Guest Editorial

Involuntary Hospitalization: The Conflict Zone of Psychiatry and Law (Revisiting Section 19 of Mental Health Act 1987)

The Delhi High Court judgment in Dr. Sangamitra Acharya and Anr. v. State (NCT of Delhi) and Ors.\(^{[1]}\) revisited the Section 19 of Mental Health Act (MHA) 1987 and interpreted the various provisions of the act. The interpretation given by the honorable judges will have an impact on the current practicing styles across the country. Though the MHA 1987\(^{[2]}\) has been repealed and Mental Health Care Act (MHCA) 2017\(^{[3]}\) will be in force from July 2018, it is still pertinent to understand and analyze the judgment in the context of psychiatric practice and mental health-care delivery in India, as the concept and provisions for involuntary admission has not changed much in the new act except for some terminology. Before analyzing the judgment, it is worth looking at the concept of involuntary admissions in psychiatry.

Involuntary admissions have a legitimate role in the delivery of mental health care and are universally practiced. The process of involuntary admissions is guided by the country’s mental health legislation. In India, till the time the Indian Lunacy Act (ILA) 1912 was in operation, the only legitimate way of involuntary hospitalization was through a “reception order” issued by a judicial magistrate. The underlying principle was that the person should be of “unsound mind” as observed by the magistrate and also certified by two doctors. The concept of unsound mind is more of how the court defines legal insanity. However, many times, the diagnosis of mental illness by psychiatrists does not comply with the definition of legal insanity. Thus, a person who has mental illness as diagnosed by psychiatrists may be uncooperative to treatment and may deny that he/she is ill, and such a person may still not satisfy the definition of unsound mind as per law. Though the medical professional and the family agree that the person is mentally ill and in need of treatment, the law will not allow involuntary hospitalization or treatment till an unsoundness of mind is established. Often, it is the family and friends who closely observe the individual’s behavior, suspect mental illness, and discuss the matter with psychiatrists. Such an individual, when seen by a common man or a magistrate, may appear to be absolutely normal. The mental health professional, on the other hand, might like to observe such an individual for sufficient length of time to ascertain the presence or absence of mental illness. To help the patient, his family, and the treating psychiatrist, when ILA 1912 was repealed and Mental Health Act 1987 came into effect, it had Section 19—admission under special circumstances. This section helped the hospitals to admit the patients for observation and treatment without needing a reception order from the magistrate. One encounters many clinical situations where in law considers the individual to be sane (no unsoundness of mind) but the relatives and the mental health professional considers him to be mentally ill and in need of treatment and care.

In the legislation, there is no mention of the problems arising from certain disorders (paranoia) or situations (marital or family conflict) that necessitate a request for involuntary hospitalization made by relatives and friends involved in a direct relationship with the individual, even though such situations are common.\(^{[4]}\)

Involuntary commitment is a derogation from the general principle of consent. Consent to care is a prerequisite for all treatment. However, consent to care can vary during the course of a relationship between the patient and the health professional. In patients with mental disorders, it may not be given definitively and may change over very short periods of time as their awareness of their problems fluctuates, particularly if they are psychotic.\(^{[4]}\)

Involuntary admission and treatment, on the basis of an examination that a person lacks capacity, are controversial because there are questions about meaning and utility of the concept of capacity. United Nations Committee on the Rights of Persons with Disabilities recommends that involuntary treatment be abandoned altogether and capacity tests avoided. A common approach to assess decision-making capacity is predominantly cognitive-based functional test of the capacity of the person to provide valid consent to treatment or refusal of treatment.

Recent proposals for reform in mental health law have a philosophical shift, with increasing interest in capacity-based criteria for involuntary psychiatric
treatment in place of traditional risk-based systems. It is suggested that changing from risk- to capacity-based approaches to decision-making will change the types and rates of involuntary treatment. It can also be argued that capacity assessment can sometimes be used to support nonintervention or poor care, leaving vulnerable adults exposed to the risk of harm. [5]

According to modern mental health legislation, two conditions need to be satisfied for involuntary psychiatric admission and treatment. One, the patient must have a mental disorder and the other, there must be a risk to the patient or others arising from the disorder. The key ethical issue in involuntary treatment involves balancing primarily two principles: the principle of autonomy (respecting the patient’s wishes) and the principle of beneficence (the professional's responsibility to act in the patient's best interests). For a choice to be autonomous, it must be intentional, made with understanding, free from external controlling influence (i.e., uncoerced) and a product of intact cognitive capacities, in particular, the capacities for coherent thought and deliberation. Correspondingly, therefore, if these criteria are not satisfied, a person's choices may not be fully autonomous, and involuntary psychiatric treatment may be justified on the grounds of beneficence (and/or nonmaleficence).

Patient-centeredness in health care requires rights with teeth, but a balance must be maintained with the professional’s freedom of right action.

The driving motivation behind recent developments in mental health law in Europe has been to protect people with mental illness (conceived as a vulnerable group) from the misuse of psychiatrists’ powers of involuntary restraint and treatment. However, in protecting rights through legislation, there is a danger of an excessively bureaucratic and legalistic approach to clinical work, which in turn may lead to unsatisfactory treatment to the patient. [6]

“The belief of the universality of implementing similar ethical codes in all cultures and societies is a mirage.”

Informed consent, involuntary admission, and confidentiality are not so empowering in some traditional and eastern societies, representing two thirds of the world’s population. Autonomy versus family-centered decision is one of the main connectors of differences between western and eastern societies. [7] However, much of the MHCA 2017 and to some extent MHA 1987 is borrowed from the European mental health legislations.

The mental health-care delivery in India has always been not so much regulated, in spite of various legislative measures. The involuntary admissions during the era of ILA 1912 had to be through the magistrate’s reception orders only. However, in most of the hospitals, the superintendents made generous use of Section 4 of ILA to simplify the admission procedure. The strategy of bypassing the law for the benefit of the patient was practiced in some mental hospitals. [8] Even now, the same practice continues in most of the hospitals. MHA 1987 had provided the option of admission under special circumstances (Section 19), under which a person with mental illness can be admitted involuntarily on the application of a third party, that is, a relative or friend. However, this provision was not used very often by the hospitals and hence escaped the attention of adequate interpretation in routine psychiatric practice.

The main observations of the court as per the judgment are that Section 19 cannot be invoked for admitting a person for the purpose of observation. Clear-cut psychiatric diagnosis and unsoundness of mind have to be established before admission under Section 19. The medical officer in charge and two medical officers should simultaneously be present physically at the time of admission, whatever time of the day it is. No discussions on phone or any other electronic means are permissible to arrive at a decision. It is also suggested that in the absence of the medical officer in charge, even if qualified emergency doctors are available, the hospital cannot entertain any emergency cases and the patient has to be sent away to a different hospital. Further admissions under Section 19 when not done as per the interpretation in the current judgment amount to a violation of a person’s right to life, liberty, and dignity granted under Article 21 of the Constitution of India.

Psychiatric hospitals are neither jails nor places where people are detained/imprisoned. In fact, the concept of asylum care is no longer held or valid. Psychiatric hospitals are active treatment centers where people with mental health problems seek help. The access to these hospitals is open to all public, unlike jails. The word detention itself is inappropriate in this context. Persons are admitted to a psychiatric hospital on their own request or their guardians’ request for evaluation or treatment of their mental health problems. Such individuals are treated with all the respect and provided all the facilities; the individual’s rights are respected and never compromised. The recently enacted MHCA 2017, in Section 2 (1) subclause (o), defines: “mental health care includes analysis and diagnosis of a person’s mental condition and treatment as well as care and rehabilitation of such person for his mental illness or suspected mental illness” (emphasis added).

So, at times when an individual is brought by the family suspecting mental illness, the psychiatric hospital may request for a brief stay to ascertain presence or
absence of mental illness, and during such a stay, the individual’s rights are always protected. Equating this to incarceration in a jail or custodial center is totally out of context. Even a court of law sends a person suspected of having a mental illness to a psychiatric hospital for observation and report. In such a case, the individual might not actually have a mental illness but can be (as per law) kept for observation for 10 days, which can be extended up to 30 days. This is not considered as incarceration in a jail. It is considered as a step to protect the interests of the individual in question.

Therefore, interpretation of the Section 19 of MHA 1987 in the light of the right to privacy and autonomy is unwarranted as during the course of hospitalization, no individual’s rights are infringed upon.

Further, even if a person is admitted under Section 19 wrongly by the psychiatrist, there is a remedy provided in the same section of the Act at subsection (3), which reads: “any mentally ill person admitted under subsection (1) or his relative or friend may apply to the Magistrate for his discharge and magistrate after giving notice to the person at whose instance he was admitted to the psychiatric hospital or psychiatric nursing home and after making such inquiry may as he may deem fit either allow or dismiss the application.”

So, admission of a person under Section 19 does not amount to infringement of the rights of any individual, and it is always done to protect a person from harm and in good faith (Section 92 of MHA 1987), and even if mistakenly done, there is remedy suggested in the act and is not considered as a criminal act done by the psychiatric hospital.

It is a common practice that the psychiatrist examines the patient and determines the need for admission. However, when the patient is not willing for admission and the relatives bring the patient in an emergency and plead for admission and the psychiatrist who examines the patient also feels the need for admission, there is no other provision in the act that allows for the admission of an involuntary patient. During the regular hours, the chance of two psychiatrists/medical officers and the medical officer in charge being present at the hospital is very likely. However, during other times, nonregular hours, night time and holidays, the duty medical officer/duty psychiatrist is the only person available to attend to the patient and the other medical officers and medical officer in charge would continue the care of the patient subsequently. It is a common practice that two doctors discuss the case findings and come to a reasonable conclusion in a given situation. As it is impossible for the medical officer in charge to be present at the hospital at all times, he/she can examine the case within a reasonable period of time and complete the formalities as per Section 19, instead of the patient and the family/friends having to go from one hospital to the other in case of an emergency only because the medical officer in charge is not available in the first hospital they approach.

It is unethical and gross injustice to the patient and family to make them search around a city in odd hours for the presence of a medical officer in charge. It is difficult even to imagine such a scenario. Can the same suggestion be given to a person with chest pain or abdominal pain? This is like saying that an acutely depressed suicidal patient, a delirious patient, or a person who is aggressive or violent does not need any help immediately even though the consequences of such inaction may cost the life of the individual or may cause severe distress to the patient and family. This is an inhuman way of thinking. Psychiatric diagnosis is made taking into account the history given by the relatives and interviewing the patient, which is termed as mental status examination (MSE). Sometimes a single MSE is not sufficient to arrive at a diagnosis and serial MSEs done over a period of 24–72 hours may be necessary. This cannot be done without keeping the patient in the hospital. There is no other provision except Section 19 for such an admission without going to magistrate for a reception order. Often, the psychiatric diagnosis is a lengthy process and cannot be done only by outpatient examination. Admission is required to determine the presence of illness, its nature, and the necessary treatment and also to certify the presence or absence of mental illness properly. If everything can be done as an outpatient, why there is the need for Section 28—detention of alleged mentally ill person pending report by the medical officer?\[2\]

Depending on the duty hours, doctors are available in the hospital. It cannot be that two/three doctors are available at the same time and also examine the patient at the same time. By interpreting section 19 that all the three doctors should be physically present at the time of admission, the real purpose and aim of introducing this provision is taken away.

It is worth remembering that the earlier legislation—ILA 1912—had only two types of admission: One is the voluntary admission, and the other is admission with reception order. As patients suffering from severe mental illnesses and those with suspected mental illness often refuse admission and care, the only option left to the family is to approach the magistrate for reception orders.

This used to cause great inconvenience to the families who had to travel long distances along with their affected relative to obtain the reception order and then go to the psychiatric hospital. Sometimes, illiteracy
makes them not understand the various procedures of obtaining a reception order, and in the process, the mentally ill person is left to fend for himself/herself making him/her a wandering lunatic.

When MHA 1987 was enacted, the lawmakers, in their wisdom, introduced the provision of Admission under special circumstances (Section 19) to help those families who are suffering and needed help to get their mentally ill relatives proper treatment and care. So, it was made simple enough for them to go directly to any psychiatric hospital with an uncooperative patient and get assessment, admission, and treatment without the hassles of procuring a reception order. It is a provision that helps the family in psychiatric emergencies. The way it is interpreted in the current judgment makes it difficult both for the family and the psychiatrist, and the purpose of this provision will be lost. It is almost back to the days of ILA 1912, which is a retrogressive step and not in tune with current advancements in psychiatry.

The MHA 1987 also envisages admission for observation and certification by the medical officer/psychiatrist in a psychiatric hospital or nursing home. In today’s context of medical practice, using communication via telephone, FaceTime, WhatsApp, and e-mail are accepted mode of communication among professional colleagues to clarify about diagnosis, to seek a second opinion, or to discuss the diagnosis and management. In fact, telemedicine and telepsychiatry have come a long way and is a boon to patients and relatives, and even the government is actively promoting this concept. Admitting a person in a hospital is not equivalent to keeping a person in custody or imprisonment. A patient’s rights are always protected in a hospital wherein the person is allowed to meet any visitor of their choice, consume the food they like and use communication channels of their choice; provided personal space; and offered a safe environment; and their personal health and safety are taken care of. Merely admitting a person for observation under Section 19 may not amount to a violation of person’s rights under Article 21.

Based on the judgment and the strictures passed by the Honorable judges, there is every possibility that psychiatric practice in India may become much more defensive. One has to wait and watch how this is going to impact the mental health-care delivery in India.

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