Indian Lunacy Act, 1912, mental health legislation has come a long way. Currently efforts are underway to modify the existing Mental Health Act taking into account the resolutions under the UN Convention on the Rights of Persons with Disabilities. The proposed Mental Health Care Bill, 2011 incorporates promising modifications, like "care-giver", "nominated representative", "consent", "support" for decision making, and "advance directive" for persons with mental illness in its rubric, which seems potentially beneficial to the patients. The proposed new bill should facilitate and strengthen a mental health policy which provides acceptable, accessible, and equitable mental health care. A law becomes meaningful when it is realistic, implementable and ethical in provisions. In this comment, we take a critical look at the proposed 'The Mental Health Care Bill, 2011' through the lens of ethical principles.

Background

Historically, legislation has played an important role in protecting and promoting the rights and interests of persons with mental illness. Mental healthcare in India was brought under the purview of legislation for the first time in the year 1858, through the Indian Lunacy Act. This facilitated the setting up of mental asylums to admit and segregate those who by reason of insanity were perceived to be troublesome and dangerous. The Act was amended in 1912 putting civil surgeons in charge of the mental hospitals instead of the Inspector General of Prisons, as in the Act of 1858. The amended Act of 1912 laid out the rules and procedures for admission to and discharges from hospitals and asylums and guided mental health care in India for the next 75 years (1). In the year 1987, the Indian Parliament passed the Mental Health Act (MHA) which came into force in the year 1991. The MHA focused largely on administrative aspects and institutional care. Since the time of its implementation, the MHA, 1987, has been criticised for focusing heavily on administrative aspects, and institutional care, and for ignoring community psychiatric care (2). The Act has also been criticised for failure to comply with the guidelines of the National Mental Health Programme and the World Health Organisation on discharge care and rehabilitation, and for being unsuccessful in addressing the problem of social stigma (3, 4).

On March 30, 2007, India joined the community of 82 countries which are signatories to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) which is the first comprehensive human rights treaty of the 21st century and marks a significant change in attitudes and approaches to persons with disabilities (5). India, as a signatory to the UNCRPD, is obligated to bring its existing laws into congruence with the basic principle of the UNCRPD which views persons with disabilities as 'subjects with rights', not 'objects of charity'. Hence, the Government of India (GOI) initiated the process of developing the National Health Bill, revision of the existing Mental Health Act of 1987, and amending the Persons with Disabilities Act. The task of amending the existing MHA 1987 was assigned by the Ministry of Health and Family Welfare (MOHFW), GOI (6) to the Indian Law Society, Pune. The draft of ' The Mental Health Care Bill, 2011, referred to as the "draft Bill" in this article, has undergone several modifications through consultative processes. It is felt that the new legislation should facilitate and strengthen a mental health policy which provides acceptable, accessible and equitable mental health care (7). The importance of ethical issues in public health policy is being increasingly recognised worldwide. A law becomes meaningful when it is realistic, implementable and ethical in its provisions.

The US National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research published the Belmont Report in 1979 (8). This report is an articulation of the key ethical principles for research and clinical care involving human subjects. The key ethical principles according to the Belmont Report are respect for persons, beneficence and non-malfeasance, and justice. Respect for persons involves honouring the autonomy of an individual to deliberate upon and act according to his/her goals and protecting the autonomy of each individual. Beneficence involves acting to "do good" for participants or to act for their well-being while also taking steps to avoid and minimise harm (i.e., non-malfeasance). These concepts of beneficence and non-malfeasance are commonly understood as expressed in the Hippocratic Oath and, thus, extend from the typical doctor–patient relationship to the context of clinical research. Justice involves fairness in the distribution, care, and service to equals in equal manner.

Hence, it is of paramount importance to look critically at the draft bill from an ethical perspective, with reference to respect and confidentiality, along with the core principles of autonomy, beneficence, non-malfeasance and justice (9). In this commentary, we examine the provisions of the draft Bill available on the website of Ministry of Health and Family Welfare, Government of India (6)

Analysis

The draft Bill incorporates several new important provisions under its fold. It lays emphasis on human respect. The

prejudicial term "mentally ill" gets replaced with "person with mental illness" in order to separate the person from the illness. This avoids branding an individual and helps in reducing the stigma. New provisions like "nominated representative," "consent", "supported admission", and "advance directives" have been introduced for persons with mental illness.

Nominated representative

Any person who is 18 years of age, and above, and is competent can appoint a person who is above 18 years age as a "nominated representative (NR)". The representative helps the patient to interact with the mental health system and also acts as a legal guardian for the patient. However, there is a possibility of conflict with the autonomy of the patient if the nominated representative does not act according to the patient's wishes. Hence, it is of great importance that the competence of the patient to appoint a representative needs to be assessed with care and concern by a mental health professional trained in assessing 'competence'. It would be better if a structured instrument is used to assess 'competence' in order to bring in objectivity. Inadequate assessment of 'competence' leads to erroneous decisions and hence compromises the autonomy of the person thereafter.

Consent

The draft Bill gives great importance to free and fully informed consent. The autonomy of the individual takes precedence over the 'best interest principle', with the exception of certain clinical situations. Unilateral decision making by the clinician citing the 'best interest principle' has been discouraged.

In situations where there is lack of full capacity to give consent, the new draft allows a nominated representative, whose bona fides and credentials are clear to the service provider, to be part of the supported decision making. This gives greater autonomy to the patient. The draft Bill makes it mandatory for the health service provider to proactively empower the patient to either accept or refuse treatment. However, during emergency medical interventions, the principle of beneficence, i.e. 'doing good', takes precedence over autonomy. In such situations, the consent may be presumed unless there is a previous declaration to the contrary.

The draft Bill requires a personal assessment of each individual case whenever there is a hint of lack of full capacity to give consent. The thorough assessment of evolving capacity and intellectual maturity and documentation involves the investment of a significant amount of time by the clinician. Though this is in keeping with the ethical tenet of autonomy, we feel that this might amount to additional workload, involving a considerable amount of time for the clinician. Moreover, clinicians need to be trained to assess the above; in the absence of adequate training and standardised instruments, the objective may not be achieved. Given the inadequacy of infrastructure and resources in our country, this needs to be examined from a pragmatic angle.

Confidentiality

The draft emphasises the confidentiality of patient-related information in both the virtual and real spaces. Confidentiality in research settings and during the proceedings of the mental health review commission is emphasised in the draft Bill.

Standard of care

The Central Mental Health Authority has prescribed minimum standards for facilities, personnel training, and services. This should help to bring equal treatment into care and also ensure that every patient receives a basic minimum standard of care, thus fulfilling the principle of justice.

Legal capacity

According to the draft Bill, all patients with mental illness have legal capacity and may/ may not require support to exercise their legal capacity. The level of safeguards provided is based on the level of support needed, with a rider that the support should be treated as a temporary phenomenon. There is provision for a review at the end of a prescribed period to check for the ability to make independent decisions and for further need of a high level of support. These provisions emphasise the autonomy of patients.

Supported admissions

This measure was earlier known as "admission under special circumstances" under which a patient could be admitted for up to 90 days under a single admission process. Under the draft Bill, this period has been reduced to 30 days, and may be extended up to 90 days. Further admission beyond this period of 90 days can be extended up to 180 days subject to certain conditions. This has been done to ensure the safety of the person. Treatment shall only be provided after taking into account any existing advance directive or with the support of the nominated representative. This covers the important ethical principle of non-malfeasance.

Prohibited treatment

The draft Bill makes a provision for prohibition of certain treatments. The policy seems to have been derived from the principle of non-malfeasance. There is a prohibition on electro-convulsive therapy (ECT) without the use of muscle relaxants and anaesthesia (unmodified ECT). However, the practical implications of this prohibition need consideration. In routine clinical practice, there are often situations like life-threatening catatonia wherein a patient may need urgent electroconvulsive therapy. Moreover, modified ECT is expensive and requires the specialised services of an anaesthetist. Given the manpower and financial constraints in our country, a complete ban on unmodified ECT may result in failure to provide this effective and life-saving treatment to all those who need it. This goes against the ethical principle of beneficence. Serious adverse effects are a rarity with unmodified ECT, and we feel that it should be allowed under rare circumstances.

The draft disallows the administration of ECTs in any form to minors. Severe mental disorders such as schizophrenia and bipolar illness often set in during adolescence and can present as catatonia which can be life threatening. It is well known, and a scientifically established fact, that catatonia responds very well to treatment with ECT. A blanket ban on ECT in minors can be potentially dangerous to the life of the patient. Hence, provision should be made to allow administration of ECTs in minors only during exceptional clinical circumstances.

The draft Bill puts significant restrictions on psychosurgery by making it mandatory to acquire approval from the State Mental Health Authority (SMHA). Psychosurgery is rare and is still an unexplored area. It is a complicated decision which should be taken by a well informed clinical team comprising of experienced neurosurgeons, anaesthetists and psychiatrists. We are not sure whether the panel of SMHA has enough expertise to decide on such complicated clinical issues. Elaborate procedures are likely to discourage a clinician from offering a potentially beneficial clinical procedure to a patient. We agree that safeguards need to be in place to avoid the exploitation of patients. To ensure the same, we feel that the decision should be at the discretion of the local institutional ethics committee. Moreover, the field of neurosurgery has advanced with the application of newer techniques with greater accuracy and fewer complications. We feel that the process of making it mandatory to obtain permission from the SMHA could impair the progress of research in psychosurgery and also may cause delay in the treatment for certain patients.

Discharge planning

In another welcome change, the new draft makes provision for discharge planning to ensure continuity of care with a proper referral and briefing of the caregiver/family member of the patient.

Advance directives

One new feature of the draft Bill, which needs to be evaluated in greater detail, is the inclusion of the provision of "advance directives". Advance statements documenting mental health service consumers' preferences for treatment during a future mental health crisis or period of incapacity have gained salience in recent years in the United States and some European countries, including the United Kingdom. The new draft Bill makes a definite effort to incorporate this practice. The new provision of "advance directives" is in keeping with the principle of autonomy. Every person, irrespective of their mental health status has a right to make a written statement known as an 'advance directive'. The 'advance directive' is a legal document which provides the individual with the autonomy to decide the manner in which he/she wishes to be cared for during a future period of illness. A patient can appoint a person in the order of precedence as nominated representative during his period of illness.

In the present draft, the advance directive needs to be certified by a medical practitioner regarding the competence of the individual. However, this might give rise to a dilemma for the clinician as certification of advance directive may potentially lead to legal entanglement. As previously discussed, the caveat of allowing any medical practitioner who may not have formal training to assess competency apply here also. The treating practitioner is bound to honour the advance directive as expressing the wishes of the patient. The draft allows the provision of amending, cancelling or revoking the advance directive to the individual at any point of time. This substantially strengthens the principle of autonomy. However, keeping to the principle of beneficence, a blanket refusal of all kinds of treatment in the advance directive is considered invalid unless approved by the district panel of the Mental Health Review Commission (MHRC).

Advance directives give a greater degree of autonomy to the patient; but they could come into conflict with the "best interest" principle. The treating doctor may hesitate to treat the patient in a crisis situation where the choice of treatment is contrary to the directive, unless an appeal is made before the MHRC for overruling of the same.

Though advance directives have been implemented in many countries and happen to be a salient feature of the draft Bill, this measure is often differently defined and interpreted in different countries. The distinguishing features are the extent to which they are legally binding, whether health care providers are involved in their preparation and whether an independent facilitator assists in their preparation. The differing nature of advance statements is related to the diverse models of care upon which they are based and the legislative and service contexts in which they have been developed (10). In this regard, it would be appropriate to evaluate this new provision with respect to existing advance directives in other countries like the USA and UK.

In the United States, the Patient Self-Determination Act of 1990 followed legislation for medical advance directives and cleared the way for psychiatric advance directives. Unlike in India, the federal nature of the US constitution translates into variations in formulation and implementation of laws among the different states. However all U.S. states permit competent adults to use generic health care decision laws to make at least some psychiatric treatment choices in advance, typically through the use of a durable power of attorney (11). Additionally, 25 states have, since the early 1990s, enacted specific psychiatric advance directive statutes (12).

While the specific features of psychiatric advance directive laws vary considerably by state, there are some commonalities. Under the Patient Self-Determination Act, any hospital receiving federal funds must notify admitted patients of their right to make an advance directive, inquire whether patients have advance directives, adopt written policies to implement advance directives under state law, and notify patients of what those policies are. No such compulsion for notification is present in the current draft in India. Another feature which is present in US advance directives, but absent in the Indian draft, is the provision of detailed checklist forms including different

options of admission and treatment to help consumers prepare advance directives. These might be useful inclusions in the Indian draft as they uphold the principle of informed decision making and thus autonomy. The principle of beneficence is highlighted in both countries by making it possible to override an advance directive if it is deemed to be against the best interest of the consumer (13).

In the United Kingdom, Scotland has pursued a different policy from that prevailing in England and Wales. In Scotland, parliament has included advance statements in recent mental health legislation, that is, the Mental Health (Care and Treatment) (Scotland) Act, 2003. The written statement may be invoked or revoked only in the presence of a witness who must certify the capacity and intent of the consumer. The Indian draft has improved upon this clause by requiring a medical practitioner to certify the competence of the individual. Under the Scotland Act, if treatment is given that conflicts with the advance statement, the responsible clinician under the Act must provide the reasons in writing to the person concerned, ie the person named under the Act, the guardian, the welfare attorney, and the Mental Welfare Commission; as well as file a copy in the person's medical records. This is slightly different from the Indian draft, wherein prior application has to be made to the district Mental Health Review Commission. In England and Wales, on the other hand, advance statements have been recognised under common law for some years, and their place has now been defined by statute in the Mental Capacity Act, 2005. However, in the case of mental disorders, mental health legislation (currently the Mental Health Act 1983) takes precedence over any provisions in the Mental Capacity Act. Advance statements can thus be overridden. Concern over public protection has outweighed concerns about patient autonomy. Advance statements have therefore taken an essentially clinical form, independent of their statutory basis (10).

In Germany, Austria and Switzerland, advance directives are legally binding upon the clinician, and can be overridden only by means of a court order (10).

To conclude, in comparison with other countries, the provision of advance directives in India seems well formulated and justifies the principle of autonomy, even as it gives due importance to the principle of beneficence.

Conclusion

The proposed 'The Mental Health Care Bill, 2011' makes several provisions which are beneficial to patients. It upholds supported decision making over the "best interests" principle and offers the option to make an advance directive on treatment issues. This is in accordance with the principle of respect for persons and helps protect the autonomy of the individual. The draft also makes a provision for supported admissions. These changes help enhance the degree of autonomy for patients which was not adequately addressed in the original act. The draft mentions the practice of non-discrimination while treating patients with mental illness, which, in turn, reflects the principle of justice. In the case of research involving patients with mental illness, the draft mandates the obtaining of free and informed consent, and the upholding of the ethical principles mentioned above. The draft Bill details the confidentiality issues of patients. It has tried to protect the rights of users and family members taking ethical principles into account. The section on prohibited treatments and psychosurgery needs to be re-examined. Overall, the proposed amendments highlight the role of ethical issues in formulating a public health policy to protect the rights and interests of users, especially those of the vulnerable groups. Rules framed over such an ethical matrix are more likely to be acceptable to the community.

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