Medicine and Society

Mental Health Legislation: The validity of divergent views

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The Mental Health Care Act 2017 was passed by the Indian Parliament and has received the assent of the President.[1] The magnitude of the burden of mental illness and the gaps in mental healthcare demanded progressive legislation, which recognizes the rights of individuals and responsibilities of a civilized society. However, the response to the process and outcome of the legislation was polarized with psychiatrists and mental health activists on opposite sides of the argument.[2] This article highlights the complexity of the issues, the divergent paradigms employed, the contradictory yet valid points of view and the need for empathy and consensus.

CHANGING SOCIETAL TRENDS

There have been important transformations within Indian society over the past century. A gradual shift to capitalistic economic and social systems also focused on the individual's right of self-determination and autonomy. However, pervasive institutional contexts, persistent paternalistic attitudes within medicine and psychiatry and social policies are a cause of many disagreements.[3] Issues related to human rights, equity and social justice added to contemporary confusion.

MEDICINE, PSYCHIATRY AND SOCIETY

Psychiatric diagnosis, therapy and practice do not occur in a vacuum. Psychiatry operates within modern society with its diverse and complex social, economic and political environments, influences and pressures.[2,4] Despite its scientific base, medicine is a system sanctioned by the society in which it is practised. Scientific knowledge consists of beliefs shared by experts. The social nature of science makes for the argument (or suggests) that scientific authority belongs to specialist communities, both within and outside medicine.

Intertwined with scientific authority, the political economy of health that is deeply rooted in capitalistic systems, supports many medical and psychiatric formulations. The technical approaches of evidence-based medicine are not necessarily value-neutral nor are they above specific interests.[5] Medicine is politics writ large and the health sector is a powerful player in national economies.

EVIDENCE, ETHICS AND VALUES

While psychiatry argues that its diagnoses are based on empirical evidence, others suggest that they are a result of value judgements. The psychiatry–antipsychiatry debates of the 1960–1970s held opposing positions related to psychiatric diagnosis as factual on one hand and mental disorder labels as based on deviance from societal values on the other.[6] Despite the Diagnostic and Statistical Manual (DSM) 5 position that psychiatric diagnoses are based on facts,[7] there is a growing realization that psychiatric diagnosis is based not only on scientific evidence but also involves complex ethical and value judgements.[4,8,9]

These ethical issues and value judgements include: (i) value commitments; (ii) value consequences; and (iii) value entailments. Value commitments embrace relieving suffering and aiding the ill, considered an ethical imperative; knowledge acquisition and scientific development are epistemic and pragmatic objectives. Value consequences, weighted according to effects of actions, include stigmatization of people through diagnostic labels, which is an ethical problem; inappropriate prescription of psychotropic medication has negative ethical consequences. Value entailments are implied or assumed in individual and global worldviews. These include neurobiological reductionism and reification in operational criteria, diagnosis and classification and the commercialization of mental healthcare with its political and economic pressures are ontological issues.[4,8,9]

Legitimate diagnoses seem to combine fact and value.[4,8,9] Dysfunction can be viewed both in terms of biology, science and fact as well as in the sociocultural context. While the DSM system emphasizes that societal norms should not be the sole criterion to assess mental disorders, it employs the definite requirement for the presence of 'clinically significant' dysfunction, distress or disability in the individual to diagnose mental disorders.[4,9] While it suggests that a negative value judgement is *per se* insufficient to diagnose mental disorders, it does not clearly acknowledge that psychiatric diagnosis seems to involve complex value judgements. However, openly acknowledging the factual and value-based nature of psychiatric diagnosis and making them explicit is crucial to understanding mental health, distress, illness and disease.

CONTRADICTORY PARADIGMS

While psychiatry continues to argue that its diagnoses, classification and treatments are evidence-based, activism by people with psychosocial disability has challenged the biomedical and psychiatric discourse. They have argued against the use of compulsory treatment for psychosocial conditions including mental illness. They contend that such approaches are influenced by prejudice, and are a breach of human right to equality and non-discrimination. These movements resulted in the United Nations Convention on the Rights of People with Disability (UNCRPD), a watershed in the human rights discourse that focused on all forms of disability including mental illness.[10]

The convention changed perspectives on mental illness when it shifted from a medical model (disease) to a social paradigm (disability). It argued that people with disability have rights equal to others, namely rights to legal capacity, liberty, physical and mental integrity and the right to informed consent. While the broad structure of the UNCRPD does not explicitly

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ban the use of force in the treatment of the mentally ill, its logic suggests prohibition of compulsion to treatment without consent.

Research supports the mental health activist's point of view that while decision-making capacity is similar in physically ill and mentally ill populations, psychiatry presumes capacity in people with the physical disease, while questioning it in those with mental illness.[11] They argue that assessing capacity only among people with mental illness is clear discrimination. They also contend that legislation that specifically targets people with mental illness adds to the disadvantage of an already marginalized group. They suggest that such laws are an easy way out for mental health professionals and that they reduce channels of communication, negotiation and persuasion.[2]

LAW AND MEDICINE

Medicine focuses on the 'Right to health and to treatment'. On the other hand, the legal perspective favours individual autonomy, choice and right to refuse treatment.[2] Medicine in India prefers its paternalistic culture while legal frameworks support contractual relationships between patients and physicians. These contrasting perspectives have resulted in an uneasy compromise. While psychiatry acknowledges that individual autonomy and choice are fundamental, they also support the take-over of decision-making in certain situations.

Most countries have mental health laws, which allow compulsory hospitalization and treatment of people with mental illness in specific circumstances.[12] These laws permit psychiatric interventions without patient consent in contexts where they are said to lack decision-making capacity and when there is presumed risk of harm to self or to others.

While the use of force was delegitimized across many sectors and the provision of treatment for physical illness without consent is seen as assault, the use of force remains problematic when employed for people without mental illness.[2] For those with such illnesses, mental health legislations and legal frameworks allow for coercion and compulsory hospitalization and enforced psychiatric interventions.

REFORMS

The new Act[1] replaces the MHA 1987, which was essentially a custodial law. The new Act incorporates many reforms including the constitution of review tribunals, appeal to quasi-judicial mental health commissions, use of advance directives and nominated representatives. It decriminalizes suicide attempts. It bans the use of electroconvulsive therapy without anaesthesia and prohibits its use in minors. It puts the onus of responsibility on the state for prevention of suicide, promotion of mental health, training mental health professionals and provision of care. It includes people with mental health conditions, caregivers, activists and judges on its central and state decision-making bodies and review commissions. It attempts to provide for checks and balances to ensure the human rights and dignity of people with mental illness. However, the absence of detail on budgets, funding and resources will be a major challenge for implementation.

CRITICISM AND POLARIZED POSITIONS

The divergent perspectives make a compromise uneasy for its many stakeholders.[2] Stakeholders have criticized the new Act. They have critiqued the Act based on their disciplinary perspectives and their worldviews. Psychiatrists view the new reforms including the use of advance directives, nominated representatives and mandatory oversight as interference in clinical decision-making.[13–15] They have argued that India is a complex and heterogeneous society; people with low mental health literacy, feudal and patriarchal cultures live side-by-side with people who have imbibed liberal values and education.[14] They also contend that the absence of a social security net essentially means that families are responsible for healthcare and social security of individuals with mental illness and hence, there is a need for shared decision making.[14] While they are not opposed to clinical oversight, they argue that district-based oversight committees will result in gross delay in treatment and suggest hospital-based boards. They also reason that low mental health literacy in the general population demands that mental health boards and commissions mainly include professionals with mental health-related backgrounds. On the other hand, activists argue that the legislation only supports the biomedical model of mental illness and does not comply with UNCRPD.[16] They argue that despite reforms in the new legislation it continues to privilege medical perspectives.

Psychiatrists criticize the Act based on their belief and support for the biomedical model of mental illness. The failure to see opposing points of view (e.g. the perspective of a mental health activist, which argues for human rights, or the antipsychiatry movement, which opposes the medicalization of mental distress and illness, etc.) does disservice to the care of people with mental disorders.[4,6,16] While psychiatrists in India are quick to believe the biological explanations and pharmaceutical solutions for all mental health, distress and illness standards originating from the West, they are much slower to change their paternalistic culture and accept rights of people with mental illness and are unwilling for any oversight of their clinical practice.

The ability to see the big picture related to mental illness, its context and complexity, seems to be lost amid polarized arguments. The failure to see the validity of opposing points of view does disservice to people with mental disorders. The reduced capacity to appreciate the role and need for these divergent perspectives for different kinds of mental illness, their diverse contexts, their varied course and outcome and dissimilar consequences on different people results in less than constructive debate on reforms. The hope is that time and increased and open dialogue will help bridge the conflicting positions that have resulted in the present impasse.

The complexity of the issues is appreciated when one examines the situation in the West. Progressive legislation similar to the current Indian legislation, a comprehensive social security net, the closure of long-stay mental institutions and good community care, which were part of the deinstitutionalization strategy, have not been entirely successful. This is reflected by 'trans-institutionalization' defined by a considerable proportion of people with mental illness seem to move between mental health facilities, the justice/prison system and living on the street.[17] It suggests that mental health legislation does not and cannot completely address the complex issues related to mental illness even in societies, which have many provisions for social security and for community treatment and care.

ALTERING PRACTICE

Psychiatry employs treatments without patient consent in situations when people lack capacity and when there is risk of

harm to self and others. While such interventions (e.g. involuntary admission) are necessary in specific situations, mental health professionals should strive to minimize their use and seek informed consent as soon as patients regain their capacity for decision-making. The willingness of psychiatrists to allow patients to decide their own choices in life, including treatments in situations where they possess capacity, and there is no risk of harm is required and part of ethical practice. Seeking consent from relatives for involuntary hospitalization and the use of restraints, while legally valid, violates the spirit of the UNCRPD.

Psychiatrists will also need to accept oversight by mental health tribunals and commissions. Physician power and status is sanctioned by society, which is now mandating oversight of their functioning to protect people with mental illness who are vulnerable to abuse of their human rights. The need for ratification of involuntary hospitalizations and the use of electroconvulsive therapy, the use of advance directives and nominated representatives and oversight of psychiatric facilities by mental health tribunals and commissions will safeguard patient rights and should be respected. Despite opposition to the legislation from the psychiatric fraternity, much of the small print continues to privilege the biomedical model. The new Act demands a change in the paternalistic mindset within the profession to a more liberal outlook. It forces the profession to grant genuine autonomy to people with mental illness and respect their choices, when they have capacity, even if they choose to disregard medical advice.

CONCLUSION

All mental health legislations discriminate against people with mental illness; their underlying assumptions increase stigma.[2] The new Act will remain a work in progress. However, the extent of its implementation, both in letter and spirit, will determine its success in reducing burden, increasing the provision of care and in supporting the rights of people with mental illness. The practice–theory and law–justice gaps demand periodic review. Laws, which fail to deliver justice, need to be reinterpreted and rewritten.

Conflicts of interest. None declared

REFERENCES

1 Government of India. Mental Health Care Act 2017. Government of India; 2017. Available at *www.prsindia.org/uploads/media/Mental%20Health/Mental%20Healthcare%20Act,%202017.pdf* (accessed 9 Aug 2017).
2 Jacob KS. Mental health legislation: Contradictory paradigms, uneasy compromise. *Econ Polit Weekly* 2016;**51:**22–4.
3 Rose A, Jacob KS. Teaching bioethics in India. *Natl Med J India* 2015;**28:**61–3.
4 Jacob KS. Robert Spitzer and psychiatric classification: Technical challenges and ethical dilemmas. *Indian J Med Ethics* 2016;**1:**95–100.
5 Rodwin MA. The politics of evidence-based medicine. *J Health Polit Policy Law* 2001;**26:**439–46.
6 Szasz TS. *The myth of mental illness*. *Am Psychologist* 1960;**15:**113–18.
7 American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Arlington, VA:American Psychiatric Association; 2013.
8 Sadler JZ. *Values and psychiatric diagnosis*. Oxford:Oxford University Press; 2005.
9 Fulford KW, Broome M, Stanghellini G, Thornton T. Looking with both eyes open: Fact and value in psychiatric diagnosis? *World Psychiatry* 2005;**4:**78–86.
10 United Nations. Convention on the Rights of People with Disability (UNCRPD); 2006. Available at *www.un.org/disabilities/convention/conventionfull.shtml*, (accessed on 24 Aug 2016).
11 Grisso T, Appelbaum PS. *Assessing competence to consent to treatment: A guide for physicians and other health professionals*. Oxford:Oxford University Press; 1998.
12 World Health Organization. Mental Health Atlas 2011. Geneva:WHO; 2011. Available at *www.who.int/mental_health/publications/mental_health_atlas_2011/en/* (accessed on 25 Aug 2016).
13 Antony JT. Mental health legislation: A journey back to 'madhouses era?' *Indian J Psychiatry* 2016;**58:**114–18.
14 Rao GP, Math SB, Raju MS, Saha G, Jagiwala M, Sagar R, *et al*. Mental health care bill, 2016: A boon or bane? *Indian J Psychiatry* 2016;**58:**244–9.
15 Antony JT. Mental health care bill-2016: An illusory boon; on close reading it is mostly bane. *Indian J Psychiatry* 2016;**58:**363–5.
16 Davar BV. Legal frameworks for and against people with psychosocial disabilities. *Econ Polit Wkly* 2012;**47:**123–31.
17 Prins SJ. Does transinstitutionalization explain the overrepresentation of people with serious mental illnesses in the criminal justice system? *Community Ment Health J* 2011;**47:**716–22.