EDITORIAL

Is there a Need for "Comfortable Treatment Options" as an Alternative to "Community Treatment Order" in the Light of MHCA–2017?

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Abstract

There is a need for introducing community treatment order (CTO) like legal measures by amendments in Mental healthcare Act (MHCA), 2017. In the future, there would be a need for well-designed studies of patients with severe mental illness with CTO options that look into outcome parameters like illness control, functionality, violence, self-harm, suicide, criminality, legal issue, and disability-adjusted life years. In addition, studies on caregivers' perspective and their quality of life, economics, and rehospitalization would shed more light on the utility of CTO in India. Envisioning similar provisions of leave of absence as a prerequisite to symptomatic person with mental illness who do not want to get admitted can be pathbreaking.

Keywords: Community treatment order, Mental healthcare Act, 2017, Serious mental illness.

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Medical interventions like use of psychotropics, modified electroconvulsive therapy (ECT) and psychosocial interventions for severe mental disorders in psychiatry are plagued by multiple hurdle and challenges worldwide. These hurdles and challenges in delivering psychiatric treatment are related to factors such as insight into illness, compliance issues, illness perception of family and significant others, myths and misconceptions, financial issues, accessibility, and availability of mental health services to name a few. In order to overcome these hurdles and challenges in India, the Mental Health Care Act, 2017[1] made provisions regarding psychiatric treatment available to the community at the primary health centers themselves. It also emphasized quality psychiatric services for emergency, child, geriatric, and rehabilitation care at community settings of international standards. In addition, it prohibited the seclusion, indiscriminate use of physical restraint and unmodified ECT. Even though the above legal measures may help in reducing few hurdles in psychiatric care in India, a refusal of medical interventions by persons with severe mental illness (SMI) is a challenge in the community for caregivers and professionals. This population account for a significant portion of person with mental illness (PWMI), who are severely ill with poor insight and have intact capacity to consent, could be potentially dangerous in the community.[2] The treatment refusals for mental illness lead to the rise of homeless mentally ill, increase in jails population with SMI (Penrose's law), and also revolving door syndrome leading to multiple admissions in psychiatric settings.

Forced or coercive treatment and covert psychiatric medication administration by the caregiver in the community are common in India, especially when the patient is potentially dangerous to the community due to SMI. The unique circumstance of forced or coercive treatment and covert or surreptitious psychiatric medication administration is debatable due to the lack of legal clarity in the Mental Health Care Act, 2017. The various stakeholders like service providers, human rights advocates, mental health activists, and patients have a highly polarized opinion and justification based on ethical principles on above common practice in the community.

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Ethical justifications for coercive treatment and covert or surreptitious administration of medication by a caregiver may come from schools based on consequences or utilitarianism.[3] The greatest good for the most significant number of people is acceptable, and ends justify the means. A duty-based or deontological (Kant) approach says right behavior is obligatory without regard for consequences as good will. It also says to act in such a way that you always treat humanity, whether it is your own person or not, never simply as a means, but always at the same time as an end.[4] In addition, the "principle of beneficence refers to a moral obligation to act for the benefit of others"[5] also supports current practice when the patient is potentially dangerous to the community due to SMI. Even while providing coercive treatment and covert or surreptitious administration of medication by caregivers, they are doing good for the patients by violating individual rights. The doctrine of double effect is not necessarily wrong, as the action produces practical and less harmful effects on individuals with SMI.[4] These medication delivery practices suggest the paternalistic approach by a caregiver. The paternalistic model in care has stemmed from existing collective growth, joint family, and social system in India. Paternalism is caregiver's support or overriding one person's known preferences or actions and justifying the effort to benefit or avoid harm to the person. This supports the "Parens Patriae" power of

the family, to protect individual members of the family who cannot care for themselves due to impaired mental capacity. So, especially country like India, there is a need for a legal provision to support the collective rights of families in the care of SMI by temporarily curtailing fundamental rights of the SMI for the benefit of the patients.

At present, Mental Healthcare Act, 2017 has no legal provision to provide community-based continued care to SMI, who are likely to skip treatment and eventually be hazardous to the community. Community-based provision should be done in the interest of society to provide treatment allowing a less restrictive alternative to hospitalization,[6] especially for PWMI who are potentially at risk for violence. Above felt needs by the community are perceived in the high-income countries. So, they have come up with a legal framework called community treatment order (CTO). This allows legally authorized community mental health treatment for SMI. This has led to many state orders and legislations like Involuntary Outpatient Commitment Law of New York 1999 or Kendra's Law, Brian's Law or mental health legislation of Ottawa 2000, Laura's Law 2002 of California for assisted outpatient treatment order, etc. It has become a legal mechanism by which people with mental health problems who needed treatment were compelled to submit to treatment on an outpatient basis and monitored in a systematic manner.[7] On the contrary, there was huge criticism for upholding the autonomy of patients' right to refuse treatment in Starson v. Swayze.[8] The purpose of CTO could vary with focus on treatment in the least restrictive environment (before admission to the hospital) or preventive relapse and avoid violence (after admission).

When we relook into evidence on the use of CTO, it is associated with decreased violence, fewer arrests,[9–11] reduction in the number of admissions, the total length of stay in the hospital, and relapses.[10] Also 70% of committed and 86% of voluntarily admitted patients reported overall positive feelings towards the staff on follow-up.[12] Reviews by Kisely SR, Campbell LA, Preston NJ showed no significant difference in service use, social functioning or quality of life compared with standard voluntary care. Based on this evidence, CTO's are enacted in around 70 jurisdictions worldwide, including the USA, Canada, Australia, New Zealand, and in England and Wales under the Mental Health Act 2007 whose principles are largely followed in MHCA-2017.

A resource-limited country like India has rich experience in handling and treating PWMI using the previous act of MHA 1987. In recent years, the enactment of the Indian MHCA 2017 tried to address many inadequacies of the previous act but failed to look into community-based treatment care for SMI. SMI patients are likely to skip treatment, have several relapses, and eventually become dysfunctional or dangerous to the community. By considering CTO as a measure, which has been already implemented in around 70 jurisdictions, it would ensure community care for SMI in the least restrictive manner. The CTO provisions in MHCA could substantially impact patient-related outcomes and also answer to question of SMI with noncompliance in the community regarding medications, family burnout, violence, and economical challenges. The right centric MHCA-2017 got tied up looking at the patient's autonomy over promoting treatment and not restoring autonomy lost due to mental illness.

The current "leave of absence" clause in sec 91 of MHCA-2017 provides time-bound community-based care for PWMI during admission. A similar clause can be amended for a postdischarge period and outpatient care setting to ensure the continuity of care in the community. This may be essential in a country like India, as there is gross deficiency in the available mental health resource and a high treatment gap among SMI. In addition, it is essential for community and family members who become vulnerable a lot at the hands of untreated PWMI. The CTO options for PWMI can enable the family to ensure the treatment, in turn, reduce potential danger, and create a safe environment at home and community. It would also reduce the hospitalizations and thus make a huge difference in quality of life (QOL) of chronic PWMI with poor insight. Thus it would allow them to lead a life of dignity by legislating a small curtailment of liberty to facilitate their treatment in community settings.

The change of "community treatment order" terminology for cosmetic appeal and removing the stigma associated with certain words like "compulsory or assisted or supervised" in treatment orders given in community care can help accept CTOs at large by families and PWMI. Using terminologies like a comfortable or continued treatment option or offer over "orders" may be preferable to gain wide public acceptance and appeal.

In conclusion, there is a need for introducing the CTO like legal measures by amendments in MHCA, 2017. In the future, there would be a need for well-designed studies of patients with SMI with CTO options that look into outcome parameters like illness control, functionality, violence, self-harm, suicide, criminality, legal issue, and disability-adjusted life years. In addition, studies on caregivers' perspective and their QOL, economics, and rehospitalization would shed more light on the utility of CTO in India. Envisioning similar provisions of leave of absence as a prerequisite to symptomatic PWMI who do not want to get admitted can be pathbreaking.

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