Electroconvulsive Therapy: A Closer Look into Legal Provisions in the MHCA, 2017

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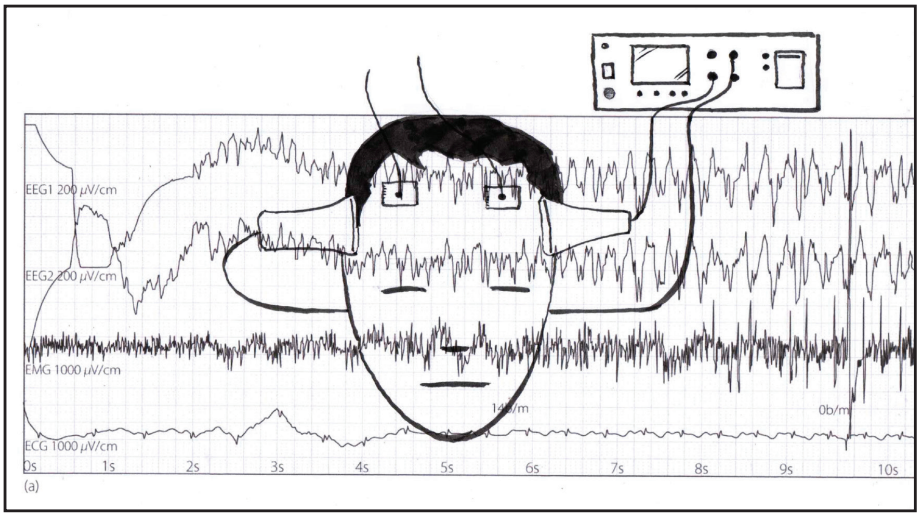
Electroconvulsive therapy (ECT) is an important biological therapy used in psychiatry. The objective of ECT is to produce a seizure by administering electrical stimulus with the help of an appropriately designed electrical device. The seizure so induced is established as the essential ingredient for therapeutic effect.[1] ECT is mainly indicated in treating severe depression, treatment-resistant depression, mania, acute schizophrenia, and catatonia.[2] In women with pregnancy, if all precautions are taken, modified ECT is considered safe to treat severe depression, as it reduces the exposure to mood stabilizers and antidepressant drugs.[3] ECT is a highly effective mode of treatment that holds importance of its own, and it may prove life-saving in catatonic, suicidal, or otherwise severely disturbed patients.[2,4,5]

The Mental Health Care Act, 2017 (MHCA, 2017) was enacted in India after it became necessary for the country to revise the Mental Health Act, 1987 (MHA, 1987), to make the mental health legislation compliant with the United Nations Conventions on the Rights of Persons with Disability (UNCRPD), 2006, which was signed and ratified by the Indian Parliament in 2007. Being a rights-based statute, the act tries to balance ensuring the protection of human rights of persons with mental illness (PMI) and ensuring their proper care, treatment, and rehabilitation. The act also has some specific provisions regarding ECT. The objective of this article is to examine these provisions regarding ECT and their implications on psychiatric practice, health care, and the treatment of severe mental disorders in which its use is indicated.

Modified vs. Unmodified ECT

Unmodified ECT refers to ECT administration without the use of any anesthetic agents and prior administration of any muscle relaxants. Modified ECT refers to the administration of short-acting or ultra-short-acting anesthetic agents, muscle relaxants, and the seizure-eliciting electrical stimulus, in that order.[2,5] Unmodified ECT was widely practiced in India till a few decades



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back.[6,7] The peripheral convulsion is far more vigorous and lasts longer with unmodified ECT than that with modified ECT.[5]As a result, there is an increased risk of musculoskeletal complications with unmodified ECT.[5] Based on 10 years of data derived from patients treated between 1980 and 1990, Tharyan et al. claimed that unmodified ECT was associated with a rate of skeletal complications that was as low as below 1%.[8] The unmodified ECT is free from the adverse effects and risks associated with the use of anesthesia and muscle relaxants.[5] For various reasons, unmodified ECT became a subject of scrutiny from judicial quarters and human rights activists.[5] Violent convulsions induced in unmodified ECT were also responsible for the distorted depiction of ECT in mass media.[9] The World Health Organization (WHO) expressed skepticism about the use of the ECT itself in its Resource Book on Mental Health, Human Rights, and Legislation (2005).[10] The brief recommendation about the ECT in the resource book begins "by mentioning the controversy regarding its very usefulness." The book categorically recommends stoppage of the use of the unmodified ECT, and also states that there is no indication for ECT use in minors; therefore, it even recommends the prohibition of ECT in minors through legislation.[10] Provisions regarding ECT in the MHCA, 2017, have been framed largely based on the recommendation of the WHO.[11]

Status of Legal Provisions Under MHCA 2017

MHCA 2017 has legally prohibited the administration of the unmodified ECT vide its section 95(1), which states that "Notwithstanding anything contained in this Act, the following treatments shall not be performed on any person with mental illness—(a) electroconvulsive therapy without the use of muscle relaxants and anesthesia; (b) electroconvulsive therapy for minors."

But the ECT to minor is not outrightly prohibited as recommended by the WHO, and subsection (2) of the same section provides an exception which states, "Notwithstanding anything contained in sub-section (1), if, in the opinion of the psychiatrist in charge of a minor's treatment, electroconvulsive therapy is required, then such treatment shall be done with the informed consent of the guardian and prior permission of the concerned Board."

Drafts for amendments in the MHA/MHCA were released at different points of time since the process began in 2010. In all these drafts, ECT to minors was outrightly prohibited as per the WHO recommendation. But after wider consultations, ECT to minors was made permissible, with a rider of prior permission of the board, in the bill presented to the Rajya Sabha. The issues regarding ECT to minors have been examined by Balhara and Mathur[12] and later by Grover et al.[13] Without going into these issues, the present article's objective is to simply examine the implications of the MHCA provisions regarding ECT only.

Section 94 of the MHCA 2017 provides for emergency treatment of PMI by any registered medical practitioner either at a health establishment or in the community for a period limited to 72 h or till the PMI has been assessed at a Mental Health Establishment (MHE), whichever is earlier. Treatment under this section can be given only when it is necessary to prevent (a) death or irreversible harm to the health of the person, or (b) the person inflicting serious harm to himself or others, or (c) the person causing serious damage to property belonging to himself or others where such behavior is believed to flow directly from the person's mental illness.

Treatment under this section has to remain limited to what is directly related to the emergency treatment of the conditions as mentioned as per the above criteria. The section specifically prohibits the use of ECT, as its subsection (3) states that "Nothing in this section shall allow any medical officer or psychiatrist to use electroconvulsive therapy (ECT) as a form of treatment."

Legal Implications of Provisions Regarding the ECT in MHCA, 2017

Now, let us critically examine the implications of the provisions regarding the ECT in MHCA 2017 on psychiatric practice. The question arises whether the ECT can be given as an outpatient treatment or as a daycare procedure or it must be given only after the patient is admitted in an MHE. The MHCA is silent on this point. As the administration of ECT requires the administration of anesthesia and muscle relaxants, patients have to stay for a few hours before they are allowed to go home. In the OPD procedure, patients receive the treatment, are observed for some time, and then allowed to go home after recovering and becoming stable. A daycare procedure is slightly different from the OPD procedure. In a daycare setting, an assigned space is allotted with all backup support and where the paient usually remains for a longer period, though not overnight. In administering modified ECT as a daycare procedure, the patients would require to remain in the ward at least for a longer time until they are examined by the treating psychiatrist to establish whether or not they are mentally and physically fit to leave the health establishment.[2] If the patient is found not fit to leave or if any complication develops, they would require to be admitted there and remain overnight in the health establishment.[2] After the promulgation of the MHCA, overnight admission is possible only in a registered MHE. The definition of the MHE has to be looked into it in this regard, which is as follows.

> **Mental Health Establishment means any health** establishment, including Ayurveda, Yoga, and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person, **where persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence, and rehabilitation, either temporarily or otherwise**; and includes any general hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person; but does not include a family residential place where a person with mental illness resides with his relatives or friends.[11]

Words used here are "either temporarily or otherwise." Therefore, if the

admission is for the purpose of treatment of his mental illness, it can be made only in a registered MHE and not in any other health establishment. The only situation in which PMIs may be admitted for treatment of their mental illness is section 94 (emergency admission) as described above. But the use of ECT is specifically prohibited for patients admitted under that section.

The emergency treatment under section 94 mentions the word "at a health establishment or in the community." A wider meaning of the words "any establishment" or "community" would include various establishments like OPD, consultation chambers, daycare homes, clinics, or any other similar type of establishment or at any place or in the community where the psychiatric treatment is delivered. Therefore, the administration of ECT, even as a daycare procedure in a clinic or a consultation chamber, may become a matter of judicial scrutiny. Even if, the ECT is administered with the fully informed consent of the PMI, as per provisions of the MHCA, such admission will constitute voluntary admission or independent admission. All voluntary/independent admissions for treatment of the mental illness of the PMI are covered under section 85 of the MHCA. Therefore, admission under section 85 is possible only in a registered MHE regardless of the informed consent of the PME. Consequently, even if a PMI has capacity to "make mental health care and treatment decision" as described section 4 of the MHCA, 2017, and expresses fully informed consent to get treated with admistration of ECT, he cannot be admitted in a health establishment other than an MHE for treatment of his mental illness.

Therefore, for the reasons described above, legal difficulties may arise if the ECT is given outside a registered MHE, even though the PMI and/or their nominated representative has voluntarily accorded their fully informed consent and even expressed a preference for the use of ECT over other forms of treatment. If admission is thought to be necessary for administration of ECT, it would become necessary to get the PMI admitted to the MHE after following the due admission process as described in the MHCA, 2017.

Comparison of Legal Provisions of the Mental Health Act (1987) and the MHCA, 2017

- The definition of the MHE in the MHCA, 2017 is mentioned above. It is drafted in such a way that "all establishments where PMI are admitted, reside at or kept in for care, treatment, rehabilitation…." would come to be regarded as MHE. Consequently, a PMI could not be admitted, for the treatment of his mental illness, to any establishment not registered as an MHE.
- In the Mental Health Act, 1987 (MHA, 1987), the definition of such establishment was as follows,

> **Psychiatric hospital or psychiatric nursing home** means a hospital or, as the case may be, a nursing home **established or maintained by the Government or any other person for the treatment. and care of mentally ill persons** and includes a convalescent home established or maintained by the Government or any other person for such mentally ill persons, **but does not include any general hospital or general nursing home established by the Government and which provides also for psychiatric services**.[14]

The definition covers the hospital or nursing home "established or maintained for the treatment and care of mentally ill persons." The definition was not exhaustive and did not cover all the places where the PMIs are admitted or kept for care. Consequently, there was no blanket ban on the admission of mentally ill persons at any other establishments.

- The MHA, 1987, did not have any prohibitive provisions regarding ECT use, be it modified or unmodified. It did not have any provision prohibiting ECT as a psychiatric treatment at any establishment or even in the community as an emergency measure or otherwise; neither did it have any specific provision regarding the use of ECT for minors.
- General Hospital Psychiatric Units (GHPU) established and maintained by the government were excluded from the purview of the definition of psychiatric hospital/psychiatric nursing home. These units did provide psychiatric services, both outpatient and indoor. Therefore, it is understandable that the MHA, 1987, did not emphasize that psychiatric treatment could be provided only at registered/licensed psychiatric hospitals/psychiatric nursing homes.

Discussion

ECT is an important and valuable mode of treatment and very useful in a clinical emergency like a major depressive episode with strong suicidal ideation, life-threatening situations because of refusal of food and medications, or mania or schizophrenia with extreme violence, proving to be life-saving in some of these situations.[4,5] Pharmacological and psychotherapeutic interventions take time before their beneficial effects are noticeable. There are many patients whose symptoms swiftly recover after treatment with ECT. But the irony is that the ECT cannot be administered in patients admitted on an emergency basis under section 94 of the MHCA in an institution that is not registered as an MHE. Therefore, if ECT is considered urgently necessary, the PMI would require getting admitted to a registered MHE. This is true even in the case of voluntary PMI, who possesses the "capacity to take mental health care and treatment decision" and has expressed his fully informed consent to get treated with ECT. It is not justified or reasonable to admit the patient to an MHE and get them temporally admitted there, for the sole purpose of administration of ECT.

Rules and regulations regarding the use of the ECT must be simplified, and there should be complete clarity in the legal provisions regarding its use. There must not be any ambiguity in the interpretation of the legal provisions to discourage its use. Framing of laws must be in such a way that an operative and effective balance is established between the protection of the rights of the PMI and the use of evidence-based clinical judgment of the psychiatrist, who shall use his expertise and clinical acumen in the best interest of the PMI. Admission in an MHE becomes heavily stigmatizing for the PMI. Prohibiting the use of

ECT as an emergency procedure gives the ECT a negative connotation and adds to the widely prevalent stigma attached to the use of ECT as a treatment mode. Therefore, getting a PMI admitted in an MHE for the administration of ECT would result in double stigma: the stigma of admission in an MHE and the stigma of being treated with ECT. Efforts should always be made to encourage and simplify psychiatric treatment as far as possible and make it less stigmatizing. This is a stated objective of the MHCA as well. Efforts should be taken to make the treatment available to the PMI in the community itself, and admission into an MHE should be a matter of last resort only. Of course, reasonable restrictions are required to protect the rights of the PMI. But it is not in the best interest of the PMI that the statutory provisions should become a hindrance in the proper treatment of their mental illness.

Way Out and Recommendations

ECT is a treatment strongly indicated and considered highly helpful in certain emergency situations and may prove to be life-saving in some situations. But the use of ECT is specifically banned in case of emergency situation under section 94. After obtaining the informed consent of the PMIs and/or their nominated representative and following advance directive, if any such have been executed by the patient, a qualified psychiatrist can easily administer ECT at any health establishment with the help of an anesthetist and required paramedical staff as a daycare procedure. Therefore, in the authors' view, prohibiting the use of ECT under section 94 by a qualified psychiatrist must be removed by way of an amendment in the MHCA, 2017. In addition, the legal provisions regarding the regular use of ECT as a treatment module in a setting other than an MHE must be simplified. A separate section or subsection allowing and regulating the use of ECT as an OPD procedure or as a daycare procedure in any health establishment should be added so that there is complete clarity regarding the use of ECT in psychiatric practice. The section/subsection may contain complete guidelines regulating ECT administration by a qualified psychiatrist in any establishment, including an MHE. This would be in the larger interest of the PMIs and their family and would help in the smooth administration of ECT where it is urgently needed.

In a nutshell, it is pertinent to say that the legal provisions regarding the use of ECT should be simplified so that a PMI in whom it is indicated and who is expected to get benefitted from it is able to get treated with it smoothly. This would be in the best interest of the PMI as well as that of society.

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References

1. Gangadhar BN, Jankiramaiah N, Jayprakash MS, et al. ECT Administration Manual, Bangalore: NIMHANS, 1997.
2. Scott AIF, editor. *The ECT Handbook: The Third Report of the Royal College of Psychiatrists' Special Committee on ECT*. 2nd ed. Royal College of Psychiatrists, 2005; 3–9.
3. Miller LJ. Use of electroconvulsive therapy during pregnancy. Hosp Community Psychiatry May1994; 45(5): 444–450.
4. Andrade C, Shah N, and Tharyan P. The dilemma of unmodified electroconvulsive therapy. J Clin Psychiatry October 10, 2003; 64: 1147–1152.
5. Andrade C, Shah N, Tharyan P, et al. Position statement and guidelines on unmodified electroconvulsive therapy. Indian J Psychiatry 2012; 54: 119–133.
6. Andrade C. The practice of electroconvulsive therapy in India: Considerable room for improvement. Editorial. Indian J Psychol Med 1992; 15: 1–4.
7. Andrade C, Agarwal AK, and Reddy MV. The practice of ECT in India. 2. The practical administration of ECT. Indian J Psychiatry 1993; 35: 81–86.
8. Tharyan P, Saju PJ, Datta S, et al. Physical morbidity with unmodified ECT: A decade of experience. Indian J Psychiatry October 1993; 35(4): 211–214.
9. Andrade C, Shah N, and Venkatesh BK. The depiction of ECT in Hindi cinema. J ECT 2010; 26: 16–22.
10. World Health Organization. *WHO Resource Book on Mental Health, Human Rights, and Legislation,* 10.2: 64. World Health Organization, 2005.
11. The Mental Health Care Act, 2017 Bare Act with Rules. Hyderabad: Asia Law House, 2019.
12. Balhara YP and Mathur S. ECT prohibition for children and adolescents in Mental Health Care Act of India: A step in the right direction? J ECT March 2012; 28 (1): 1–2.
13. Grover S, Avasthi A, and Gautam S. Inpatient care and use of electroconvulsive therapy in children and adolescents: Aligning with Mental Health Care Act, 2017. Indian J Psychiatry 2019; 61: 155–157.
14. The Mental Health Act, 1987. Bare Act. Delhi: Delhi Law House, 1988.