

Legal and Ethical Aspects of Mental Health Care

The Mental Healthcare Act 2017 (MHCA 2017),^[1] explicitly talks about the rights of patients with mental illness (PWMI) and lays down the ethical and legal responsibilities of mental health professionals and the government. The rights of PWMI are at par with the fundamental rights of human beings and need to be clearly talked about as they belong to a vulnerable group from evaluation, treatment, and research perspectives. Such rights translate into the ethics of psychiatric care that relate to respect for autonomy; the principle of non-maleficence, beneficence, and justice; confidentiality (and disclosure); boundary violations; informed consent (and involuntary treatment); etc.^[2,3] I will discuss the ethical, legal, and related issues pertaining to the manuscripts published in this issue of the journal.

THE MENTAL HEALTHCARE ACT 2017

In their article pertaining to MHCA 2017, the authors,^[4] critically evaluate the pros and cons of the new ACT. They commend the act for endorsing the rights (especially insurance) of PWMI and recommending decriminalization of suicide and the *lesbian, gay, bi-sexual, transgender, questioning/queer (LGBTQ) community*. They also mention the non-representation of the Indian Psychiatric Society and inadequate address of the burden of care experienced by the caregivers. The caregivers of PWMI are the real ambassadors of mental health; they sincerely understand the genuine service that psychiatrists have provided in this country over many decades. No doubt, human rights of PWMI have to be protected at all times; however, it cannot be one-sided. There is an equal and strong need to involve the caregivers in framing mental health policies that are ethically and legally sound and at the same time tailoring to their needs and the ground realities of this developing country, such as poverty, illiteracy, unawareness regarding mental illness, stigma, discrimination, etc. In view of the new challenges thrown by MHCA 2017, such as mental health capacity assessment, advance directive, nominated representative, etc., the authors stress regarding the need to actively collaborate with “the media, police, NGOs, human rights activists ... and police.”^[4]

ETHICAL ISSUES

Ethic is defined as “a set of moral principles, especially ones relating to or affirming a specified group, field,

or form of conduct.”^[5] Technically, ethics talk about morality and desirable way of behaving but may not be binding on an individual. However, when it comes to medical ethics, these are essential (not desirable) requirements based on which a physician is mandated to act. The legal aspects of patient care are determined by country-specific regulations, which in turn are governed by medical ethics. For instance, when an Indian psychiatrist is alleged of “wrongdoing,” it is determined whether he acted contrary to “medical ethics,”^[6] *or to the pertaining laws in the country.*^[1] Thus, the ethical and legal responsibilities of a psychiatrist are intertwined.

Confidentiality and disclosure

The patient–physician relationship is bound by the moral and ethical sanctity of confidentiality, more so in mental health. This is one of the fundamental responsibilities of the psychiatrist.^[1,6] In clinical practice, however in certain situations, the PWMI themselves waive-off this confidentiality clause. In India, PWMI are mostly accompanied by caregivers. Few PWMI wants their information and diagnosis to be disclosed to such caregivers. Considering this as implied consent, till some time back, such disclosure was done in the absence of an explicit written informed consent. A typical scenario would be a lady under treatment for psychiatric illness for the previous 10 years suddenly turns up to the treating psychiatrist and discloses that she got married around a month back and now plans to conceive. Her spouse also wants to discuss regarding the diagnosis, treatment, and the need for and the safety of psychotropics in pregnancy. The spouse may, unfortunately, use the disclosed information for any purpose (including divorce) and the lady may sue the treating doctor for breaching the confidentiality. Hence, as the lady herself wants her information to be shared with her spouse and the confidentiality clause is going to be breached, written informed consent should mandatorily be obtained from her, including permission as to how much can be disclosed and this should be documented in the patient’s notes. Such written authorization from the patient may protect the psychiatrist in the Court of Law.

It is interesting to know the sociodemographic variables that determine such disclosure. Gupta *et al.*^[7] conducted a study on remitted psychiatric patients. Younger age,

female gender, and higher educational status were more significantly associated with the patients' unwillingness to disclose their concerns with others. The authors recommend that these factors may be considered when making ethical decisions.

Lack of adequate information regarding forensic patients with mental illness

Diagnosis is of paramount importance to manage psychiatric patients effectively which rests on adequate history from significant others, as psychiatrists cannot rely solely on mental status examination. When individuals are admitted involuntarily through Honorable courts and prisons into tertiary level public hospitals, there is a lack of adequate history. This is more common with those referred from prisons. Attempts are made to discuss with the prison medical officer and caregivers. The caregivers are either untraceable or unwilling to discuss. Also, because of unawareness regarding mental disorders, the only history obtained from the medical officer is of the patient being irritable or displaying suicidal threats. This is not enough to arrive at a diagnosis. Thus, the lack of adequate history is a major problem in a forensic psychiatric setting. The management of such patients, thus, is mostly based on inpatient observation. In recent times, in India, there is an increased focus on training of judiciary and prison medical officers which is a welcome step. There is also a dire need to have a judicial policy that mandates caregiver's and/or family member's presence while referring such individuals to psychiatry hospitals.

With this background, a retrospective chart review was conducted on female forensic inpatients.^[8] About 73.9% of the sample was referred from prisons and 26.1% from the Honorable courts. In view of the alleged crime, 21.7% of subjects were referred for assessment of fitness to stand trial. Majority of them (30.43%) were charged with the killing of close family members, such as husband or child. On retrospective evaluation, approximately half of the study sample had an illness at the time of occurrence of the crime. About 30.4% of the individuals were diagnosed as having psychotic disorders, and 47.8% had a mood disorder. A significant clinical improvement was reported in 87% of patients which is encouraging. It remains to be seen whether the improvement gained persist in the long term, especially those referred from prisons. Also, how such patients fare after discharge from the psychiatry hospital and after release from prisons, because of treatment nonadherence and other prognostic factors? This study focused only on female gender; do male forensic patients fare differently?

LEGAL ISSUES IN PSYCHIATRIC CARE

Psychiatrist appearing in the Court

In their article, "Psychiatrist in Court: Indian scenario,"^[9] the authors discuss the legal aspects of psychiatric care when psychiatrists are summoned as an expert witness. They opine that the "psychiatry residents often do not get first-hand exposure to the Court proceedings." The reason for this may be threefold. First, many residents get trained in General Hospital Psychiatry Units (especially, private colleges) that are not directly attached to forensic psychiatry units. They have a peripheral posting of just around 2–4 weeks to such centers. Second, the residents, being doctors-in-training, work under the supervision of faculty; hence, the Honorable courts do not consider them competent to give evidence. Third, the faculty members may not involve them in legal aspects of patient care, believing it is not their responsibility. In my place of work, which is a tertiary level teaching public hospital, the psychiatry residents are routinely involved in legal aspects of patient care. The faculty should make sure that the residents are actively involved in the legal aspect of patient care, such as medical boards, discharge committee meetings, certification, etc. Only when they are exposed at this stage of their career, once out of residency, they would be in a position to manage such issues independently.

Outcome of insanity pleas

The psychiatrists appear in Honorable courts as an expert witness and give evidence but are unaware as to what happens later. I commend the investigators for researching a hitherto underresearched topic in Indian scenario,^[10] relating to insanity pleas.^[11] If an accused has a proof that he was under treatment prior to the crime, the treating psychiatrist is likely to be summoned; in 32 out of 67 cases (47.76%), the treating psychiatrist was asked to appear. The time interval between the "visit to a psychiatrist" and the subsequent "date of crime" ranged from 1 to 1800 days, which is alarming in the sense that a PWMI may commit crime immediately following the consultation. More so, if there is a documentary evidence of mental illness, there is a higher chance ($P < 0.012$) of acquittal on the grounds of mental illness. Both in those cases where the Honorable Court did not feel the need for psychiatrist's evidence (24 cases) or in those six cases where the psychiatrist opined that there was no mental illness, the accused was not acquitted on the grounds of mental illness. Also, the 16 out of 56 accused (28.57%), who had mental illness as per psychiatrists' opinion, were acquitted on the grounds of mental illness ($P = 0.002$). The 18 (17.65%) cases out of a total of 102 cases were acquitted on the grounds of mental illness. The Honorable High Courts' judgment was mostly in line

with the judgment of the lower Court and heavily relied on the documentary evidence of mental illness. The psychiatrists' opinion was an important parameter, which is quite encouraging. The results strongly point toward the need for proper documentation.

Abscinding behavior in patients with mental illness

When PWMI abscond from psychiatric hospitals, especially closed wards, it places an enormous burden on the hospital staff in terms of the legal implications. The absconders may not take care of self and may be at risk of harm to self, others, and property. Though absconding from psychiatric hospitals or nursing homes is quite common, no Indian data are available in the published literature, probably because of the concern that it may reflect negatively onto the staff and hospital administrators. Though this is an unfortunate event, we need not feel inhibited researching this as absconding is common in any closed setting including high secure prisons^[12] and general hospitals,^[13] and psychiatric hospitals worldwide,^[14-16] and in India,^[17] are no exception.

It is heartening to note that an article dealing with this important, albeit unaddressed issue is published.^[18] Among the in-patients, the absconding behavior was found in 4.5% of the individuals. They were mostly males, with a diagnosis of schizophrenia or mood disorder with comorbid substance-use disorder, with impaired insight and high perceived coercion being the predictors of absconding behavior. About 22.2% of the nine absconders committed suicide. A previous history of self-harm and wandering away from home in those absconded points toward the need to inquire regarding this as part of history taking. This study focused on open wards where PWMI consent for admission and the caregivers who stay are responsible for patient care. It is pertinent to study absconding behavior in the closed ward setting where PWMI are admitted involuntarily (through courts and prisons) without caregivers, thus placing more "responsibility" on the hospital authorities. There is a dire need to employ polices to prevent such incidents by rationalizing pharmacotherapy; adequate use of restraints and seclusions as per guidelines;^[1] electroconvulsive therapy for agitated patients; strengthening the hospital security by constructing stronger wards with tall walls and fencing, adequate personnel, sophisticated gadgets, and alarms; timely discharge from the hospital; etc. It also points to the need for prison mental health services where forensic patients can be managed securely in the prison itself.^[19]

For patients with severe mental retardation, dementia, and severe and enduring obvious mental illnesses, such as severe psychosis, who are at risk of absconding behavior,

few of my psychiatry colleagues as part of informal discussion suggested use of metal bracelets (kadas that are religiously acceptable) with details engraved (names, phone numbers, and address of patient and caregiver); bands; and implants, gadgets, watches, and chips with GPS location device and trackers. However, these need to be used after obtaining written informed consent, but the concerns expressed are cost, need for battery charging, can be thrown away, technology not so advanced for universal application, etc. Other concerns expressed were ethical and legal issues, stigma, restriction of civil liberties, violation of privacy, infringement to capacity, practicality, etc. The tattoos with name, phone, and address of the caregiver seem to be a reasonable option, as these cannot be discarded and may have a fashion statement, the future suggestion being tattoos with radioactive (but safe) traceable ink material that can be tracked (*in a conversation with Live CME Psychiatry WhatsApp group members: 2019 Feb., 06*). However; based on ethical and legal guidelines, these need further discussion before implementation.

DISABILITY BENEFIT OF PERSONS WITH MENTAL ILLNESS

Disability in mental illness is a state where the patient has shown symptomatic recovery with the available treatment modalities, however, has deficits that lead to significant problems with self-care, interpersonal, social, and occupational functioning, and impaired quality of life that may need aggressive rehabilitation.^[20,21] Balakrishnan *et al.*^[22] scholarly reviewed various aspects of the Rights of Persons with Disabilities Act, 2016,^[23] especially regarding the certification guidelines. They point toward the ambiguity related to screening instruments, resource allocation, and the need for inclusive education. They recommend increased focus and reservation for patients who have a disability due to mental illnesses and specific learning disorders; and decentralization of the disability certification, for example, certification of severe or profound intellectual disability at the primary health center (PHC) itself. This would prevent inconvenience to end users, reduce workload at tertiary level psychiatric centers, would be cost-effective and less time consuming, and would lead to higher recruitment of mental health professionals, especially qualified psychiatrists and clinical psychologists at PHC itself. However, such certification should be done by a medical board *mandatorily comprising a qualified psychiatrist and clinical psychologist* and not by other professionals such as pediatricians.

"With rights, come responsibilities!" "An individual has a mental illness, is aware of it, exercises his right to not

take treatment, commits a crime, attributes the crime to mental illness, and claims no responsibility for the crime as it was due to the mental illness.” An example in the context of disability would be that few patients have insight into their mental illness with intact mental capacity but exercise their “right to refuse treatment.” Thus, they do not want to take responsibility for getting treated. However, to avail benefits, they “claim disability” on the grounds of mental illness. How can such an individual exercise his right to refuse treatment; but at the same time claim “benefits” related to his mental illness?

The poverty of our patients may sometimes override our clinical assessment; however, it is the State’s responsibility to take care of the financial status of its citizens. Psychiatrists should only be concerned about mental illness and the resulting disability. Thus, even a rich person who has a disability due to mental illness should get disability benefits. *The disability benefits must be independent of the financial status of PWMI.* A limited budget is allocated for disability benefits, and improper certification may prevent benefits to really deserving PWMI; such individuals should be carefully evaluated. This is of paramount importance in general hospital psychiatry units where the nonpsychiatric medical professionals may not be aware of the real concept of disability due to mental illness, hence may fail to understand as to why a particular procedure is being followed by the psychiatrists. We need to educate them regarding the legal intricacies of dealing with PWMI.

CONCLUSION

Every PWMI is a potentially medicolegal case unless proved otherwise. However, we need not be fearful but cautious while evaluating and treating them and be aware of the legal angle which ultimately boils down to the ethical aspects. It is paramount that the fear of being accused of “violation of rights” should not prevent us from providing legally sound ethical psychiatric care in the “best interest” of the PWMI, vis-à-vis responding to the genuine concerns of caregivers, especially parents who bear the brunt of patients’ illness.

“All approaches to medical ethics, be they empirical, legal, sociological, theological or philosophical should aim at being practically useful ... good medical ethics must help inform and guide those who are directly involved in moral issues in medicine and healthcare. This means that above all, good medical ethics is clinically relevant.”^[24] “The need is for balancing idealism with pragmatism of how much is feasible and how much should be attempted.”^[25] It is important that the medical ethics should not become archaic impractical laws; but scientifically sound, implementable guidelines taking

into consideration the ethos, and these should be periodically updated.

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