FORENSIC PSYCHIATRY IN INDIA

Interface of Indian Laws & Mental Health

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2021

978-81-951544-6-3

NIMHANS Publication No. **196**

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Typesetting: Medscientist Pvt Ltd., India

Citation

Naik SS, Damodharan D, Kumar CN, Math SB (Eds). Forensic Psychiatry in India – Interface between Indian Law and Mental Health. NIMHANS Publication No: 196; 2021, ISBN: 978-81-951544-6-3

NIMHANS Publication No. **196**

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Message from the Director

There are complex interfaces between psychiatry and the law. Historically, while the earlier laws focused largely on protection of society from persons with mental illness, over the last century, the focus has shifted to protecting persons with mental illness and their rights within society. Forensic psychiatry has in turn also expanded from merely looking at laws regulating admission and discharge from hospitals to legal provisions to assess and support decisions making in persons with mental illness, ensuring right and access to treatment in the least restrictive circumstances, and various other civil issues.

There have been several changes in laws related to mental illness and two mental health care acts have come into force within a span of just three decades, while it took seven decades for the repealing of the Indian Lunacy Act. In current times psychiatrists also need to be aware of the various legal aspects of psychiatric service delivery, assist colleagues in other fields of medicine and law in relation to medico-legal aspects of mental illness, be trained as expert witness in court to provide expert evidence related to mental illness, insanity defense, testamentary capacity, fitness to stand trial. They may be called upon to provide expert opinion on fitness to work, situations involving marital issues, as well as issues of child abuse and mental illness related to the elderly. Psychiatrists providing online care also need to be conversant with the legal issues in tele-psychiatry and current guidelines for the same.

This update on the current practice related to forensic psychiatry in India will undoubtedly help psychiatrists in practice and in academic institutions to be conversant with various aspects of the law and psychiatry.

Congratulations to the authors for bringing out this timely publication.

Dr. Pratima Murthy
Director, NIMHANS.

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राष्ट्रीय मानसिका स्वास्थ्य एवं तंत्रिका विज्ञान संस्थान (राष्ट्रीय प्रमुख्याथा संस्थ) बेंगलुरू – 29
ರಾಷ್ಟ್ರೀಯ ಮಾನಸಿಕ ಆರೋಗ್ಯ ಮತ್ತು ನರವಿಜ್ಞಾನ ಸಂಸ್ಥೆ ರಾಷ್ಟ್ರೀಯ ಪ್ರಾಮುಖ್ಯತೆ ಸಂಸ್ಥೆ ಬೆಂಗಳೂರು–29

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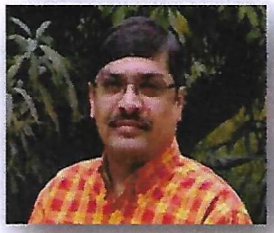

Message from the HOD

Forensic psychiatry focuses on the relationship between mental health and the existing law. The ever-rising voices for human rights, ethics in clinical practice and the enactments and amendments of legislature related to mental health have broadened the scope of this constantly evolving field in psychiatry. It is vital for post-graduate residents as well as practicing psychiatrists across the country to be trained and updated about the developments in this critical domain.

Newer developments under the Protection of Children from Sexual Offences Act (POCSO, 2012), Juvenile Justice Act (JJA, 2015), Rights of Persons with Disabilities Act (RPWD, 2016), and Mental Healthcare Act (MHCA, 2017) are conceptualized from the service user perspective and are dedicated to improve the standards of ethics and human rights. Current provisions from these laws on the rights of person with mental illness or disability, capacity assessment, advance directives, nominated representative, supported admissions, available grievance redressal mechanisms, minimum standard rules for mental health establishment, protection and special privileges offered to women and children, prison mental health and the mandates made on the respective governments to ensure the provisions are followed are indeed new developments in the field of psychiatry.

In this context, the forensic psychiatry unit of the Department of Psychiatry, NIMHANS has compiled and edited this book as a useful resource to guide and empower the psychiatry residents, practicing psychiatrists and other mental health professionals in their routine assessment and management of persons with mental illness from the forensic perspective.

Best wishes to the team and the readers.

Dr. Y.C Janardhan Reddy
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PREFACE

IN INDIA, psychiatry trainees and specialists often practice in the realm of mental health and law interface. It involves both application of their clinical proficiency in legal contexts and legal implication of their clinical practice, duties and responsibilities. Unlike the western psychiatry, psychiatrists don two hats, a "treating psychiatrist" as well as a "forensic expert" to patients, due to lack of an evolved forensic psychiatry in the medical healthcare system. Thus, the onus of learning and understanding the nuances of laws associated with medical and mental health rest on the fraternity. The Latin Maxim "*ignorantia legis neminem excusat*" ('ignorance of law is not an excuse') indicates that awareness of newer laws and amendments of existing Indian laws is the only way to overcome challenges, abide to the law during the delivery of psychiatric services and further improve the clinical care.

National Institute of Mental Health and NeuroSciences (NIMHANS), Bengaluru has five-decade long history of evolution and practice of Forensic Psychiatric Services. The forensic psychiatry experts Prof. Channabasavanna, Prof. C R Chandrashekhar, and Prof. Pratima Murthy have played crucial role in establishing the forensic psychiatry unit. They guided several students in conducting research on the ethics and legal dimensions of psychiatry. The current forensic psychiatry unit of the Department of Psychiatry, NIMHANS includes Drs. Suresh Bada Math, C Naveen Kumar, Sydney Moirangthem, Guru S Gowda, senior residents and post-doctoral fellows in forensic psychiatry. They reviewed Indian legislations, literature published in medical journals to bring forth this novel, overarching reading material, supported by access link to learning videos in each chapter. This book has several resource materials for forensic assessment and reporting, pinned as appendices at the end of chapters for the ease of access in readers' routine practice.

The ever-rising voices for human rights, ethics in clinical practice and the enactments and amendments of legislature related to mental health has broadened the scope of this constantly evolving field in psychiatry. Psychiatrist, as an expert witness, performs a professional role in legal conflicts involving insanity defense, testamentary capacity, fitness to stand trial, fitness/capacity to resume work as mandated by law. From a novice psychiatry trainee to a well-established mental health professional, these circumstances may initially create a sense of unease. Essential understanding about the interface of mental health and law, consulting colleagues and legal professionals for advice, and regular updates about the developments in forensic psychiatry might help to allay this unease and empower professionals to develop expertise in this field. This book covers the role of psychiatrist as an expert witness, provisions of different legislatures relevant to child and adult psychiatry, Tele-Medicine and Telepsychiatry practice guidelines, certification in psychiatry and importance of prison mental health amongst others.

We are positive that this book will educate the psychiatry trainees and practitioners and make them feel more confident in assessing and managing the medico-legal aspects of their patients. We hope the learnings from this book will orient the postgraduate trainees and clinical practitioners towards the legal implications of psychiatric practice, further inspire readers to explore the debatable and give impetus to explore yet-unknown topics of forensic psychiatry.

- **Shalini S Naik, Dinakaran Damodharan, C Naveen Kumar & Suresh Bada Math**

CONTENTS

Chapter 1

Introduction to Forensic Psychiatry

Dinakaran Damodharan, Shalini S Naik, Channaveerachari Naveen Kumar, Suresh Bada Math

Highlights

- Forensic psychiatry is a sub-specialty of psychiatry that deals with the interface between medical and legal aspects of psychiatry training and practice.
- Existing forensic psychiatry training during post-graduation is rated as poor/very poor by nearly half of the psychiatry residents.
- The field of medicine, psychiatry in particular, and the law are constantly evolving. It is the duty of the psychiatrist to be in up-to-date terms about both the systems.
- NIMHANS Forensic Psychiatry evaluation proforma, ward observation proforma and fitness to stand trial related details are discussed in this introduction chapter.
- Competency based training programs/modules to improve the knowledge and practice of psychiatry trainees are the need of the hour.

Introduction

FORENSIC PSYCHIATRY is a sub-specialty of psychiatry that deals with the interface between medical and legal aspects of psychiatry training and practice. This includes the mental health perspectives and expertise in civil, criminal, and other legislative concerns. Psychiatrist with necessary knowledge in the interface of law and psychiatry and ability to provide adequate information relevant to the concerns of the legal system in a timely fashion makes a forensic psychiatry expert. Forensic psychiatry is not given adequate importance during post-graduate psychiatric training. Existing curriculum is rated as poor/very poor by 45% of the psychiatry residents respondents in a nation-wide online survey (1). Almost one-third of the faculty too felt their competency is poor/very poor in imparting the necessary forensic psychiatry training to their students (1). Given the importance of the medico-legal aspects of psychiatric practice, there is an urgent need to improve the forensic psychiatry training during post-graduate residency programs.

Psychiatry and Law

Generally, medical service system and professionals are guided by the legal system. Specifically, psychiatry is regulated more often than other specialities. The laws that govern the medical specialities are listed in table 1.1.

The field of medicine, psychiatry in particular and the law are constantly evolving. It is the duty of the psychiatrist to be in up-to-date terms about both the system while being an expert. Psychiatrist may be called to testify in the following instances;

- In allegations of civil or criminal negligence by self
- To opine on the negligence by other professionals
- To opine on admission, discharge and treatment procedures
- To examine and testify about the insanity defence
- To evaluate and opine on sexual perversions

- To assess and report the fitness to stand trial
- To evaluate and opine on the testamentary capacity
- To assess the capacity to make contract or manage property
- To examine the claims of reported psychological injury/trauma
- To opine on the fitness to continue work/job
- To examine the fitness to hold/carry weapons for defence personnel
- To get assistance for the decision about divorce and child custody
- To assess and quantify the intellectual disability
- To evaluate and intervene the child in a case of sexual abuse

Table 1.1: Legislations associated with modern medicine and psychiatry

Modern medicine comes under the governance of
• Indian Medical council Act 1956 • Medical termination of pregnancy Act 1971 • Preconception and prenatal diagnostic testing Act 1994 • Transplantation of human organs Act 1994 • National Trust Act 1999 • Domestic violence Act 2005 • Clinical establishment Act 2010 • Juvenile justice Act 2015 • HIV/AIDS Prevention and control Act 2017 • Surrogacy Bill 2019 • Consumer protection Act 2019
In addition, Psychiatry also comes under the governance of
• Mental health care Act 2017 • Rights of persons with disability Act 2016 • Narcotics drugs and psychotropic substances Act 1985 • Protection of children from sexual offences 2012

Functioning of forensic psychiatry unit

Forensic psychiatry unit functions to provide for the individuals suspected/diagnosed to have mental illness in conflict with the existing civil or criminal law. A multidisciplinary team involving psychiatrists, psychologists, social workers, and mental health nurses attend to both out-patient and in-patient services and needs related to such individuals. Forensic psychiatry in-patient wards are part of male and female closed wards. The prisoners may be transferred to psychiatry facility for the following needs; assessment of mental health status, diagnosis, treatment of behavioural problems like violence and suicidal behaviour, to assess decision making capacity, fitness to stand the trial, to review the existing psychiatric illness, and for opinion on insanity defence (2). Such referred patients are assessed by a postgraduate psychiatry resident (trainee) using a structured Forensic Psychiatry Detailed Workup Proforma (See Appendix -1.1). After the detailed assessment, the case is discussed with the senior resident on the same day of referral and findings are noted in the file. Ward observation and serial mental status examinations are documented on a daily basis. Ward behaviour of each patient is documented every day using the Ward Behavioural Observation Report (see Appendix -1.2). The documentation of each referred prisoner in the forensic psychiatric file is meticulous and monitored by a senior resident and two forensic psychiatry consultants The case is discussed in a multidisciplinary grand round, held once every week, consisting of two forensic

psychiatry consultants, and consultants from clinical psychology, psychiatric social work, psychiatric nursing and residents/trainees from the concerned departments. This multidisciplinary team is provided with the responsibility for assessing, diagnosing, managing the patient and providing legal opinion to the judiciary. Additionally, on case-to-case basis, relevant psychosocial and neuropsychological assessments like Intelligent Quotient (IQ), personality assessments and brain lobar functions assessment are applied to enhance the holistic understanding of the individual.

NIMHANS Forensic Psychiatry Workup Proforma

Structured assessments are carried out for each referred prisoner using the workup proforma developed in-house and revised multiple times since decades to suit the assessment to be relevant to the current clinical and legal context. The Proforma is divided into many parts; socio-demographic details, identification marks, referral related questions, case and prison stay related details, behavioural observation details from the authorities, chief complaints, history of the presenting illness, past history, family history, premorbid personality, general physical examination, systemic examination, record of injuries, mental status examination, cognitive functions, judgment and insight evaluation, followed by formulation, provisional diagnosis and management plan with detailed notes from senior resident and forensic psychiatry consultant.

Socio-demographic details recorded include the routine demographic parameters along with place of examination, details of accompanying persons, details about reliability and adequacy of the information. This is followed by recording information about the source and reason of referral along with details about the accompanying letters and documents. Crime or case related information is collected next with focus on charges against the person, legal status, current trial progress, duration of stay at prison along with prison observation report obtained from the authorities.

Chief complaints from the referring authority and the person referred are documented in chronological order. Circumstances around the incident or conflict with law or regarding the alleged crime are collected before collecting the information on presenting illness. Since the incarceration or trial may have contributed as precipitating factors for the presentation and to provide clarity to the team about the temporal order of the symptoms, this clarification about circumstances surrounding the alleged incident or crime is indeed the essential first step. Following this clarification, detailed account of the history of presenting illness is sought. The information is documented with a focus on thoughts, emotions and behaviours of the individual during the said time period. Probable predisposing, precipitating, aggravating and relieving factors are clarified for each symptom with the person. Biological functions like sleep, appetite and sexual activities are enquired. Occupational and social functioning of the individual during the time period while he/she was suffering from the symptoms is assessed to understand the severity of interference of the pathological symptoms in their routine daily life. Relevant negative history is collected to differentiate probable closely related diagnostic conditions with caution towards presence or absence of substance use, medical conditions and other related concerns.

Details related to past medical and psychiatric illnesses and treatment availed for those conditions are collected. Information regarding any one allergy or drug reactions is documented. Importantly, the source of availing such information is clearly recorded. Relevant family history available from the patient and other sources is documented. Medical and psychiatric conditions in closely related family members and their treatment details are noted. A three-generation genogram of the family of origin is prepared with focus on age, occupation and illness status of the available family members. Personal history including developmental, educational achievements, job related, marital and sexual history is collected with special attention paid to history of high-risk behaviours and substance use. For women, detailed menstruation and pregnancy related information is documented with date of the last menstrual period. From all the available sources, premorbid

characteristics of the individual's personality are clarified.

History clarification is followed by medical examination. General examination includes assessment of pulse rate, rhythm, temperature, blood pressure in standing and supine positions, respiratory rate, height, weight, body-mass-index, pallor, icterus, cyanosis, clubbing, lymphandenopathy, oedema, oral examination, neck examination and ophthalmic fundus examination. This is followed by detailed examination of cardiovascular, respiratory, gastrointestinal and musculo-skeletal systems. Detailed structured neurological examination is carried out starting from higher functions tests, cranial nerves assessments, motor, reflexes, sensory, cerebellar, skull and spinal system examination. Whole body injury mapping is done and pictorially represented in the case sheet.

Mental status of the individual is assessed with focus on specific time period (say over last 2-4 weeks). General appearance and behaviour, psychomotor activity, speech, thoughts, emotions, perceptions and cognition are assessed. Wherever relevant, structured assessments like Mini-Mental Status Examination (MMSE) and Kirby's assessment Proforma for uncooperative persons are utilised. Individual's personal and social judgment and insights about the symptoms or illness is ascertained. This evaluation is followed by a diagnostic formulation and provisional diagnosis.

Detailed plan of management is provided in the next section. Blood, urine and radiological investigations, structured psychometric assessments are requested as relevant. Sexually transmitted diseases work up and urine toxicology screening are advised as needed. Ward observation report and serial mental status examination are included for all the referred individuals. If further documents (like FIR, letter from the court, family members' report) are needed, they are specifically requested through the proper channel. Clinical supervisors' opinion and management plan are documented and relevant letters are sent to the authority about the status of the individual. These letters include information about the current status of the admission, assessments done, diagnosis made, treatment given, further information sought and probable duration of further stay required in the hospital. Signature of the psychiatry trainee and the supervisors (senior resident and consultant in-charge) are provided at the end of the Proforma with date and time.

Ward observation report

NIMHANS ward observation report is filled by the psychiatry trainee with the help of attending mental health nurse on a daily basis (see Appendix 1.2) (3). Ward observation report includes assessments in the following domains; biological, occupational and social functioning in the ward, activities of daily living, behavioural excess and deficits with key observations about the individual's behaviour when the ward staffs are not monitoring them and specific behaviour while medications are offered. Assessment related to sleep, appetite, bowel, and bladder activities are included under biological functions. Social functioning observations include interaction with fellow in-mates in the ward, interaction with other ward staffs, following rules and norms of the ward and attitude towards the treating team. Participation in ward activities, physical exercises and recreational activities are enquired under occupational functioning. Self-care, bathing, dressing, and grooming are included under the activities of daily living domain. Violence, aggression, smiling, crying and talking to self, self-injurious behaviour, suicidal attempts and substance use are recorded under the behavioural excess domain. Reduced speech, reduced activity levels, reduced motivation, and poor interaction are documented under behavioural deficits. Such structured behavioural observation reports provide additional information and complementary to the day-to-day serial mental status examination. This helps in improving the rapport with the individual and in better understanding the individual's mental status and concerns in a systematic manner.

Fitness to stand trial

NIMHANS Fitness to stand trial assessments consist broadly of 5 sections; assessments of cognitive functions, understanding about charges against the individual, knowledge about court proceedings, understanding about their lawyer and understanding about behaviour in the court. Cognitive assessments include tests of orientation to time, place, and person and attention span. Section-2 explores the individual's understanding about the charges framed against them, penalties if charges are proven, their understanding about bail, judgment and appeal. Section-3 examines the person's understanding about the court proceedings. The types of courts, roles of the Judge, different lawyers (self and opposition), witnesses, stage and progress of the trial, trial attendance and individual's rights during the trial are explored in this section. Section-4 explores the individual's understanding about their lawyer, payment of fees, trust related concerns and the role they may play in helping their lawyer to build the case. Section-5 discusses the possible individual's behaviours during the trial. This includes behaviours related to presenting self in front of the Judge, listening and answering the questions appropriately and handling certain difficult circumstances like hostile questioning. Fitness to stand trial assessment proforma used in NIMHANS is provided in Appendix 1.3.

Confidentiality in forensic assessments

During a routine clinical interview or psychological therapy session, the privilege of patient/client confidentiality is maintained. However, when a person called by the legal team to interrogate/assess the client, it is the duty of the psychiatrist to inform and warn the person regarding the limited confidentiality of the assessment. The expert should explain the ethical reasons that the interview and information provided might be legally recorded and the same has to be carefully documented. As per the Indian evidence Act 1872, personal documents may not be revealed without the consent of the individual. The expert need not voluntarily reveal the available confidential information unless ordered by the court. The treating psychiatrist as a "fact witness" may protest the request of confidential information of his/her patient. When ordered by the court to reveal such information, the doctor may decide to produce in written format addressed to the entitled person to receive it rather than divulging it in open court room.

Conclusion

Competency based training programs/modules to improve the knowledge and practice of psychiatry trainees are the need of the hour. Professional organisations like Indian Psychiatric Society too have a responsibility in conducting regular continuing medical education programs/seminar in the critical topics of forensic psychiatry to improve the teaching competency of psychiatry faculty.

Video link: https://youtu.be/mtv_2qkRZQY

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Appendix 1.1

Forensic Psychiatry Detailed workup Proforma

Date: **Time:** **Hospital ID:**

Place of Examination:

Accompanying Persons:

Information: Reliable/adequate

Name of the Patient with alias:

Sex: Male/Female/Third gender **Age .....**

Marital status: ……. **Education**: …….

Occupation: ……

Father Name: ……

Mother Name: ……

Residential address with mobile number:

Identification Marks:

a)

b)

Referring authority:

1) Magistrate 2) Prison Superintendent 3) Medical officer 4) Others (specify) ----------

Reason for referral:

1) For certificate 2) Treatment 3) Fitness to stand trial 4) Fitness for job 5) Testamentary capacity 6) any other (specify) ----------

Accompanying letters (Referral letter details with date):

1)

2)

3)

4)

Legal status:

1) UTP No:

2) CTP No:

3) Reception Order No:

4) On Bail:

5) Disciplinary action (suspended/dismissed)

6) any others

Duration of stay in prison/Police Station:

Charges against the patient/ Information regarding the conflict with law
(if possible,include IPC sections; if patient is from prison)**:**

Behavioral Observation report from the referring authority:

a) Provided b) Notprovided (If present please summarize here)

Chief complaints as per the referring authority or accompanying person:

Chief complaints as per the patient:

Circumstances around the incident or conflict with law or alleged crime:
(Please collect information one week prior and one week after the alleged crime or in conflict with law)

History of Presenting Illness:
(Please specify the sources of information)

(Add Additional Resident Sheets)

Past history of Medical/psychiatric illness and Treatment history:
(Please specify the sources of information)

Family history:
(Please do three generation pedigree charting with names of each family members, age, occupation and illness)
Please do the pedigree charting as per the persons withmental illness provided information

Personal history:
(Please collect information on substance use /high-risk behaviour)

Premorbid personality:
(Ask the person to describe himself if no informant is available)

Mental Status Examination and Cognitive Function:

Medical Examination

General Physical Examination

Pulse			Pallor	
Blood Pressure	Supine		Icterus	
	Standing		Cyanosis	
Temperature			Clubbing	
Respiratory Rate			Lymphadenopathy	
Pupils			Oedema	
Height			Oral Examination	
Weight			Fundus	
Body Mass Index				

Systemic Examination

Cardio Vascular System			
Heart Rate		Heart Sounds	
Murmurs			

Other Positive Findings (If Any):

Respiratory System			
Air Entry		Adventitious Sounds	
Breath Sounds			

Other Positive Findings (If Any):

Per Abdomen examination			
Inspection		Organomegaly	
Palpation			

Other Positive Findings (If Any):

Genito-Urinary System -

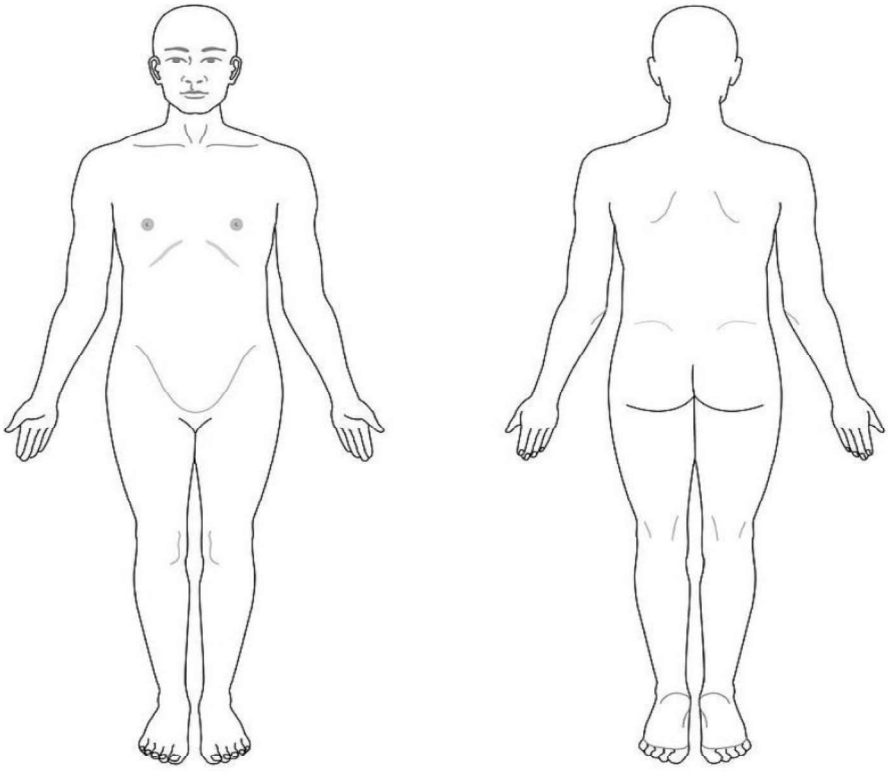
Musculoskeletal System -

Nervous System

A. Level of Consciousness: Alert___ Lethargic___ Stupor___ Coma___
B. Handedness
C. Speech
D. Posture
E. Gait
F. Involuntary movements
G. Skull and Spine
H. Extra Pyramidal Side Effects
I. Meningeal Signs -
J. MMSE/HMSE Score -

Nervous System		Right	Left
Cranial Nerve			
Motor System	Bulk		
	Power		
	Tone		
Reflexes	Biceps		
	Triceps		
	Supinator		
	Knee		
	Ankle		
	Corneal		
Sensory System	Pain		
	Touch		
	Temperature		
	Pressure		
	Position		
CerebellarSystem	Finger Nose test		
	Dysdiadochokinesia		
	Tandem Walking		
	Rombergs		
	Stereognosis		

Injury Marks -



Mental Status Examination / Mini-Mental Status Examination / Kirby Proforma:

Cognitive Function:

Judgement:

Insight:

Formulation:

Provisional Diagnosis:

Plan of management:

I. Investigation planned

a) Haemogram
b) Renal Function Test
c) Liver Function Test
d) Serum Electrolyte
e) Thyroid Function Test
f) Fasting Blood Sugar
g) Fasting Lipid Profile
h) HIV/VDRL/ HbS Ag (case to case basis)
i) Urine for drug screening (case to case basis)
j) Imaging (case to case basis)

II. Psychological Assessment

a. Serial Mental Status Examination
b. Ward Observation
c. Psychological testing
   - Intelligence Quotient testing (case to case basis)
   - Personality assessment (case to case basis)
d. Any other please mention

Requesting for more information (letters to be dispatched):

a. FIR from the police station
b. Letter to the Court / The Prison
c. Family members to provide history and to plan for management
d. Referral to legal aid clinic
e. Any other letters:

Signature of the Junior Resident Doctor: **Date:**

Doctor's Name:

Consultant/Senior Resident's Notes **Time……..**

Signature of the Consultant/Senior Resident: **Date:**

Doctor's Name:

Appendix 1.2

Ward behavioral observation report

- **Biological functioning:**
  - Sleep
  - Appetite
  - Bowel/Bladder habit
- **Social Functioning:**
  - Interaction with other inmates of the ward
  - Interaction with hospital staff
  - Following the norms / rules of the hospitals
- **Occupational functioning:**
  - Involvement in ward activity
  - Involvement in exercise
  - Involvement in recreational /rehabilitation activity
- **Activities of daily living:**
  - Self-care
  - Bathing
  - Dressing
  - Grooming
- **Behavioral excess:**
  - Violence
  - Aggression
  - Hallucinatory behavior such as talking to self / laughing to self
  - Crying to self
  - Self-injurious behavior
  - Suicidal behavior
  - Substance use
- **Behavioral deficit:**
  - Withdrawn behavior
  - Motivation to involve
  - Speech
- **Behavior of the patient when staff is not observing:**
- **Reaction when medication is offered:**

Appendix 1.3

Fitness to stand trial Questionnaire

Name:

Subject No:

Cognitive functions:

1) What is today's date or day of the week?
2) What is the time now?
3) Which place is this? (City/hospital)
4) Who is this person? (Pointing attendant/ staff/ police)
5) Count twenty to one (backwards) or Weekdays forwards and backwards?

Understanding the charges:

1) What are the charges framed against you?
2) What are the possible penalties if charges are proven?
3) What is bail and who grants it?
4) What is judgment?
5) What do you mean by appeal?

Understanding the court proceedings:

1) What are your rights as under trial prisoner? (Prisoner's rights)
2) Who is the chief of the court?
3) Who has the authority to release you from the prison?
4) Who will assist you in fighting your case?
5) What is the role of your lawyer in the court (defense counsel)?
6) What is the role of a prosecution lawyer?
7) How does your trial/case progresses?
8) What is meant by witness?
9) Do you know that there may be witness against you?

10) What should be done if one of the witnesses tells a lie against you?

11) In which court will your trial take place?

12) What happens if you don't attend the court?

Helping the attorney/lawyer:

1) What is your lawyer's name?

2) What will you do if you are unable to hire the services of a lawyer?

3) How will you help your lawyer to defend your case?

4) Do you trust your lawyer?

Behavior in the court:

1) What must you do when the magistrate enters the court?

2) How will you address the magistrate?

3) What should you do before answering the questions in the court of law?

4) What must you do if opposite lawyer asks you a question for which you do not know the answer?

5) What must you do if opposite lawyer asks certain provoking questions?

6) What happens if you behave inappropriately (shouting, violent, aggression) in the court?

Chapter 2

Insanity defense

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Highlights

- Derivation of Insanity defense and M'Naghten rule
- Comparison of M'Naghten Defense with other Insanity defenses
- Section 84 in Indian context
- Important supreme court verdicts related to Insanity defense
- Difference between medical and legal insanity

Introduction

IN MODERN LEGAL SYSTEMS, individuals are entitled to raise defenses during their trials to show that they were not fully responsible for their criminal conduct. The system permits the use of defenses to ensure that the accused receives condign punishment, or proportional justice. One of the most important criminal defenses is the insanity defense, which is based on the proposition that a defendant with a mental defect should not be held criminally responsible (1). Most formulations of the insanity defense are based on either cognitive or behavioural impairments. With respect to the cognitive component, it is considered unjust to punish a person who suffers from a mental defect that prevents him/her from comprehending the nature of his/her action (2).

It has been historically considered unjust to punish an individual for an act the individual could not control, and doing so does not serve the basic objectives of the criminal law. These objectives have traditionally been: 1) deterrence of future criminal behaviour by the convicted person and the rest of society; 2) rehabilitation of the criminal; 3) protection of the public by incarcerating the convicted-person in a penal institution; and, 4) retribution for society (3). These goals of the criminal law cannot be furthered by imposing criminal punishment upon a person who lacks the mental capacity to comply with the law. One who is incapable of conforming conduct to the law will not be deterred from repeating undesirable behaviour by being punished, nor will the punishment of mental incompetents serve as an example to similar persons who might commit crimes.

Derivation in the law

In the legal system, there are two general requirements for criminal sanction against an individual: mens rea and actus reus. Mens rea refers to the intent to commit an act and have a desired consequence (e.g., intending to pull a trigger and having the escaping bullet hit someone for a murder charge), and actus reus refers to the act fitting within the criminal statute (e.g., someone needs to be dead for there to have been a murder). The insanity defense derives from the idea that certain mental diseases or defects can interfere with an individual's ability to form mens rea as required by the law (4,5).

Various insanity defenses

M'Naghten Insanity Defense

The M'Naghten insanity defense, also called the **right-wrong test**, is the most common insanity defense used across the world. It is also the oldest and was created in England in 1843. The defense is named after Daniel M'Naghten. M'Naghten was under the paranoid delusion that the Prime Minister of England, Sir Robert Peel, was trying to kill him. When he tried to shoot Sir Peel from behind, he inadvertently shot Sir Peel's Secretary, Edward Drummond, who thereafter died. M'Naghten was put on trial for murder and, to the shock of the nation, the jury found him not guilty by reason of insanity (6). After a public outcry at this verdict, the British House of Lords developed a test for insanity that remains relatively intact today. The M'Naghten insanity defense is *cognitive* and focuses on the defendant's awareness, rather than the ability to *control* conduct. The defense requires two elements (see Table 2.1). First, the defendant must be suffering from a *mental defect* at the time he or she commits the criminal act. The mental defect can be called a "defect of reason" or a "disease of the mind," depending on the jurisdiction. Second, the trier of fact must find that because of the mental defect, the defendant did not know both the nature and *quality* of the criminal act or that the act was *wrong*. The terms "defect of reason" and "disease of the mind" can be defined in different ways, but in general, the defendant must be cognitively impaired to the level of not knowing the nature and quality of the criminal act, or that the act is wrong. Some common examples of mental defects and diseases are psychosis, schizophrenia, and paranoia.

Irresistible impulse insanity defense

This defense has lost popularity over the years. In some cases, the irresistible impulse insanity defense is *easier* to prove than the M'Naghten insanity defense, resulting in the acquittal of more mentally disturbed defendants. In jurisdictions that recognize the irresistible impulse insanity defense, the first element is the same as M'Naghten; the defendant must suffer from a mental defect or disease of the mind. However, the second element adds the concept of **volition**, or free choice. If the defendant cannot control his or her conduct because of the mental defect or disease, the defendant's conduct is excused even if the defendant understands that the conduct is wrong. This is a softer stance than M'Naghten, which does *not* exonerate a defendant who is aware conduct is wrong.

Substantial capacity test

It is the insanity defense created by the ***Model Penal Code***. The Model Penal Code was completed in 1962. The substantial capacity test is as follows: "A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law". The defense has two elements. The first element requires the defendant to have a mental disease or defect, like the M'Naghten and irresistible impulse insanity defenses. The second element combines the **cognitive** standard with **volitional**, like the irresistible impulse insanity defense supplementing the M'Naghten insanity defense. In general, it is easier to establish insanity under the substantial capacity test because both the cognitive and volitional requirements are scaled down to more flexible standards. Unlike the M'Naghten insanity defense, the substantial capacity test relaxes the requirement for complete inability to understand or know the difference between right and wrong. Instead, the defendant must lack *substantial*, not total, capacity. The "wrong" in the substantial capacity test is "criminality," which is a *legal* rather than moral wrong. In addition, unlike the irresistible impulse insanity defense, the defendant must lack *substantial*, not total, ability to conform conduct to the requirements of the law. Another difference in the substantial capacity test is the use of the word "appreciate" rather than "know." As stated previously, appreciate incorporates

an emotional quality, which means that evidence of the defendant's character or personality is relevant and most likely admissible to support the defense.

Durham insanity defense

The Durham defense is also called as the **Durham rule** or the **product test**. In general, the Durham insanity defense relies on ordinary principles of **proximate causation**. The defense has two elements. First, the defendant must have a mental disease or defect. Although these terms are not specifically defined in the *Durham* case, the language of the judicial opinion indicates an attempt to rely more on objective, psychological standards, rather than focusing on the defendant's subjective cognition. The second element has to do with **causation**. If the criminal conduct is "caused" by the mental disease or defect, then the conduct should be excused under the circumstances.

Table 2.1: Various insanity defenses

Law	First component	Second component
M'Naghten defense	Mental disease or defect of mind	Inability to know nature or quality of the criminal act or that the criminal act was wrong
Irresistible impulse defense	Mental disease or defect of mind	Inability to know nature or quality of the criminal act or that the criminal act was wrong or Inability to control conduct
Substantial capacity defense	Mental disease or defect of mind	Lacks substantial capacity to appreciate criminality of conduct or to confirm conduct of the law
Durham defense	Mental disease or defect of mind	Criminal conduct caused by mental disease or defect of mind

Insanity defense in India

Even, in India, insanity defense law, Section 84 IPC is solely based on the M'Naghten rules. Although no changes were made in the law till now an attempt was made in 1971, by the Law Commission of India to revisit the Section 84 in their 42nd report, but no changes were made.

Section 84 of IPC deals with the *"act of a person of unsound mind* (7)." "Nothing is an offence which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law (8) ."

For the sake of easy understanding, the Section 84 IPC can be divided into two broad categories of, major criteria (medical requirement of mental illness) and minor criteria (loss of reasoning requirement) (1). Major criteria (mental illness requirement) mean the person must be suffering from mental illness during the commission of act. Minor criteria (loss of reasoning requirement) mean the person is:

a. Incapable of knowing the nature of the act or
b. Incapable of knowing his act is wrong or
c. Incapable of knowing it is contrary to law.

This means that an act does not constitute a crime unless it is done with a guilty intention called "mens rea." Hence, Section 84 IPC fastens no culpability on persons with mental illness because they can have no rational thinking or the necessary guilty intent.

Supreme Court decision on Insanity defense in India

Every person who is suffering from mental illness is not exempted from criminal liability. In the case of *Hari Gobid Singh versus State of Madhya Pradesh* (9) the Supreme Court observed that Section 84 sets out the legal test of responsibility in cases of alleged mental insanity. There is no definition of 'mind soundness' in IPC. However, the courts have mainly treated this expression as equivalent to insanity. But the term 'insanity' itself does not have a precise definition. It is a term used to describe various degrees of mental disorder. So, every mentally ill person is not ipso facto exempt from criminal responsibility. A distinction must be made between legal insanity and medical insanity. A court is concerned with legal insanity, not medical insanity.

In the case of *Surendra Mishra versus State of Jharkhand* (10) It was pointed out that 'every person suffering from mental illness is not ipso facto exempt from criminal liability.' Furthermore, in another case of the Supreme Court, in determining the offense under Section 84 of the IPC, held that' it is the totality of the circumstances seen in the light of the recorded evidence' that would prove that the offense was committed.' It was added: "The unsoundness of the mind before and after the incident is a relevant fact (11)."

Unsoundness of mind must be at the time of the commission of the Act. The first thing to be considered when defending insanity is whether the accused has established that he was unsound at the time of committing the act. The word "insanity" is not used in Section 84 of the penal code. In *Rattan Lal versus State of Madhya Pradesh* (12) it was well established by the court that the crucial point of time at which the unsound mind should be established is the time when the crime is actually committed and whether the accused was in such a state of mind as to be entitled to benefit from Section 84 can only be determined from the circumstances that preceded, attended and followed the crime. In other words, it is the behaviour precedent, attendant and subsequent to the event that may be relevant in determining the mental condition of the accused at the time of the commission of the offense but not those remote in time. The benefit is available only after it is proved that at the time of committing the act, the accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or that even if he did not know it, it was either wrong or contrary to law. In *Santosh Maruti Mane vs The State of Maharashtra,* the apex court found that the accused was guilty as there was not sufficient evidence to prove that the accused was unaware of his behaviours (13).

Supreme court on Burden of proof: In a recent case, *Devidas Loka Rathod versus State of Maharashtra* (14), the apex court discussed the law pertaining to plea of insanity under section 84 of the IPC. The court said that the accused may place all the relevant evidence oral, documentary or circumstantial before the court, but the burden of proof upon him is no longer than that rests upon a party to civil proceedings. The accused has only to establish his defense on a preponderance of probability, after which the onus shall shift on the prosecution to establish the inapplicability of the exception.

Burden of proof in insanity defense

There is generally a **presumption** that criminal defendants are *sane*, just as there is a presumption that they are *innocent*. Therefore, at a minimum, a defendant claiming insanity must produce evidence that rebuts this presumption. Some states require the prosecution to thereafter prove sanity beyond a reasonable doubt or to a preponderance of evidence. So, the onus of proving the existence of circumstances (Section 84 IPC) for insanity defense would be on the accused (Section 105 of the

Evidence Act) and the court shall presume the absence of such circumstances. The accused has to prove by placing material before the court such as expert evidence, oral and other documentary evidence, presumptions, admissions or even the prosecution evidence, satisfying that he was incapable of knowing the nature of the act or of knowing that what he was doing was either wrong or contrary to law. The Supreme Court have ascertained that the crucial point of time at which unsoundness of mind should be established is the time when the crime is actually committed and the burden of proving this, lies on the appellant for claiming the benefit of the Section 84 provision.

Medical vs. legal component

Medical insanity means any person who is suffering from any kind of mental illness whereas legal insanity means person suffering from mental illness should also have a loss of reasoning power (1). A court is concerned with legal insanity and not medical insanity. The insanity defense is the subject of much debate because it excuses even the most evil and abhorrent conduct, and in many jurisdictions, legal insanity functions as a perfect defense resulting in *acquittal*. However, the insanity defense is rarely used and hardly ever successful. This is generally because of the difficulty in proving *legal* insanity. Many criminal defendants suffer from mental illness and can produce evidence of this illness such as psychiatric or layperson testimony. Often, mental disturbance is apparent from the defendant's conduct under the circumstances. However, legal insanity differs from *medical* insanity and is generally much more difficult to establish. While the purpose of a medical diagnosis is to eventually *cure* the defendant's disorder, the purpose of criminal law is to *punish* the defendant. Thus, the defendant's conduct is not excused if the defendant or society can benefit from punishment (1,15).

Under section 84 IPC, only legal insanity falls in the purview and not medical insanity. To show a person is legally insane following components are mandatory: a) the accused was insane, b) he/she was insane at the time of the crime, c) as a result of unsoundness of mind, the accused was incapable of knowing the nature of the act or he was doing what was really wrong or contrary to law.

Critics on insanity defense

Those who favour abolishing or severely limiting the insanity defense have the following arguments:

a) The key terms in the various insanity tests are so vague as to invite speculation and intuitive moral judgements in the guise of factual determinations;

b) There is little or no basis in psychiatry for allowing expert witnesses to testify—as they often do, in conclusory terms—concerning the differentiation between persons who are personally blameworthy and those who are not;

c) It is therapeutically more desirable to encourage treatment of persons as actors responsible for their conduct, rather than as involuntary victims 'playing a sick role,'

d) The insanity defense discriminates against persons who commit crimes because of influences on their personalities other than mental disease or defect.

Finally, opponents of the insanity defense claim that, in practice, it is a 'rich person's defense' because usually it is only the wealthy who can afford the array of experts needed to mount a convincing defense. These scarce psychiatric resources, they argue, should be spent in treatment of those who have been committed or imprisoned.

How do psychiatrists get involved in cases that involve the insanity defense?

One way that psychiatrists get involved in insanity cases is through their patients. This would necessitate the unfortunate event where a patient is involved in a criminal matter. The patient and his or her counsel choose to make his or her state of mind at the time of the alleged incident an issue and you, as the treating physician, are called to testify. The other common way psychiatrists end up playing a role in these cases is as a consultant who is serving to evaluate the individual as well as the circumstances of the crime. In such a case, you are actually seeing the person under a court order or at the request of one of the attorneys, and it is quite different than seeing a patient, especially when issues such as confidentiality come up (1).

What it means when someone is found not guilty by reason of insanity?

When a defendant is found not guilty by reason of insanity it does not mean he or she necessarily goes free. Commonly, states have requirements for treatment or institutionalization after such a finding. Some states require such confinement for the length of time the person would have received if convicted as a minimum, so he or she may end up spending more time confined than if he or she did not raise such a defense. Like other areas of the law, this varies from state to state.

Other kinds of verdicts given in Insanity defense trials

Guilty but insane

This verdict would be used when a defendant commits a crime but did not have the necessary intent because of a mental disease (16). If the jury renders this verdict, the defendant would undergo a psychiatric examination and a court hearing to determine if he were still suffering from a mental disease. If so, he would be committed to a mental hospital. When in the opinion of the hospital staff he had recovered and could safely be released, the court would have another hearing. If the court was in agreement with the psychiatrist's opinion, it would then order the defendant's discharge.

Guilty but mentally ill

The defendant convicted under this verdict would be one who had an understanding of what he was doing at the time of the crime but was hindered to some degree by a mental illness. In other words, the defendant was not insane when he committed the offense, but was influenced by a mental illness (17). This verdict is not a replacement for the traditional insanity defenses. Rather, it offers the jury a *middle ground* between acquittal by reason of insanity and conviction. Procedurally, the convicted defendant would receive a sentence under the applicable criminal law, but would also receive a psychiatric evaluation. If he still suffered from a mental illness, he would be institutionalized. If his mental health was restored within the time period of the criminal sentence, he would then go on to prison. If the mental illness and institutionalization were to continue beyond the length of criminal sentence, a new civil commitment hearing would have to be held to insure the constitutionality of further detention.

Conclusion

Psychiatrists may be asked to assist the court in determining whether certain mental disorders affected a person's ability to form the intent necessary to make that person legally culpable. The medical discipline describes the patient's mental status on a continuum that ranges from extremely ill to completely healthy. However, the legal language is clearly categorical in nature, either criminally responsible or not responsible. While a psychiatrist is concerned with medical treatment of individual patients, courts are concerned with the protection of the society from the possible dangerousness from these patients. Psychiatrist needs to understand that it is not only the fact that the person is suffering from mental illness but it is the totality of the circumstances seen in the light of the evidence on record

to prove that the person was also unable to appreciate the nature of the act or wrongdoing or that it was contrary to the law is appreciated in the court of law for insanity defense.

Video link: https://youtu.be/mCeYO1e7xso

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Chapter 3

Admission and discharge procedures in MHCA, 2017

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Highlights

- Evolution of Mental Health Care Act (MHCA) 2017
- Admission, Treatment and Discharge procedures as per MHCA, 2017
- Dos and Don'ts of Emergency treatment
- Prohibited and restricted medical procedures under MHCA 2017
- Responsibilities of key stakeholders towards care and management of persons with mental illness

Introduction

THE TRANSITION OF MENTAL HEALTH ACT 1987 to the latest Mental Health Care Act (MHCA) 2017 has been necessitated as India signed the United Nations Convention on the Rights of Person with Disabilities (UNCRPD) and subsequently ratified the same on October 1, 2007. It was believed that the former Mental Health Act 1987 did not adequately protect the rights of persons with mental illness (PMI) nor promoted their access to mental health care. In order to fulfill this obligation of UNCRPD, India has harmonized all the existing laws in alignment with the convention and thus Mental HealthCare bill had evolved.

Paradigm shift in Psychiatric care

In the past one century, there has been a paradigm shift in delivering care to PMI in India.

- **Indian Lunacy Act 1912 –** Custodial care of PMI
- **Mental Health Act 1987 –** Treatment of PMI
- **Mental HealthCare Act 2017 –** Protect human rights during treatment of PMI

Preamble of MHCA 2017

The spirit and philosophy of MHCA 2017 are as follows.

- It is an act to **provide mental health care and services** for PMI
- To **protect, promote, and fulfill the rights** of such persons during delivery of mental healthcare and services
- And for **matters connected** therewith or incidental thereto.

Important terminologies in MHCA 2017

The commonly used terms in the context of admission and discharge procedures are defined in the chapter I of MHCA 2017 gazette.

- "***Mental illness***" means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life,
  - Includes mental conditions associated with the abuse of alcohol and drugs
  - Excludes mental retardation
- "***Minor***" means a person who has not completed the age of 18 years
- "***Relative***" means any person related to the person with mental illness by blood, marriage or adoption
- "***Care-giver***" means a person who resides with a person with mental illness and is responsible for providing care to that person
  - Includes a relative or any other person who performs this function, either free or with remuneration
- "***Informed consent***" means consent given for a specific intervention,
  - **without** any force, undue influence, fraud, threat, mistake or misrepresentation,
  - obtained after disclosing to a person adequate information including **risks and benefits** of, and **alternatives** to, the specific intervention in a language and manner understood by the person
- "***Least restrictive alternative***" or "***least restrictive environment***" or "***less restrictive option***" means offering an option for treatment or a setting for treatment which--
  - Meets the person's treatment needs; and
  - imposes the least restriction on the person's rights

Although the MHCA 2017 **defines** the term "mental illness", it further states in chapter 2 that the mental illness shall be **determined** in accordance with such nationally or internationally accepted medical standards (including the latest edition of the International Classification of Disease of the World Health Organization).

- **"*Nominated representative*" (NR)** is elucidated in chapter IV.
  a) Every person who is not a minor shall have a right to appoint a NR
  b) An individual can be appointed as the nominated representative in the advance directive by PMI
  c) A relative (or) a care-giver
  d) A suitable person will be appointed by the concerned Board when (a), (b) and (c) are not available or unwilling to be NR
  e) If no such person is available to be appointed as a nominated representative, the Board shall appoint the Director, Department of Social Welfare, or his designated representative, as the nominated representative of PMI
  f) The Legal guardian shall act as NR for a minor. However, if the legal guardian is not acting in the best interests of the minor or deemed to be unfit to act as the NR of the minor, any suitable individual who is willing to act as NR for the minor will be appointed by the concerned Board.

- "***Mental Health Professionals***" (MHP) as described in Chapter – VII are clinical psychologists, mental health nurses, and psychiatric social workers.
- In Chapter I, professionals having a MBBS or an equivalent degree in **Modern Scientific Medicine** or a post-graduate degree (**Ayurveda**) in Mano Vigyan Avum Manas Roga or a post-graduate degree (**Homoeopathy**) in Psychiatry or a post-graduate degree (**Unani**) in Moalijat (**Nafasiyatt**) or a post-graduate degree (**Siddha**) in Sirappu Maruthuvam are regarded as "***Medical practioners***" (MP).
- ***"Capacity to make mental healthcare and treatment decisions"*** has been described in chapter –II. It is a person's ability to
    a) Understand the information that is relevant to take a decision on the treatment or admission or personal assistance
    b) Appreciate any reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance; or
    c) Communicate the decision by means of speech, expression, gesture or any other means.
- Every person, including PMI shall be deemed to have capacity to make decisions regarding his or her mental healthcare or treatment unless otherwise proven.
- **"*Advance Directive*"** is a document made in writing, specifying any or all of the following
    i. The way the person wishes to be cared for and treated for a mental illness
    ii. The way the person wishes not to be cared for and treated for a mental illness
    iii. The list of individuals (in order of precedence) whom he or she wants to appoint as his or her NR.

  Every person who is not a minor has a right to make an advance directive.

Rights of PMI during admission and discharge

MHCA 2017 elaborates the rights of PMI under chapter V exhaustively. However, the rights of PMI pertaining to admission and discharge procedures are enlisted below.

- Right to access mental health care
- Right to community living
- Right to protection from cruel, inhuman and degrading treatment
- Right to equality and non- discrimination
- Right to information
- Right to confidentiality
- Right to access medical records
- Right to personal contacts and communication
- Right to legal aid
- Right to make complaints about deficiencies of services

Chapter XII of MHCA 2017

The twelfth chapter of MHCA 2017 discusses about the "Admission, Treatment and Discharge" (refer figure 1)

Admission has been classified into two kinds:

(1) Independent admission when he/she requests for their own admission (Section 86) or a nominated representative (NR) requests for admission in case of a minor (Section 87)

(2) Supported admission when a nominated representative requests for the admission (Sections 89 and 90)

Reporting to the Mental Health Review Board (MHRB) is clearly a new addition as compared with to its predecessor MHA 1987. All admissions of section 86, 87, 89 and 90 must be intimated to the MHRB in a stipulated timeframe such as

- Within 72 hours for women and minors
- Within 7 days for adult male

INDEPENDENT ADMISSION & DISCHARGE

Independent (Formerly termed 'Voluntary' in MHA 1987) admission – Section 86

(See form A under Appendix 3.1)

- It is performed for those who have capacity to make mental healthcare and treatment decisions
- Any person who is not a minor makes a request to the MP/MHP
- Admission is considered only if the attending MP/MHP opines that
  - Mental illness is severe enough requiring admission
  - If the patient is likely to get benefitted from the admission
  - Capacity is intact
- PMI must abide by the rules or bylaws of the mental health establishment
- No treatment must be given without informed consent of PMI
- Consent of NR is not required
- Patient should be discharged at his or her own will
- Doctor's permission is not required for discharging the patient under this section.

Admission of a minor – Section 87

- NR has to request to the MP/MHP/Psychiatrist of the mental health establishment for the admission of minor
- Examination must be conducted by 2 psychiatrists (OR) 1 psychiatrist and 1 MHP (OR) 1 psychiatrist and 1 MP must conduct examination of minor have independently examined the minor on the day of admission or in the preceding seven days and also draw conclusion independently based on their examination. Conditions necessitating admission are
  - illness is severe enough to require admission
  - admission is in the best interest of the minor
  - no other way to fulfill the clinical need
  - all community alternatives have failed
- There has to be a separate facility for minors i.e., they must be kept separately from adults and the environment must meet their developmental needs.

- In the case of minor girls, where the NR is male, a female attendant shall be appointed by the male NR.
- NR or person appointed by the NR shall accompany the patient at all times during admission
- With informed consent of NR, minor shall receive treatment
- Information to the MHRB within 72 hours
- MHRB holds the right to visit and interview minors or review their medical records.
- MHRB shall carry out a mandatory review within a period of 7 days of being informed, of all admissions of minors.
- If the NR no longer supports admission of the minor or requests discharge of the minor, the minor shall be discharged by the mental health establishment.

Discharge of the independent patient – Section 88

(see form D under Appendix 3.1)

Discharge immediately when a patient admitted under section 86 requests for. However, discharge can be prevented if the condition for supported admission (section 89) gets fulfilled.

SUPPORTED ADMISSION & DISCHARGE

Supported (Formerly termed 'Involuntary' in MHA 1987) admission - Section 89

If the PMI is ineligible to receive care and treatment as an independent patient because the person is unable to make mental healthcare and treatment decisions independently, then he or she will need very high support from his or her NR in making decisions. The essence of supported admission is that when PMI's decision-making capacity is compromised, NR will support the PMI to make decisions i.e., shared or supported decision-making, replacing the older proxy decision-making.

- One psychiatrist and a MHP or a MP must independently conclude one or more of the following justifications for admission under section 89, based on the examination conducted on the day of admission or in the preceding 7 days (see form E under Appendix 3.1)

  (i) Has recently threatened or attempted or is threatening or attempting to cause bodily harm to oneself

  (ii) Has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him/her

  (iii) Has recently shown or is showing an inability to care for oneself to a degree that places the individual at risk of harm to oneself

- Steps involved
  - Capacity assessment establishing that the PMI is unable to make mental healthcare and treatment decision
  - Application to both psychiatrist and MHP/MP by the NR (see form B under Appendix 3.1)
  - Psychiatrist and MHP/MP must certify by that the mental health establishment is the least restrictive care option possible in the said circumstances.
  - Review advance directive, if any available
  - Admission and treatment of PMI with high support needs in mental health establishment is limited to 30 days under section 89.

- Review for capacity assessment every 7 days. Whenever the patient regains his or her capacity to engage in mental healthcare and treatment decision, the admission can be shifted to section 86 (Independent/Voluntary admission).
- If the patient continues to lack capacity beyond 30days and admission with high support needs is warranted, then the admission can be continued up to 90 days as per section 90. (see form C under Appendix 3.1)
- Two psychiatrists must independently evaluate the patient and opine on the need for continuation of admission under section 90 (Justification for admission is similar to that of section 89). (see form E under Appendix 3.1)
- Capacity assessment must be performed once in every 15days under section 90. Once the patient acquires the capacity to consent, either admission can be transferred to section 86 or can be discharged on patient's request for discharge.
- Treatment during the admission under section 89 and 90
    - It is the treating clinician's responsibility to enquire and review the availability of advance directive.
    - Informed consent of patient with the support of NR
    - If patient requires nearly 100% support in treatment decision making process, it needs to be clearly documented and informed consent of NR can be sought on behalf of PMI, for treatment in such conditions.

- All supported admissions under section 89 must be reported to the MHRB (within 3days for women & minors; within 7 days for adult male) whereas all supported admissions under section 90 must be reported to the MHRB within 7 days.
- MHRB can ask treating psychiatrist or medical practioners to submit "plan for community-based treatment" in all admissions under
- Patient can challenge the admission under sections 89 and 90 in the MHRB
- Under section 90, the admission can be extended up to 180days.

Leave of absence – Section 91

(see Appendix 3.2)

The medical officer or psychiatrist may grant leave of absence from mental health establishment to any PMI admitted under section 86, 87, 89 or 90 subject to condition if any (see Appendix 3.2. Consent from the NR must be obtained.

Emergency Treatment - Section 94

A registered medical practitioner can give medical treatment to a PMI either at a mental health establishment or in the community for a maximum period of 72 hours with informed consent of NR in order to prevent death or irreversible harm to the health of person or person inflicting serious harm to himself or person causing serious damage to the property.

During a disaster or emergency declared by the appropriate Government the period of emergency treatment may extend up to 7 days.

Electroconvulsive therapy (ECT) shall not be used as a form of emergency treatment.

PROHIBITIONS AND RESTRICTIONS

Prohibited procedures - Section 95

The following procedures are strictly prohibited

a) ECT without anesthesia (Unmodified ECT)

b) ECT for minors (However, if the psychiatrist opined ECT is required for a minor, then the informed consent of the guardian and prior permission from the Board must be obtained.)

c) Sterilization of PMI

d) Chaining of PMI

Restriction on psychosurgery for persons with mental illness - Section 96

Psychosurgery shall not be performed as a treatment for mental illness unless the PMI provides the informed consent and approval from the concerned Board is sought to perform the surgery.

Restraints and seclusion - Section 97

PMI shall not be kept in seclusion and only physical restraint should be used to prevent imminent harm to self or to others under on-going supervision of medical personnel (see Appendix 3.3). It should not be used for punishment. The method, nature of restraint, justification for its imposition and the duration of the restraint must immediately be recorded in the patients' medical records. NR of PMI must be informed of physical restraint within 24 hours.

Discharge planning - Section 98

The treating psychiatrist is expected to be responsible for the PMI's care and future treatment in consultation with PMI and/or NR. However, there is no alternative provision to deal when the PMI is not interested to continue medication after discharge or stopped treatment after going into community.

Decriminalizing Suicide - Section 115

Attempt to commit suicide is a cry for help but not a crime. MHCA 2017 acknowledges that a person who performs suicidal act is presumed to be suffering from mental stress or illness at the time of the act. Hence, such person must be provided with mental health care and treatment to reduce the risk of recurrence of attempt to commit suicide and should not be punished under the section 309 of Indian Penal Code (IPC). However, the clause "unless proved otherwise" of this section may make the police to investigate for the cause. Decriminalizing suicide will enhance the reporting of suicide, aid in seeking psychiatric help and reduce the legal procedural burden on patients and their families.

RESPONSIBILITIES OF KEY AGENCIES [Chapter – XIII]

Duties of police officers in respect of persons with mental illness (Section 100)

When officer in-charge of a police station finds any wandering mentally ill person or anyone demonstrates risk to himself or others or incapability in taking care of oneself due to mental illness in their jurisdiction, he or she must take the PMI to the nearest public health establishment within 24hours.

Magistrate order for the admission of PMI (Section 102)

Magistrate can authorize a PMI to be admitted at a public MHE for assessment and treatment for not more than 10 days and MHP must submit a report to the Magistrate by the end of this period.

Prisoners with mental illness (Section 103)

A prisoner with mental illness must be transferred to the psychiatric ward in the medical wing of the prison or to a mental health establishment with prior permission of the Board. The medical officer of prison must send a report to the Board certifying that there are no prisoners with mental illness in the prison once in every 3 months.

Persons in custodial institutions (Section 104)

The in-charge of custodial institutions such as beggars' homes, orphanages, women's protection homes and children homes must take any of its resident with a mental illness to the nearest MHE for assessment and treatment.

Conclusion

The MHCA 2017 empowers PMI through their rights, autonomy, and minimizes existing medical and social paternalism in Indian healthcare system. The act upholds the autonomy of the PMI and mandates to seek informed consent during mental healthcare procedures. However, in case of PMI with absent insight, mental retardation, psychotic symptoms, cognitive dysfunction and incomplete recovery, obtaining a valid informed consent can be challenging and conflictual. The MHRB has a crucial role to play when there is a conflict with the consent-related issue in mental health care and treatment decision.

Video link: https://youtu.be/SVosJtmgjdk

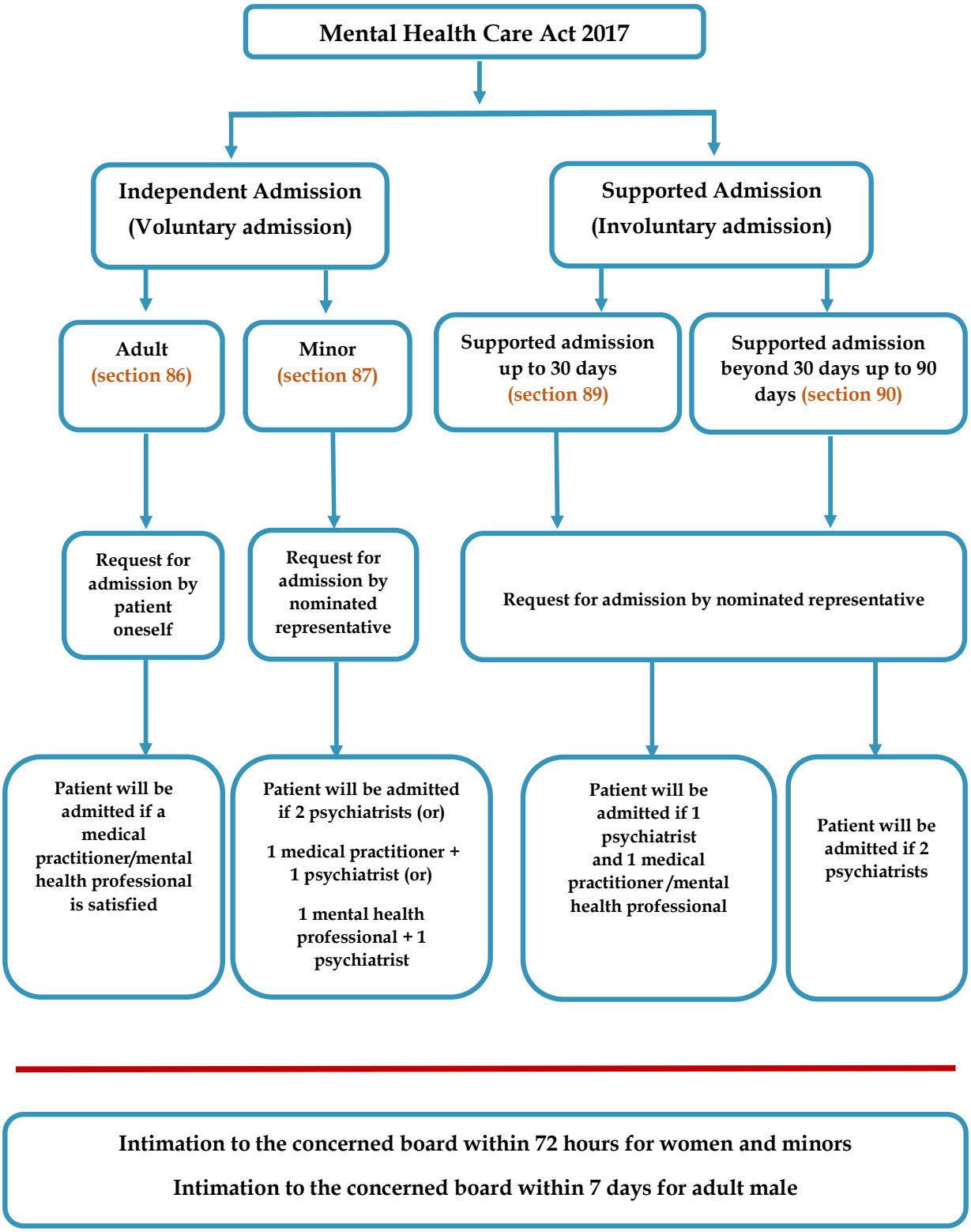
Suggested readings

1. Gowda M, Gajera G, Srinivasa P, Ameen S. Discharge planning and Mental Healthcare Act 2017. Indian Journal of Psychiatry. 2019 Apr 1;61(10):706.
2. Final Draft Rules MHC Act, 2017.

   Available_from: https://main.mohfw.gov.in/sites/default/files/Final%20Draft%20Rules%20MHC%20Act%2C%202017%20%281%29.pdf
3. Neredumilli PK, Padma V, Radharani S. Mental health care act 2017: Review and upcoming issues. Archives of Mental Health. 2018 Jan 1; 19(1):9.
4. Math SB, Basavaraju V, Harihara SN, Gowda GS, Manjunatha N, Kumar CN, et al. Mental Healthcare Act 2017 – Aspiration to action. Indian Journal of Psychiatry. 2019 Apr 1;61(10):660.
5. Jagadish A, Ali F, Gowda MR. Mental Healthcare Act 2017 – The way ahead: Opportunities and Challenges. Indian J Psychol Med. 2019;41(2):113–8.
6. THE MENTAL HEALTHCARE ACT, 2017 GAZETTE.

   Available from: http://egazette.nic.in/WriteReadData/2017/175248.pdf

Figure 1: Various admissions under MHCA 2017



Appendix 3.1

Form – A

Request for independent admission at NIMHANS, Bangalore-560029

(MHCA 2017 Sec 86 & Rule 8)

To, Date:

The Psychiatrist,

Unit - …… Department of Psychiatry,

NIMHANS, Bangalore

Sir/Madam,

I, Mr./Mrs./Ms. _____Hospital No. _____ age ____ son/daughter of _____, residing at _____ have mental illness with following symptoms since _____

1. _____
2. _____
3. _____

The following papers related to my illness as available with me are enclosed:

1. _____
2. _____
3. _____

I wish to be admitted in your establishment for treatment and request you to please admit me as an independent patient.

Mr./Mrs/Ms _____, who is my _____ (specify relationship) will be staying with me during my admission period to help in the treatment process.

A self-attested copy of my identity Proof is enclosed.

Address……..……

……...……

……..Mobile no.……

Alternative Mobile/Land Line no ……..

Email……..

Signature ……..

Name ……

Date & Time ……

List of enclosures: ……

……

……

……

……

N.B:- Please strike off those which are not required

Form – B
Request for Admissions with High Support Needs
At NIMHANS, Bangalore-560029
(MHCA 2017 Sec 89 and Rule 8)

To, Date:
The Psychiatrist,
Unit …… Department of Psychiatry,
NIMHANS, Bangalore

Sir/Madam,

I, Mr. / Mrs./Ms. …….., residing at ……
Nominated representative of Mr./Mrs/Ms…… Hospital No…….
aged…… son/daughter of ……request for his/her admission in your establishment for treatment of mental illness.
Mr. /Mrs. /Ms. ……..…….. has / not written Advance Directive.
Mr./Mrs/Ms …… has been having the following symptoms since _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

The following papers regarding my appointment as nominated representative and information related to treatment of his/her mental illness are enclosed:

1. Advance Directive
2. _____
3. _____
4. _____
5. _____
6. _____

A self-attested copy of my identity Proof is also enclosed.

Kindly admit him/her in your mental health establishment as patient with high support needs.

Address……..……
……..……
……..Mobile no……
Alternative Mobile/Land Line no ……..
Email:…….

Signature ……..
Name ……
Date & Time ……

N.B:- Please strike off those which are not required

Form – C

Request for Continuous Admissions with High Support Needs

At NIMHANS, Bangalore-560029

(MHCA 2017 Sec 90 and Rule 8)

To, Date:

The Psychiatrist,

Unit ……..…… Department of Psychiatry,

NIMHANS, Bangalore

Sir/Madam,

I, Mr. / Mrs./Ms. …….., residing at ……

Nominated representative of Mr./Mrs/Ms……Hospital No…… aged…… son/daughter of ……, who is/was an inpatient in your establishment under supported admission category, request for his/her continued admission beyond thirty days/readmission within seven days of discharge for the reasons stated below.

1……..

2……..

3……..

4……..

5……..

Kindly continue his/her admission /readmit him/her in your mental health establishment as patient with high support needs beyond thirty days.

Mr./Mrs./Ms. …….. has/ not written Advance Directive.

A self-attested copy of my photo identity Proof is enclosed.

Address……..……

……..……

……..Mobile no……

Alternative Mobile/Land Line no ……..

Email:…….

Signature ……..

Name ……

Date & Time ……

List of enclosures:

1) Copy of the self-attested photo ID proof
2) Copy of the Advanced Directives
3) ……
4) ……
5) ……
6) ……

N.B:- Please strike off those which are not required

Form - D

REQUEST FOR DISCHARGE BY INDEPENDENT PATIENT

(MHCA 2017 Sec 88 and rule 8)

To, Date:
The Psychiatrist,
Unit …… Department of Psychiatry,
NIMHANS, Bangalore

Sir/Madam,

Subject: - Request for discharge.

I, Mr. /Mrs. …… Hospital No……. residing at ……aged…… son/daughter of……, was admitted in your mental health establishment as an independent admission patient on ……. I now feel better and wish to be discharged. If any other reason/s for discharge, please mention below

1 ……

2 ……

3 ……

Kindly arrange to discharge me immediately.

Address……..……
……..……
……..Mobile no……
Alternative Mobile/Land Line no ……..
Email:…….

Signature ……..
Name ……
Date & Time ……

N.B.:- Please strike off those which are not required.

Form - E

Independent Opinion of a Psychiatrist/ Medical Officer for Admission

(Under Sec 89 or 90 of MHCA 2017)

This is to certify that I, Dr…… working as a ……under unit-……. have sought information of the history of presenting illness, examined personally and independently Mr./Ms./Mrs……Hospital No…… son/daughter/spouse/others of Mr/Ms/Mrs ……

Please tick the appropriate choice below and provide explanation:-

1. has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself or
2. has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or
3. has recently shown or is showing an inability to care for himself to a degree that places the individual at risk of harm to himself

Explanation for the choice/s

In my opinion, Mr/Mrs…… Hospital No ……requires supported admission under Sec 89 or 90.

Signature of the Psychiatrist/ Medical Officer

……..…..…

Name of the Psychiatrist/ Medical Officer

……..…….

Date:…….

Time:…….

N.B.:- Please strike off those which are not required.

Appendix 3.2

REQUEST FOR LEAVE OF ABSENCE

(By Nominated Representative)

(MHCA 2017 Sec 91 and rule 9)

To, Date:
The Psychiatrist,
Unit …… Department of Psychiatry,
NIMHANS, Bangalore

Sir/Madam,

Subject: - Request for leave of absence

Mr./Mrs/Ms ……..……Hospital No……. residing at …… aged …… years was admitted on ……to your mental health establishment.

I, as nominated representative of Mr. /Mrs/Ms …… request that he/she be granted leave of absence from (date & time)…… to…… …… for the reason stated below:
1 ……
2 ……
3 ……

The proof of my appointment as nominated representative is enclosed.

I will be responsible for care and treatment of Mr./Mrs/Ms……. while he/she is on leave of absence from the mental health establishment.
Address……..……
……..……
……..Mobile no……
Alternative Mobile/Land Line no ……..
Email:…….

Signature ……..
Name ……
Date & Time ……

N.B.:- Please strike off those which are not required.

Appendix 3.3

Physical Restraint Monitoring and Reporting Form

[Regulation 18, Mental Healthcare (CMHA) Regulations, 2020]

Name of the Patient: **Date:**

Sex:

Age:

File No:

Provisional Diagnosis:

Date of Admission:

Indication for Physical Restraint (encircle): (1) Violence (2) Agitation (3) Aggression (4) Self-harm (5) Suicidal attempt (6) Other (specify)……

Informed Consent of the Nominated Representative taken: Yes/ No

Name and Signature of the Nominated Representative: If informed

If Consent not taken, mention the reason:

Date and Time of Physical Restraint:

Date	Time	
	From	To

Overall assessment of medical conditions of the person under physical restraint including injuries, blood supply to limbs, blood pressure, pulse, etc. or any other relevant parameter:
……..……..……
……
……..

Mention the dose and frequency of medications administered during the Physical Restraint:

Medication	Dose	Route	Frequency	Total dose	Side-effects

Name, Signature and Seal of the person in-charge of the mental health establishment

Chapter 4

Psychiatric Advance Directive, Nominated Representative and Rights of persons with Mental Illness

Sharad Philip, Avinash Shekhar, Shalini S Naik, Barikar C Malathesh, Guru S Gowda, Channaveerachari Naveen Kumar, Suresh Bada Math

Highlights

- Various kinds of Advance directives
- Psychiatric Advance Directives in MHCA 2017
- Who can be a Nominated Representative (NR) and the roles and responsibilities of NR
- Rights of persons with Mental Illness in MHCA 2017

Introduction

THE MENTAL HEALTH CARE ACT (MHCA) 2017 in its spirit and principle has upheld the rights of every individual with regards to their mental health care and treatment related decision making. This chapter discusses the newer concepts included in MHCA 2017 namely, Advance Directive, Nominated Representative and Rights of persons with Mental Illness. The United Nations Convention on Rights of Persons with Disabilities (UNCRPD)(1) is one of the most important milestones in the disability rights movement. Indian parliament ratified this convention in May 2008 (2). Previously, incapacity was presumed along with mental ill health. Article 12 of UNCRPD enshrines in it a right to equal recognition before the law for all. It states that capacity is to be presumed until proven otherwise for all. Article 12 details the states' duties to provide the requisite supports to ensure the exercise of legal capacity by all persons with disabilities at par with others. Any such support provided to exercise the legal capacity must take into account the supported persons rights, will, preferences, values and must avoid all conflicts of interest. This chapter introduces the readers to chapters 3, 4 and 5 of the Mental Health Care Act (MHCA). Chapters 3 and 4 of MHCA are based on the principle of article 12 of UNCRPD and chapter 5 describes the rights of person with mental illness which find mention in multiple other articles of the UNCRPD.

ADVANCE DIRECTIVES

Advance directives (ADs) are documents written by any competent persons (except minors) anticipating a period of incompetence. These documents are written in the context of healthcare; mental or physical or both. These documents can contain treatment choices, proscribed procedures. In India, the use of such documents has been introduced in mental health care.

Advanced directives were first used in "end of life" care. The "Living Will:" proposed by Kutner in 1968 (3) heralded the era of advanced decision making in end-of-life care. He highlighted

that if a person can decide "in advance" about their estate after their demise, they should also be allowed to decide "in advance" what happens to their body. This allowed people to state binding decisions on life prolonging measures before they encounter such a situation. This also reduced the burden of the family to take decisions of life and death of others. Focus would change from fear of death to dying with dignity. This novel approach saw legal recognition in the California natural Death act 1976 (4) and the Federal Patient Self Determination Act of 1991 (5) in the United States. The two legislations mandated all healthcare facilities receiving any government funding to inform all inpatients regarding their right to make an AD. They were legally binding but had low uptake and completion. Many factors can explain this such as reduced clinician endorsement, reduced involvement of clinicians in the drafting stage, death being a concept that is not brought up easily and concentration on left over time than what after the death. Dr. Thomas Szasz in "The Psychiatric Will"(6) offers the psychiatric patient to anticipate the times of incompetence and can direct the treatment in advance.

Psychiatric Advanced Directives (PADs)

Psychiatric Advanced Directives (PADs) include the provision for healthcare powers of Attorney / Healthcare Proxy: one can nominate another person to whom decision making could be delegated. Powers of attorney execute business on behalf of someone who appoints/gives them power. However, in healthcare this is known as durable healthcare power of attorney for the reason that even if the client differed from the proxy decision, the latter would be upheld in times of incompetence. Decision making can be divided into two types depending on who makes the decision for the client. Supported decision making is the client makes the decision for themselves with support of trusted individual/individuals in the future. Here the client retains their autonomy and is able to exercise their legal capacity. Substituted decision making is where someone else or a surrogate will make decision for the client (7).

The concept of "advanced directive" has evolved over the years. Broadly there are three major types of Psychiatric advanced directives that have been developed over the years. These three types differ by the extent of collaboration of patient, legal services and healthcare services (8):

Classic psychiatric advance directives are written by the client alone without any assistance. As part of this AD, the client can give informed consent to treatment, express their personal values and choices for future treatment or nominate a proxy for decision making in future emergencies or in periods of lost decision-making capacity. These can be prescriptive (what to do), proscriptive (what not to do), or both. Although this enhances the freedom of the client, it is hampered by the lack of information and support. Due to lack of specific crisis-related situation choices and treatment details, they are at times not carried out and are likely to be overruled by carers. This type of AD is therefore associated with poor experiences and lower completion rates (9,10,11).

Facilitated psychiatric advance directives are a form of directive in which a trained health professional or social worker helps the service user in producing a valid directive. This form of ADs had increased completion rates (11). The most researched F-AD method is a manualized intervention consisting of semi structured, guided discussion with the facilitator (11). It includes the provision of information and explanation about past treatment experiences to aid the service user in development of the directive.

Another recent form of F-AD is Advance Directives Based on Cognitive Therapy (ADBCT), which is done in 2- 8 sessions (12). This aims to first explore the client's "cognitive representation of illness" model, where clients understanding about his illness and the ways used to cope with their problems will discussed. This works on collaborative approach and "concordance model", where the difference of opinions is acknowledged and respected (13). The facilitator can incorporate problem-solving strategies to overcome any cognitive barriers. Facilitated psychiatric Ads are likely to get influenced by the opinion of the facilitator, so facilitator needs to be cautious about this point.

Joint crisis plans are another form of AD (14). Here a third-party facilitator who is not part of the treatment team (unlike the F-AD facilitator) takes the lead and negotiates with the healthcare team and the service user in producing a directive. This facilitator might be a mental health professional from a different part of the service, a caregiver or a legal advocate. In the first appointment, the facilitator helps the client and his case manager to formulate the future plan. During the second meeting, the facilitator involves their other parties including caregivers, family members, and psychiatrist to finalize the content. The facilitator's role is to encourage and support discussion. If there is difference of opinions and an agreement cannot be made, this is documented to reflect the lack of consensus.

Psychiatric Advance Directives in MHCA 2017

The MHCA, 2017, (15) has introduced the concept of PADs in chapter 3 (Section 5–13). The stipulated document is a hybrid of the supported decision making and a choice of substitution decision making. The drafter wishing to make advance treatment decisions (about their mental healthcare) must write their prescriptions and/or proscriptions for future care and treatment. They may also additionally nominate a surrogate decision-maker who is referred to as the nominated representative (NR) (Section 14–18). Thereafter, this must be submitted to the Mental Health Review Boards (MHRB), where it will be registered. This document will only be followed when the person loses capacity as per section 4 only for mental healthcare related decisions. The onus is on the service user to provide the copy of their PADs to the mental health professional. It may also be written by the legal guardians of minor service users.

The MHRB is provided as the appellate authority to adjudicate all disputes regarding PADs and NR. When assessing the contested PAD, the act lays down a set of five guiding questions as follows:

(a) Was the drafter adequately and **c**omprehensively informed?

(b) Did the drafter anticipate the **c**urrent situation?

(c) Did the drafter have the **c**apacity at the time of making the PAD?

(d) Was the PAD made under any influence/**c**oercion?

(e) Is the PAD **c**ontrary to any existing law?

They can be remembered as the 5 **'c'**s. The MHRB has been tasked with the provision of an online registry for these documents. Mental health professionals while providing care as per a valid PAD cannot be held liable for unforeseen consequences of the decisions made by the drafter. Section 82 says that the MHRB has the powers to review, alter, or modify the PADs. Further, the MHCA, in

Section 81, stipulates that the central government has to create a guidance document for medical practitioners regarding capacity assessments. This will have implication on PADs.

Section 122 of the act confers power on the Central Mental Health Authority (CMHA) to make regulations regarding powers for PADS registration/application. As per the CMHA notification (16) released on 18th December 2020, any person may utilise the Form A included in it for making their PAD (see Appendix 4.1). This form should be provided free of cost at every mental health establishment. Pads will be registered with the MHRB set up to have jurisdiction where the applicant resides. The form makes it necessary for NRs to provide consent in the PAD application. Any number of NRs may be appointed as per the form. It also requires disclosure of allergies to any medications or treatments by the applicant.

Sections 89 and 90 of MHCA also mandate that PADs should be taken into account in all cases of supported admissions. Section 122 of the same act also mentions that the Central Mental Health Authority is empowered to make and bring about modifications to the procedures relating to PADs

Research on Psychiatric Advance Directives in India

We were able to find few published studies from India related to ADs in psychiatry. Most notably, all these studies have been conducted in the South Indian states of Karnataka, Kerala and Tamil Nadu.

The first study (17) examined whether persons with psychotic illnesses would be able to write valid PADs as per the provisions that are given in the draft of 2011 MHCB. Along with their caregiver, they were given information regarding PADs using pictorial charts in individual sessions by research assistants. Of the total sample of 112 participants, only 93 had the capacity and wrote PADs. All participants wrote valid PADs, among which >65% did so independently, 29% required "prompts" and 6% required scribes. None of the participants used PADs for blanket refusal of treatment. On average, it took about 20 min for them to write a PAD.

Another qualitative study (18) assessed the responses from outpatients and caregivers before and after completing a PAD. Patients reported that after completion of PAD, they felt more self-efficacious. Of the 51 interviews, 39 were with patients and 12 were with caregivers. Among caregivers, 11 reported disagreeing with the presumption of capacity for their patients to make treatment choices. Six of the caregivers reported misgivings about PADs, such as "PADs would add no value in giving any more control to the patients about their treatment". Overall, caregivers expressed concerns regarding the misuse of these legal provisions by patients and were sceptical of the patient's capacity to decide on their own treatments. A second paper from same authors (19) reported quantitative data of 75 outpatients with a content analysis of their PADs. Most patients chose to continue their current treatments.

Another study (20), conducted at NIMHANS, reported that among inpatients about to be discharged, most tend to make greater use of the prescriptive sections of PADs. This study evaluated nearly 200 inpatients that had received acute care and were ready to be discharged. 67% of the patients felt that PADs are needed, 24% were ambivalent, and 9% felt PADs are not needed in India. However, 96% of the patients were able to formulate their own PADs. Among the patients who made PADs, 94% chose an NR, and most of them chose a family member as their NR. The patients, in the majority, agreed with the treatments initiated for them and retained mostly what they had been prescribed.

In a study (21) in Karnataka, 50 patients were interviewed at GHPU in a private medical college. Of them, the majority insisted on retaining their current treatments and wanted to know more about PADs. The study included persons with Severe Mental Illness like schizophrenia, and bipolar affective disorder, who were asymptomatic for the preceding 3 months. Among the 45 patients who understood the concept of ADs, 89% were willing to make a PAD. Among them, 15% refused future hospitalization, 22% refused future chemical restraints, 47% refused future ECTs, and 62% refused future physical restraints.

A study (22) was done at NIMHANS by the author SP examining the feasibility of PADs among outpatients in remission or minimally ill (with CGI-Severity scores of one or two). The authors used Education-cum-Assessment Tool (EAT) in providing information regarding PADs and the modes of facilitation required by the patients. Both caregivers and patients were educated in a standardized manner regarding the legislative provisions on PADs. Once educated, they were asked to make their PADs. The caregivers were then asked for opinions on the PADs made by their patients. Key results of this study were that the average time spent to make a PAD was about 15 min. This included the time taken to educate the patients about PADs. They found that EAT scores can be used as a measure of patient's ability to understand and retain information. Furthermore, it was noted that among the 100 patients, two could independently write their PADs, one required facilitation only by reminding, and four others required facilitation as assistance in writing. The rest, 93 participants required both reminding and assistance in writing. Caregivers agreed to support their ward's PADs only as long as it was effective and practical. Most caregivers opted for collaborative decision-making models, and majority recognized patients, caregivers and treating professionals as the only stakeholders.

A qualitative study in Kerala (23) examined the perspectives of PADs using focus group discussions and in-depth interviews among service users, advocates and mental health professionals. They found that the predominant themes identified were freedom of choice, issues of making an AD, its suitability in a crisis, apprehension of future care, capacity at time of making the AD, nominated representative issues, limitations on treatment options as a result of AD and possibility of increased defensive practice in psychiatry. Half of the patient group agreed and argued for the need of autonomy, while the other half left their treatment to the doctor's discretion. Majority of caregivers were against ADs. In this study, they found that some psychiatrists were apprehensive about of ADs. While stakeholders were sceptical of the logistics, access, and equity of the implementation of PAD, advocates agreed that patients should be given the freedom to choose.

Research on Psychiatric Advance Directives: International Perspective

Nicaise *et al*. examined PADs as a complex intervention in a realist systematic review (24). The existing literature reports three broad functions of PADs:

Enhancement of autonomy

At an interpersonal level, allowing the client to express their treatment preferences and to make statements about their life and illness is the way to develop their involvement in the treatment. PADs allow for the autonomous choices made in advance to replace the illness related incompetence to make such treatment choices. Hence, this empowerment can be a tool for recovery. One of the limitations of this extension of autonomy is that it does not have the capability of learning, correcting and hence changing with time and context. This limitation can be partly overcome by using structured

formats. A method that the drafters can employ would be to regularly update their PAD to reflect changing contexts that they anticipate.

Improved therapeutic alliance

Service users report improved levels of satisfaction after a better dialogue with their professional career. Hence the procedures and formalities of drafting PADs is important. If the procedure of formatting PADs is collaborative, therapeutic alliance will improve. Thus, collaboration may potentially result in better drafting.

Facilitation, being a collaborative process, improves PADs completion rates and better clinical utility (8). The formal involvement of multiple stakeholders coming together in drafting PADs have been used in research. One such instrument is the above-mentioned Joint Crisis Plan (JCP). JCP has been evaluated in RCTs (25,26) in the UK and found to be effective in terms of reducing involuntary admissions and improving therapeutic relationships. Wellness Recovery Action Plan (WRAP) is a self-monitoring instrument which has been developed exclusively for patients with schizophrenia in the United States. It is by the client with or without the help of the service provider. It is aimed at early identification and treatment of symptoms. A crisis plan mentioning a health care proxy may or may not be included. Notably, WRAPS and JCPs are not legally binding documents.

An integration of care services

Studies exploring PAD implementation have mostly restricted themselves to reporting on completion rates, provider and user acceptance, readmission rates, visits to the emergency ward etc. but not on fidelity of services to the PAD. There are multiple systems involved in mental health care especially for the involuntary such as law enforcement, judiciary, community, health care systems, etc. More collaborative PAD formats would clarify these nuances.

A professional may determine if the client is competent or not and the PAD drafted should be followed or not. However, not all patients will agree or comply with the judgement of decisional incompetence. This may lead to differing opinions of when PADs should come into effect and influence the subjective experience of the client.

Consent - A PAD may also be used as a vehicle of consent to future treatments. When introducing legally binding directives, there is an apprehension amongst clinicians that it would be used to withdraw consent for all future treatment. However, this apprehension is not borne out in the existing literature. PADs have rarely been used to withdraw consent for all treatments. However, a few anecdotal cases exist (27).

Ulysses clause/ Odysseus pact/ Self-binding directive – It is a directive within a directive where the drafter allows care-providers to disregard expressed intent and choices during periods of incompetence. This means that it cannot be revoked or modified by the drafter. There is a controversy regarding its inclusion. Care-providers view the retention of this clause as integral to supported decisions made in the PAD. From the user's perspective, their stated choices are being revoked and their freedoms are curtailed.

As per a recent review, 3 Asian countries - India, Singapore and Philippines have provisions for surrogate decision makers. Only 2 countries - India and Philippines have provisions for advanced

directives. They noted that the role of family, incongruence with societal concerns, cultural norms and structure of healthcare system to be barriers unique in Asian settings.

In a Cochrane review of RCTs on PADs, Campbell and Kiseley (28) were able to offer the following suggestions for the different stakeholders. For the service users, they recommended that currently, there is no evidence from RCTs that PADs are beneficial. For the professionals, they recommend further research on more extensive and collaborative forms of PADs. However, there is not enough evidence to recommend their incorporation into routine clinical practice. To the policy makers, they opine that legally binding PADs are not beneficial. They recommend more collaborative PADs to maximize benefits.

Implications for practice

Firstly, it must be realised by all practitioners that PADs can be used for positive benefits. Future practitioners will benefit by encouraging their clients to draft PADs collaboratively. They must also encourage completing the legal formalities/ procedures so that this can be entered into database. These are services that will be value add to the alliance/relationship with the patient and their family. This can improve patient retention and improve practice.

Secondly, practitioners must be aware of the procedures and functioning of the review boards especially with regards to PADs. Noteworthy, is the exemption from any liability arising on account of treating someone according to their PADs.

Thirdly, adequate and appropriate information should be given to the family regarding the PADs as legal instrument to determine treatment choices/courses. This knowledge can be empowering to carers when applying to the review boards in case of any concerns. This provision of information must be by the practitioner.

Lastly, we urge practitioners to register in the government databases and be aware of changes to procedures. We also suggest that practitioners vie for working in the MHRB.

NOMINATED REPRESENTATIVE IN MHCA 2017

The MHCA, 2017 in chapter 4 stipulates that every person who is not a minor has the right to appoint a Nominated Representative (NR) for decision making during periods of their incompetence. Such a NR must also be competent and not a minor. Written approval from the NR is required before appointing them. NRs need to consider the values, principles and ethics of the person. The duty of NR is to empower their wards in understanding the need for making decisions, the consequences of a particular decision and consequences of not making a particular decision. In case of any conflicts of interest, they are to recluse themselves. NRs are responsible to report any abuse or exploitation of the service user during the periods of lost capacity. They are to make decisions in the best interests of their wards. For wandering persons with mental illness, the representative of Director, Department of Social Welfare, is the default NR. A provision for temporary appointment of NR, by application to the treating psychiatrist, pending MHRB decision, has also been incorporated.

RIGHTS OF PERSONS WITH MENTAL ILLNESS

Chapter V of MHCA 2017 discusses Rights of persons with Mental Illness (PMI). This chapter is the heart and soul of this legislation as reflected in the preamble of MHCA 2017 emphasizing to protect,

promote, and fulfil the rights of PMI during the delivery of mental healthcare and services. The previous Mental Health Act, 1987 focused on admission and treatment of persons with severe mental illness in mental hospitals when they are detained against their will. However, MHCA 2017 tries to regulate almost all mental health establishments (MHEs). It is essentially patient-centric, safeguards PMI's rights, and encourages PMI to exercise their individual autonomy at every level of mental healthcare. Hence, no treatment can be given to PMI without his or her informed consent except in the conditions where capacity to consent is established to be compromised by medical practitioners and mental health professionals.

Right to access mental health care (Section 18)

Every person shall have a right to access mental healthcare and treatment from mental health services of affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, or disability in Government run or funded establishments.

Mental health services include

i. Provision of acute mental healthcare services such as outpatient and inpatient services
ii. Provision of half-way homes, sheltered accommodation, supported accommodation
iii. Provision for mental health services to support family of person with mental illness or home-based rehabilitation
iv. Hospital and community-based rehabilitation establishments and services
v. Provision for child mental health services and old age mental health services

It emphasizes to ensure that the long-term care in a mental health establishment for treatment of mental illness shall be used only in exceptional circumstances, for as short a duration as possible, and only as a last resort when appropriate community-based treatment has been tried and shown to have failed. The Government has to ensure that no person with mental illness (including children and older persons) shall be required to travel long distances to access mental health services and such services shall be available close to a place where a person with mental illness. Basic and emergency mental healthcare services shall be available at all community health centers.

Right to Community living (Section 19)

Every PMI has a right to live in, be part of community and not be segregated from society. He or she shall not continue to remain in a mental health establishment merely because he or she does not have a family or is not accepted by his family or is homeless or due to absence of community-based facilities. When it is not possible for a PMI to live with his family or relatives, or where a PMI has been abandoned by his family or relatives, the Government shall provide support as appropriate including legal aid and to facilitate exercising his or her right to family home and living in the family home. Till such time, Government shall provide for or support the establishment of less restrictive community-based establishments including half-way homes, group homes and the like for persons who no longer require treatment in more restrictive mental health establishments such as long stay mental hospitals within a reasonable period.

Right to protection from cruel, inhuman and degrading treatment (Section 20)

Every PMI shall have a right to live with dignity and shall be protected from cruel, inhuman or degrading treatment in any mental health establishment and shall have the following rights,

a. To live in safe and hygienic environment;
b. To have adequate sanitary conditions;
c. To have reasonable facilities for leisure, recreation, education and religious practices
d. To privacy
e. For proper clothing so as to protect such person from exposure of his body to maintain his or her dignity
f. To not be forced to undertake work in a mental health establishment and to receive appropriate remuneration for work when undertaken
g. To have adequate provision for preparing for living in the community
h. To have adequate provision for wholesome food, sanitation, space and access to articles of personal hygiene, in particular, women's personal hygiene be adequately addressed by providing access to items that may be required during menstruation
i. To not be subject to compulsory tonsuring (shaving of head hair)
j. To wear own personal clothes if so wished and to not be forced to wear uniforms provided by the establishment

Right to equality and non- discrimination (Section 21)

Every person with mental illness shall be treated as equal to persons with physical illness in the provision of all healthcare services which shall include the following, namely: –

i. There shall be no discrimination on any basis including gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class or disability
ii. Emergency facilities and emergency services for mental illness shall be of the same quality and availability as those provided to persons with physical illness
iii. PMI shall be entitled to the use of ambulance services in the same manner, extent and quality as provided to persons with physical illness
iv. Living conditions in health establishments shall be of the same manner, extent and quality as provided to persons with physical illness
v. Any other health services provided to persons with physical illness shall be provided in same manner, extent and quality to persons with mental illness
vi. Every insurer shall make provision for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness.

Additionally, a child under the age of 3 years of a woman receiving care, treatment or rehabilitation shall ordinarily not be separated from her during her stay in mental health establishment unless the treating Psychiatrist is of the opinion that there is risk of harm to the child

from the woman due to her mental illness or it is in the best interest and safety of the child, the child shall be temporarily separated from the woman during her stay at the mental health establishment but the woman shall continue to have access to the child under supervision of the staff of the establishment or her family during the period of separation.

The decision to separate the woman from her child shall be reviewed every 15 days and separation shall be terminated as soon as conditions which required the separation no longer exist.

Right to information (Section 22)

Right from admission or the start of treatment, it is the duty of the medical officer or Psychiatrist in-charge of the person's care to ensure that full information is provided to him or her promptly. PMI and his or her nominated representative shall have the rights to the following information

i. The provision of this Act and the criteria for admission under which he or she has been admitted
ii. Of his or her right to make an application to the concerned Board for a review of the admission
iii. The nature of the person's mental illness and the proposed treatment plan that includes information about treatment proposed and its known side effects
iv. Receive the information in a language and form he or she can understand.

Right to confidentiality (Section 23 & Section 24)

PMI shall have the right to confidentiality in respect of his or her mental health, mental healthcare, treatment and physical healthcare, applies to all the information stored in electronic or digital format in real or virtual space. No photograph or any other information relating to a PMI undergoing treatment at a mental health establishment shall be released to the media without his or her consent. All health professionals providing care or treatment to a PMI shall have a duty to keep all such information confidential which has been obtained during care or treatment with the following ***exceptions***,

i. Release of information to the nominated representative to enable him to fulfill his or her duties
ii. Release of information to other mental health professionals and other health professionals to enable them to provide care and treatment to the PMI
iii. Release of information if it is necessary to protect any other person from harm or violence
iv. Release only such information as is necessary to prevent threat to life
v. Release of information upon an order by concerned Board or the Central Authority or High Court or Supreme Court
vi. Release of information in the interests of public safety and security

Right to access medical records (Section 25)

All persons with mental illness shall have the right to access their basic medical records. The mental health professional in charge of such records may withhold specific information in the medical records if disclosure would result in any of the following

i. Serious mental harm to the PMI or

ii. Likelihood of harm to other persons by the PMI

Mental health professional shall inform the PMI of his or her right to apply to the concerned Board for an order to release such information when any information in the medical records is withheld from him or her.

Right to personal contacts and communication (Section 26)

A PMI admitted to a mental health establishment shall have the right to refuse or receive visitors and to refuse or receive and make telephone or mobile phone calls or send and receive mail through electronic mode including through e-mail at reasonable times.

Right to legal aid (Section 27)

It is the duty of magistrate, police officer, medical officer or mental health professional in charge of a mental health establishment or custodial institution to inform the PMI that he or she is entitled to receive free legal services to exercise any of his or her rights mentioned in the MHCA 2017 under the Legal Services Authorities Act, 1987 and also provide the contact details of the availability of such services.

Right to make complaints about deficiencies in provision of services (Section 28)

Any PMI or his/her nominated representative shall have the right to complain regarding deficiencies in provision of care, treatment and services in a mental health establishment to the medical officer or mental health professional in charge of the establishment. If not satisfied with their response, then the complaint can be proceeded to the concerned Board and if further not satisfied with their response, to the State Authority.

Conclusion

A watershed moment in mental healthcare has been crossed with enactment of the MHCA. The focus has now been on rights-based care in a manner emphasizing the quote "Nothing about us without us" – the right to self-direct one's own mental health care has now been provided. The PADs, NRs and rights of PMI are legally assured and must now be ensured in every aspect of service provision. We foresee clients being served better as service providers pursue compliance to the act. These provisions provide the much-needed emphasis on care rather than just treatment and in this way are progressive and aspirational.

Video link: https://youtu.be/FV0Mz5Z7oHk

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Appendix 4.1

FORM – A

[Regulation 3, Mental Healthcare (CMHA) Regulations, 2020)]

FORM FOR MAKING, AMENDING/ REVOKING AND CANCELLING ADVANCE DIRECTIVE

1. Name (Attach copy of photo identity document proof): _____
2. Age (Attach copy of age proof for being above 18 years of age): _____
3. Father's/ Mother's Name: _____
4. Address (Attach copy of proof): _____

   Note. - Any valid identity proof like Birth Certificate, Driving License, Voter's Card, Passport, Aadhaar card, etc. shall be admissible as address proof and age proof.
5. Contact number(s): _____
6. Registration no. of previous advance directive (to be filled in case of amendment/ revocation/cancellation of advance directive): _____
7. I wish to be cared for and treated as under (not to be filled in case of revocation/ cancellation of advance directive):

   _____

   _____
8. I wish not be cared for and treated as under (not to be filled in case of revocation/ cancellation of advance directive):

   _____

   _____
9. Any history of allergies, known side effects, or other medical problems

   _____

   _____
10. I have appointed the following persons in order of precedence (Enclosed photo ID and age proof), who are above 18 years of age to act as my nominated representatives to make decisions about my mental illness treatment, when I am incapable to do so (not to be filled in case of revocation/ cancellation of advance directive):

    (a) Name: _____ Age_____

    Father's/Mother's name: _____

    Address: _____

    Contact number(s): _____

    Signature: ……...……. Date_____

(b) Name: _____ Age_____

Father's/Mother's name: _____

Address: _____

Contact number(s): _____

Signature: ……...……. Date_____

[Any number of nominated representatives can be added]

11. Signature of applicant……. Date_____
12. Signature of witnesses:
13. Mr. / Ms. _____ has the mental capacity to make/ amend/ revoke/ cancel an advance directive at the time of signing this form and has signed it in our presence of his/ her own free will.
    - Witness 1: (Name)……. (Signature)……. Date……...
    - Witness 2: (Name)……. (Signature)……. Date…….

Enclosure(s):

Note: - Please strike off those which are not required.

Chapter 5

Capacity Assessment

Shalini S Naik, Dinakaran Damodharan, Lakshmi Sravanti, Lakshmi Nirisha, Channaveerchari Naveen Kumar, Suresh Bada Math

Highlights

- Capacity assessment for mental healthcare is an essential element in the clinical application of the Mental Health Care Act (MHCA) 2017.
- Central Mental Health Authority (CMHA) released a guidance document on capacity assessment
- Comprehension, decision making ability and communication form the three vital components of capacity assessment as per the guidance document

Introduction

CAPACITY ASSESSMENT is a new addition in the Mental Health Care Act (MHCA) 2017 (1). This Act promotes and protects patient's autonomy to make decisions on mental health care, irrespective of the complexities in the task. A nominated representative can support in decision-making process only when the person with mental illness (PMI) is proven to have the incapacity for mental healthcare decisions as described in the Section 81(1), the Central Mental Health Authority (CMHA) formed an expert committee that developed a guidance document on the procedures to assess for the capacity assessment and document the same in August 2019. It is a guidance document but not a legal rule or regulation. It is a semi-structured, assesses essential domains related to an individual's decision-making capacity to consent, consumes relatively less time making it easy-to-use in busy clinics, outpatient department, inpatient wards etc. and task-specific i.e., it is performed for various purposes such as deciding about admission or treatment or discharge or for writing an advance directive. This chapter focuses on guiding clinicians on the clinical application of capacity assessment.

Constitutional rights and Mental capacity

The article 21 of the Constitution of India talks about 'right to life and liberty'. Here, liberty means being able to exercise one's legal right to make one's own decision. It can also be called as "right to self-determination." Thus, it is a rights-based decision-making process, curtails the paternalistic attitude of family or clinicians to decide for PMI by proxy that is prevalent in our Indian cultural settings for many years.

By definition, mental capacity means "ability to make a particular decision at the time it needs to be made or in the relevant time" The mental capacity is dynamic in nature, i.e., it can vary within an individual across different times of assessment, for example; an individual may have a capacity at

the age of 40 years and can lose it with aging process or due to a head injury or mental illness. Thus, the time of assessment for mental capacity is crucial.

Chapter 2, section 4 of MHCA 2017 states that "everyone including a PMI is invariably considered to have a capacity to make decisions regarding his or her mental healthcare treatment." In a nutshell, this section dictates capacity in relation to the ability of the patient to (a) comprehend the information or (b) weigh risk and benefits of receiving or refusing the treatment/admission/ personal assistance or (c) communicate his/her decision. If a PMI has any one of the above components, he or she can refuse treatment. Further, the medical officer or mental health professional (MHP) has to prove that a PMI lacks capacity before initiating involuntary treatment. A PMI may refuse treatment due to lack of insight into mental illness, severe symptoms, and his or her symptoms interfering the process of decision-making. Family members usually find it difficult to manage individuals with serious mental illness who have no insight, and usually, such patients refuse admission and treatment. A psychiatrist will be able to provide treatment for a minor group of PMIs who have insight into their mental illness. Hence, there is an urgent need for clarification and amendments that need to occur for the Section 4 where "or" needs to be deleted and substituted with "and" between 4a, 4b, and 4c (2).

Mental Competency versus Mental Capacity

Competency is a legal term. The court which will declare a person is competent or not. For instance, if the court declares Mr. A is not competent legally then he will lose a valid will thereby cannot perform a legally valid contract under the Constitution of India. It is seldom dynamic, i.e., a person is considered legally incompetent until the law restates that he has become competent. On the other hand, the mental capacity is dynamic, task-specific, relevant to time, on a continuum, requires assistance of varying degree. Capacity assessment is to be systematic, rather than arbitrary based on a person's condition or behavior. It is essentially a clinical decision but does not equate to psychiatric diagnosis. Also, Clinician has to assess for capacity irrespective of an individual's past psychiatric diagnosis. Mental capacity can be temporarily affected in conditions such as Delirium and permanently impaired in conditions like Alzheimer's Dementia.

Capacity versus Insight

Mental capacity and Insight into psychiatric illness are not synonymous or mutually exclusive (see Table 5.1). Insight is merely one of the components of capacity. For instance, this person may not have complete insight at all about his alcohol use but he executes all his work in his office and he is able to earn money so it is safe to say he doesn't have insight but he has capacity.

Similarly, cognitive impairment is another component of capacity. It is possible that a person with mild cognitive deficit i.e., during the early course of Dementia may still be able to make decisions and thus his capacity is deemed to be intact.

Table 5.1: Vital components of assessment for capacity and insight

Capacity	Insight
1. Comprehension of information	1. Awareness of illness
2. Appreciation of risk of accepting or refusing mental healthcare and treatment (Reasoning power)	2. Attribution of illness to various causal factors
3. Communication of the decision	3. Acceptance to adhere to the treatment

Contributory factors of Mental Capacity

There are many variables playing important role in the decision of mental capacity, depicted in figure 5.1

1. **Medical conditions**. For example, a person due to metabolic encephalopathy or meningitis loses the mental capacity; the doctor will make a decision for him at that time.
2. **Inadequate information or knowledge** about the medical condition.
3. **Cognition –** A reasonable degree of cognitive abilities is necessary to make any logical decision.
4. **Organic brain disorders –** Brain is the seat of making any judgement
5. **Substance use** - Intoxication with drugs or alcohol can impair the capacity
6. **Psychiatric diagnosis –** some but not all persons with severe schizophrenia or severe bipolar affective disorder especially mania do lose capacity. However, there is no systematic study examining the association between psychiatric diagnosis and loss of mental capacity.
7. **Violence –** poses risk of harm to others and thus, supported admission is warranted.
8. **Insight –** absence of insight leads to loss of capacity
9. **Affect –** For example, the elated mood and secondary grandiose ideation in mania may interfere with decision making.
10. **Socio-cultural beliefs –** some patients may have their own religious belief and preference to some other treatment modality. In such cases, they have lost capacity but rather they have taken a decision which may or may not yield good results. They have a right to decide what treatment they want.
11. **Symptoms –** for instance, delusions will come in the way of executing tasks due to perceived false-threats.

Principles of Capacity assessment

Presumption of capacity

Similar to the phrase "everyone is sane unless otherwise is proven", every person including PMI has mental capacity unless it is proved that he or she doesn't have a capacity to do perform a particular task. Section 14(9) of MHCA 2017 states that "all persons with mental illness shall have capacity to make mental healthcare or treatment decisions but may require varying levels of support from their nominated representative (NR) to make decisions" This principle reflects the equality before the law for PMI. Whenever a person is proven to have lost the capacity, NR will help the patient in making joint or shared decision. In such case, the PMI has to be provided with mental health care in a least restrictive environment.

Unwise/inappropriate decision

Section 4(3) states that "When a person makes a decision regarding his mental healthcare or treatment which is perceived inappropriate or wrong by others, it shall not mean that the person does not have the capacity to make mental healthcare or treatment decision" For instance, if a person with alcohol

dependence syndrome says "I would like to stop alcohol use with my will power, I don't want any treatment". Here the capacity is well preserved as he is taking a decision i.e., self-determination. In this context, the clinician will have to give respect for PMI's self-determination.

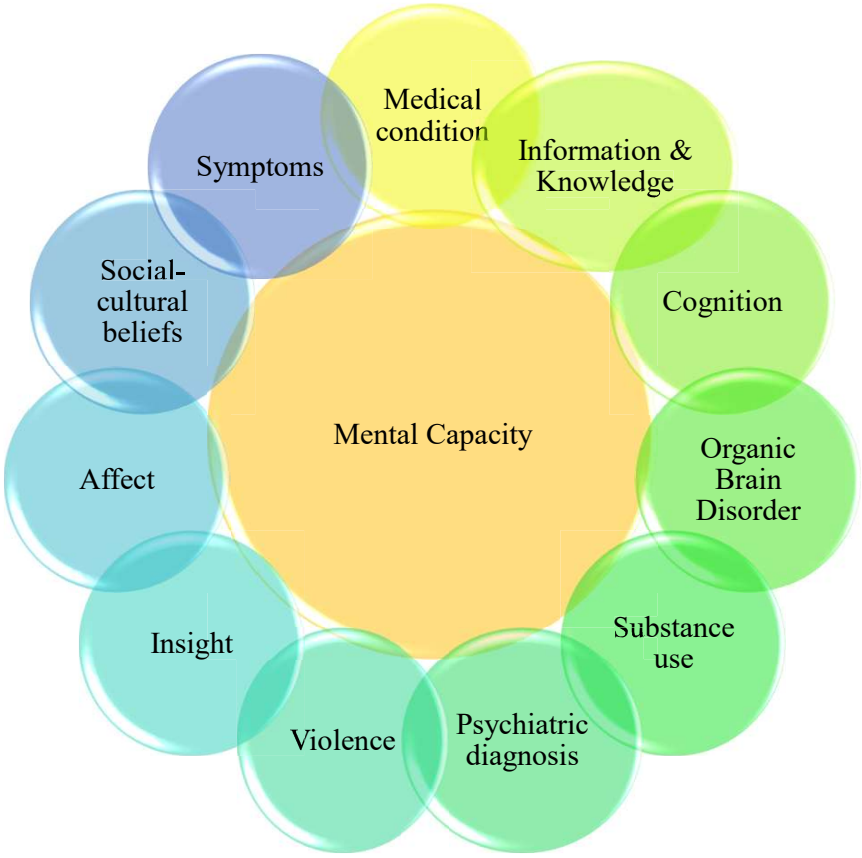

Figure 5.1: Factors determining Mental Capacity

Mental illness and capacity

Section 3(5) states that "the determination of a person's mental illness shall alone not imply or be taken to mean that the person is of unsound mind unless he or she has been declared as such by a competent court"

In the best interest of patient

Information provided is to be understandable to the individual. Maximum effort to enhance decision-making ability is to be made before capacity assessments. Capacity assessment is to be done in the background of a trusting and collaborative professional relationship. Assessments will have to be thorough and proportionate to the complexity, importance, and urgency of the decision.

Capacity Assessment tools

They are used for several purposes such as for admission, treatment, participating in research, preparing a valid will etc. They are various kinds such as structured, semi-structured or unstructured. It is best to have semi-structured scales as it will cover domains of capacity assessment and will also

give room for clinician to explore unique aspects in each individual patient to further make interpretations and draw inferences on capacity. There is risk of loss of information if it is too structured and may have risk of drawing subjective bias as inference if it is unstructured.

1. The MacArthur Competence Assessment Tool for Treatment (MacCAT-T) (3) - It is semi-structured and requires about an hour to assess decision-making abilities relevant for judgments about subjects' competence to consent to treatment. It is considered to be the gold standard capacity assessment tool. It has two components – a structural test and a functional test. The functional test is to be completed only after the structural test. Structural test is regarding the presence of a disorder of the brain or mind. Functional test is regarding impairment of decision-making. The functional test will include understanding relevant information, retention of the information, usage, and weighing of the different options, choice, and communication of the choice.
2. Brief informed consent test (4)
3. Quality of informed consent questionnaire (5)
4. Evaluation to sign consent (6)
5. Competency assessment interview (7)

Who can perform Capacity assessment?

As per section 81(1) of MHCA 2017, every medical practitioner and mental health professional shall, while assessing capacity of a person to make mental healthcare or treatment decisions, comply with the guidance document prepared by the expert committee. It includes

- Medical Practioners (MBBS, AYUSH)
- Psychiatrist
- Psychiatric Social Worker
- Clinical Psychologist
- Mental Health Nurses
- A Professional having a degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam.

Indications for Capacity assessment

Capacity to make mental healthcare and treatment decisions assessment can be carried out on any person more than 18 years of age during the following situations

1. When a person is planning for the registration of advanced directive - section 11(2)d
2. Before invoking already registered advance directive - section 5(3)
3. Prior to independent admission - section 86(2)c
4. Prior to supported admission under section 89 (1)c

5. Capacity assessment has to be repeated every week during the supported admission under section 89– as per section 89(8)
6. Prior to supported admission beyond 30 days - under section 90 (12)
7. Capacity assessment has to be repeated every 14 days when admitted under section 90 – as per section 90(11)
8. Before giving any information of the person to his or her NR i.e., information of PMI can be given only when he or she does not have a capacity – Section 22
9. Treatment related decision other than admission – section 4. For instance, when intervention where a separate consent process and documentation is necessary such as electro-convulsive therapy, capacity assessment must be performed prior to obtaining consent from the patient.
10. Research on PMI can occur only with an informed consent. Any research program on incapacitous patients can occur only with prior approval of the research project from the State Mental Health Authority and consent from the NR – Section 99

For persons aged less than 18 years, the legal guardian will by default be a NR to make any decision about the minor's mental healthcare and treatment. Hence, capacity assessment has not been indicated in them.

How to document capacity assessment?

All professional staff involved in the care and treatment of a patient who lacks capacity must keep a record of long-term and/or significant decisions made about the mental capacity. The record must have the following information.

- Who did the assessment?
- When and where did the assessment take place?
- What was the decision made?
- Why was that decision made?
- How was that decision made?
- Who was involved?
- What all information was used in making this decision?

It is advised to use 'Assessment Proforma' as given in the Guidance document by CMHA expert committee (see Appendix 5.1)

Assessment Proforma

It is ratified by CMHA in August 2019 and comprises of the following information.

- Demographic details – name, age, sex, hospital ID of the patient
- Place date and time of assessment
- Purpose for assessment such as admission/treatment/advance directive

After determining that the person has lost the capacity, then the MHPs or medical officer must look for whether the PMI has registered any advance directive in the past. The advance directive will have information what treatment this person wishes to take and which treatments he or she will not want to receive and the details of individuals elected as his or her NR.

Capacity assessment as per the 2019 Guidance document

- In certain situations, when a person is very violent, excited, catatonic or delirious, it is impossible to hold a meaningful conversation, and the clinician can ascertain the PMI demonstrates the obvious lack of the capacity; it needs to be clearly documented.

- **Comprehension –** Understanding the information. Questions related to orientation to time, place and person. If the person lacks comprehensive abilities, then the clinician has to clearly document how it was elicited. For example, what questions were asked, what the responses of the patient to each of the questions were.

- **Decision making ability –** Provision of relevant information about pertaining to illness, mental health care and effects and side-effects of treatment options, alternate treatment options. person using simple language, which such person understands or in sign language or visual aids or any other means to enable him to understand the information.
  - Does he or she acknowledge that he has mental illness? - yes or no
  - Appreciating the reasonable foreseeable consequences of a decision or lack of decision on treatment or admission or personal assistance
  - The patient should know what the benefits and risk are if he refuses treatment and what the benefits and risk that clinician is foreseeing.
  - Does the individual agree to receive treatment suggested by the treating doctor? - yes or no
  - Lastly, clinician has to document the explanation why PMI has agreed to receive or refuse treatment

- **Communication –** Communicating the decision by the means of any speech expression or gesture or any way is able to communicate whether he is accepting the treatment or not that has to be documented here.

- The questions in the guidance document are to anchor and the clinicians are free to ask as many questions as possible.

Conclusion

Capacity assessment is influenced by several factors such as weighing risks, understanding seriousness of the outcome of a decision, understanding of the wishes and preferences of the individual, and psychosocial factors of PMI. The binary decision regarding capacity by MHCA can be a challenging clinical judgement. Wishes and preferences of a PMI with capacity are emphatically placed higher than anything else in formulating the mental health care and treatment. PMI lacking mental capacity will require support in deciding on physical health care which is beyond the remit of the MHCA and calls for another statutory law governing decisions for incapacitous individuals.

Video link: https://youtu.be/edWO1a7Wo-o

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Appendix 5.1

NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES, BENGALURU – 29

(Institute of National Importance)

Capacity Assessment for Treatment decisions including Admission

Name: **Age/Sex:** **P. No:** **Date/Time:**

Place of assessment: **Advance Directive:** Present/Absent

Purpose of this assessment: Admission/Treatment/Advance Directive/Any Other

(For admission under section 102/103 of MHCA 2017, rest of the assessment can happen in the ward)

Nominated Representative: Name: ID:

Diagnosis (provisional):

Note: Provide explanation for each question

Obvious lack of capacity	Is he/she in a condition, that that one cannot have any kind of meaningful conversation with him/her (such as being violent, excited, catatonic, stuporous, delirious, under alcohol or substance intoxication/severe withdrawal, or any other (explain below)) .....? (Yes/No) If yes, then go to 4. If no, then go to 1.

1. Understanding the information that is relevant to take a decision on the treatment or admission or personal assistance (Understands the nature and consequences of the decision; possible options explained)			
A. Is the individual oriented to time, place and person? (Yes/No/Cannot assess) Explanation:	**B**. Has he/she been provided relevant information about mental healthcare and treatment pertaining to the illness in question? (Yes/No) If no, provide explanation:	**C.** Is he/she able to follow simple commands like (i) show your tongue (ii) close your eyes? (Yes/No/Cannot assess)? Explanation:	**D.** Does he/she acknowledge that he has a mental illness? (Yes/No/Cannot assess) Explanation:

2. Appreciating reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance.

A. Does the individual agree to receive treatment suggested by the treating team? (Yes/No/Cannot assess) Explanation: If yes, go to 2b. If no, go to 2c. If cannot assess, go to 3	**B.** Does he/she explain why he/she has agreed to receive treatment? (Yes/No/Cannot assess) Explanation:	**C.** Does he/she explain why he/she does not agree to receive treatment? (Yes/No/Cannot assess) Explanation:

3. Communicating the decision as per question (1) by means of speech, expression, gesture or any other means (Specify).

A. Is the individual able to communicate his/her decision by means of speech, writing, expression, gesture or any other means? (Yes/No/Cannot assess)

Explanation:

4. Based on the examination and relevant history, behavioural observation, clinical findings and mental status examination findings noted in the medical records,

I believe that Mr./Ms. ……..... (Strike off the choice that is not applicable)

a. Has capacity for treatment decisions including admission

b. Needs 100% support from his/her nominated representative in making treatment decisions including admission

Name and Signature of the Psychiatrist/Mental health professional/ Medical Practitioner

5. Fill the following if the choice is **4.a**.:

I, Mr./Ms ....., agree to make decisions in respect of my mental healthcare and treatment.

Name and Signature of the Patient

Date……

6. Fill the following if the choice is **4.b**.:

I, Mr./Ms ...., the nominated representative of Mr./Ms. ..... agree to make decisions with respect of his/her treatment.

Name and Signature of the Nominated Representative

Date……..

Chapter 6

The Protection of Children from Sexual Offences (POCSO) Act, 2012

Dinakaran Damodharan, Lakshmi Sravanti, Kiragasuru Madegowda R, John Vijay Sagar

Highlights

- Childhood Sexual Abuse (CSA) includes different forms of sexual victimization of children.
- National Crime Records Bureau (NCRB) India, in their 2019 annual report suggested a total of 148185 crimes against children were registered. About 35.3% of them were under the POCSO Act
- The Protection of Children from Sexual Offences (POCSO) Act, 2012, was enacted by the Indian government on 19th June 2012 as a strong and empirical legal framework for the protection of children from sexual offences.
- Psychiatrists also play a vital role in creating awareness about CSA, POCSO Act and reducing the shame and stigma prevalent in the society surrounding this topic.
- It calls for collaboration of multiple agencies – those from the government sector, health sector, schools, child care institutions, law enforcement, judiciary bodies and non-governmental agencies to combat this social evil.

Introduction

Sexual offences against children are a horrifying reality and a global concern. Childhood Sexual Abuse (CSA) includes different forms of sexual victimization of children. CSA encompasses sexual harassment, commercial exploitation, sexual assault, penetrative sexual acts, non-penetrative sexual acts, and pornography among others. In addition to various adverse medical and social consequences in the immediate aftermath, CSA eventually results in adverse physical and mental long-term consequences if the environment is not conducive to healing. CSA may occur in different settings that include home, school, child care institutions and community. Evidence from a meta-analysis suggests the prevalence of CSA to be 8-31% and 3-17% among girls and boys respectively (1). National Crime Records Bureau (NCRB) in their 2019 annual report suggested a total of 148185 crimes against children were registered. About 35.3% of them were under the POCSO Act (2). In most instances of CSA, the perpetrators are usually 'known' to the victims. Many families hesitate to seek professional help fearing embarrassment due to stigma surrounding the issue and instead blame the child for the incident. Perpetrator being known to them is one of the many other factors that add to their hesitation. For those who decide to seek help, mental health professionals and paediatricians are often the first line of contact. They are mandated to play a responsible role of identifying the notified abuse, reporting the abuse and importantly providing comprehensive immediate care to the victim and their relatives. The importance of regular follow-up and long-term rehabilitation of the victims cannot be understated. A proportion of health care professionals may not be trained in managing and reporting

CSA. As a psychiatrist, it is important to understand the adverse consequences of CSA and legal aspects of identifying, reporting and managing CSA. With this background, in this chapter the authors intend to discuss the evolution of POCSO Act, the scope of the Act, challenges in implementing the Act and common clinical scenarios relevant to psychiatry practice.

Evolution of the Act

It is pertinent to note, before 2012, there were no specific law in India related to sexual crimes against children. Earlier, such offences against children were booked under the common Indian Penal Code (IPC). Also, different forms of sexual abuse, like showing pornography to children, could not be prosecuted. Provisions to prosecute sexual offences against boys were conspicuously missing. The entire process of availing justice through the legal system was a horrifying proposition for the victims and families. Intense questioning of the child victim in courts and the negative media coverage meant that there was an increased risk of re-victimization. Additionally, merely securing justice, which can be as elusive as it can get, did not ensure recovery of victim from the trauma endured. Essential preventive and rehabilitative measures were also lacking. The inordinate delays in justice delivery would disrupt the life of the child and their family. Importantly, the burden of proof was solely on the victim that led to less number of cases reported compared to the scale at which the offences took place. Further, the prevalent social stigma and lack of institutional safeguards made families of victims decide against reporting of the events.

In this background, with India being party to the "United Nations Convention on the Rights of the Child" is also under a legal obligation to protect children from such abuse and exploitation. The POCSO Act, 2012, was enacted by the Indian government on 19th June 2012 as a strong and empirical legal framework for the protection of children from sexual offences. The central government released the rules for the Act on 14th November 2012. The principal Act was amended on 5th August 2019 to include "death penalty" (Section-6) for aggravated penetrative sexual assault on children. The National Commission for Protection of Child Rights (NCPCR) has been mandated to monitor the implementation of the POCSO Act, 2012. NCPCR has released a 'User Handbook for Implementation of the POCSO Act' (developed by the Mumbai based NGO – "Prerana") which is another major initiative taken by the Commission intended to explain the various provisions of the Act in a simple language and is a useful guide for all stakeholders. It is a comprehensive manual that focuses on a practical and hands-on approach. It also establishes systematic guidelines and user guides to deal with POCSO Act related cases in a multidisciplinary manner, through various pictorial charts and flow diagrams (3).

The scope of the POCSO Act, 2012

The POCSO Act received the assent of The President on 19th June 2012. This is an Act to protect children from sexual offences, harassment and pornography. The Act is child-friendly and eases the administrative mechanisms for reporting and recording of evidences. Special courts, special public prosecutors, and speedy trials are incorporated to ensure ease of legal functioning. It provides for the establishment of special courts for the trial of such offences. The Act consists of 9 Chapters and 46 sections discussed in Table 6.1. From a clinical perspective, Chapter-5, Sections-20 and 21 describes the need for mandatory reporting of the offences/ materials/objects from the hospital to the appropriate authority and the punishment for failing to report the cases respectively. Section-21 states any person who fails to report the commission of the said offence shall be punished with an

imprisonment of 6 months or fine or both. Any person, who is in-charge of the institution, if fail to report the offence committed by their subordinate, shall be punished with an imprisonment of one year or fine or both. Additionally, the Act does not lay down that the mandatory reporter has an obligation to inform the child/family/guardian about the reporting. The reporter need not investigate the offence or even know the perpetrator and these are left for investigation by appropriate agencies.

Chapter-6, section-27 discusses the medical examination of the child victim. This medical examination must be conducted notwithstanding the status of first information report or complaint not being registered with appropriate agency. The examination must be conducted after obtaining the consent from the parents/guardian. If the victim is a girl child, the examination shall be conducted by a woman doctor. Parents or any person the child trusts may be allowed to be with the child during the examination. In case of no relatives available, the examination may be conducted in the presence of a woman appointed by the Head of the hospital/institution.

In addition to the role mandated by the law with respect to examination and reporting, psychiatrists also need to understand and evaluate the impact of trauma on the child's physical and mental well-being. Adequate assessment of common mental health problems following trauma and appropriate management of physical and mental injury are important. Special focus should be laid on evaluation of substance abuse and self-injury/suicidality-related concerns. It is indeed important to provide multidisciplinary care with an acute and long-term approach while managing CSA victims. Measures to prevent further trauma, abuse and victimization must be part of the comprehensive management plan. Psychiatrist may also play a role in creating awareness about CSA, POCSO Act and reducing the shame and stigma prevalent in the society surrounding this topic. Additional educative measures could be undertaken to promote essential life education and prevent CSA in the community.

Table 6.1: Outline of the POCSO Act, 2012

Chapter	Description	Sections and salient features
I	Preliminary	Sections 1-2 Short title and definitions
II	Sexual offences against children	Sections 3- 12 A. Penetrative Sexual Assault B. Aggravated Penetrative Sexual Assault C. Sexual Assault D. Aggravated Sexual Assault E. Sexual Harassment And describes the punishment under each assault respectively. Section-6: (Amended in 2019) to include death penalty for aggravated penetrative sexual assault
III	Using child for pornographic purposes and punishment therefore	Sections 13-15 Describes the offence and punishment where a child is used for pornographic purposes

IV	Abetment of, and attempt to commit an offence	Sections 16-18 Explains abetment of and attempt to commit an offence and describes the punishment related to such acts
V	Procedure for reporting of cases	Sections: 19- 23 Describes the procedure of reporting offences including the role of media and other organizations (securing the identity and privacy of the child). Prescribes punishments for not reporting the crimes and for false complaints (mandatory reporting).
VI	Procedures for recording statement of the child	Sections: 24-26 Explains the procedure of recording statement and medical examination of the child (child-friendly mechanisms are emphasized)
VII	Special courts	Sections: 27-32 Describes the appointment of special courts and special public prosecutors. Section-29 specifically states regarding the "presumption" of certain offences under section such as 3,5,7 and 9 Section – 30 states the mental state of the perpetrator is presumed to be "culpable" unless proved otherwise
VIII	Procedure and powers of special courts and recording of evidence	Sections: 33- 38 Describes the roles, responsibilities, procedures to be followed and powers of the special courts
IX	Miscellaneous	Sections: 39-46 Describes the rights and guidelines related to child availing assistance. Prescribes the roles of nodal agencies in creating awareness and monitoring the implementation of the Act.

Child-friendly mechanisms in the Act

The following listed mechanisms are emphasized in the Act to make the entire police, medical and legislative processes child-friendly and prevent the victim from further trauma, abuse and re-victimization.

Child-friendly procedures for recording the statement

- Police personnel should inform the parents/guardians in advance of the date of recording of the statement.
- Police personnel should not be in uniform.

- To the extent possible, statement of the child shall be recorded by women police officer not below the rank of Sub-Inspector at the residence of child or at a place where he usually resides or a park nearby or at a place of child's choice (Section 24).
- The statement to be recorded in the language spoken by the child (Section 25).
- During the recording, the parents/guardians or support persons or any other adults trusted by the child shall be allowed to accompany the child.
- The statement shall be written/typed as the child speaks or recorded using audio-video instruments, as available after informing the child.
- It is important to allow the child to get frequent breaks and to make the child comfortable during recording of the statement and also the trial (Section 33).
- In the case of a special child or a disabled child, it is essential to avail the help of an expert or specialists (Section 26).
- While recording the statement using an audio-visual device, the quality of the equipment should be assessed beforehand (Section 26).
- Once the statement is recorded, it is the duty of the officer to read out the statement loudly to the child and parents/guardians. If there are any changes or corrections to be made, it has to be done then and there.
- It is mandatory for the officer to provide a copy of the statement to the child and the family.
- It is essential to provide the child and family with the complete details – especially the name, designation and telephone number of the officer in-charge of the case (Rule 4).
- It is also important to explain in brief the next steps that follow post the recording of the statement (Rule 4).
- During the entire process, the officer is expected to provide full support and protection to the child and inform the child and his parent or guardian or other person in whom the child has trust and confidence, of the availability of support services including counselling, and assist them in contacting the persons who are responsible for providing these services and relief (Rule 4).
- The child shall not remain in the police station at night for any reason (Section 24).
- Further, it is the role of the officer to ensure that the child and the accused do not come in contact with each other after the registration of the complaint throughout the entire judicial process (section 24 & 36).

Child-friendly procedures for medical examination

- The child victim who is in need of urgent medical care and protection, SJPU/local police shall within 24 hours of receiving information about the crime, arrange to take such child to the nearest hospital or medical care facility centre for emergency medical care (Rule 5 (1)).
- Rule 5 of the Act states that Emergency Medical Care is to be provided by any medical facility private or public. Sexual Assault is, therefore, a Medical Emergency.
- If a person has come directly to the hospital without the police requisition, the hospital is bound to provide treatment and conduct a medical examination with consent of the survivor/parent/guardian (depending on age) (Rule 5 (3)). However, the doctor is mandated to report such instances invariably to the police (Section 20).
- The medical examination of child shall be conducted whether FIR or complaint is registered or not, by a women doctor, if the victim is girl. In case parent is not available for any reason, medical examination of child shall be conducted in the presence of a women nominated by the head of the medical institution (Section 27).
- Consent to be obtained from the child/parent/guardian before proceeding with the examination (Section 41) (Section 164(A) CrPC).
- Under Rule 5(4), the minimum management protocol of the victim to be undertaken by the registered medical practitioner is listed.

Other Child-friendly procedures

- If the Special Juvenile Police Unit (SJPU) or local police has reasonable grounds to believe that the child is in need of care and protection, then, it shall after recording the reasons in writing, make arrangements to give the child such care and protection (including admitting the child into shelter home or to the nearest hospital) within 24 hours of the report (Section 19 (5)).
- The SJPU or local police shall report the matter to the Child Welfare Committee (CWC) and the Special Court within 24 hours including the need of the child for care and protection and steps taken in this regard (Section 19 (6).
- Identity of the child and the family has to be safeguarded throughout the process (Section 23).
- The Act also mandates establishment of child-friendly Special Courts in every district (Section 28).
- The burden of proof is on the accused and not on the victim (Section 29).
- The Special public prosecutor or the counsel of the accused may pose the questions to the child only through the special court and not directly (Section 33).
- The child shall not be called repeatedly to testify in the court (Section 33).
- The POCSO Act requires that the evidence of the child be recorded by the Special Court within 30 days of taking cognizance of the offence. Any delay shall be recorded in writing. As far as

possible, the trial shall be completed within a period of one year from the date of taking cognizance of the offence (Section 35).

- Appointment of a Special Public Prosecutor (Special PP) for every Special Court for conducting cases only under the provisions of POCSO Act (Section 32).
- The Special Court shall create a child-friendly atmosphere and allow the child to be accompanied by a family member, guardian, friend or relative in whom the child has trust or confidence to be present in the court (Section 33).
- The family or the guardian of the child shall be entitled to the assistance of a legal counsel of their choice for any offence under the Act. They are also entitled for free legal counsel from Legal Services Authority (Section 40).
- Under Rule 4 (7), Child Welfare Committee is to appoint Support Person to render assistance to the child through the process of investigation and trial.
- The Special Court may recommend award of compensation where the accused is convicted, or where the case ends in acquittal or discharge, or the accused is not traced or identified, and in the opinion of the Special Court the child has suffered loss or injury as a result of that offence (Rule 7).

CRITICAL APPRAISAL OF POCSO ACT, 2012

As discussed above, POCSO Act, 2012 is a child-friendly and a much-needed legislation. It set precedence by becoming a separate law in India to address sexual crimes against children and highlights child-friendly mechanisms to ensure smooth implementation. However, there are certain conceptual issues that have been critiqued by the scientific community and child right advocates. We briefly allude to its limitations and illustrate challenges faced during commonly encountered clinical scenarios. The role of psychiatrist/mental health professional in execution of the Act depends on the pathway of care by which the child has reached the professional.

Protection does not just mean "punishing an offender after a crime has been committed". However, this act seems to focus entirely on punishment for offences but does not suggest any means for prevention of CSA, which would truly constitute "protection of children against the crime". India is a country, where CSA issue is still a taboo and the act does not specify institutions that can promote awareness and dialogue among the common public. It also does not allude to primary preventive programs or suggest reformative measures (such as establishing rehabilitation centres) for "potential" offenders and offenders that can help in reducing commission of crime and recidivism respectively. This makes one wonder if it really stands true to its name – "Protection of Children from Sexual Offences" Act.

Firstly, reporting of crimes is very low. Merely 3% of CSA offences uncovered by a national level study conducted under the aegis of Ministry of Women and Child Development were reported to authorities (5). Although the act mandates the setting up of Special Courts to expedite trials of these offences, the issue of pendency is looming large coupled with low conviction rates. As per the NCRB report of 2019, the rate of conviction is about 35% and pendency is almost 90% (2). POCSO

Amendment Act, 2019 introduced death penalty in the context of aggravated penetrative sexual assault (6). While the intention is well-appreciated, with a very low conviction rate and large number of pending cases, introducing harsher punishment cannot be a solution until all other shortcomings are addressed. Moreover, there is a debate that this move may further reduce reporting of offences (due to fear of capital punishment – especially in cases of intrafamilial abuse) and or may result in physical harm to the child – including murder of the victim by the offender (in an attempt to destroy evidence). While the debate on deterrent effect of capital punishment on sexual offenders continues in the global scientific community, sensitizing various stakeholders involved, improving the infrastructure to actually make the process child-friendly, ensuring speedy trials and preventing procedural lapses are the need of the hour. It should also be revised to plug the existing loopholes and provide appropriate measures to protect children from this horrific crime in a holistic sense.

Guidance on Mandatory reporting

The purpose of mandatory reporting, under POCSO, is to ensure that sexual offense comes to light and gets punished, to ensure child's safety from further abuse, to provide justice to the concerned child, and to prevent abuse of other children. However, parents and caregivers are usually reluctant to report CSA (4). The reasons may be varied ranging from stigma associated with sexual abuse to fear of legal procedures and systems. It is important to include not only the parents/caregivers but also the older children and adolescents to be part of the decisions on reporting and legal action. It is recommended, therefore, that mandatory reporting is not a one-off procedure but that it follows a process which entails the following:

- Written documentation of the child's (or family's) report/account of sexual abuse in an official manner
- Explaining to the child and family that there are laws about CSA (POCSO) and that it is recommended that they report the abuse with reasons for how and why it could be advantageous to them, i.e., how it would ensure the safety of the child/other children, get the perpetrator to be punished, etc
- Understanding the child and family's hesitancy to report, i.e., to elicit the reasons and fears they have not to want to report, and then to try and address these fears and concerns one-by-one.
- Assuring the child and family that confidentiality would be maintained through the processes of reporting, i.e., the press/media/school/general public would not be aware of the identity of the child.
- Explaining all processes involved in reporting, to child and family, preparing the family and child about the sequence and type of reporting that would be necessary at each stage gives them greater clarity and reassurance and increases the likelihood of their reporting abuse
- To start with healing interventions and tell the child that we can re-visit the reporting issue at a later point when he/she feels ready to do so
- To always support a child's decisions to report to police/legal personnel and work with the parents to get on board with their child's decisions to do so.

Thus, it is recommended that reporting be embedded in the process of psychosocial interventions for the child and family rather than a disconnected, stand-alone process that needs to be done immediately—and which then only serves to exacerbate the confusion and trauma that the child and family is already experiencing soon after the abuse incident/ disclosure or discovery.

Clinical scenario - 1

A 10-years old child, first born of a nonconsanguineous marriage from a high socio-economic status studying in fifth standard (CBSE medium), temperamentally easy, with family history of generalized anxiety disorder in second-degree relative (paternal grandfather) and OCD in another second-degree relative (maternal grandmother) is brought by parents to out-patient department with symptoms suggestive of anxiety – fearfulness, multiple somatic complaints, reducing academic performance, sleep disturbances (difficulty falling asleep) of two years duration that have increased in severity over the last two months. Previously, a very outgoing child with interest in extra-curricular activities but now there is history suggestive of loss of interest in participating in such activities and avoiding social situations – especially where older men are involved.

Role of a psychiatrist

Firstly, like in any other scenario – one is expected to make a working diagnosis by enquiring further and ruling out symptoms of other possible psychiatric illnesses. In this case, it is important to note that child is not forthcoming with history of any kind of child sexual abuse. Only clue is – avoiding "older men". At times, even a single indicator would not be available in first presentation. Further details can be elicited by taking history carefully. Whenever, history of CSA is established, immediate need is to ensure safety of the child by informing the parents so that further contact with the abuser is prevented. The psychiatrist must ensure that medical examination is done, if not done, child then needs to be referred for a medical examination (for medical and forensic purposes). But who should a psychiatrist refer to? Is information regarding designated/approved medical centres in each state available for such reporting? If a psychiatrist sees such a child in his/her clinic, should one refer directly to an appropriate hospital or through proper channel by reporting to appropriate authorities (SJPU)? There is lack of clarity on these issues. However, despite parents' reluctance to report the case to police, the onus lies on the mental health professional to whom the child has revealed about CSA to report to concerned SJPU.

Clinical challenges

When and how to probe? What about confidentiality? These are not addressed in the act. There is no right time to probe or ask questions pertaining to abuse. These questions should be a part of interviewing every child to rule out its possibility, especially when the index of suspicion is high. If the child reveals CSA, whether or not the child gives the consent, confidentiality can be breached in the best interests of the child. Moreover, in India parents are legal guardians for children less than 18years old, hence they need to be informed about the event.

Learning points

Usually, children are not forthcoming to report history of CSA. This could be due to internal (lack of awareness about CSA and its consequences, shame, guilt, and or fear of being blamed/punished) and or external (consequence of grooming by the abuser and or pressure not to report exerted by the

perpetrator or family members) barriers. At times, children report of CSA when half-way through the therapy sessions. Therefore, clinician must not only acquire skills to dissect out history in a graded and sensitive manner, but also have knowledge of the dynamics and various ramifications of CSA.

Clinical scenario – 2

A 17-years old boy studying in 11th standard from a middle socioeconomic status, temperamentally difficult, with a family history of depression in first-degree relative (mother) and prominent anankastic personality traits in two first-degree relatives (both the parents) presents to the out-patient department with his parents with chief complaints of oppositional, rebellious behaviour of one year duration, worsened over last six months with attempts at self-harm (cutting), irritability, substance use (alcohol – harmful use) and suicidal ideation. Symptoms occurring on a background of having a romantic relationship with a friend against wishes of his parents with a history of consensual intercourse. He has an elder brother who works for a Multi-National Company. His relationship with him also has become strained over the past six months.

Role of a psychiatrist

After routine psychiatric evaluation and necessary management, one should educate the boy and the family about the law. It is important to improve their understanding about legal consequences of such actions as per the existing law and a life skills approach towards sexuality can be taken in management. As per the existing law one is bound to report to concerned authorities. However, it is the duty of the government to give a clarification on how to deal with such situations.

Clinical challenges

In this case scenario, it is clear that the sexual relationship was consensual. Whether the mental health professional should report to such a case? Cases of such sexual experimentation in adolescents are becoming more prevalent, there needs to be an amendment stating whether this constitutes abuse or not and how to approach such situations?

Learning points

Such scenarios involving consensual physical relationship between adolescents is a point of debate as POCSO Act does not consider adolescents of 16-18 years of age as consenting individuals. It also does not specify the age difference (between victim and abuser) to define an abuse. The High Court of Madras to clear this observed that the age of child be reduced to 16years from 18years (7). However, it is not the same across all the states. Until there is clarity and clear definition of age – efforts must go into educating the youth about the existing law to prevent. This can be included in the sexuality education curriculum. More importantly, there is a need for lawmakers to clarify practical issues pertaining to such scenarios and ensure uniformity to reduce confusion.

Clinical scenario – 3

A 6-year-old girl is studying in first standard from a low socioeconomic status, temperamentally easy with family history of alcohol use (harmful use) in first-degree relative (father) is brought by parents with a history of crying spells, behavioural disturbances (anger outbursts, irritability), somatic symptoms, sleep disturbances (nightmares, bed-wetting) and school refusal of ten days duration. The

symptoms were triggered when the child was allegedly sexually abused (penetrative sexual assault in the school context). Parents filed a First Information Report (FIR) with a police station (from appropriate jurisdiction after being redirected by staff from two different police stations). While the family is keen to pursue legal action against the perpetrator, the child is not aware of the likely proceedings and is currently disturbed to be engaged in any kind of conversation regarding the incident. The family has already been to a government hospital as suggested by the police for medical examination and the report has confirmed the allegations.

Role of a psychiatrist

Ensuring safety and crisis resolution (appropriate psychosocial support to the family, symptomatic relief and therapeutic engagement of child), liaising with the social work team, to provide – regular home visits to check on the family and provide support as required. If the case has not been referred by the concerned SJPU – one should inform and update the authority. In case the family comes on police order, the mental health professional should send an update to the SJPU regarding the case. Court may ask the treating psychiatrist for a report on the mental status of the child to conduct trial. On some occasions, the team may also be requested to – provide a support person for the child during the trial. High courts of different states have laid down certain guidelines that the mental health professionals must familiarise themselves with.

Clinical challenges

After an initial period of crisis resolution, when the child is able to engage effectively in therapy (e.g., play therapy), it is often noticed that the symptoms are under control. However, they tend to be triggered – by events such as need to go to the police station, depose in the court as child witness etc. This may lead to hindrances in therapy and psychiatrist must not try new things in haste but pace it as per the readiness of the child. During the process – family may want the child to retract her statement because of – fear (due to lack of protection); the perpetrator may threaten the family or extended family members may pressurize the parents to withdraw the case (due to stigma and fear of embarrassment). Child may end up doing so. Inordinate delays in the process of delivery of justice often lead to victims retracting their statements. What is worse is that victims are re-victimized not once but multiple times during the process. Can the courts make it mandatory for a child mental health professional to assist the legal authorities during cross-examination? Especially in children with IDD (Intellectual Developmental Disorders) who are also more prone to CSA and in need of such support, it is more important to include such procedural amendments.

Learning points

The situation calls for involvement of multiple agencies, however, it is important not to elicit information from the child repeatedly by different professionals involved. Only the appropriate authorities as specified by the POCSO Act (police and magistrate) need to intervene. This not only prevents secondary victimization but also prevents contamination of the evidence. Lack of knowledge about child development of different stakeholders involved in CSA cases can lead to inadvertent re-victimization of children who are already suffering from trauma of abuse. This defeats the total purpose of the law. Therefore, it is necessary to sensitize lawmakers, members of CWCs, SJPUs, NGOs and judiciary to effectively navigate through this concern.

Conclusion

CSA is a social problem. Therefore, it needs collaboration of multiple agencies – those from the government sector, health sector, schools, child care institutions, law enforcement, judiciary bodies and non-governmental agencies to combat this social evil. While there is a very child-friendly act in place, it takes efficient implementation of the same to provide justice to the victims. Therefore, all the stakeholders should coordinate to provide best of care to all the children. Legal authorities should take cognizance of its limitations and provide appropriate provisions to address the same. Moreover, it is the duty of every responsible citizen to ensure a safe, enriching and secure environment for children to grow with dignity and protect them from any kind of violence. As they say, "Charity begins at home", so every common man can play his/her role in contributing towards improving awareness by encouraging people to talk openly about it and reducing stigma.

Video link: https://youtu.be/8EzrDdvnv8A

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Chapter 7

Juvenile Justice Act (JJA), 2015

Shalini S Naik, Barikar C Malathesh, Chethan Basavarajappa, Suresh Bada Math

Highlights

- National Crime Records Bureau (NCRB) reported a total of 32,235 crimes committed by juveniles in the year 2019
- Three prominent statutory bodies under Juvenile Justice Act (JJA) 2015 are Juvenile Justice Board (JJB), Child Welfare Committee (CWC) and Central Adoption Resource Authority (CARA) for carrying out procedures related to children in conflict with law, children in need for care and protection and children for legal adoption respectively
- When a heinous offence committed by a juvenile aged between 16-18 years, JJB may perform on their own or direct any experienced mental health professional to perform preliminary assessment of juvenile's mental and physical capacity of to commit such offence, ability to understand the consequences of the offence and the circumstances in which he or she allegedly committed the offence

Introduction

CHILDREN get into the legal framework of societal functioning when they are neglected, abandoned, victims of violence or indulge in activities that are in conflict with law. Provision of remedial and therapeutic measures for such children must be a vital part of our culture. Each person in the society must own up the responsibility to understand the causes of children's inabilities to handle their problems and the situations in which their problems arise. Further, everyone should implement this knowledge in an attempt to prevent emotional maladjustments as people live and develop their own individual patterns of adjustment in social settings. The Juvenile Justice (JJ) Act, 2000 established the principles, systems, processes and related statutory bodies to cater to the basic needs of children through proper care, protection, development, treatment and social reintegration. The main statutory bodies defined under the Juvenile Justice Act (JJA) 2015 are the Juvenile Justice Board (JJB) to manage children in conflict with law (CCL), the Child Welfare Committee (CWC) to manage children in need of care and protection and Central Adoption Resource Authority (CARA) for legal adoption procedures of children (see figure 7.1). The Integrated Child Protection Scheme (ICPS) and Protection of Children from Sexual Offences (POCSO) Act, 2012 establish further safety nets and protection systems. The Integrated Child Protection Scheme (ICPS) is a centrally sponsored scheme aimed at building a protective environment for children in difficult circumstances, as well as other vulnerable children, through Government-Civil Society Partnership. POCSO Act has been enumerated in chapter 6. This chapter has two broad components, the former half discusses on preliminary assessment reporting and psychiatrists' role in addressing CCL and the latter part elaborates the structure and functions of three significant statutory bodies under JJA, 2015.

"It is easier to build strong children than to repair broken men"

- Fredrick Douglass

JUVENILE DELINQUENCY

Juvenile delinquency is an act of committing a criminal offence by a person who has not completed 18 years of age. It is a growing concern as most of these juvenile delinquents are also children in need for care and protection. In other words, they are also victims with a complex set of needs, urging a public health approach that balances both welfare and justice models.

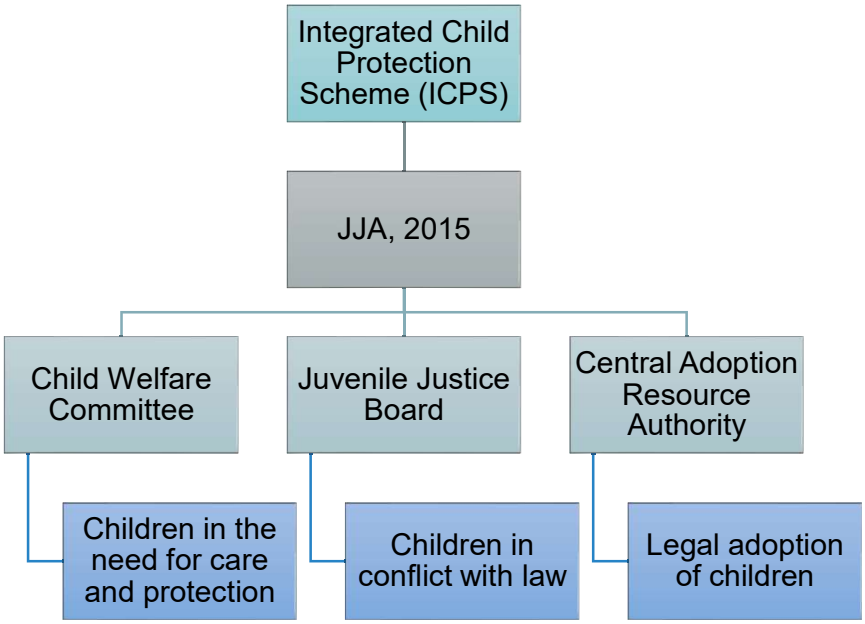

Figure 7.1: Statutory bodies under Juvenile Justice Act (JJA), 2015

Extent of the problem

Following the involvement of a juvenile in the Nirbhaya gang rape case that shook the country in December 2012, juveniles in conflict with the law are constantly grabbing attention across all the sectors of Indian population. National Crime Records Bureau (NCRB) has recently published 'Crime in India' report for the year 2019 that a total of 32,235 crimes committed by juveniles (1). 92% of the cases involving juveniles were Indian Penal Code (IPC) related crimes and rest were Special and Local Laws (SLL) related.

- 37.8% of all crimes involving juveniles were of offences affecting human body that includes hurt and grievous hurt (49.7%), rape (10.3%) and assault on women to outrage her modesty (10%).
- 37% of juvenile crimes were against property. Of them, theft constituted for 72.9% followed by burglary and robbery accounting for 17.8% and 5.8% respectively.
- Cases under the Protection of Children from Sexual Offences Act (POCSO), 2012 accounted for 51.2 % of the cases under SLL.

- Often, the presumed factors contributing to involvement of juveniles in crimes is a low level of education and nature of parenting experienced. However, the NCRB report shows that almost 45% of the juveniles involved in these cases were educated between matriculation and higher secondary, 28% had education up to primary level, and only 9% were illiterate. Further, it reveals that 85% of the apprehended juveniles lived with their parents, 9% lived with guardians and only 6% were homeless.

- 98.8% of juvenile crimes were committed by boys and around three-quarters of the juveniles were between 16 to 18 years of age.

- **Recent trends -** In the case of juveniles between 16 to 18 years, offences booked under SLL crimes have increased between 2016 and 2019, while the same under IPC has decreased by 14% since 2016 – the latter could possibly be due to effective enforcement of the Juvenile Justice (Care and Protection) Act, 2015. It is important to note that this act contains a provision which permits the court to hold a trial of a child aged above 16 years, as an adult after a preliminary assessment when he or she has committed a heinous offence.

Risk factors and protective factors

Delinquency is a resultant of the interaction of various factors across multiple contexts (individual, family and community) on an individual's development occurring over several years.

A risk factor is anything that increases the probability that a person will suffer harm whereas a protective factor is something that decreases the potential harmful effect of a risk factor.

Risk and protective factors for juvenile delinquency have been identified in the following four domains (see table 7.1):

1. Individual
2. Family
3. Peers
4. School, neighborhood, and community

No single risk factor leads a juvenile to delinquency. Typically, cumulative exposure to multiple risk factors (across all the domains) increases likelihood of experiencing negative outcomes including delinquency.

Each risk factor influences children at different stages of their development. For instance, individual and family factors occur earlier than the peer risk factors during their developmental years.

Since risk and protective factors are dynamic in nature, the child welfare system must adopt a reiterative approach in assessing delinquency and rendering welfare services to prevent future delinquency (3).

JJ ACT 2015

Background

In the aftermath of Nirbhaya (Delhi Gang rape) case that occurred in December 2012 where a 17 years old juvenile was involved in committing heinous crime, Juvenile Justice Bill was revamped in 2015 to allow juveniles in conflict with Law in the age group of 16–18, involved in Heinous Offences, to be tried as adults. Juvenile Justice (Care and Protection of Children) Act (JJ Act), 2015 has replaced the pre-existing Indian Juvenile Delinquency law, and Juvenile Justice (Care and Protection of Children) Act, 2000. JJ Act received the assent of the President on the 31st December, 2015, and came into force from 15 January 2016.

Table 7.1: Domain-wise risk and protective factors for juvenile delinquency

Domain	Risk factors	Protective factors
Individual	▪ Early antisocial behaviour ▪ Emotional factors such as low behavioral inhibitions ▪ Poor cognitive development ▪ Hyperactivity ▪ Poor academic performance	▪ Positive social skills ▪ Willingness to please adults ▪ High IQ ▪ Religious affiliations
Family	▪ Inadequate or inappropriate child rearing practices ▪ Home discord ▪ Maltreatment and abuse ▪ Large family size ▪ Parental antisocial history ▪ Poverty ▪ Exposure to repeated family violence ▪ Divorce ▪ Parental psychopathology ▪ Teenage parenthood ▪ A high level of parent-child conflict ▪ A low level of positive parental involvement	▪ Children's participation in shared activities with family (including siblings and parents) ▪ Providing a forum to discuss problems and issues with parents ▪ Availability of economic and other resources to help children have multiple positive experiences ▪ The presence of an adult (with a positive outlook and hope for the child) in the family/extended family who can mentor and be supportive
Peers	▪ Spending time with peers who engage in delinquent or risky behaviour ▪ Gang involvement ▪ Less exposure to positive social opportunities because of bullying and rejection	▪ Positive and healthy friendships Engagement in healthy and safe activities with peers during leisure time (e.g., clubs, sports, other recreation)
School/ neighborhood/ Community	▪ Schools that are unsafe and fail to address the academic, social and emotional needs of children and youth ▪ Low educational aspirations & social disorganization in the community ▪ Living in an impoverished neighborhood ▪ High crime neighborhoods	▪ Schools that address not only the academic needs of youth but also their socio-emotional needs and learning ▪ Schools that provide a safe environment ▪ A community/neighborhood that promotes and fosters healthy activities for children and adolescents

In addition, to comply with recommendations of The Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption 1993 (Hague Adoption Convention), the JJ

Act 2015 is in pursuit of creating a universally accessible adoption law for India. It gets ahead of the Hindu Adoptions and Maintenance Act (1956) (applicable to Hindus, Buddhists, Jains, and Sikhs) and the Guardians and Wards Act (1890) (applicable to Muslims), for the legal procedures of adoption, however, it does not replace them. Henceforth, JJA 2015 has three essential components

1. Children who are in conflict with law
2. Children who need care and protection
3. Legal adoption procedures of children

PRELIMINARY ASSESSMENT

In case of a heinous offence alleged to have been committed by a child, who has completed or is above the age of 16 years, the JJB shall conduct a preliminary assessment with regard to his mental and physical capacity to commit such offence, ability to understand the consequences of the offence and the circumstances in which he or she allegedly committed the offence.

- Preliminary assessment is not a trial. However, it is to assess the capacity of a juvenile to commit and understand the consequences of the alleged offence.
- JJB can do the preliminary assessment itself or may take the assistance of experienced psychologists or psycho-social workers or psychiatrists other experts.
- Preliminary assessment rests on the principle of "presumption of innocence" i.e., any child shall be presumed to be an innocent of any mala fide (criminal intent) up to the age of 18 years.
- As discussed under section 15, the matter shall be disposed of by the JJB within a period of three months from the date of first production of the child before the Board.
- If the JJB concludes that a juvenile should be tried as an adult based on the preliminary assessment and owing to the nature of criminal allegations, then the JJB will pass an order that the child must tried as an adult assigning reason for the same and shall follow the procedure, as far as may be, for trial in summons case under the Code of Criminal Procedure, 1973.
- Under the tenet of a new clause "fair trial", a child- friendly atmosphere must be ensured looking into his or her special needs during the preliminary assessment. (see child friendly mechanism in chapter 6)

Three important documents crucial for preliminary assessment

Social Investigation Report

A report of a child containing detailed information pertaining to the circumstances of the crime, antecedents of the crime, the situation of the child on economic, social, family, education/schooling, parenting, psychosocial and other relevant factors, and the recommendation thereon. It is prepared by a Probation Officer or the voluntary or non-governmental organization, along with the evidence produced by the parties for arriving at a conclusion.

Social Background Report

It is an important document for the welfare of the CCL while deciding their care. It includes statement of witnesses and other documents prepared during the course of investigation by the Child Welfare Police Officer/ Special Juvenile Police Unit within in one month of CCL produced to the JJB.

Preliminary Assessment and reporting (see Appendix 7.2)

Preliminary assessment has to be weighed on the following five factors.

A Mental capacity

B Physical capacity

C Ability to understand the consequences of the offences

D The circumstances under which the alleged offence was committed

E Criminogenic factors

A. Mental capacity

- Planning the crime
- Motivation (mens rea)
- Avoiding detection
- Destruction/tampering of the evidence
- Behaviour during and after the crime
- Physical mental and drug assessment report
- Comprehension, risk assessment and communication

B. Physical Capacity

- Height and weight of the CCL
- Age-appropriate physical growth
- Occupation
- Number of people involved in the crime (accomplice)
- Nature of the weapon used
- Any physical disability noted
- Nature of injuries and post-mortem report of the victim

C. Ability to understand the consequences of the offences

- Ability to recognize the unlawful behaviour as "wrong" (Actus reus)
- Attaining sufficient maturity of understanding to be aware of the nature and consequences of his or her conduct in regard to the act of which the child is accused

D. The circumstances under which the alleged offence was committed

- Child was provocated or incited by someone to commit the offence
- Perceived or real, threat or unfulfilled need leading the child to do the unlawful act

E. Criminogenic factors

- History of antisocial behaviors
- Anti-social personality pattern
- Anti-social cognition (attitudes/beliefs/values in favor of crime)
- Antisocial associates
- Family circumstances – broken families, substance use or criminal offences in the family
- Low levels of involvement and performance at school/work
- Low levels of satisfaction in non-criminal pursuits

Guidance on Preliminary assessment

Community Child & Adolescent Mental Health Service Project under the Department of Child & Adolescent Psychiatry, NIMHANS in collaboration with the Department of Women & Child Development, Government of Karnataka had developed "Guidance notes" on the Preliminary Assessment Report for Children in Conflict with Law (3).

The **Guidance document** outlines to perform detailed psychosocial and mental health assessment first and determine the following subsequently. (See Appendix 7.1)

A. **Mental & Physical Capacity to Commit Alleged Offence** – takes account of child's abilities to make appropriate social decisions and judgements (which translate into actions and behaviors) that could have been affected by the child's life circumstances and mental health or developmental problems.

B. **Circumstances of Alleged Offence** – about the factors and circumstances that made the child vulnerable to committing offence.

C. **Child's Knowledge of Consequences of Committing the Alleged Offence** – considers that child understands of social/interpersonal and legal consequences of committing offence along with child's insights into the act of committing such an offence.

D. **Other Observations & Issues** – this is regarding the child's social temperament/ child's behaviour in the observation home/ level of motivation for change/ if any positive behaviour observed.

E. **Recommendations** for treatment and rehabilitation interventions for the child, based on the interests and desires of the child.

The Preliminary Individual Assessment Report for Juvenile Justice Board has been attached in appendix – 7.2

Role of mental health professional in preliminary assessment

Mental Health professional has two crucial roles to play – one as a forensic expert/specialist and the other as child or mental health specialist.

As a forensic expert/specialist

As per the JJ Act 2015, the objective of the preliminary assessment of a child is to 'evaluate the role of the child in the alleged offence, as well as his mental condition and background'. In keeping with this, the psychosocial and mental health assessment report provides information on the child's mental condition and background, namely the developmental level of the child, family history and relationships, school and education, involvement in child labour, peer relationships and experiences of trauma and abuse; it also provides information on any mental health disorders and developmental disabilities that the child may have. Finally, the report must have recommendations for treatment and rehabilitative interventions for the child.

Furthermore, a psychiatrist must have cognizance of the following

- Understanding the structure and function of JJB and CWC
- Identifying key stakeholders and establishing communication with them and advocating for the needs and rights of children
- Seeking background information from the social investigation report of CCL from the probationary officer of Special Juvenile Police Unit (SJPU)
- Communication regarding child's treatment and follow-up with other authorities/agencies as required
- Providing services as specified in the preliminary assessment report

Role as a clinician/child mental health specialist

To **minimize risk factors** by using various psychotherapeutic elements.

1. Impulsivity is targeted because it is a risk factor for delinquency that can moderate the effects of other risk factors. It prevents the juvenile from overseeing the consequences of his or her delinquent behavior.
2. Replacing delinquency-related avoidant coping with pro-social coping skills such as confrontation and seeking social support through social problem-solving skills.
3. To improve social perspective-taking skills, because delinquent juveniles inadequately recognize and interpret the intentions and motivations of others through attributing more hostile intent to others and showing a lack of cognitive empathy.
4. Critical reasoning to aid juveniles in the process of pro-social decision-making by challenging rigid and dichotomous thinking.

To **increase protective factors** against future delinquency

1. Making right choices and planning,
2. Having non-delinquent friends/partner,

3. Having meaningful daytime and appropriate leisure activities
4. Having a good relationship with parents/family
5. Early and sustained engagement of parents in skills training is critical.
6. Positive parental involvement (positive parenting and parental rewards) will aid in desistance from offending. Parental involvement in training enhances the long-term outcomes
7. Positive feedback, behavioral exercises, homework assignments, and positive (parental) reinforcement increase the juvenile's self-esteem, who will apply the trained techniques in daily life thus enhancing generalizability and social acceptance.
8. Periodical assessment and feedback on impulsivity, coping skills, hostile intent attribution, lack of cognitive empathy, and cognitive distortions are helpful.
9. Social skills training (SST) for juvenile delinquents and juveniles at risk for offending improve social skills as a means to reduce the risk for re-offending. SST addresses social interaction, pro-social behavior, and social cognitive skills.
10. Techniques such as modeling, positive reinforcement, coaching, and role-playing are frequently used. SST has been found most effective for older, less aggressive juvenile offenders, who were treated on diversion (not probation or incarceration) because their problems were not too severe, and they had cognitive abilities enough to profit from the training.

Role of a Psychiatrist in sensitization of stakeholders

At individual and systems-level

Challenges

- Attitudinal barrier – Paternalistic attitude, preconceived notions and prejudices while analyzing an offence instead of understanding the context in which the child committed an offence
- Judgement and labeling – use of terms such as "Offenders" "criminal" will disrupt the doctor-child relationship
- Lack of experience and sense of inadequacy in handling CCL can evoke anxiety in clinicians thereby becoming a hindrance in addressing child's clinical and forensic needs. It could be overcome by undergoing training to acquire pre-requisite skills in adopting a child-centric approach

Potential strategies to solve the challenges

Child's dignity is first priority. Hence, stakeholders such as public prosecutors, psychiatrists, house mothers and fathers, child care institute in-charges, staff at Non-Governmental Organizations (NGO), police personnel must be sensitized about the dynamic and complex interplay of child's psyche and unmet environmental needs and its impact on child's behaviour in the short-term and long-term. Activity-based learning is more helpful than knowledge- imparting. Below mentioned Case vignettes can be used for activity-based learning exercises.

At community level

Barriers

- Stigma, discrimination and marginalization of juvenile offenders
- Poor coordination and cooperation amongst schools, Panchayat, local NGOs and other stakeholders

Strategies to address the barriers

- School programs for students and teachers
- Parent programs
- Sensitization of police personnel

} About life skills, decision making and legal aspects

- Training and capacity building in mental health professionals regarding assessment, reporting and treatment
- Training and capacity building of NGOs along with District Mental Health Programme (DMHP) teams
- Workshops for community leaders
- Integrating with Rashtriya Kishore Swasthya Karyakram (RKSK) and Ayushman Bharath programmes that deal with adolescents' health comprehensively
- Identifying high risk communities and empowering NGOs by providing technical assistance to face various challenges.

Case Vignette

A clinical scenario is elaborated here to draw attention to the complex interplay between various biopsychosocial factors and its ramifications.

P is a 16-year-old child from a single-parent family; his father (who died) was an alcoholic and there was domestic violence at home (also directed at the child). He decided to drop out of school and started to engage heavily in substance abuse— mainly alcohol and solvents. He started to steal, along with his peers, in order to procure substances. He had a system with his peers, of sharing the substances they managed to procure. During one of these times, there was a conflict. The child overheard his two peers plotting to kill him; so, he feared of getting killed. He waited until they fell asleep, he decided to hurt them really badly so that they would get scared of him. But in doing so, he ended up killing them. He came into conflict with the law for murder charges.

Role of a psychiatrist

- First of all, **gather information**
  - To seek information on the circumstances of the crime, antecedents of the crime, the situation of the child on economic, social, family, schooling, parenting, and other psychosocial factors information from the **Social Investigation report** provided by the probationary officer or NGOs
  - To procure **social background report** that details on the statement of witnesses prepared by the Child Welfare Police Officer/ SJPU

- **Clinical evaluation and management**
  - After routine psychiatric evaluation with the child, the child can be initiated on the treatment for his psychiatric condition.
  - Urine toxicological evaluation
  - Detailed physical examination – examine age-appropriate physical and mental development, document external injuries and identification marks
  - It is important to educate him and his family about the law and improve their understanding about legal consequences of such actions as per the existing law.
  - Discuss about the medical, and socio-legal consequences of substance use and methods to overcome craving and peer pressure.
- For the **preliminary assessment and reporting** (upon JJB's instruction)
  - Data & time of crime; detailing of the circumstances around the crime
  - Gather substantial details about why his peers had planned to kill him the child.
  - He attacked them when his peers were asleep, indicative of he had planned extensively to injure them when they are less active to fight against him
  - He wanted to hurt but not intended to kill his peers suggestive of his motivation behind crime is to inflict injury but not murder them.
  - Details on the weapon used and injuries inflicted on to the victim by him and vice-versa.
  - Whether child was intoxicated with substance of abuse or performed the act under the influence of any commanding or discussing voices
  - Probe into how his behaviour was during and after the crime and if he made any attempt in tampering the evidence or has made an effort in seeking emergency medical help for the deceased ones
  - At the beginning of an unlawful fight, explore the attitude manifesting as an intention of instantly attacking the accused person with dangerous means or in a deadly manner
  - Whether the child was aware the injury that he inflicted could lead to death and also the mere act of harming someone is in contrary to the law.
  - Collect details of past history of theft and explore his attitude about these anti-law activities
  - Observe if the child has a pattern of engaging in substance use and anti-law behaviors to cope with his emotional and interpersonal crises

JUVENILE JUSTICE BOARD (JJB)

Structure

The State Government shall constitute one or more Juvenile Justice Boards for every district, for exercising the powers and discharging its functions relating to CCL under JJA 2015.

A Board shall consist of

- One Metropolitan Magistrate or a Judicial Magistrate of First Class not being Chief Metropolitan Magistrate or Chief Judicial Magistrate with at least three years' experience
- Two social workers (at least one shall be a woman) who are actively involved in health, education, or welfare activities pertaining to children for at least seven years or a practicing professional with a degree in child psychology, psychiatry, sociology or law.

Section 8 of Chapter III elaborates the functions and responsibilities of JJB. It must direct the Probation Officer, or in case a Probation Officer is not available to the Child Welfare Officer or a social worker, to undertake a social investigation into the case and submit a social investigation report within a period of fifteen days from the date of first production before the Board to ascertain the circumstances in which the alleged offence was committed. It must adjudicate and dispose of cases of CCL in accordance with the process of inquiry including preliminary assessment

Orders that may or may not be passed by JJB

- *Orders regarding a child not found to be in conflict with law* – If the JJB is satisfied on inquiry that the child brought before it has not committed any offence in contrary to any law, and then Board shall pass order to that effect. Further, if the JJB deems that the child is in need of care and protection, it may refer the child to the Committee with appropriate directions (Section 17).
- *Orders regarding child found to be in conflict with law* – If the JJB is satisfied on inquiry that a child irrespective of age has committed a petty offence, or a serious offence, or a child below the age of 16 years has committed a heinous offence, and based on the nature of offence, specific need for supervision or intervention, circumstances as brought out in the social investigation report and past conduct of the child, the JJB may, as per section 18
    - a Allow the child to go home after advice or admonition by following appropriate inquiry and counseling to such child and to his parents or the guardian;
    - b Direct the child to participate in group counseling and similar activities
    - c Order the child to perform community service under the supervision of an organization or institution, or a specified person, persons or group of persons identified by the Board
    - d Order the child or parents or the guardian of the child to pay fine. Provided that, in case the child is working, it may be ensured that the provisions of any labour law are not violated
    - e Direct the child to be released on probation of good conduct and placed under the care of any parent, guardian or fit person, on such parent, guardian or fit person executing a bond, with or without surety, as the Board may require, for the good behaviour and child's well-being for any period not exceeding 3 years
    - f Direct the child to be released on probation of good conduct and placed under the care and supervision of any fit facility for ensuring the good behaviour and child's well-being for any period not exceeding three years;
    - g Direct the child to be sent to a special home, for such period, not exceeding 3 years, as it thinks fit, for providing reformative services including education, skill development,

counseling, behaviour modification therapy, and psychiatric support during the period of stay in the special home.

- *Order that may not be passed against a child in conflict with law* – No child in conflict with law shall be sentenced to death or for life imprisonment without the possibility of release, for any such offence, either under the provisions of this Act or under the provisions of the Indian Penal Code or any other law (section 21).

CHILD WELFARE COMMITTEE (CWC)

Structure

The State Government shall constitute one or more Child Welfare Committees for every district, for exercising the powers and to discharge the duties conferred on such Committees in relation to children in need of care and protection under JJA 2015.

The Committee shall consist of

- One Chairperson
- Four other members – of them, at least one shall be a woman and another, an expert on the matters concerning children

Functions and responsibilities of the CWC is enumerated in Section 30 of Chapter V. They are

1. Taking cognizance of and receiving the children produced before it
2. Conducting inquiry on all issues relating to and affecting the safety and wellbeing of children under this Act
3. Directing the Child Welfare Officers or probation officers or District Child Protection Unit or NGOs to conduct social investigation and submit a report before the Committee
4. Conducting inquiry for declaring fit persons for care of children in need of care and protection
5. Directing placement of a child in foster care
6. Ensuring care, protection, appropriate rehabilitation or restoration of children in need of care and protection, based on the child's individual care plan and passing necessary directions to parents or guardians or fit persons or children's homes or fit facility in this regard
7. Selecting registered institution for placement of each child requiring institutional support, based on the child's age, gender, disability and needs and keeping in mind the available capacity of the institution
8. Conducting at least two inspection visits per month of residential facilities for children in need of care and protection and recommending action for improvement in quality of services to the District Child Protection Unit and the State Government
9. Certifying the execution of the surrender deed by the parents and ensuring that they are given time to reconsider their decision as well as making all efforts to keep the family together.
10. Ensuring that all efforts are made for restoration of abandoned or lost children to their families following due process, as may be prescribed

11. Declaration of orphan, abandoned and surrendered child as legally free for adoption after due inquiry
12. Taking *suo moto* cognizance of cases and reaching out to children in need of care and protection who are not produced before the Committee.
13. Taking action for rehabilitation of sexually abused children who are reported as children in need of care and protection to the Committee by Special Juvenile Police Unit or local police, as the case may be, under the Protection of Children from Sexual Offences (POCSO) Act, 2012
14. Dealing with cases referred by the JJB
15. Co-ordinate with the police, labour department and other agencies involved in the care and protection of children with support of the District Child Protection Unit or the State Government
16. In case of a complaint of abuse of a child in any child care institution, the Committee shall conduct an inquiry and give directions to the police or the District Child Protection Unit or labour department or child helpline services (child helpline number – 1098)
17. Accessing appropriate legal services for children

ADOPTION

To streamline adoption procedures for orphan, abandoned and surrendered children, the existing Central Adoption Resource Authority (CARA) has been given the status of a statutory body to enable it to perform its function more effectively. Adoption Regulations 2017 were framed by the CARA under JJ Act 2015 (4). It replaces the Guidelines Governing Adoption of Children to further strengthen the adoption programme in the country and became operational from 16th January 2017.

Functions of CARA

a) To promote in-country adoptions and to facilitate inter-State adoptions in co-ordination with State Agency

b) To regulate inter-country adoptions

c) To frame regulations on adoption and related matters from time to time

d) To carry out the functions of the Central Authority under the Hague Convention on Protection of Children and Cooperation in respect of Inter-country Adoption

Adoption of a child from a relative by another relative, irrespective of their religion, can be made as per the provisions of this Act.

Governing principles of Adoption

The following fundamental principles govern adoptions of children from India

a) The child's best interests shall be of paramount consideration while processing any adoption placement

b) Preference shall be given to place the child in adoption with Indian citizens and with due regard to the principle of placement of the child in his own socio-cultural environment, as far as possible

c) All adoptions shall be registered on Child Adoption Resource Information and Guidance System and the confidentiality of the same shall be maintained by the Authority

Child eligible for adoption is

a) Any orphan or abandoned or surrendered child, declared legally free for adoption by the CWC

b) A child of a relative

c) Child or children of spouse from earlier marriage, surrendered by the biological parent(s) for adoption by the step-parent

Eligibility of prospective adoptive parents (section 5 of Adoption Regulations 2017)

The parent must be mentally alert and highly motivated to adopt a child for providing a good upbringing to him or her.

1. The prospective adoptive parents shall be physically, mentally and emotionally stable, financially capable and shall not have any life-threatening medical condition
2. Any prospective adoptive parents, irrespective of his marital status and whether or not he has biological son or daughter, can adopt a child subject to following
    a consent of both the spouses for the adoption shall be required, in case of a married couple
    b a single female can adopt a child of any gender
    c a single male shall not be eligible to adopt a girl child
3. No child shall be given in adoption to a couple unless they have at least two years of stable marital relationship.
4. The age of prospective adoptive parents, as on the date of registration, shall be counted for deciding the eligibility and the eligibility of prospective adoptive parents to apply for children of different age groups as mentioned in table 8.2.
5. In case of couple, the composite age of the prospective adoptive parents shall be counted.
6. The minimum age difference between the child and either of the prospective adoptive parents shall not be less than 25 years.
7. The age criteria for prospective adoptive parents shall not be applicable in case of adoptions by relatives or step-parent.
8. Couples with three or more children shall not be considered for adoption except in case of special need children and in case of adoptions by relatives or step-parent.

Table 7. 2: Eligibility of prospective adoptive parents based on their age

Age of the child	Maximum composite age of prospective adoptive parents (couple)	Maximum age of single prospective adoptive parent
Up to 4 years	90 years	45 years
Above 4 and up to 8 years	100 years	50 years
Above 8 and up to 18 years	110 years	55 years

Procedure for adoption by Indian prospective adoptive parents living in India

(Section 58 of JJA 2015 and section 9 of Adoption Regulations 2017)

1. Indian prospective adoptive parents living in India, irrespective of their religion, if interested to adopt an orphan or abandoned or surrendered child, may apply to a Specialised Adoption Agency
2. The Specialised Adoption Agency shall prepare the home study report of the prospective adoptive parents and upon finding them eligible, will refer a child declared legally free for adoption to them along with the child study report and medical report of the child.
3. On receipt of acceptance of a child from prospective adoptive parents along with the child study report and medical report of the child signed by such parents, the Specialised Adoption Agency shall give the child in pre-adoption foster care and file an application in the court for obtaining the adoption order.
4. On receipt of a certified copy of the court order, the Specialised Adoption Agency shall send immediately the same to the prospective adoptive parents.
5. The progress and wellbeing of the child in the adoptive family shall be followed up and ascertained.

Procedure for inter-country adoption of an orphan or abandoned or surrendered child

(Section 59 of JJA 2015 and section 8 of Adoption Regulations 2017)

1. If an orphan or abandoned or surrendered child could not be placed with an Indian or non-resident Indian prospective adoptive parent despite the joint effort of the Specialised Adoption Agency and State Agency within sixty days from the date the child has been declared legally free for adoption, such child shall be free for inter-country adoption: provided that children with physical and mental disability, siblings and children above five years of age may be given preference over other children for such inter-country adoption, in accordance with the adoption regulations, as may be framed by the Authority.
2. An eligible non-resident Indian or overseas citizen of India or persons of Indian origin shall be given priority in inter-country adoption of Indian children. Child shall be allowed to be given in inter-country adoption only

   (a) After sixty days, if the child is below five years of age

   (b) After thirty days, if the child is above five years of age or is a sibling

   (c) After fifteen days, if the child has any mental illness or physical disability
3. On receipt of acceptance of a child from prospective adoptive parents, the Specialised Adoption Agency shall file an application in the court for obtaining the adoption order and send to State Agency and to the prospective adoptive parents and obtain a passport for the child.
4. The Authority shall intimate about the adoption to the immigration authorities of India and the receiving country of the child.

5. The prospective adoptive parents shall receive the child in person from the Specialised Adoption Agency as soon as the passport and visa are issued to the child.
6. A foreigner or a person of Indian origin or an overseas citizen of India, who has habitual residence in India, if interested to adopt a child from India, may apply to Authority along with a no objection certificate from the diplomatic mission of his country in India.

Procedure for inter-country relative adoption

(Section 53 of Adoption Regulations 2017)

1. A Non-Resident Indian or an Overseas Citizen of India, interested to adopt a relative's child, may approach an Authorised Foreign Adoption Agency or the Central Authority in the country of residence for preparation of their Home Study Report and for online registration in Child Adoption Resource Information and Guidance System
2. The adoptive parents shall receive the child from the biological parents after receiving no objection certificate from the Authority and shall facilitate the contact of the adopted child with his siblings and biological parents from time to time.

Punitive measures for adoption without following prescribed procedures

(Section 80 of JJA 2015)

Punishable with imprisonment of either description for a term which may extend up to 3 years or with fine of one lakh rupees or with both.

Conclusion

More often than not, the crime is resultant of failure in providing adequate care, equity and justice to them at individual, system and community levels. Unlike adults, children who commit crimes are less blameworthy and also, they have a tremendous potential for transformation. Hence, the juvenile correctional services must aim and progress relentlessly towards justice to CCL. Child welfare organizations must strive to improve their effectiveness in providing abused and neglected children with safe shelters. For abandoned or orphaned children, non-Institutional care choices like adoption, foster care are streamlined in this act. Duty, commitment, and coordination between different partners in child protection and recruitment of experienced social workers will enhance the proficient use of ICPS from a grass-root level.

Video link: https://youtu.be/8K6U5iDcx8A

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Appendix 7.1

Guidance notes for the clinical evaluation of Children in Conflict with the Law

(Age 16 to 18 Years)

Name of Child:
Age:
Sex:
Place of Origin:

A. Mental & Physical Capacity to Commit Alleged Offence

The child's ability to make social decisions and judgments are compromised due to:

- Life skills deficits (emotional dysregulation/ difficulty coping with peer pressure/ assertiveness & negotiation skills /problem-solving/ conflict-resolution/ decision-making)
- Neglect / poor supervision by family/poor family role models
- Experiences of abuse and trauma
- Substance abuse problems
- Intellectual disability
- Mental health disorder/ developmental disability
- Any other (specify):

No treatment/ interventions provided so far to address the above issues

B. Circumstances of Alleged Offence

- Family History:
- School History:
- Child Labour:
- Peer Relationships:
- Abuse and Trauma:
- Mental Health Disorder/ Developmental Disability:

C. Child's Knowledge of Consequences of Committing the Alleged Offence

- Child's Understanding of Social/ Interpersonal and Legal Consequences of Committing Offence:

D. Other Observations & Issues

E. Recommendations

Appendix 7.2

Preliminary Individual Assessment Report for Juvenile Justice Board

This assessment report is dated:

Name of Child:

Age:

Sex:

Place of Origin:

Place of preliminary assessment: Outpatient/Inpatient

Date of preliminary assessment:

A. Physical Capacity to commit alleged offence: Height, Weight, physical abilities, substance intoxication

B. Mental Capacity to commit alleged offence: Behaviour during the crime, planning involved behind the crime, knowledge that he will be punished and tampering of evidence

C. Circumstances around the alleged offence: Accomplices, data & time of crime

D. Understanding capacity of the consequences of the alleged offence

E. Understanding capacity that alleged offence is in contrary to the law

Chapter 8

An overview of Telemedicine Practice Guidelines and Telepsychiatry Operational Guidelines in India

Sujai Ramachandraiah, Damodharan Dinakaran, Chethan Basavararajappa, Narayana Manjunatha, Channaveerachari Naveen Kumar, Suresh Bada Math

Highlights

- The burden of mental illness in India is significant, as the lifetime prevalence of mental illness is over 13% in the general population
- Telemedicine can be a tool to redistribute the mental healthcare workforce concentrated in urban areas
- Telemedicine encompasses delivery of health care services (across a distance) by all health care professionals using information and communication technologies (for exchange of medical information)
- In order to encourage widespread adaptation of telemedicine in these times of need, Government of India released Telemedicine Practice Guidelines 2020
- Indian Psychiatric Society (IPS) and NIMHANS also released Telepsychiatry Operational Guidelines 2020, which is an adaptation of Telemedicine Practice Guidelines 2020 for needs of telepsychiatry practice
- In this chapter, we discuss salient features of Telemedicine Practice Guidelines 2020 and Telepsychiatry Operational Guidelines 2020, relevant to Forensic Psychiatry

Introduction

THE BURDEN OF MENTAL ILLNESS IN INDIA is significant, as the prevalence of mental illness is 10.56% in the general population (1). We have only 0.3 psychiatrists per one lakh population in India (2). Most of these psychiatrists are restricted to urban areas. Telemedicine can be a tool to redistribute the mental healthcare workforce concentrated in urban areas. Telemedicine encompasses delivery of health care services (across a distance) by all health care professionals using information and communication technologies (for exchange of medical information). It also covers use of information and communication technologies for research and evaluation in health care, and for continuing medical education of health care providers (3).

In India, telemedicine service formally began in 2001, as a pilot project of Indian Space Research Organization (ISRO) and Apollo hospital (4). Following this, Government of India with the collaboration of ISRO, Department of Information Technology (DIT), Ministry of Communications and Information Technology, various state governments, and several premier technical and medical institutions all over the country, has implemented multiple telemedicine initiatives like National Cancer Network (ONCONET), National Rural Telemedicine Network, ICMR-AROGYASREE, Karnataka Internet-Assisted Diagnosis of Retinopathy of Prematurity (KIDROP), MukhyaMantri e-

Eye Kendram, mCessation (Quit tobacco). Many central government medical institutions like National Institute of Mental Health Sciences (NIMHANS), Postgraduate Institute of Medical Education & Research (PGIMER), Sanjay Gandhi Post Graduate Institute of Medical Sciences (SGPGIMS), All India Institute of Medical Sciences (AIIMS) have been providing telemedicine services for more than a decade. Private sector initiatives in telemedicine, such as by Apollo hospital, Narayana Hrudayalaya, Sankara Netralaya, Schizophrenia Research Foundation (SCARF), have been in service for almost two decades (4,5).

Over the past two decades, Government of India has taken major policy initiatives to promote telemedicine service in India such as: 'Recommended Guidelines and Standards for Practice of Telemedicine in India' was released in 2003, 'National Standards on Telemedicine' was notified in 2003, 'National Steering Committee on Telemedicine' was constituted in 2005, 'National Standards for Electronic Health Records (EHR)' was drafted between 2010 to 2013, 'the framework for Information Technology Infrastructure for Health', 'National Task Force on Telemedicine' was setup in 2005, 'National Digital Health Authority (NDHA)' was proposed under National Health Policy-2017 (5). In spite of the above initiatives and policies, adaptation of telemedicine service in India is poor due to: inertia in adoption of telemedicine by health care workers due to unfamiliarity and lack of confidence in its efficacy, high initial cost of setting up telemedicine infrastructure, poor adoption by patients due to cultural barriers (in-person consultation appears to be the norm), unreliable internet connectivity (reliability of psychiatry assessment was poor in low bandwidth telepsychiatry), lack of continuous electricity, poor internet/mobile telephone penetration, language barrier, lack of technological literacy, poor interoperability of medical record keeping, lack of clarity on legal issues (5-9).

There are many legislations governing practice of modern medicine and information technology in India. Many gaps in legislations and lack of clear guidelines pose a risk to patients and registered medical practitioners (RMPs), which discourages widespread adaptation of telemedicine. COVID-19 pandemic and ensuing travel restrictions put many patients at disadvantage of accessing health care service. In order to encourage widespread adaptation of telemedicine in these times of need, Government of India released Telemedicine Practice Guidelines in March 2020 (10). Indian Psychiatric Society (IPS) and NIMHANS also released Telepsychiatry Operational Guidelines in May 2020, which is an adaptation of Telemedicine Practice Guidelines 2020 for needs of telepsychiatry practice (11).

In this chapter, we discuss salient features of Telemedicine Practice Guidelines 2020 and Telepsychiatry Operational Guidelines 2020, relevant to Forensic Psychiatry.

Telemedicine Practice Guidelines 2020

The Ministry of Health and Family welfare, India released the "Telemedicine Practice Guidelines" in March, 2020 to guide RMPs to use telemedicine as part of their normal medicine practice. This guideline was prepared by the Board of Governors, in supersession of the Medical council of India, in partnership with National Institution for Transforming India (NITI Aayog). This guideline is part of the appendix V of 2002 regulations on "Professional conduct and ethics" under the Indian Medical Council Act, 1956.

Salient features

The professional and ethical norms and standards that apply to traditional in-person care, also apply to telemedicine consultation. The guidelines state that professional judgment of a RMP should be the guiding principle for all telemedicine consultations i.e., the RMP should exercise their professional judgment to decide whether a telemedicine consultation is appropriate in a given situation or an in-person consultation is needed in the interest of the patient. The guidelines cover all modes of communication with patient such as audio, video, text and digital data exchange. It covers both synchronous and asynchronous types of teleconsultations. The consultations covered by the guidelines are classified and defined based on the purpose e.g., first and follow up consultation. The guideline covers direct consultation with patient, consultation with care giver, another RMP and health care workers also. In all emergencies, the guidelines advise in-person consultation with nearest RMP and where it is not possible, to restrict teleconsultation to first aid, counselling and advice on referral. It mandates all RMPs intending to provide telemedicine consultation to undergo an online course within three years of its notification. RMP can use any telemedicine tool for teleconsultation e.g., telephone, video, internet, chat platforms etc.

The guidelines state that the RMP should verify patient's identity by name, age, address, email ID, phone number, registered ID. The RMP must also ensure a mechanism for the patient to verify RMPs identity by name, qualification, professional registration, contact details. The RMP should ascertain the age of patient, in case of minors, teleconsultation should be allowed only in the presence of an adult, after confirming the identity of the accompanying adult. Consent for teleconsultation is mandatory and should be recorded. When the patient contacts the RMP for teleconsultation, consent is implied. An explicit consent should be obtained and recorded in any form (text, audio, video) when RMP, health worker or care-giver initiates telemedicine consultation.

The RMPs must make sufficient effort to collect adequate information before any professional judgement. If needed, in-person consultation should be considered to collect more medical information. All patient records i.e., clinical details, investigation reports, images etc should be appropriately maintained. Log or record of telemedicine consultation e.g., phone logs, email records, chat/ text record, video interaction logs etc should be maintained. A copy of prescription provided also should be kept in the patient records. Medications should be prescribed only after appropriate diagnosis. The guidelines categorise drugs in to list-O, A, B and prohibited list. List-A drugs can be prescribed only on video consultation if it is first consultation. Prescription can be transmitted electronically to the patient and explicit consent from patient is required if it is sent to pharmacy directly.

The guidelines do not cover use of digital technology to conduct surgical or invasive procedures remotely, research, evaluation and continuing education of health workers using telemedicine technology, consultations outside the jurisdiction of India, specifications for hardware/software/infrastructure used in telemedicine. The guidelines also define professional misconduct e.g., not ensuring privacy and confidentiality of patient, prescribing medications without appropriate diagnosis, prescribing medicines from restricted list, soliciting patients for telemedicine consultation through advertisement or inducements, insisting on telemedicine consultation when patient requests for in-person consultation.

Technology platforms providing telemedicine consultations should ensure due diligence before listing any RMP on its online portal. Platform should display the name, qualification, registration number, contact details of every RMP listed on the platform. Technology platforms based on Artificial Intelligence/Machine Learning are not allowed to counsel the patients or prescribe any medicines to a patient. Only RMPs are allowed to consult and prescribe medicines.

Critique

The guidelines cover all modes of communication and different types of teleconsultations, ensuring easy access to health care for people from all corners of the country. The guidelines ensure safety of patients by insisting on appropriate identification of RMPs, patient confidentiality and privacy, appropriate consent. The guideline also allows consultation with caregivers, ensuring legal sanction for proxy consultations. The guidelines also restrict unauthorised use of telemedicine by minors, by insisting on presence of adults during the teleconsultation. It also provides the right to refuse teleconsultation by a RMP or patient, ensuring autonomy of both the parties. The guidelines regulate the process of teleconsultation by defining first/follow up consultation, by categorising medications and restricting their use. Professional misconduct is defined by the guidelines, promoting adequate standard of professional conduct. The guidelines govern the functioning of technology platforms by insisting on verification of authenticity of RMPs registered in such platforms and by restricting use of Artificial Intelligence/Machine Learning in direct care of patients.

The guidelines do not cover breach of confidentiality or privacy by the patients. They do not clarify the geographical jurisdiction for legal/ethical complaints e.g., where should a patient from Delhi consulting a RMP from Karnataka approach (Delhi or Karnataka medical council) for any issues arising out of teleconsultation. The guidelines do not clarify the authority of professional responsibility when there is a teleconsultation between one RMP to another. Guidelines do not the cover the research through telemedicine platform, thus providing scope for ambiguity for use of this platform in research. The guidelines remain silent on the scope of health insurance cover for teleconsultations. The electronic prescriptions can be used multiple times, leading to misuse of medications. These electronic prescriptions also do not conform to Drugs and Cosmetics Act, 1940 and Pharmacy Act, 1948 (12).

Telepsychiatry Operational Guidelines 2020

These guidelines are an adaptation of Telemedicine Practice Guidelines 2020, and were prepared by NIMHANS and IPS to guide psychiatrists. The guidelines focus on video conference based telepsychiatry service. The main aim of the guidelines is to assist psychiatrists in setting up telepsychiatry services.

Salient features

The guidelines adapt telemedicine practice guidelines for telepsychiatry practice by incorporating provisions of Mental Health Care Act, 2017. The guidelines cover interaction with persons in conflict with law. All forms of advertisement of telepsychiatry are discouraged. The guidelines also suggest precautions to be followed on social media platforms for RMPs. Technical suggestions (including electronic health record) for setting up telepsychiatry service are provided. The guidelines provide instructions for differing or terminating the telepsychiatry consultation i.e., withdrawal of consent, difficulty in assessing capacity to consent, requiring emergency care, persons in conflict with law,

when there is a request for certificate or health records. The guidelines also provide for telepsychiatry consultation with caregivers without patient's consent when there is loss of capacity to consent, in patients with moderate to severe dementia. The guidelines list psychotropics under list-A, and B as provided by the telemedicine practice guidelines. The guidelines do not encourage prescription of injectable psychotropics on telepsychiatry consultation. The guidelines also cover telepsychotherapy practice e.g., to initiate telepsychotherapy only after a psychiatric evaluation and diagnosis has been made.

Critique

The guidelines simplify telemedicine practice guidelines for adaptation to telepsychiatry practice. It incorporates Mental Health Care Act, 2017. It also provides practical suggestions for setting up a telepsychiatry practice. The guidelines also make an effort to categorise psychotropics according to the list of medications advised by telemedicine practice guidelines. The guidelines cover interaction with persons in conflict with law, telepsychiatry consultation with caregivers without patient's consent in special circumstances, which reduces ambiguity (for psychiatrist) on considering telepsychiatry consultation. The rationale for categorisation of psychotropics under list-A, B is not clear e.g., Aripiprazole is not in list-A, but Risperidone is included in it. Routinely used psychotropics like Zolpidem, Diazepam are restricted from telepsychiatry consultation. Consent form for telepsychiatry consultation is elaborate. Telemedicine practice guidelines advocate single phrase or simple sentence for consent.

Conclusion

Telemedicine practice guidelines were released in an effort to encourage adaptation of telemedicine by RMPs and patients, especially during this pandemic to ensure universal access to healthcare. These guidelines provide clarity on the modes of communication, types of teleconsultations allowed in India. There is a need for clarity on the jurisdiction for grievance redressal, professional responsibility in teleconsultations between RMP to RMP. The guidelines also should govern breach of privacy and confidentiality by the patient. Health insurance cover for teleconsultation should be defined under the guidelines in future amendments. There should be a provision to prevent multiple dispensing of medications from a single electronic prescription i.e., the guidelines should conform to Drugs and Cosmetics Act, 1940 and Pharmacy Act, 1948 (12). Telepsychiatry operational guidelines are an effort to adapt telemedicine practice guidelines for telepsychiatry and this has been accomplished fairly with minor deficits. Further, there should be a rationale revision of drug lists.

Video link: https://youtu.be/wkxJmXjjDcg

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Chapter 9

Medical Negligence and Consumer Protection Act, 2019

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Highlights

- Medical negligence is the breach of a legal duty to care towards patients. Patients possess right to initiate action against it
- Doctor-patient relationship is 'contractual' and any medical service where a patient is charged fee can be dealt under the new Consumer Protection Act (CPA), 2019
- Telemedicine services also fall under the ambit of CPA 2019

Introduction

THE RELATIONSHIP between doctors and their patients forms the cornerstone of healthcare. This relationship has been conceptualized in various philosophical and sociological forms for several centuries (1). This relationship has also tremendously swayed between idealization and devaluation of doctors. In **the *Indian Medical Association v. V P Shantha*** *case,* the Honorable Supreme Court held that medical services would be treated as services under the Consumer Protection Act (CPA) 1986. This landmark decision embarked on the doctor-patient relationship as 'contractual' (2,3)

Negligence is defined as conduct that falls below the standard established by law for the protection of others against unreasonable risk of harm (4). The standard is that of a reasonable professional under similar circumstances. There are reports which state that only 15% of medical negligence cases are genuine, however more systematic studies are required (5). Violence against doctors has made newspaper headlines several times in the last decade (6). This has led to threats, insecurity, and fear of constant scrutiny in the lives of doctors. In this chapter, the authors have discussed the evolution of the concept of medical negligence, important components that are required to establish medical negligence, differences between civil and criminal negligence, and its implications in clinical practice. The relevance of CPA for medical professionals has been described with emphasis on the changes in the newer version of the act.

Evolution of medical negligence

Ancient legal framework

The Code of Hammurabi developed by Babylon's kings which is dated to about 1754 BC is the oldest known source that mentions medical negligence. It describes codes that fix the fees for treatment and liabilities for improper treatment. These include brutal forms of punishment such as cutting off the hands of the surgeon who caused the death of a man with severe wounds while operating on him. Thereafter several laws have been described such as the 'Law of Talion' which demands 'an eye for an eye, a tooth for a tooth', Egyptian and Roman civil law. In Indian literature, the 'Charaka Samhita'

and the 'Sushrutha Samhita' describe 'mithya' and 'mithyopachara' respectively, to describe the wrong treatment and improper conduct of the doctors towards their patients. The 'Manusmriti', 'Arthashashtram' and 'Yajnavalkya Smriti' describe the need to pay for the damages caused by physicians based on the severity of the injury caused to their patients (4).

Contemporary legal framework

The industrial revolution in England provided an impetus to the accelerated growth of the law of negligence. In 1838, CJ Tyndall while determining a medical negligence suit said, "every person who enters a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill" (7). Subsequently, the judgment of ***Bolam v Friern Hospital Management Committee*** (8) revolutionized the concept of medical negligence. In the year 1957, Mr. Bolam was undergoing unmodified Electro Convulsive Therapy (ECT) as a treatment for his mental illness. He sustained a fracture of the acetabula during the procedure of ECT. The claimant argued that the doctor was in breach of duty by not using a muscle relaxant during the procedure. There was a divided opinion amongst professionals as to whether a muscle relaxant should be given during ECT as the practice of both modified and unmodified ECT was prevalent during this period. The House of Lords formulated the following proposition, which is popularly known as the '**Bolam's test**'-"a medical professional is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art… putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view". This principle of Bolam's test was recognized in India by the Supreme Court's landmark judgment ***Laxman Balkrishna Joshi v Trimbak Bapu Godbole*** (9) in 1968.

Another landmark decision in 1996 is an English tort law, the ***Bolitho vs City and Hackney Health Authority*** (10). In this case, a two-year-old boy named Patrick Bolitho was suffering from croup and was admitted to St. Bartholomew's Hospital. Patrick had two episodes of dyspnoea associated with pallor which had recovered spontaneously. The same was informed to his doctor who did not attend to the patient. Minutes after the second episode of dyspnoea patient suffered from a cardiac arrest and suffered severe brain damage and later died. Patrick's mother sued the local health authority and argued that he could have been saved if he was intubated. The health authority admitted that there was a breach in the duty of care as the doctor did not come to see the patient. The treating doctor argued that even if she had attended the patient during the episode, she would not have intubated him and that such a decision would have been consistent with a respectable body of professional opinion hence the breach of duty did not cause the death of the patient. If the Bolam law is applied here, the doctor would not have been held negligent as a body of doctors held that they would not have intubated the child for the given history and course of illness. However, the court did not follow this course of reasoning. It held the doctor liable because she did not attend to the patient at a relevant time point. The doctor needs to bring a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Therefore, Bolam's test still stands, except when "a judge can be satisfied that the body of expert opinion cannot be logically supported at all".

Assessment of negligence

The following components form the crux of the assessment of medical negligence:

(a) A duty of care, (b) Breach of duty, and (c) The injury should have occurred as a consequence of the breach of duty, and (d) Damages (11). These are discussed below.

a) Duty of care: A doctor has a right to choose his patient. He can either accept to treat the patient or may decline to treat him. This is known as 'professional privilege'. If the doctor accepts to treat the patient, a doctor-patient relationship is established and during the subsistence of the relationship, the doctor owes a 'duty of care' towards the patient. Also, when a doctor is employed by an agency or institute, he loses his right of choice if the employer agrees to treat the patient. An exception to the 'professional privilege' is during a medical emergency where a doctor would owe a duty of care towards the patient by default and does not get to choose the patient. The doctor has an ethical obligation to treat a patient in an emergency since he is bound by the Hippocratic Oath. In the Indian setting, doctors are also legally bound to render emergency services as per the Indian Medical Council's Professional Conduct, Etiquette and Ethical Regulation, 2002 (12) and the landmark judgment of the Supreme Court in ***Paramanand Katara v Union of India & Others (1989)*** (13). In this case, the petitioner filed an application under Article 32 of the Constitution of India. The victim succumbed to the injuries incurred during a road traffic accident and was reportedly taken to a hospital by a Samaritan. However, the hospital authorities informed him that the patient should be taken to another hospital that was authorized to manage medico-legal cases. The patient died before he reached the designated hospital. After this case, preservation of human life was given the highest importance and every doctor irrespective of whether he is employed by the Government or otherwise has been given a professional obligation to extend services during a medical emergency.

b) Breach in the duty of care: In the ***Laxman Balkrishna Joshi v Trimbak Bapu Godbole (1968)*** (9), the Supreme Court laid the 'expected standard' of care for doctors as "…the practitioner must bring to the task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor very low degree of care and competency..." In this case, a young boy succumbed to a fracture of the femur. It was held that the reduction of the fracture was under the effect of morphine and no general anaesthesia was used. This treatment resulted in fat embolism, which was the proximate cause of the death of the boy. The Breach of duty might be an act of omission or commission that prevents a doctor from providing an expected standard of care.

c) A direct link between the breach of duty and injury to the patient: There has to be a causal relationship between the nature of the breach of the duty and the damage caused to the patient as described in the ***Laxman Balkrishna Joshi v Trimbak Bapu Godbole (1968)*** (9) case. Also, the damage or harm caused to the patient should not be either remote or unforeseeable.

d) Damages: While injury refers to the actual physical harm incurred due to a breach in the duty of care, 'damages' refer to a broader construct. Damages account for the various financial and emotional aspects of the injury. For example, if a patient has missed work due to the injury, has required frequent trips to the hospital, emotional distress secondary to the injury, cost of accommodation and travel, etc. can all be accounted as damages and financial compensation may be sought for the same (11).

Criminal Negligence

a) Defining criminal negligence: The principle of negligence as described in the assessment of negligence section remains the same for both civil and criminal suits. However, in a criminal suit, the

degree of negligence has to be gross or of a very high degree or amounting to "recklessness". Therefore, if the 'grossness' of negligence is high, then it would fall under criminal negligence, otherwise, it would be negligence actionable in tort or civil cases. The prosecutor has to prove that the defendant is negligent beyond a reasonable doubt (4).

b) Judicial stand on criminal negligence: The criminal liability of doctors revolves around some landmark judgments of the Supreme Court which have been discussed in this section. The first case being ***Dr. Suresh Gupta v NCT of Delhi (2004)*** (14)**.** In this case, the patient died while being operated upon for a nasal deformity, by a team comprising of a surgeon and an anesthetist. It was contended that the doctors failed to insert a cuffed endotracheal tube of the correct size to prevent the aspiration of blood during the surgery, which ultimately caused the death. The trial magistrate booked the doctors under S.304-A of the Indian Penal Code (IPC). When the case went to the Supreme Court, the orders of the lower courts were quashed; the doctor was exonerated of any criminal liability and was only subjected to liability to compensate under the law of torts. The Supreme Court stated that unless there is a higher degree of morally blameworthy conduct and gross negligence on the part of the doctor, it is not proper to impose criminal liability upon the doctor. It was also observed that the act complained against the doctor must show negligence or rashness of such a high degree as to indicate a mental state, which can be described as apathetic towards the patient.

In the following year, another judgment, ***Jacob Mathew v State of Punjab & Another (2005)*** (15), brought several reformations in the manner in which cases of negligence are handled at the ground level. In this case, a terminally ill patient died during his treatment. It was contended by his son that his father's death occurred due to the carelessness of doctors in general and non-availability of an oxygen cylinder and that an empty cylinder was fixed to his father's mouth due to which he died. The lower court had charged the doctor under S.304-A of IPC. The Supreme Court held that negligence is an essential ingredient of the offense. The negligence has to be established by the prosecution and must be culpable or gross and not the negligence merely based upon the error of judgment. It was also acknowledged that the investigating officers or the judicial Magistrates do not have sufficient knowledge of medical science, to determine whether the act of the accused doctor amounts to rash/ gross negligence that falls in the purview of a criminal suit. The impact on the reputation of the doctors was also acknowledged and the following guidelines were framed for arresting doctors in case of a criminal suit:

i. In case there is an allegation of criminal negligence, the complainant should produce prima facie evidence of negligence
ii. The Investigating Officer should obtain an independent and competent medical opinion on the available facts
iii. The routine arrest of a doctor is not encouraged and should be considered as a last resort.

In ***Kusum Sharma & Ors vs Batra Hospital and Medical Research Centre and Others (2010)*** (16)**,** a young man suffering from abdominal pain was operated on for an adrenal tumor which was visualized on ultrasonography by a doctor. The patient develops several complications after the surgery and thereafter is taken to several other hospitals after which he dies. His wife presses charges of criminal negligence against the index hospital where the patient was treated. The Supreme Court this time gave clear guidelines about how the charges of medical negligence should be considered. These are summarized as follow:

i. Breach of duty exercised either as omission or commission of something which is not expected from a reasonable man

ii. Liable only when conduct falls below that of the standards of a reasonably competent doctor

iii. A doctor is expected to bring a reasonable degree of skill and knowledge, nor the highest or the lowest

iv. Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable skill and competence

v. In the realm of diagnosis and treatment, there is a scope for genuine difference of opinion

vi. Negligence to be established by the prosecution must be culpable or gross and not merely an error of judgment.

c) Punishment for criminal negligence under Indian Penal Code (IPC): Section 304-A of the IPC reads "whoever causes death of any person by doing rash or negligent act not amounting to culpable homicide, shall be punished with imprisonment of either description for a term which may extend two years, or with fine, or with both".

Civil Negligence

a) Defining civil negligence: Any medical negligence that is not criminal negligence would come under the ambit of civil negligence. It has to be proved by a preponderance of the evidence. Therefore, it is proven by a balance of probabilities where the judge or jury decides whether it is more than likely that the party committed the offense that caused the injury.

b) Judicial stand on civil negligence: The civil liability of doctors has been discussed in this section with some important judgments. The judgment of ***Dr. Balram Prasad vs. Kunal Saha & Ors.*** (17), was passed in 2013. In this case, the court held three doctors and the AMRI hospital in Kolkata culpable of civil liability for medical negligence which led to the death of Anuradha, a child psychologist, and wife of claimant Dr. Kunal Saha. In 1998, she suffered from skin rashes and in the process of treatment was administered steroids. She subsequently suffered from Toxic Epidermal Necrolysis as an adverse reaction to the treatment. While she was battling with the complications of treatment and required critical intervention, her doctor was unavailable. She ultimately succumbed to her illness in the same year. Both criminal and civil liability charges were pressed against the doctors and the hospital. The criminal negligence charges were absolved by the Supreme Court in 2009. However, the civil charges were proved to be valid and the claimant received compensation of 5.96 crores and additionally a 6% interest on this amount for 15 years (1998 to 2013). The compensation was calculated using the multiplier method. This judgment has provided the highest monetary compensation in India to date.

In ***Samira Kohli vs Dr. Prabha Manchanda & Anr (2008)*** (18) judgment, the Supreme Court has elaborated on various aspects of obtaining consent. This judgment was linked to a case in which hysterectomy with bilateral salpingo-oophorectomy was performed as a further treatment while informed consent from the patient was obtained only for diagnostic laparoscopy. The informed consent for hysterectomy was obtained from the patient's mother during the procedure of laparoscopy as a hysterectomy was deemed necessary by the doctor on medical grounds and as the patient was under the influence of general anesthesia. The Supreme Court held that while the surgery

was of benefit to the patient as it was saving time, suffering, pain, and expenses, this was no ground for defense for not taking consent from the patient. Hence, the appellant received compensation for the same. The court also gave additional details regarding consent and information disclosure.

c) Contributory negligence: Contributory negligence is when the patient contributed to the harm incurred, by his act or omission or commission. This may reduce the liability and damages sentenced to the medical professional. The compensation may be reduced to such an extent as the court thinks just and equitable, having proportionate regard to the patient's degree of responsibility for the injury. Importantly, it does not come into play in criminal negligence cases. In ***Rohini Devi vs H.S Chudawat and Another (2001)*** (19), failure to ensure follow-up treatment was held to be contributory negligence and hence the appellant was not entitled to any compensation in this case.

The Consumer Protection Act vis-à-vis the medical profession

The Consumer Protection Act (CPA) in India was passed in 1986 with the rationale of promoting and protecting the rights of the consumers. Whether medical services came under the ambit of CPA was not clear, hence a writ petition was filed in the Supreme Court under Article 32 of the Constitution of India. In this judgment, ***Indian Medical Association v. V P Shantha*** (2), it was held that medical services would be treated as services under CPA 1986. This judgment has been the law of the land thereafter. On 20th July 2020, the CPA 2019 was made effective. The definition of services under section 2(42) of CPA 2019 is "inclusive" and categorically excludes only two types of services i.e., those which are free and those which are "personal". However, "free" services provided by a hospital or doctor would still fall under the ambit of the CPA if other patients pay for the same service (20). Regarding personal services, one needs to differentiate between the "contract for personal services" and the "contract of personal services". The former deals with a contract where the provision of service depends on one's skill, knowledge, and discretion (ex: doctor-patient relationship) while the latter deals with the provision of services that involves obeying orders to perform an assigned job (ex: Chauffer-master relationship). Interestingly, the "contract of personal services" does not come under the ambit of the CPA 2019 (3). If compensation is sought through CPA, it would be through the Consumer Dispute Redressal Agencies. However, if the service does not come under the CPA, compensation can still be sought in civil or criminal courts.

Changes in the New Consumer Protection Act, 2019

Table 9.1 provides a comprehensive summary of the important changes in the CPA 2019. The CPA 2019 is more comprehensive compared to its precursor. There has been an introduction of regulatory bodies such as the Central Consumer Protection Authority (CCPA), e-commerce and telemarketing, provisions of an unfair contract, product liability, mediation, regulations on advertisements, and video-conferencing for hearings. There are several changes in pecuniary jurisdiction and court fees. The introduction of e-commerce appears to be a glaring advancement and perhaps acted as an impetus for the CPA 2019. Telemedicine services also come under the ambit of CPA 2019. Further, all doctors are mandated to provide a receipt or a bill for the payment obtained for their services (consultation). This is required for both the in-person and telemedicine consultation. If it is not provided, it shall be deemed to be an unfair trade practice.

Table 9.1: Comparison of the CPA 1986 with CPA 2020

S. No	Areas	CPA, 1986	CPA, 2019
1	Objectives	Better protection of the interests of consumers Establishment of consumer councils for the settlement of disputes	Protection of the interests of the consumers Establish authorities for timely and effective administration
2	Number of Chapters	4	8
3	Number of Sections	31	107
4	Change in nomenclature	District Forum	District commission
5	Regulator	No separate regulator	Central Consumer Protection Authority
6	Relevant newer inclusions	Not applicable	E-commerce, telemarketing, Unfair contract, product liability, pecuniary jurisdiction, mediation, endorsement of goods, misleading advertisements, offense, and penalties
7	Complainant	As defined	The extended definition includes: In the case of a minor, his parent or legal guardian
8	Deficiency	As defined	The extended definition includes: Deliberate withholding of relevant information by the service provider
9	Unfair contract	Not defined	Includes: imposing on the consumer any unreasonable charge, obligation, or condition which puts such consumer at a disadvantage
10	Product liability	No provision in the consumer court	Compensation available for product liability
11	Consumer rights	As defined	Addition of rights: protection, informed, assured, be heard, redressal, and consumer awareness
12	The limitation period for filing a complaint	2 years	2 years with a provision for condonation
13	Filing jurisdiction	Place where the seller's office is located	Additional provision: complaint can be filed where the complainant resides or works
14	Electronic filing	Not available	Available
15	Pecuniary jurisdiction	Based on the value of the compensation claimed District Forum: up to 20 lakhs State Commission: 20 lakhs to 1 crore National Commission: above 1 crore	Based on the value of the goods or services paid as consideration District Commission: up to 1 crore State Commission: 1 crore to 10 crores National Commission: above 10 crores
16	Appeal deposit	50% of the amount or 25,000 rupees, whichever is less	50% of the amount ordered by the district commission before filing an appeal before the state commission
17	Court fees	As defined	No fees for consideration of <5 lakh rupees; For amount >5 lakh: 200 to 2000 rupees in District Commission 2,500 to 6000 rupees in State Commission 7,500 rupees in National Commission
18	Mediation	Not available	Provision for settlement and partial settlement through mediation is available. One can't appeal against the settlement done through mediation.
19	Non-compliance with an order of the commission	Punishable with imprisonment for a term which shall not be less than one month, but which may extend to three years and/or with fine which shall not be less than two thousand rupees, but which may extend to ten thousand rupees	The imprisonment term is the same but the fine has been increased, which shall not be less than twenty-five thousand rupees and may extend to one lakh rupees, or with both
20	Bench	Circuit bench	Regional benches to be appointed by the Central Government by notification
21	Experts to assist NC or SC	No provision	On application by a complainant or otherwise, may direct any individual or organization or expert to assist the National Commission or the State Commission
22	Dismissal of Frivolous or vexatious complaints	The complainant shall pay cost not exceeding rupees ten thousand	No provision
23	Video conferencing	No provision	Consumers can seek tele-hearings

Litigation and compensation under the CPA, 2019

India has witnessed an alarming increase in medical litigations after the *Indian Medical Association v. V P Shantha* case judgment was passed (21, 22). This could be implicated to factors like increased consumer awareness, the flexibility of consumer forum, the cost involved in medical care, litigant mind-set of the population, commercialization of treatment, deteriorating doctor-patient relationship,

less consultation time due to huge burden and limited resources. Some of the newer provisions for litigation and their processes under CPA 2019 have been enumerated:

A. **Grounds for litigation**: (a) failure to issue a receipt or bill to the patient (b) failure to take an informed consent comes in the ambit of unfair trade practice (c) failure to maintain confidentiality (d) false endorsement of services or any misleading advertisement and (e) product service liability and "deficiency" in services which encompasses "any act of negligence or omission or commission by such person which causes loss or injury to the consumer and deliberate withholding of relevant information by such person to the consumer".

B. **Process of litigation**: (a) there is no requirement of the fee for filing litigation for services (considerate) up to 5 lakhs, (b) for filing litigation for services that cost more than five lakh rupees, a nominal fee needs to be paid which has been summarized in table 1, (c) availability of electronic filing of complaints, (d) availability of tele-hearings, and (e) changes in the pecuniary jurisdiction reducing logistic issues in filing complaints which have been discussed earlier.

Under the CPA, 2019, the liability for manufacturing defects could be diverted to the product manufacturers and sellers. For example, if a doctor placed an ear implant that broke inside the ear after the operation due to its manufacturing defect, then the product manufacturers would be held responsible for the mishap and not the doctor. There is a likelihood that the new provisions could propagate an increase in the number of frivolous litigations against doctors due to the simplification of procedures, newer identified grounds for litigation, and lack of any retribution for filing false complaints, and the paperwork of doctors may increase substantially.

Computing compensation

The principle of computing compensation under common law is called “restitutio in integrum”, which refers to ensuring that the complainant is in the position that he would have been had the wrong not been committed (23). However, the method of calculating compensation is unpredictable and varies significantly between cases in the absence of a standard method of calculation. The multiplier method was created to facilitate compensation in relation to the motor vehicle accidents via a “no-fault” liability system (17). This method accounts for the loss of income of the victim only. It is calculated by multiplying the victim’s salary minus his expenditures (savings) with the total number of years that the victim would have earned his salary. The usual formula utilized to calculate compensation is [(70-age) x annual income + 30% for inflation -1/3 for expenses) (24). There are several drawbacks of using a multiplier method especially for the ones who are unemployed like children, senior citizens, homemakers etc. The Supreme Court has therefore added additional dimensions for computing compensation like medical costs incurred compensation towards physical and mental agony, and compensation towards loss of consortium and cost of litigation. Large pay-outs awarded by courts might be prudent to ensure accountability, deter medical negligence, unethical practice. However, non-availability of resources could compromise the care of the patients. The high rates of compensation may lead to the propagation of defensive practices, higher charges on consultation, impairment of the mental health of doctors due to a constant fear of scrutiny, bankruptcy, and more time spent in legal proceedings compromising patient care. Doctors could migrate to areas with better resources which could compromise care in the rural areas of the country.

Reducing the potential liabilities: Importance of adhering to standard guidelines

In 2015, the Supreme Court ordered the state of Tamil Nadu to pay a compensation of 1.3 crores in the judgment of ***Krishnakumar vs State of Tamil Nadu & Ors.*** (25) The claimants had alleged that the doctors failed to perform a mandatory screening for retinopathy of prematurity (ROP) for the victim who was born after 29 weeks of the gestation period (preterm birth) and also that the family was not informed about this condition or advised any need for the medical review in future. In another similar case in 2019, ***Maharaja Agrasen Hospital vs Master Rishabh Sharma*** (26), the child was not screened for ROP and is currently suffering from irreversible blindness and was awarded a compensation of 72 lakhs. These two cases emphasize the importance of following clinical practice guidelines in routine clinical practice. As discussed earlier, telemedicine also comes under the ambit of CPA 2019. The practice of telemedicine is increasing due to various factors like advancement in technology, awareness, affordability, acceptability, convenience, and the requirement due to the COVID-19 pandemic. The guidelines for telemedicine are laid and one would have to adhere to these to ensure a safe and transparent practice (27).

Cancellation of licence

Medical professionals have to adhere to standard requirements related to clinical practice which include having a valid registration, licence, following the professional conduct, etiquette and ethics as per the guidelines provided by the Medical Council of India (1933-2020) which has been succeeded by the National Medical Commission (NMC) in September 2020 (12). NMC is the regulatory body for doctors and has the power to cancel their license to practice in case of violation of the stated rules and regulations as per the Indian Medical Council Regulations, 2002 and the National Medical Commission Act, 2019 (28,29). Resorting to medical malpractice like false endorsements, boundary violation, issuing false certificates, accepting bribes etc., can attract litigation in civil, consumer and criminal courts and also an enquiry by the NMC.

Conclusion

The introduction of several novel provisions, changes in the existing provisions, and simplification of the procedures in the CPA 2019 will all act synergistically in protecting consumer rights in India. As the brunt of compensation is most of the time borne by doctors, it might be important that all doctors have indemnity insurance as more than 80% of healthcare in India is dispensed by the private sectors (24). There should be a uniform and predictable method of calculating compensation or a no-fault liability system geared up having upper limits or 'caps' to the compensation amount. Also, non-availability of resources could compromise the care of the patients hence the State is also responsible for lapses or deficiency in care and it is hard to implement a first-world regulatory structure to a third-world. Busy clinical practice might lead to an error of judgment and it should be taken into consideration during the trial. A policy change is desirable to reduce the number of working hours to unburden the doctors. The number of cases in the district forum is likely to increase considerably due to the changes in the pecuniary jurisdiction. It would be essential to have mechanisms for timely dispensation of cases to prevent violence against doctors. This would require an increase in the resources, especially at the district level. For the lack of any inherent retribution for filing false complaints, the number of frivolous cases might increase, therefore mechanisms like fining false complaints should be rolled in and if the doctors are not found guilty, loss of pay should be granted

to them. As the resolution of litigations requires expertise, it is recommended that doctors should be a part of the bench of various commissions and mediation cells. Another interesting area is the legalization of cross-system practices in our country. In an attempt to reduce the treatment gap and to increase the provision of health to all, the government has taken steps towards the legalization of the cross-system practice (30). Several ethical and legal issues arise on how the doctors will be tried in the court of law in case of a negligence suit in this regard. Will an AYUSH doctor be expected to have the same reasonable standard of care while prescribing allopathy treatment as an MBBS doctor? Or would it be better if the government made efforts to make all the systems of medicine accessible to the public and best leave it to them to decide their preference to a particular system, thereby abolishing cross-system practices? (30)

Video link: https://youtu.be/jT84-8dSYjc

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Chapter 10

Civil Responsibilities

Noorul Hasan, Vinay Basavaraju

Highlights

- Legislations for patients with physical and mental health challenges have upheld their civil and fundamental rights.
- However, safeguarding rights of patients endorsed by Indian constitution and laws is a psychiatrist's responsibility
- It is not just limited to the rights of persons with mental illness enumerated in MHCA 2017; it spreads to a wide range of civilian roles assigned to any person such as marriage, divorce, making a contract, dealing property matters, adoption, testamentary capacity, etc

Introduction

IF MENTAL HEALTH is a gift, then social health is the elixir for this community. Social health lies in building one's character, developing interpersonal relationships and forming a salubrious surrounding. A healthy (socially) person understands the circumstances and acts accordingly.

Every nation wants its citizens to be socially fit. Civil responsibilities roughly mean the active participation of the individual in the public life for the welfare of the individual or community. Hence, citizenship is bestowed with civil responsibilities. Medical Jurisprudence and Forensic sciences speak briefly about civil responsibilities. It mainly focuses on the rights and duties of a doctor towards his patient and vice-versa.

As per the Indian legislations, a person with unsound mind is incapable of distinguishing his actions whether right or wrong, cannot write a valid will, cannot enter into a contract, cannot stand or vote in elections, cannot adopt or give a child in adoption, and cannot give his organ for transplantation to others. Hence, the law protects these civil rights of the mentally ill, so it is the responsibility of psychiatrist to safeguard those rights by endorsing the civil laws. (1).

Interface between mental health and law exists in the following domains (see figure 10.1)

1. Issues relating to the curtailment of liberty during admission and treatment
2. Civil Responsibility
3. Criminal responsibility

What is Civil law?

Law can be broadly classified into 'Criminal' & 'Civil Law'. Civil law, as opposed to criminal law, comprises *contract law* and *tort law*, and has evolved to settle disputes (see table 10.1). The object of a civil action is to correct the wrongdoing that has been committed and the state is responsible for providing the procedure to resolve the dispute.

There are four general areas of civil law in which psychiatrists traditionally have been called for evaluation and consultation: (2)

1) Family and domestic relations problems - divorce proceedings, often specifically with regard to child custody and visitation; annulment proceedings; procedures to obtain abortion; or for evaluation of family problems prior to legal action, with the intent of avoiding family disruption.
2) Competency determination, guardianship proceedings; contracts; probate.
3) Commitment proceedings.
4) Actions in tort accident cases involving traumatic precipitation of mental illness; workmen's compensation cases; cases of malpractice and negligence.

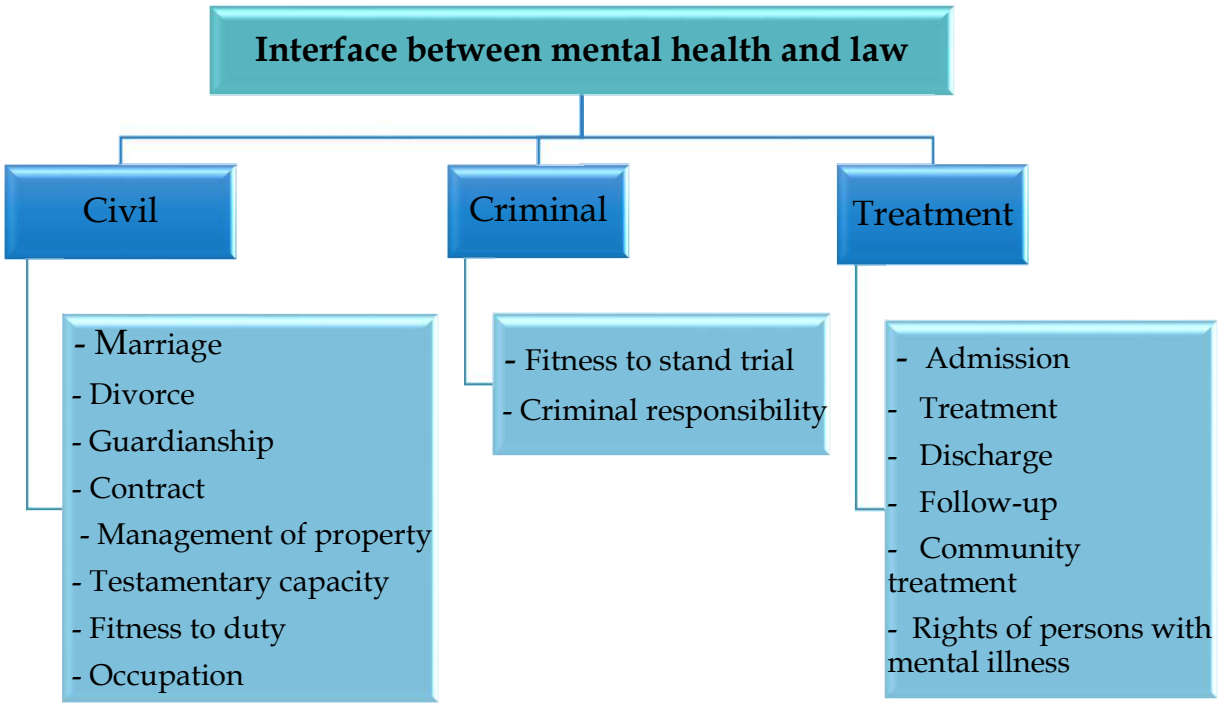

Figure 10.1: Circumstances where patient's rights require psychiatrist's attention

Following are some of the civil laws pertaining to mental health (1) :

1. Marriage and mental health legislations. Various laws related to marriage and divorce existing in India and family court Act 1984
2. The Evidence Act, 1925 :- section 118
3. Indian Contract Act,1872 :- section 6, 11, and 12
4. Right to vote and stand for election :- Art 326,102 of the constitution of India
5. Testamentary capacity - Indian Succession Act 1925, section 59.

Insanity and feigned insanity

Pertaining to legal issues related to marriage, divorce, contract, making of a will etc., it is the responsibility of the psychiatrist to prove the insanity of the person concerned. Hence it is important to understand the difference between the Insanity and Feigned insanity. **Feigned insanity** is defined as the simulation of **mental illness** in order to deceive.

Amongst other purposes, **insanity** is **feigned** in order to avoid or lessen the consequences of a confrontation or conviction for an alleged crime. Table 10.2 has important pointers to differentiate insanity from feigned insanity **(Rosner R.., 1990)** (3) .

Table 10.1: Differences between Civil Law and Criminal Law

Dimension	Civil law	Criminal law
Definition	Deals with the disputes between individuals, organizations, or between the two, in which compensation is awarded to the victim.	Is the body of law that deals with crime and the legal punishment of criminal offenses.
Purpose	To deal with the disputes between individuals, organizations, or between the two, in which compensation is awarded to the victim.	To maintain the stability of the state and society by punishing offenders and deterring them and others from offending.
Case filed by	Private party	Government
Standard of proof	"Preponderance of evidence." Claimant must produce evidence beyond the balance of probabilities.	"Beyond a reasonable doubt":
Burden of proof	Claimant must give proof however; the burden may shift to the defendant in situations of Res Ipsa Loquitur (The thing speaks for itself).	"Innocent until proven guilty": The prosecution must prove defendant guilty.
Type of punishment	Compensation (usually financial) for injuries or damages, or an injunction in nuisance.	A guilty defendant is subject to Custodial (imprisonment) or Non-custodial punishment (fines or community service).

Marriage (under the Hindu marriage act, 1955)

Family is a fundamental institution entitled for procreation. This institution begins with socially recognized marriage. It is a right of men and women of marriageable age to get into the marriage. Marriage is a constitutional right that exists only if both the parties have consented over it, given that they are above 18 years of age (Sec (iii)21 years for bridegroom and 18 years for bride).

Marriage exists only if both the parties have given consent to enter into it (Sec-5(ii) (a,b,c)). Consent given can be legally acceptable when the parties involved are sane and fully aware of the particulars in it (Sec-5(ii) (a, b, c)). Marriage is not merely a means of satisfying of biological needs

but the initiative of procreation, parenting and much more. Soundness of mind is one of the pedestals of marriage.

A marriage between two parties, either of them suffering from mental illness and unable to understand and give consent for the marriage is considered void. Divorce can only be applied if mental illness is considered to be incurable in spite of adequate treatment and illness is more than three years continuously but the other party has to pay for the maintenance of the mentally ill person.

Table 10.2: Differences between Real Insanity and Feigned Insanity

Factors	Real Insanity	Feigned Insanity
Onset	Usually Gradual	Dramatic/Sudden
Motive	Absent e.g., no criminal record	Present e.g., commission of crime
Predisposition	Usually present e.g., history of insanity or stressful factors such as sudden financial loss, grief etc.	Absent
Symptoms and signs	Uniform and present whether the patient is being observed or not.	Present only when conscious of being observed, variable and always exaggerated and do not resemble any particular mental disease.
Facial expression	Peculiar e.g., vacant look.	No peculiarity, frequently changing, exaggerated and voluntary.
Insomnia	Persistently Present	Does not persist
Biological function	Patient can withstand exertion of hunger, fatigue and sleep for several days.	Cannot withstand and usually breaks down.
Social functioning	Persistently decline	Episodic
General Appearance and Behavior	Poor personal hygiene. Dirty, filthy, (Signs of self-neglect)	Personal hygiene is well preserved. Not dirty and filthy
Frequent Examination	Does not mind	Resents for fear of detection

Muslim marriage act differs from Hindu marriage act in the following:

- Since 7th century AD (From the time of Mohammedian Prophecy)
- Age for marriage (Puberty)
- Polygamy accepted (A Muslim male can marry up to 4 wives if the groom is able to maintain the justice between the wives and if not having one wife is better practice for a Muslim).
- 'Mahr or Dower' (It is mandatory for the groom to gift the bride, it can be gold, money etc.,)
- It is a civil contract
- No concept of Sapinda relationship
- Registration under the Mohalla Masjidh (Sir-khazi)

- Ceremony not compulsory
- Marriage with non-muslim possible (marriage valid)
- 'Iddat' is mandated after divorce or death of husband for a period of 4 months and 10 days, in this period Islam prohibits re-marriage of the bride.
- Female has inheritance of rights in property (of husband & of father)

As per the Hindu marriage act 1955, the special marriage act 1954 and the Indian divorce act for Christian consider unsoundness of mind is a condition affecting the capacity to marry. In the Parsi marriage and divorce act unsoundness of mind is not a ground for divorce. Muslim law also considers unsoundness of mind before marriage is a criterion for nullity of the marriage, though the differences exists pertaining to duration of insanity (1)

Divorce

Divorce is the dissolution of marriage. Parties in marriage can be legally disassociated by petitioning together to a district court. Among various grounds, insanity is a fundament for dissolution of marriage. According to Hindu Marriage Act, Parsi marriage Act, and Christian marriage Act, respondent has been incurably of unsound mind or has been suffering continuous or intermittently from mental disorder of such a kind and to such an extent that the petitioner cannot reasonably expected to live with him. As per the Muslim marriage Act, Muslim women can seek divorce on the ground that her husband has been insane for a period of 2 years.

Indian divorce act (for Christians) – unsoundness of mind is a ground for divorce on two conditions:

- It must be incurable
- It must be at least for 2 years immediately before filing the petition

Case law: Gurnam Singh v. Chad Kaur (1)

In this case, the court held that a diagnosis of schizophrenia only established the existence of a mental disorder. For a decree of nullity, it was essential to prove that the ailment rendered the respondent incapable of marriage and the procreation of children. The respondent was an educated individual who had given birth to a daughter. In the face of this fact, though the existence of mental disorder was established, the court refused to nullify the marriage because incapacity consequent to the disorder was not proved.

Contract

A contract is an agreement between two parties that is enforceable by law. Every person who is able to understand and arrive at a rational judgement is considered to be sane and eligible for entering into a contract. If one of the parties to a contract is insane and the other party is unaware of the fact, then such a contract is valid. Insanity that develops during the course of a contract doesn't make it invalid unless the obligation to be met is hindered.

Case law: Inder Singh Vs Parameshwardhari Singh

"A", a son got a piece of land according to the will of his deceased father. He made a contract with a land owner to sell it for Rs. 7000 and got advance of Rs. 700. The wife of the deceased (mother of the

transferor) argued that the property is worth Rs. 25000 and her son is a lunatic. The court declared the contract void on the ground. The landowner went for an appeal. The appellant argued that his mother is a stranger to the contract and claimed Privity of contract. But Justice Sinha held that "A" was incapable of understanding the particulars of the contract during the time of agreement. The court held that Contract with an unsound person is void.

Transfer of Property

Transfer of property deals with the change of Ownership of immovable property. The owner of the property is the only person responsible for managing the affairs of his property and transferring them.

Sanity plays a key role in determining the capacity to transfer the property of the owner. If the transferor is of unsound mind, then the court would confirm the insane nature by appointing a psychiatrist for inquisition. The psychiatrist should certify that the transferor is insane to such a degree that he is incapable of managing his property and its affairs.

Case law: Meenu Seth Vs Binu Seth

Appellant was the wife of Binu Seth, filing for appointment of a guardian for the property of her husband who is alleged to be mentally retarded. The trial court made an inquisition and the medical reports depict that Binu Seth is not mentally retarded to have guardian for his property. His mother and brother went for an appeal and the higher court quashed the order. The court enquired the medical records of Binu Seth and appointed for a medical inquisition done by Institute of Human Behaviour and Allied Sciences.

Testamentary capacity

One would like to ensure that his property goes to the genuine recipients who could utilize it in a proper way after his demise by making a valid will (4). A Will is an important document which enables the individual/living person to rightfully leave his assets to whoever he chooses to, after his death. It is a legal declaration of a person's intention which he desires to be performed after his death.

After the death of a person, his property devolves in two ways: (i) According to the respective laws of the land when no Will is made – i.e., intestate (ii) By way of Will – i.e., testamentary. Testamentary capacity is the status of being capable of executing a valid will.

Doctors at sometimes, is called upon to witness the execution of the will. **Duty of the doctor** is to check the person's Orientation, concentration, memory, nature of the will, reasoning power, extent and value of his property, manner of distribution, and reason for distributing and with adequate reality reason to be tested in the absence of all attendants, provided he/she should not be under intoxication of any substances. Finally, to check whether any pressure or influence has been brought on him by anyone.

Important elements in Testamentary Capacity

- It is a voluntary act on the part of the testator
- Testator should have a sound disposing mind
- Testator should know what he is doing by making a will

- Testator should have the capacity to know the extent of his/her property
- Testator should be aware of the potential beneficiaries
- Testator should be aware of the consequence of his/her decision
- Testator should be free from undue influence/fraud/coercion
- Testator must know the contents of will

As per the Indian Succession act, the following persons cannot make a Will: -

- **Lunatic, insane persons**
- Minor i.e., below 18 years of age.
- Corporate bodies by their very nature are incapable of making a Will, though they may benefit under the Will of an individual partner.

Other group of disabled persons, who can make a Will area as follows,

- Persons who are deaf or dumb or blind are not thereby, incapable in making a Will, unless they are of sound mind
- Persons, who are ordinarily insane, may make a Will during an interval while they are of sound mind.
- Person affected by delusion disorder can make a valid will if the delusion (psychopathology) is not related in any way to the disposal of the property.

Note: A **codicil** is also a testamentary document, but not necessarily identical to a will. In some jurisdictions, it acts as supplement to will and it may serve to amend, rather than replace, a previously executed will. In others, it may serve as an alternative to a will.

Adoption

Juvenile Justice Act, 2015 has many salient features, one among them is that it speaks crystal clear about *Adoption* (5). Chapter 8 of this act details about rulings, pertaining to eligibility, procedure, Inter-country adoptions, court procedures and adoption agencies. There are 3 important bodies related to this procedure: They are District courts, Central Adoption Resource Authority (CARA), Specialized Adoption Agencies (SAA) **

It has the following steps:

1. Prospective parents should apply in Specialized Adoption Agencies (SAA)
2. SAA will carry out the home study report within a specific period of time
3. Adoptee's home study and medical report will be referred to the prospective adoptive parents
4. After the acceptance by prospective adoptive parents SAA will apply for adoption order from court
5. After the clearance and order from the court, the prospective adoptive parents can follow up the child for adoption proper.

As per the act a single or divorced person can adopt a child, but a single male cannot adopt a female child.

** *For further reading kindly go through the chapter-7 on JJ Act 2015*

Torts law

Civil law, as opposed to criminal law, comprises contract law and tort law, and has evolved to settle disputes (6). Civil wrong (negligence) committed by one individual against another is known as TORT, where, a person fails to take proper care and hence it resulted in damage.

This law seeks to resolve disputes over attribution of blame and responsibility for harm. For example, in a psychiatry perspective, emotional distress caused in an individual following an intentional or negligent civil act will be dealt not under the criminal law but by the Torts law.

- A plaintiff must prove four essential elements to prevail in a tort suit based on negligence: ***duty, breach, cause, and harm.***
- In the context of malpractice claims, the duty element of the tort is normally established by showing the existence of a doctor–patient relationship
- Once the issues in the four elements proved, then it is mandatory to prove the temporal relation between the bad act and the projected consequences, otherwise compensation cannot be sought.

Courts have recently found that psychiatrists also owe duties to third parties in two contexts. When, for example, a psychiatrist recognizes, or reasonably should recognize, that a patient poses an imminent threat of serious harm to an identifiable third party, in many states it is one of the civil responsibilities of psychiatrist to protect that individual from injury. Failure to warn the intended victim or notify the police may be a breach of the duty (7). The breach in this brings about negligent tort if there is a lack of foreseeability, which warrants compensation**.**

Tort law is divided into Intentional and Unintentional tort, further the causation element is classified into two categories: cause in-fact and proximate cause (see Table 10.3).

Table 10.3: Difference between Intentional and Unintentional torts

Intentional Torts	Unintentional Torts
1. **Assault:** Threat or an attempt to do physical harm (Physical/Verbal) 2. **Battery:** Is an act that results in the harmful or offensive physical contact. 3. **False imprisonment:** Limiting of someone's freedom without the authority or right to do so. 4. **Invasion of privacy:** The act of going into someone's personal life or becoming involved in a situation where one is not permitted.	**Negligence:** A conduct that deviates from accepted standards of duty & care.

Guardianship

State has the authority to protect incompetent/disabled persons and preserve their property (***Parens patriae***) (7). Person to whom courts have given such power to manage the personal interests and property of an incompetent person on behalf is called as **Guardian.**

- Testamentary guardian, plenary guardian and special guardian are some of the types of guardians.
- Section 14 of Chapter II of the Rights of Persons with Disabilities Act (2016) speaks about Limited Guardianship which is a type of special guardian meant for taking legally binding decisions on behalf of people who are disabled or mentally ill.
- "Limited guardianship" means a system of joint decision which operates on mutual understanding and trust between the guardian and the person with disability, which shall be limited to a specific period and for specific decision and situation and shall operate in accordance to the will of the person with disability.
- Also, if they have recovered the ability to manage their affairs can apply to have competence restored or can appeal against the appointment of limited guardian as per RPWD Act 2016.

Right to Vote, Organ donation

Following are some of the salient areas where psychiatrists will assist the competent court in assessing the soundness of mind,

- Representation of People's Act, 1951 (Section 16) :

  This Act provides the procedural framework for elections in India and similarly disqualifies a person from being registered to vote if he or she is of "unsound mind", and is found to be so by a "competent court".

- Transplantation of Human Organs Act 1994 (Amendment 2014) :

  According to this act, a mentally ill person is incapable of giving a valid consent for organ transplantation unless there exists a valid consent given by the guardian.

Conclusion

The Constitution of India has protected her citizens by granting various civil and fundamental rights, irrespective of their gender, race, religion, class, soundness of mind, etc. However, those physically and mentally challenged people find it difficult to access and utilize their rights. Various legal provisions and enactments have paved way for the upliftment of physically and mentally challenged people (RPWD act, 2016. MHCA, 2017). These legislations secured their rights but those words get life in hands of medical professionals. The psychiatrist/medical professionals are responsible for endorsing those laws and are the champion of Insane / Disabled People's rights.

Video link: https://youtu.be/4bJz8qWFobM

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- Section 11, Indian Contract Act, 1872
- Section 12, Indian Contract Act, 1872
- Section 6, Indian Contract Act, 1872
- Article 23, International Covenant on Civil and Political Rights, 1960.

Chapter 11

Prison Mental Health

Manisha Murugesan, Dinakaran Damodharan, Shalini S Naik, Rajani Parthasarathy, Channaveerachari Naveen Kumar, Suresh Bada Math

Highlights

- Over 10 million people are held prisoners in various penal institutions at a given point of time, across the globe. The prevalence of mental illness is reported to be consistently high in this population.
- Some of the mental illnesses by its virtue are risk factor for committing a criminal violence. While, the factors associated with imprisonment might exacerbate or cause new onset of mental illness in others.
- The rates of psychosis have been reported to be 3.6% in males and 3.9% in female inmates across the globe, while the review of data in LMIC specifically points to higher rates up to 6.2%. Similarly, the rate of major depression ranges from 10.2% to 16%.
- Study and surveys on infrastructure of prisons reveal lesser utilization of resources, lack of adequate man power. In India, the medical and mental health needs of prisoners are largely unmet.
- Providing psychiatric service in correctional settings have unique set of challenges, ethical considerations and barriers about which knowledge is needed in order to provide optimum care.

Introduction

THE WORLD PRISON population list reports that more than 10.35 million people are held in penal institutions across the globe (1). The prevalence of mental illness and substance use disorders in prison population has been consistently reported to be disproportionately higher than the prevalence in the community, across the globe. The disorders include psychosis, substance use, personality disorders and major depression which in turn are risk factors for increased suicide rates (2). However, the assessment and management of psychiatric disorders in prisons remain low. There are multiple theories and reasons for higher prevalence of mental illness in prisoners. Mental illness among prisoners may be present before imprisonment or develop during imprisonment (see figure 11.1).

Criminality and Mental illness

Prisons have been a place of isolating violent and aggressive persons with mental illness, since their invention. **"Trans-institutionalism"** refers to institutionalizing mentally ill in prisons from hospitals and mental institutes to prisons, documented in several studies in the past (3). Also, a hypothesis regarding the increasing rates of mentally ill in prisons states that, with deinstitutionalization and inadequacy of community services for such people has led to increase in homelessness, unemployed

and untreated mentally ill persons in the community, thereby increasing the chances and rates of crime (4).

Association of mental illness with criminal behaviour have been reported for several of the psychiatric disorders. The link or level of convergence is not straightforward (5).

a Some mental disorders may have their core symptoms as behavioural manifestations which are criminally offense. For e.g.: paraphilias, kleptomania, pyromania and others.

b Certain disorders may connote a criminological offense, but some of the symptoms can be expressed without breaking the law. Hence causality of illness and crime is not a one-to-one relationship. For eg: substance use increases the risk for committing a crime under intoxication. In personality disorders like antisocial personality disorders have dimensions and behaviour which in themselves are not unlawful as other disorders listed above.

c Illnesses where the convergence is not straightforward include other disorders such as schizophrenia and depression, where the causality is more complex. For eg: a person with agitated depression can end up being harm to others while many with same illness may never commit any crime.

Despite a high relative risk, violence due to mental illness is not that frequent once all other causes of violence in society are taken into account. This risk has been estimated at about 3% and, when substance abuse and alcoholism are included, at about 10% (6).

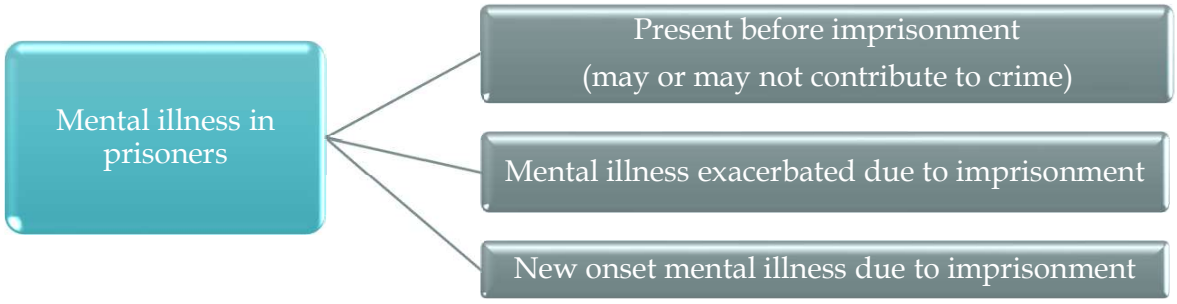

Figure 11.1: Interplay of imprisonment and mental illness

Risk of mental illness in Prisons

Although as seen as above, people with mental illness have risk of violence and criminal acts, not everyone who commit an offence have a mental illness prior or while committing the act (7). However, there are factors associated with imprisonment, which may increase the risk for mental illness among inmates. The stress of being imprisoned may precipitate mental illness in a person who is biologically prone for mental illness (8). The other factors which increase the risk includes structural and social factors such as:

- Isolation from outside world/ environment
- Enforced solitude
- Overcrowding

- Lack of privacy
- Inadequate infrastructure (poor hygiene, lack of facilities, poor food quality)
- Lack of meaningful activities
- Ill- treatment/abuse by staff or other inmates
- Inadequate medical attention
- Lack of screening for pre-existing mental illness

The extent to which these factors contribute to mental illness in inmates is unclear. However, the rate of screening, identification and treatment of mental illnesses in prison remains low.

Prevalence of mental illness in Prisons

A meta-analysis of prevalence of psychosis and major depression in prison population of 24 countries reports the pooled prevalence of psychosis to be 3.6% in males and 3.9% in females and pooled prevalence of major depression to be 10.2% in male prisoners and 14.1% in females, in the last decade (see Table 11.1) (9).

A systematic review of data on prison mental health from 2003 to 2015 reports high documented prevalence of mental illness among prisoners.

A recent meta-analysis and systematic review of mental illness and substance use disorder in a total of 14,527 incarcerated individuals in 13 LMIC(Lower- and Middle-Income Countries) including India, reports the pooled one-year prevalence rate of psychosis to be 6.2% (95% CI 4.0-8.6) the rates of which is 16 times higher than general population in the same regions.

Table 11.1: Prevalence of psychiatric diagnosis in adult prisoners

Disorder	Men		Women	
	Prevalence (%)	**C.I**	**Prevalence (%)**	**C.I**
Psychotic illness	3.6	3.1-4.2	3.9	2.7-5.0
Major depression	10.2	8.8-11.7	14.1	10.2-18.1
Alcohol misuse	18-30		10-24	
Drug misuse	10-48		30-60	

Source: Fazel S, Hayes AJ, Bartellas K, Clerici M, Trestman R. Mental health of prisoners: prevalence, adverse outcomes, and interventions. Lancet Psychiatry. 2016 Sep;3(9):871-81.

The pooled prevalence rate of depression is reported to be 16.0% (95% CI 11.7-20.8) and 3.8% (1.2-7.6) for alcohol use disorder and 5.1% (2.9-7.8) for other substance use disorders (10).

Some of the disorders have high variations in their prevalence studies, such as Adult ADHD (Attention Deficit Hyperactive Disorder) rates vary from 11% to 26%. Similarly rates of personality disorders reported range from 7 to 10% in high-quality clinical based diagnosis studies while rates as high as 65% have been reported in studies using screening instruments (9). The heterogeneous findings may arise as many of the diagnostic instruments used for the studies have not been validated to be used in prison population and hence there is a risk of over diagnosis. Also, the heterogeneity may reflect the actual variation in prevalence in various communities across the world and also the

attitude, approach of judiciary of the country towards mental illness and crime and availability of treatment facilities in the correctional systems (11).

OVERVIEW OF INDIAN SCENARIO

Prison statistics

In India, as per the "Prison statistics India 2019" released by the National Crime Report Bureau (12), the number of prisoners lodged in 1350 various jails and prisons across India is 4,78,600 while the actual capacity of the prisons being 4,03,739 leading to an occupancy rate of 118.5%. Among them, 43.4% of them belong to the age group of 18 to 30 years and 41.6% of them having literacy profile of education less than tenth standard.

A total of 7394 (1.5%) of inmates were reported to have mental illness of which 50.7% are convicts while 48.7% are under trail and 0.2% were detenues as on 31st Decemeber, 2019. However, the details regarding type and nature of illness are not reported.

A total of 165 un-natural deaths have been reported in the prisons in 2019, out of which 116 of them had committed suicide with predominant mode being hanging. Further, 10 inmates were murdered by other inmates and 20 died in accidents. Deaths due to natural causes were reported to be 1544 inmates with cardiovascular ailments, ageing, tuberculosis, HIV and related ailments being the causes of death. Among death due to illness, drug/alcohol withdrawal has been reported to be cause of death of 37 (2.7%) inmates and schizophrenia with epilepsy in 19 (1.4%) inmates.

With regards to rehabilitation and welfare of the prisoners, it has been reported that a total of 1,14, 262 prisoners were provided education in 2019 and only 54,726 inmates were given vocational training. Only handful of states has full-fledged hospitals with medical officers and nurses in their central prisons and district jails. The total medical staffs actually posted in jails are 1962 against the sanctioned strength of 3320.

Studies on mental illness in prisons

A review of studies, reports and data on mental illness among prisoners in India from the year 2000 to 2017 reports that schizophrenia was the most common diagnosis followed by depression and adjustment disorder (13). Among substance use disorders, alcohol use, cannabis use, opioid use and nicotine use were evidently reported. A study on 118 prisoners in a central jail in Rajasthan reports that 58.8% of them had substance abuse/ dependence prior to imprisonment (14). Depression was reported in 16.1% of the inmates while psychosis in 6.7% of the sample, screened using Indian Psychiatric Interview Schedule (IPIS). A recent cross-sectional study of 400 inmates in a district jail of Rohtak, Haryana reports the prevalence of depression to be 18% and anxiety to be 8% (15).

'**The Bangalore Prison Mental Health Study**' was conducted by NIMHANS in 2008-2009, in collaboration with Department of Prisons, Government of Karnataka and Karnataka State Legal Services Authority to estimate the prevalence and patterns of major and minor psychiatric morbidity and substance use and the mental health needs of the prisoners in addition to providing training for prison staff to identify and provide systematic interventions for mental health issues in the prison (16). A total of 5024 prisoners in the central jail Bangalore were assessed. The occupancy rate in the prison was 248% with majority (65.4%) of the inmates were under trial male prisoners in their early 20s. According to the MINI interview, 27.6% had mental illness and when substance use was included

79.6% individuals had a diagnosis of either mental illness or substance use disorder. 2.2% had psychosis, with predominantly schizophrenia and a significant number(16.7%) had substance use related psychosis. The rates of life time depression were found to be 12.7% and 9.1% had current depression. It was found that every 2 to 3 prisoners under trial for every 100 were at risk of attempting self-harm in prison. Nearly fifteen of every 100 under trial prisoners were diagnosed with antisocial personality disorder, the rate of which is 7 to 8 times higher than general population.

More than 34% of the prisoners reported difficulty in accessing health care needs and every one in two prisoners reported to be ill-treated by prison staff. Most prisoners (90%) did not attend any occupational training or rehabilitation services during the time of the study. Among the 201-prison staff, stress was reported by 81% of them, attributing to the concerns over their personal safety and difficulty in managing the prisoners. They also reported depression and sadness (32%) , worries (39%) , headaches (46%) and ulcer symptoms (97%). In terms of enhancing the mental health of inmates as part of prison reforms, it was seen that about 23% of inmates had improvement in the symptoms of anxiety and depression when meditation techniques were taught. Studies on structural and administrative factors that influence the mental health morbidity of the inmates are lacking.

Implications of the study findings

The findings reveal the mental health status of prisoners in a central prison facility. It is clear that the health care needs of prisoners are largely unmet in our country. The factors related to imprisonment such as poor infrastructure, lack of facilities, isolation and lack of social support and absence of social reforms and rehabilitation makes the inmates prone for increased risk of mental illnesses and suicide. The relative higher rates of stress, depression, anxiety and substance use disorders when compared to psychosis and other disorders shows that there are many modifiable risk factors that can be adequately addressed (17). Further, scope of promotive, preventive and rehabilitative interventions for the inmates are huge which needs to be addressed.

CORRECTIONAL PSYCHIATRY

The term "*Correctional Psychiatry*" can be considered as a branch of Forensic Psychiatry, involving psychiatric practice in correctional settings (18). This includes studying the incidence, prevalence, determinants and management of mental disorders in prison settings and the response of the correctional system to the mentally ill offender and also the relationship between criminality and mentally ill. Therefore, psychiatric practice in correctional settings has a unique boundary between "law" and medicine (19). It is absolutely necessary for the psychiatrist to be aware of the existing judicial policies, laws and structure of the setting and the unique problems associated with it including the personal safety of the Psychiatrist. Despite the challenges, it is essential to provide standard treatment of care, while preserving the human rights and dignity of the inmates (20).

Challenges and barriers for providing service

There are numerous potential ethical challenges while practicing psychiatry in these settings (21). The problem of dual role of being inmate's treating physician and as an employee of the local, state government authority could be challenging. Although it is recommended that responsibility of the physician to the patient to be of paramount importance, the reality of practice in a setting of power and control, it might be viewed as an impediment by the prison staff. The principle of power and

control by the staff may lead to potential harsh treatment towards the mentally ill while enforcing the rules and regulations. Hence the Psychiatrist needs to play dual role of being the patient advocate as well as need to participate in ensuring safety and security. The patient confidentiality might be difficult to be maintained in the correctional settings, as the prison staff accompany the inmate for evaluation, examination and oversees and monitors the treatment in the prison (22). The instances where confidentiality cannot be maintained include:

- When the patient is suicidal
- When the patient is homicidal / assaultive and there is risk of harm to other inmates
- When the patient has clear and elaborative plan of escaping from the setting.

The demands and wants of the inmates may differ from the 'needs' of the inmates. Medical autonomy here is impeded by the enforcement of regulations. Only the needed, essential services can be provided for the inmates. The violent, disruptive and self-harm acts by inmates with mental illness may be viewed as only "behavioural problem" by staff and tend to consider them as *manipulators* or *malingers*. Such cases need thorough evaluation and recommendations by a Psychiatrist (23). The risk of such violence and self-harm are highest during the initial period of incarceration. Hence the staff and medical personnel need to be aware of the risk in every individual inmate while getting incarcerated.

Addressing the mental health needs

In order to address the mental health care needs of the prisoners, the recommendations to provide corrective and rehabilitative services include the following (16):

- **Proper evaluation and assessment of every prisoner upon entry**: with a focus on general physical health, mental health and substance abuse and documentation of the same. This should be followed by referral for evaluation and treatment for the same.
- **Improving the general conditions of the prisons**: including the hygiene and quality of food and water, and prevention of overcrowding.
- **Mental health care in prison**: need for established protocols for crisis intervention, handling of behavioural emergencies. To ensure availability of medications, psycho-social interventions, rehabilitative services, after-care service and support.
- **Handling of stress**: enhancing peer and staff support systems, providing stress management and counselling services.
- **Training of prison staff**: sensitisation of mental illness and behavioural manifestations and skills to handle them. Also, addressing the mental health needs of the staff.
- **Increasing the human resources**: adequate doctors, nurses, counsellors and prison staff to address the needs of the inmates and to increase the prison functioning to the expected UN standards (24).
- **Health care needs**: physical health care needs which are both acute and chronic in nature, of both communicable and non-communicable illnesses.

Improving other resources such as the efficiency of trial procedures and reducing the load of under-trails, ensuring adequate resources are allocated to prisons and systematic sensitization and training of judiciary, lawyers and police are recommended to improve the status of prison functioning.

Mental Health Care Act (MHCA) 2017 on mentally ill prisoners

Section 103 of the MHCA 2017 gives the responsibilities of the prison staff in taking care of prisoners with mental illness (25). In case a prisoner needs admission for mental health care in mental health establishment, then the transfer has to be made. In cases wherein admission in psychiatric ward in the medical wing of the prison is needed, but there is no provision for a psychiatric ward, the patient may be transferred to a mental health establishment with prior permission of the ward. The medical officer of the prison needs to send quarterly report to the concerned board certifying therein that no prisoner with mental illness is in the prison or jail. The appropriate Government are expected to establish mental health establishment in the medical wing of at least one prison in each state and union territory which needs to be registered under Central or State Mental Health Authority.

Rights of persons with mental illness in prisons

In the Mental Healthcare Rules 2018 (rights of persons with mental illnesses), chapter IV is on Prisoners with Mental Illness. The central schedule gives the minimum standard for mental health care in prison, which mandates screening of mental illness and substance abuse in all inmates at time of entry into the prison. It is recommended that each prison has one Psychiatrist and 4 counsellors for every 500 inmates and at least a 20 bedded psychiatric facility for every 500 inmates. All central prisons should have dedicated tele-medicine services and prison after care services. Further details on "Minimum Standard for Mental Healthcare in Prison" are given in the Appendix 11.1.

Conclusion

Prison health needs including the mental health needs have to be a priority of public health system. The prisoners are from the community and return to the community. When the needs are not adequately met before sending back to the community, the risk for recidivism increases (27). The current rate of recidivism is about 7 to 8% in our country (12). Also, difficulties in readjusting to the community can increase their risk for developing mental health issues. With increasing awareness and emphasis on addressing the needs of prisoners, it is necessary to improving funding and tap the available resources to provide optimal care. Recent evidences on tele-psychiatric services of prison inmates indicate it to be a potential avenue that can be explored (28). Further, there is a need for longitudinal studies, interventional studies and consistent documentation and data maintenance on the mental illnesses and disorders in the prison population which will improve our understanding and identify the lacunae which can be filled effectively.

Video link: https://youtu.be/NZHPM37JngE

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Appendix 11.1

Minimum standards and procedures for mental healthcare services in prisons

Minimum Standards for Mental Healthcare in Prison

1. Prompt and proper identification of persons with mental health problems should be done.
2. Screening of all inmates during the time of entry to prison including the following:
    a. Mandatory physical and mental status examination
    b. Questionnaire screening for substance use
    c. Urine testing for common drugs of abuse
    d. Periodic random urine drug testing
3. Identification of persons with serious mental illness and proper treatment and follow-up for this group.
4. Ensuring the availability of minimum psychiatric medication in the prison to facilitate prompt treatment (Antipsychotic medication, antidepressant medication, anxiolytic medication, mood stabilizers, anticonvulsant medication, etc).
5. Availability of psycho-social interventions for prisoners with a range of mental health problems.
6. Protocols for dealing with prisoners with suicidal risk, with behavioral problems and crises related to mental illnesses as well as to prison life.
7. Suitable rehabilitation services for prisoners with mental illness. Specific attention to the aftercare needs of prisoners with mental illness including providing medication after release, education of family members, steps to ensure treatment compliance and follow-up, vocational arrangements, and for those without families, arrangements for shelter.
8. Implementing of National Mental Health Program inside the central prisons
9. Dealing with the psychological stress of prison life
    a. Counseling for stress needs to be provided to all prisoners in both individual and group settings. .
    b. Prisoners must be encouraged to proactively seek help for any emotional problems, substance use problems or physical health problems.
    c. Training the prison staff in simple counseling skills. Empowering some of the sensitive, motivated convicted prisoners to be effective peer counselors.
    d. One to one counseling upon entry, during periods of crises and upon need or request.
10. Addressing substance use problems
    a. Identification of substance use problems through questionnaires, behavioral observation and urine drug screening.

b. Detoxification services and making suitable pharmacotherapy available for detoxification.

c. For persons with dependence, making available long-term medication as well as motivational and relapse prevention counseling.

d. Specific interventions to be made available include the following:

i. Tobacco cessation services (behavioral counseling, nicotine replacement therapy, other long-term tobacco cessation pharmacotherapy.

ii. Alcohol - benzodiazepines for detoxification, vitamin supplementation for associated nutritional problems, counseling and long-term medication.

iii. For Opiates - buprenorphine or clonidine· detoxification, long-term medication including opioid substitution (methadone/buprenorphine; opioid antagonists like naltrexone).

iv. All drug users need to be evaluated for injecting use, for HIV/STI (including Hepatitis Band C screening) and appropriately treated.

v. There is a need for urgent human resource enhancement.

11. Professional Human Resources in the Prison [All central prisons must ensure the presence of at least]

i. 1 doctor for every 500 patients. In addition, every prison must have one .each of the following specialists providing care - physician, psychiatrist, dermatologist, gynecologist and surgeon.

ii. 2 nurses for every 500 prisoners

iii. 4 counselors for every 500 prisoners. These trained counselors (with a degree in any social sciences/any recognized degree with counseling experience (medical counseling/legal counseling/ psychosocial counseling/rehabilitation/education) can carry out the following tasks

a. Assessment

b. Counseling

c. Crisis intervention (family crisis, bail rejection, verdict pronouncement, interpersonal difficulties, life events, serious physical or psychiatric illness) .

d. Legal counseling, pre-discharge counseling

e. Rehabilitation counseling

f. Substance use counseling

g. Training prison staff and peer counselors

12. Inpatient services

a. At least a 20-bedded psychiatric facility for every 500 prisoners

13. Prison aftercare services

    a. All prisoners should have pre-discharge counseling on coping strategies, healthy life style practices and support systems they can access

    b. For persons with mental illness, they shall be referred to any mental health establishment for after care in community

14. Documentation

    a. Computerized data base and tracking system for all prisoners

    b. Surveillance of health conditions on a regular basis with adequate emphasis on confidentiality and proper information regarding 'these procedures to the prisoners

    c. Health records for prisoners with basic health information, pre-existing health problems, health problems that develop during imprisonment, details of evaluation and treatment, hospitalization details, health status and advice at release

    d. This information must be given to the prisoner to facilitate continuing health care after release.

15. All central prisons shall have dedicated tele-medicine services to provide health care

16. Following medicines shall be made available

Oral psychotropic medication

- Risperidone
- Olanzapine
- Clozapine
- Haloperidol
- Chloropromazine
- Trihexyphendyl
- Imipramine
- Amitriptyline
- Fluoxetine
- Sertraline
- Paroxetine
- Valproate
- Carabamazapine
- Lithium
- Clonidine
- Atomoxetine
- Lorezpam

- Diazepam
- Oxezepam
- Disulfiram
- Naltrexone
- Acamprosate
- Nicotine Gums
- Varenicline

Injectable psychotropics

- Inj. Fluphenazine
- Inj. Haloperidol
- Inj. Fluphenthixol
- Inj. Lorezpam
- Inj. Diazepam
- Inj. Promethazine
- Inj. Thiamine/Multivitamin

Chapter 12

Legal aspects in the certification of Third Gender

Naveen Manohar Pai, Shalini S Naik, Guru S Gowda, Suresh Bada Math

Highlights

- The census data of 2011, 4.88 lakhs adults and 54,845 children were estimated to be Transgender (TG) and 66% of them lived in rural parts of India
- TGs have lower rates of literacy, employment, face stigma and discrimination and higher suicidal rates.
- The Transgender Persons (Protection of Rights) Act, (TGPA) 2019 formulates welfare schemes and programmes including healthcare provisions to facilitate and support livelihood for TG persons including their vocational training and self-employment
- The TGPA, 2019 provides a mechanism for the certification of gender identity as transgender or third gender for any age of 18 years and above transgender person

Introduction

TRANSGENDER (TG) is often used as an umbrella term for identifying all those individuals who have discordance or discomfort between expressed gender and gender assigned at birth (1). Being identified as TG or Gender diverse is considered to be a matter of human diversity and not pathology (2). The International Classification of Diseases 10th edition (ICD 10) continues to classify 'Transgender' under the subcategory of Transsexualism (3). This particular category attracted a lot of criticisms over the years from various organisations which have urged the World Health Organisation (WHO) to retract this diagnostic entity. While experts in the area of Transgender health say that this diagnostic category pathologize a variant of the normal behaviour, and few others have framed it as a more fundamental issue of human rights (4) . The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) however has removed this particular classification while retaining the diagnosis of Gender Identity Disorder (GID) of childhood (see table 12.1). Nevertheless, the ICD-11 working group on sexual disorders and sexual health has recommended retaining the diagnosis of 'Gender Incongruence of Adolescent and Adulthood' under the category of conditions related to sexual health (5). The primary focus of this category is on the experience of incongruence between the gender role and assigned sex. Another debate is that removal of GID from the classification may further worsen the difficulties of TG adults already struggling with inadequate access to private and/or public healthcare for medical and surgical care. (4)

The size and distribution of Transgender and Gender Non-Conforming (TGNC) individuals

Ascertaining the size and distribution of Transgender and Gender Non-Conforming (TGNC) individuals in the population helps us in understanding the needs of these individuals, aids in framing health policies to address their health care needs and plan appropriate research accordingly. A recent review indicates that people who self-identify as TGNC represent a sizable proportion of the

general population with realistic estimates ranging from 0.1% to 2%, depending on the inclusion criteria and geographic location (6). But this is subject to a wide variation in terms of differing clinical presentations, discrepancies in inclusion of the definition of transgender, cultural diversity specific to this population, and wide variations in the time periods covered in different studies. Scientific studies estimating the proportion of TG in the Indian population are lacking (7). In the Census of 2011 for the first time in India, data on TG was collected. Around 4.88 lakhs adults and 54,845 children were estimated to be TGs (8). However, these estimates were collected based on self-reporting of individuals as TG and further compiled under the gender category of males making it difficult to understand the socio-economic condition and distribution of TG individuals in the population.

Table 12.1: Salient features and comparison of ICD-10 and DSM-5 diagnostic criteria of Transgender (3,10,11)*

Criteria	ICD - 10	DSM - 5
Concept of gender	Gender is binary	Gender is fluid
Diagnostic category	Gender identity disorder	Gender dysphoria
Name of the diagnosis	Transsexualism	Gender dysphoria in adolescents and adults
Overlap with diagnosis of Disorders of Sexual Development (DSD)	Not specified	If an individual with a DSD also satisfies the diagnostic requirements for gender incongruence, both diagnoses should be assigned
Time required to establish the diagnosis	Minimum of 2 years	Minimum of 6 months
Diagnostic criteria	a) Desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make one's body as congruent as possible with one's preferred sex through surgery and hormonal treatment	**Criterion A:** Two of the following must be present a) A marked incongruence between one's experienced/ expressed gender and primary and/or secondary sex characteristics b) A strong desire to be rid of one's primary and/or secondary sex characteristics c) A strong desire for the primary and/or secondary sex characteristics of the other gender d) A strong desire to be of the other gender e) A strong desire to be treated as the other gender f) A strong conviction that one has the typical feelings and reactions of the other gender
Associated distress or impairment in important areas of functioning	Evidence of significant distress or impairment in social or other important areas of functioning must be present	**Criterion B:** Evidence of the condition being associated with clinically significant distress or impairment in social, school, or other important areas of functioning must be present

***Source:** Soll BM, Robles-García R, Brandelli-Costa A, Mori D, Mueller A, Vaitses-Fontanari AM, et al. Gender incongruence: a comparative study using ICD-10 and DSM-5 diagnostic criteria. Brazilian Journal of Psychiatry. 2018;40(2):174–80

Legal definition of Third gender

The Transgender Persons (Protection of rights) act, 2019 defines a **Transgender person** as any person whose expressed gender does not match with the gender assigned to that person at birth and includes trans-man or trans-woman (whether or not such person has undergone Sex Reassignment Surgery or hormone therapy or laser therapy or such other therapy), a person with intersex variations, genderqueer and person having such socio-cultural identities as *Kinner, Hijra, Aravani* and *Jogta* (9). This definition is slightly different from the ICD-10 and DSM-5 definitions (as highlighted in Table 12.1) and the legal definition also includes individuals with disorders of sexual development and the definition shall be used for all issues and matters related to the law.

Recognising the legal rights of the Third Gender: An International Perspective

In recent years, TG persons around the world have made tremendous strides toward achieving legal recognition. The Trans Murder Monitoring Project, an initiative that collects and analyzes reports of transgender homicides worldwide, recorded 1,731 murders of TG persons globally between 2007 and 2014. Many were of a shockingly brutal nature, sometimes involving torture and mutilation. Outright violence is not the only threat to the lives of TG persons. They are as much as 50 times more likely to acquire HIV than the general population because stigma and discrimination create barriers to accessing health services. Systematic marginalization and have led to higher suicidal rates as per the studies done in United States, Canada and Europe.

In 2012, Argentina formed a law that is considered the gold standard for legal gender recognition. It says anyone aged over 18 years can choose their gender identity, undergo gender reassignment, and revise official documents without any prior judicial or medical approval, and children can do so with the consent of their legal representatives or through summary proceedings before a judge. In the subsequent three years, four more countries—Colombia, Denmark, Ireland, and Malta explicitly eliminated significant barriers to legal gender recognition.

To date, 24 countries (includes India and Pakistan in Asia) recognise third gender/ transgender identity while Poland had vetoed the Gender identity law and rest countries continue to derecognise the third gender/ transgender identity

Recognising the legal rights of the Third Gender: An Indian Perspective

The census data of 2011 reports that over 66% of the population identified as third gender lived in rural areas. They had lower literacy rates compared to the general population (46% compared to 74% literacy in the general population). (8) They had lower rates of successful employment and the majority of them were unable to sustain work beyond 6 months. The reason for the same were manifold such as discrimination in the society, educational facilities and workplace; high prevalence of HIV, substance use disorders, depression and suicide; and lack of medical facilities catering to the needs of these individuals (12). The monograph published by the Peoples Union for Civil Liberties, Karnataka (PUCL-K) have given comprehensive accounts on violent stories of abuse and sexual violence and the embedded fear of sexual and gender non-conformity in the mainstream society, thus, negating the claims of equal citizenship and protection for all according to the Constitution of India (13).

The Articles 15 and 16 of the Indian constitution explicitly prohibits discrimination on the grounds of "sex" and provides all individuals with the fundamental right to equality and equal protection under the law (14). Furthermore, article 21 of the Indian Constitution states that every person is allowed to lead a dignified life including diversity in self-expression (14). However, the Indian Penal Code (IPC), Section 377 criminalized consensual sexual acts between two consenting adults in private and was presumed to be violation of these fundamental rights. In the first of a series of noteworthy cases, ***Naz Foundation, a Non Governmental Organisation (NGO) filed a writ petition*** (a public interest litigation against the government) challenging the constitutional validity of Section 377 of the IPC, 1860 and to decriminalize section 377 IPC in the high court of Delhi (15). In a historic judgment that spearheaded the Lesbian, Gay, Bisexual, and Transgender (LGBT) activist movement, the Delhi high court in 2009 ruled in the favour of decriminalizing IPC sec 377. However, as per the judgement, the provisions of IPC sec 377 would still continue to govern non-consensual penile non-vaginal sex and penile nonvaginal sex involving minors. It was challenged by a civil appeal by ***Suresh Kumar Kaushal and others vs Naz Foundation and others*** in the honourable supreme court. A two-judge supreme court bench said that the 2009 order of the Delhi High Court is "constitutionally unsustainable as only Parliament can change a law, not courts" and overturned the judgement of the Delhi high court and reinstated Section 377 of the Indian Penal Code in 2014 (16).

Challenging the decision given by the honourable Supreme Court in ***Suresh Kumar Kaushal and others vs Naz foundation and ors.*** Navtej Singh Johar, a dancer who identified as part of the LGBT community, filed a Writ Petition in the Supreme Court in 2016 stating section 377 of the Indian Penal Code of 1860 was unconstitutional as it violated article 14 and article 21 of the Indian Constitution which guarantees right to sexuality and sexual autonomy to be a part of these fundamental rights and further demanding for a reasonable classification between natural and unnatural consensual sex. An emphasis was also made on the judgment given by the honourable supreme court in ***Justice K. S Puttaswamy vs Union of India*** which delivered a unanimous verdict in 2017 stating the Constitution of India confers each individual with a fundamental right to privacy under article 21 which suggested that autonomy and privacy are inextricably linked (17). After hearing the arguments, the five-judge bench of the Indian Supreme Court unanimously held that Section 377 of the IPC, 1860, in so far as it applied to consensual sexual conduct between adults in private, was unconstitutional. (18) With this, in 2018 the honourable supreme Court overruled its decision in ***Suresh Kumar Kaushal v. Naz Foundation*** that had upheld the constitutionality of Section 377.

In this pretext, the ***National Legal Services Authority (NALSA)*** filed a ***civil petition*** in the honourable Supreme Court demanding legal provisions to recognize persons who fall outside the binary gender (male/female), including persons who identify as "third gender" (19). It drew attention to the fact that TG persons were subject to "extreme discrimination in all spheres of society" which was a violation of their right to equality. After much deliberation about the breach of fundamental rights to non-binary gender and consultation with the "Expert Committee on Issues Relating to Transgender" constituted under the Ministry of Social Justice and Empowerment, the honourable Supreme Court in a landmark judgement dated 15th April 2014 granted legal recognition for "third gender". It placed one's gender identity within the framework of the fundamental right to dignity under Article 21 and held that all individuals including transgender persons were entitled to fundamental rights under Articles 14, 15, 16, 19(1)(a), and 21 of the Constitution. (19)

This was an important milestone because it not only gave legal recognition to non-binary gender identities but also upheld their fundamental rights as per the constitution of India. As per this judgement Central and State governments were deemed to take proactive action towards securing TG persons' rights. It highlighted the fact that article 14 and 19(1)(a) of the constitution which talks about the right to equality and freedom of expression was outlined in gender-neutral terms ("all persons") and by default these would also apply to TG persons. (19) It further clarified gender identity as "an innate perception of one's gender" and not restricting it to biological characteristics (such as chromosomes, genitalia and secondary sexual characteristics). The court upheld the right of all persons to self-identify their gender and declared that *hijras* and eunuchs can legally identify as "third gender" (19). No third gender persons should be subjected to any medical examination or biological test which would invade their right to privacy in addition to directing the state and central governments to develop mechanisms for realising and making legal provisions for "third gender"/transgender persons (19).

The Transgender Persons (Protection of rights) Act, 2019

These landmark judgments paved the way for the legislation which is now known as **The Transgender Persons (Protection of rights) Act, 2019,** and came into effect on 5th December 2019 (9). The legislation highlights the need for formulating welfare schemes and programmes including healthcare provisions to facilitate and support livelihood for TG persons including their vocational training and self-employment. It safeguards the fundamental rights of these TG and gender diverse individuals and aims at providing a safe space for them to function in society. Section 3 of the act prohibits any and all forms of discrimination against TG individuals either in public or private, educational institutes, offices, healthcare facilities or public places, and any individual who is found to be guilty of the same, directly or indirectly leading to harm or endangerment to the life of TG individuals shall be liable to punishment with imprisonment for a term not less than six months and may extend to 2 years with fine (9),

Section 15 of this Act insists the appropriate Governments to set up a separate HIV serosurveillance centre for these individuals, facilities for medical and surgical care which provide gender affirmation surgeries, hormonal therapy (9). In addition, it also directs the appropriate governments to bring out a manual for healthcare of TGs in India in accordance with the World Professional Association for Transgender Health (WPATH) guidelines. The act also provides for inclusion of health education of sexual minorities in both undergraduate and postgraduate medical curriculum and provision of comprehensive health insurance schemes for the benefit of transgenders. As per section 16 of the act a national council for TG has been formulated on 21st August, 2020 which shall oversee all the social welfare measures and policies related to TGs.

The act directs the National Council for Transgender Persons (NCTP) for addressing the grievance of TG persons along with advice to the Central Government on the formulation of policies, programmes, legislation and projects with respect to TG persons.

National Portal for Transgender Persons (NPTP) has been launched in November, 2020. TG persons can apply certificate and ID cards digitally without having to visit any government office. Additionally, TG persons can monitor the status of their application that ensures transparency in the process. The issuing authorities are also bound by strict timelines to process the applications and

issue certificates and identity cards without any necessary delays. Once the certificate and I-card are issued, the applicant can download them from the portal itself.

The Social Defence under the Ministry of Social Justice and Empowerment (MSJE) began to focus on policies and programmes for the rehabilitation and welfare of TG persons besides senior citizens, victims of substance (Drug) abuse and beggars. During the year 2019-20, MSJE has released an amount of Rs. 1.5 crore to the National Backward Classes Finance & Development Corporation (NBCFDC) for the welfare and skill development training of members of TG community and for organizing health camp for the TG community and Rs. 1crore to National Institute of Social Defence (NISD) for undertaking programs for empowerment and rehabilitation of TGs.

Certification of Transgender or third gender

Under sections 4-6 of **The Transgender Persons (Protection of rights) Act, 2019,** a transgender person who is a major (age of 18 years and above) can apply for obtaining the certificate of gender identity as transgender or third gender. As per **The Transgender Persons (protection of rights act) Rules, 2020**, they shall do so by submitting an application for Transgender ID card with an affidavit stating they are transgender along with a clinical psychologist report. Upon receipt of this application the District Magistrate shall grant the Transgender certificate and identity card within 60 days of receipt of this application (9,20). The Transgender certificate shall serve as a proof of recognition which shall be recorded in all official documents pertaining to the individual and can be used to avail all welfare measures available for the benefit of these individuals. Upon completion of the Sex reassignment surgery (SRS) the transgender, under section 7 of this act the transgender shall be eligible to apply for gender change certificate (as per their expressed gender). They shall do so by submitting an application for gender change certificate as prescribed in **The Transgender Persons (protection of rights act) Rules, 2020**, along with the medical certificate from the Medical Superintendent or Registered Medical Officer of the hospital from where they have undergone the SRS. The district magistrate under whose jurisdiction the transgender has been residing for the past one year upon receipt of the application shall grant the gender change certificate and identity card (9,20) (see figure 12.1)

Role of Psychiatrist in care of the Transgender

A Psychiatrist must familiarize themselves with gender-nonconforming identities and expressions, and be knowledgeable with the assessment and treatment of gender dysphoria, sexual health concerns, and the assessment and treatment of sexual disorders (21). Psychiatrists must develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender-nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families.

It is crucial for Psychiatrists working with the TGNC population to create a gender-affirming environment as often these individuals look for subtle clues in the healthcare settings to determine if they would have a positive mental healthcare experience (22). All mental healthcare staff must be trained and must familiarize themselves to refer to such Transgender individual with their preferred pronouns and their correct gender identity. It would be preferable to have Transgender and other sexual minority friendly photographs, stickers, symbols and posters representing a diverse patient population (23). Reading materials and brochures in the waiting rooms may include some of the

information and materials pertinent to the Transgender community (23). While examination, the clinician should begin by ask open-ended questions and have a non-judgmental attitude throughout the interview so as to nurture a warm and friendly environment where they can discuss their issues (22). The provider should ask about the person's gender identity and their preferred pronoun(s), which should be used when addressing the person throughout the visit (22).

Psychiatrist may often find a referral from primary care physicians or endocrinologists or other medical specialties to establish gender dysphoria (24, 25). It is of utmost importance to maintain a good rapport and establish a therapeutic alliance with these individuals and minimise the frequent change in the person in order to retain these individuals in the treatment loop. Psychiatrists should bear in mind that transgender individuals who seek consultations are in different stages of transition, some of them may have clear views about the kind of interventions and treatments that they would want to have, for e.g.- individuals may seek consultation for assessment and obtaining referral for hormonal or surgical interventions; psychotherapy unrelated to gender concerns; or other professional services such as to seek psychological support for family members (partners, children, extended family). (21) While some individuals may need help for psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming-out process. It is of utmost importance to identify the individual's reason for seeking professional or health care assistance and mental health professionals should ascertain the purpose of help-seeking before carrying out further assessments and management.

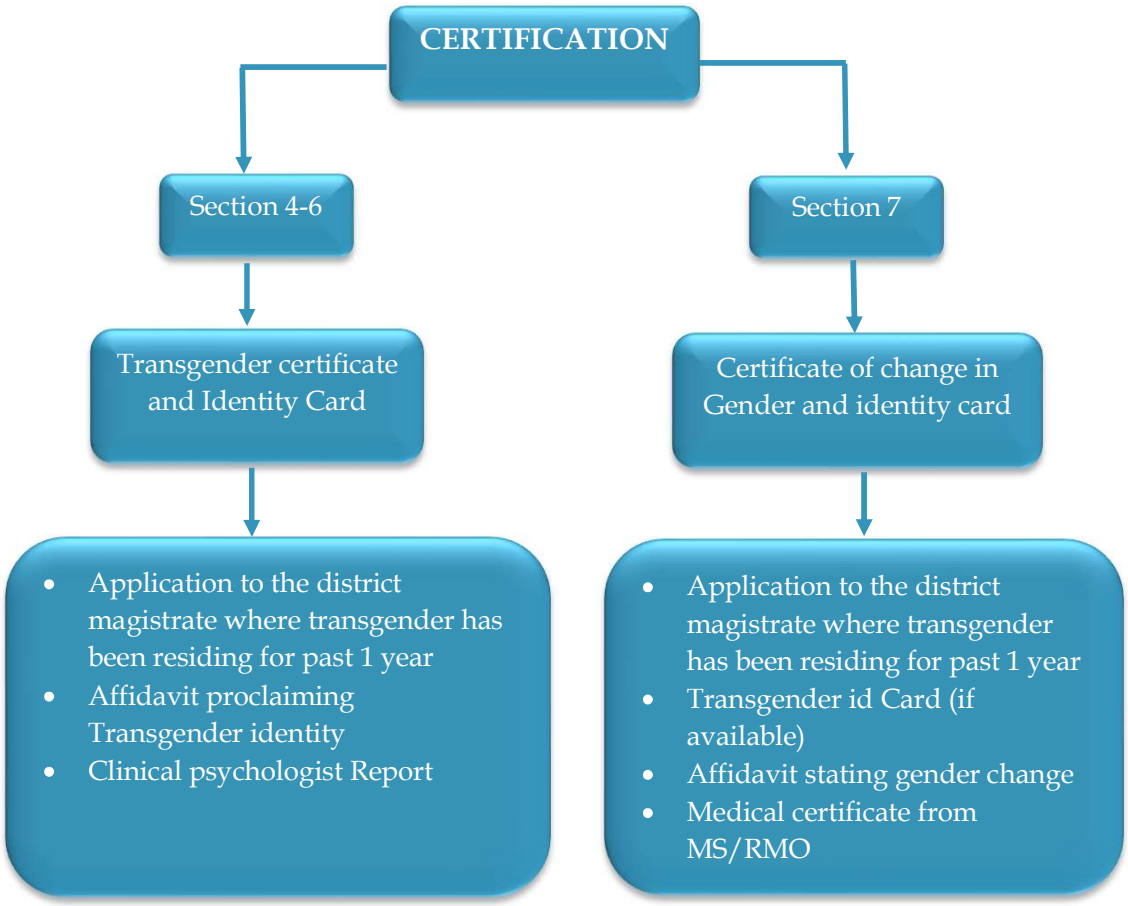

Figure 12.1: Flowchart illustrating Certification procedure for Transgender and change in Gender

Role of Psychiatrist in Hormonal therapy

It is the duty of the psychiatrist, either independently or as a part of the multidisciplinary teams, to assess the readiness of transgender individuals to undergo hormonal therapy. Just expressing a desire to undergo hormonal therapy or mere possession of a gender recognition certificate does not in itself provide all the necessary clinical information required to assess the suitability and readiness for available medical interventions.

Assessment for the suitability and readiness for masculinising/ feminizing hormonal therapy: (21,24)

- Assessment of expectations from hormonal or medical interventions and the impact of these interventions on the psychological and social functioning of these individuals
- Detailed psychiatric, medical, or surgical history including any contraindications for medical or hormonal procedures.
- Assessment of understanding about the likely impact of medical interventions on physical health including the loss of fertility.
- Preparing the individuals for the said intervention and plan for aftercare.
- Advice on positive lifestyle behaviours such as encouraging to adopt a healthy lifestyle, regular exercises, advice, and treatment of substance use (depending on the level of motivation of these individuals).
- Discussion of various support strategies and identification of support networks for these individuals to thrive after the said intervention.

Criteria for Hormonal therapy:

- Persistent, well-documented gender dysphoria for 6 months
- Psychological preparedness for Hormonal Therapy.
- Capacity to make a fully informed decision and to consent for treatment free of any and all forms of coercion. *
- The individual should be of the age of 18 years or above
- The well controlled medical or mental health condition, if any issues are present.
- Psychotherapy is not an absolute prerequisite (it is optional) for Hormonal therapy

Referral to the endocrinologist or hormone prescribing physician:

For referring a person for hormonal therapy, a recommendation letter from one psychiatrist is sufficient. The recommended content of the referral letter for feminizing or masculinizing hormone therapy should include the following (21):

- The Transgenders name as per the birth certificate and the individuals chose name along with identifying characteristics.

* The capacity assessment shall be done as per the guidance document available in accordance with section 4 of the Mental Healthcare Act 2017

- The Transgenders name as per the birth certificate and the individuals chose name along with identifying characteristics.
- Results of the Psychiatric evaluation and psychosocial assessment of Transgender, including any psychiatric diagnoses.
- The duration of the professional's relationship with the Transgender, including the type of evaluation and therapy or counselling to date.
- A statement on Transgenders capacity to make informed consent and a brief description of the clinical rationale for supporting the Transgenders request for hormonal therapy
- A statement that the referring psychiatrist is available for coordination of care and can be contacted through established means of professional communication.

It is the primary duty of the endocrinologist or the hormone prescribing physician to provide information to the individuals regarding the potential risks and possible complications involved, including the impact of hormonal therapy on physical changes and mental health. The endocrinologist or the hormone prescribing physician has to take the prior informed consent for hormonal therapy, before initiating the hormone therapy.

Role of Psychiatrist in Sexual Reassignment Surgery

Sexual reassignment surgery is often considered the last but the most crucial step in the treatment of gender dysphoria. Genital and breast/chest surgery are not merely another elective procedure, the majority of these procedures are often irreversible. The psychiatrist who receives the referral shall independently assess the persons as following

Assessments of persons for SRS *(21,26)**:***

- Assessment of expectations from the desired surgical procedure and the impact of these interventions on the psychological and social functioning of these individuals
- Psychological preparedness for surgery
- Detailed psychiatric, medical or surgical history, contraindications to the prescribed procedures if any.
- Details of the hormonal therapy, if any, including duration, dosing, any adverse effects.
- Knowledge and information about the different surgical techniques (as discussed by the surgeon), limitations of the procedure to achieve the ideal or desired result and the likely benefits
- Preparing the individuals for the prescribed surgical intervention and plan for aftercare.
- Discussion of various support strategies and identification of support networks for these individuals to thrive after the said intervention.
- Ascertain if the individual has applied for or obtained a certificate of identity as a transgender person from the district magistrate.

Criteria for non-genital (chest/breast) & genital surgery:

- Persistent well-documented Gender Dysphoria
- Capacity to make fully informed decisions and consent for treatment. *
- The individual should be of the age 18 years or above
- The individual should possess a transgender certificate issued by the district Magistrate.
- If physical and mental health problems are present should be well controlled in past one year.
- Has lived full time in his/ her desired gender role for the past 12 months.
- Psychotherapy or hormone therapy is not an absolute prerequisite (it is optional) for genital or non-genital surgery.

However, for individuals undergoing feminising surgery or breast augmentation procedures, hormonal therapy for a minimum duration of 12 months is advisable.

Referral for Sexual Reassignment Surgery

For persons requesting genital surgery, (e.g.- orchidectomy, salpingo-oophorectomy/hysterectomy, genital reconstructive surgeries), non-genital breast/ chest surgery (e.g.- chest reconstruction, mastectomy or augmentation mammoplasty) one referral from a qualified psychiatrist is sufficient along with transgender certificate issued by the district Magistrate. However, WPATH recommends individuals to be evaluated by two psychiatrists (preferably one of the psychiatrists not be involved in the care of the individual who is requesting for SRS) independently who shall undertake their assessments and then give two separate referrals.

The recommended content of the referral letter for feminizing or masculinizing hormone therapy includes the following (21):

- The Transgenders name as per the birth certificate and the individuals chose name along with identifying characteristics.
- Results of the Psychiatric evaluation and psychosocial assessment of Transgender, including any psychiatric diagnoses.
- The duration of the professional's relationship with the Transgender, including the type of evaluation and therapy or counselling to date.
- A statement that capacity to make a informed consent by the person and a brief description of the clinical rationale for supporting the Transgenders request for sexual reassignment surgery
- A statement that the referring psychiatrist is available for coordination of care and can be contacted through established means of professional communication.

It is the surgeon's responsibility to determine that an individual is sufficiently healthy, physically and Psychologically, to undergo surgery. It is the primary duty of the surgeon to provide information to

* The capacity assessment shall be done as per the guidance document available in accordance with section 4 of the Mental Healthcare Act 2107.

the individuals regarding the potential risks and possible complications of the various techniques, including the impact of surgical procedure to physical health including the loss of fertility and the surgeon has to take a prior informed consent for the surgery.

Post-operative care

Persons who follow-up regularly after surgical treatments for gender dysphoria had better surgical and psychosocial outcomes. (21) It is equally important for these persons to follow-up with psychiatrists as persons may have spent maximum time in consultation and the psychiatrists can provide assistance in post-op adjustment difficulties. Upon completion of the SRS (genital surgery) a medical certificate from the Medical Superintendent or Registered Medical Officer of the hospital from where they have undergone the SRS shall be provided which will help the individuals to apply for Certificate of Gender change from the district Magistrate.

Continuum of Care:

TGNC individuals require health care throughout their lives, although their needs and requirements may vary depending on the life stage and stage of transitioning. There is merit in maintaining the continuity of care in order to address any mental health issues or stigma faced by these individuals, possible consequences of life-changing surgeries and any other issues that hinder the psychological wellbeing and progress of these individuals. (21) Engagement in the treatment process is absolutely essential and the duration and frequency of contact may be decided based on a case-by-case basis and can be flexible based on the needs of the individual. (26) Mental healthcare services which incorporates the views and needs of the person, which are appropriate and sustainable with good liaising with other psychiatrist and Mental health professionals and healthcare service providers (e.g., endocrinologist/ surgeon, etc.) will not only benefit these individuals but promote dignity, respect and equality for trans people.

Alternative means of consultation via telemedicine may also be provided as per the individual circumstances but in person face-to-face consultations are necessary at least during the initial phases of the treatment. (27) The Psychiatrist should exercise their professional judgment to decide whether a tele-therapy consultation is appropriate in a given situation or an in-person therapy is needed and can be referred in the interest of the person. Suitability of person for online therapeutic alliance needs to be taken into account before considering and also during tele-therapy. Psychiatrist providing teletherapy should abide by the same professional standards, ethical norms and laws as applicable to traditional in-person therapy. (27)

Conclusion

The Transgender Persons (Protection of Rights) Act, 2019 provides a mechanism for their social, economic and educational empowerment. It will benefit a large number of TG persons, mitigate the stigma, discrimination and abuse against this marginalized section and bring them into the mainstream of society. This will lead to inclusiveness and will make the TG persons productive members of the society. As a psychiatrist, it is essential to identify and manage mental health problems that may arise during the process, or after the completion of transitioning. Also, to ensure TG persons have adequate social support by identifying social networks in which the individuals can thrive.

Video link: https://youtu.be/aJRH0e1GKEs

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Appendix 12.1

Form – 1

[See rules 2(d), 3(1) and 6(1)]

Application form for issue of transgender certificate of identity under Rule Transgender Persons (Protection of Rights) Rules, 2020 read with Section 6* / 7* of the Transgender Persons (Protection of Rights) Act, 2019

*** Strike out whichever is not applicable**

State Emblem State Government of (name of the State) Office of the District Magistrate		
Application form for issue of a transgender certificate of identity under Rule Transgender Persons (Protection of Rights) Rules, 2020 (read with Section 6* / 7* of the Transgender Persons (Protection of Rights) Act, 2019 * Strike out whichever is not applicable)		
1	**Name**	
(i)	Given name (in capital letters)	
(ii)	Changed/Chosen name (in capital letters)	
(iii)	Out of (i) and (ii), name to be printed in the certificate of identity and in the identity card	
2	**Gender**	
(i)	Assigned at birth	
(ii)	Requested in the application	
3	**Date of birth**	dd/mm/yyyy
4	**Educational qualification**	
5	**Present address**	
6	**Permanent address**	
7	**If there is a source of income, the annual income:**	
(i)	Under Rs 1,00,000	YES / NO
(ii)	Between Rs 1,00,001 and 3,00,000	YES / NO
(iii)	Above Rs 3,00,000	Please specify the amount:
8	**Do you have any of the following documents? If so, please submit self- attested photocopies of the certificates stated below.**	
(i)	Date of birth certificate	YES / NO
(ii)	Aadhaar card	YES / NO
(iii)	PAN card	YES / NO
(iv)	Election Voter Identity Card	YES / NO

(v)	Ration card	YES / NO
(vii)	Passport	YES / NO
(viii)	Bank passbook	YES / NO
(ix)	MNREGA Card	YES / NO
(x)	Caste certificate (SC/ST/OBC/Others)	YES / NO
9	**Medical history (for those applying under section 7 of the Transgender Persons (Protection of Rights) Act, 2019**	
(i)	Have you undergone any medical intervention in the context of transgender transition?	YES / NO
(ii)	Please give details	
(iii)	Name and complete address of the Hospital or medical institute	
(iv)	Name of the issuing authority along with the date	
(v)	Any other medical status you would like to share	
(vi)	Have you been issued any certificate of identity under Section 6 and Section 7 under the Act, or any other ID Card issued by the State Authority before the commencement of these Rules? If so, enclosed the same.	
10	Any other information you would like to give	
11	Have you attached affidavit prescribed in Form –2 of the Transgender Persons (Protection of Rights) Act, 2019 under Rule--Transgender Persons Protection of Rights) Rules, 2020	
12	Have you attached the passport size photographs?	Yes/No

Enclosed:_____documents as mentioned in the application

Declaration

1. I declare that the particulars furnished by me are true and correct.
2. Information provided in this application will be treated as confidential and shall not be shared with any person or organisation save the Central and / or State security agencies, any other agency as provided by Law; and for statistical and policy framing purposes.

Place: Date:	Signature or left-hand thumb impression of the applicant Given name of the applicant

Form – 2

[See rules 2(b) and 4(1)]

Format of affidavit to be submitted by a person applying for certificate of identity for transgender persons under Rule 4 of the Transgender Persons (Protection of Rights) Rules, 2020 read with Section 6 of the Transgender Persons (Protection of Rights) Act,2019

(Affidavit should be on non-judicial stamp paper of Rs.10/-) Competent Notary Civil, District (Name of the District), (Name of the State)

I, (Name), son/daughter/ward/spouse of (name of the parent/guardian/husband), aged

(in completed years), residing at (address), (Tehsil), (District), (State) (Pin code) do hereby solemnly affirm and declare as under:

1. I am currently residing in the above address.
2. I perceive myself as a transgender person whose gender does not match with the gender assigned at birth.
3. I declare myself as transgender.
4. I am executing this affidavit to be submitted to the District Magistrate for issue of certificate of identity as transgender person under Section 6 of the Transgender Persons (Protection of Rights) Act, 2019 under Rule Transgender Persons (Protection of Rights) Rules, 2020.

.* strike out whichever is not applicable.

Deponent

(Signature of the Applicant)

Verification

I, (Name), hereby state that whatever is stated here in above serial Nos. 1 to 4 are true to the best of my knowledge.

Deponent

(Signature of the Applicant)

Tehsil Date

Identified by me

Advocate

Public

Before Me

Notary

Form – 3

[See rules 2(e) and 5(1)]

Form of certificate of identity to be issued by District Magistrate under Rule 5 Transgender Persons (Protection of Rights) Rules, 2020 read with section 6 of the Transgender Persons (Protection of Rights) Act, 2019

Photograph of the certificate holder District Magistrate to attest the photograph

1. On the basis of the application dated dd/mm/yyyy to the undersigned it is certified that Shri / Smt./ Km/ Ms (name) son / daughter / ward of Shri/ Smt. (name of the parent or Guardian) of (complete residential address of the applicant) is a transgender person.
2. His / her birth name is_____.
3. This certificate is issued in terms of the provisions contained under Rule 5 Transgender Persons (Protection of Rights) Rules, 2020 read with section 6 of the Transgender Persons (Protection of Rights)Act, 2019.
4. It is also certified that Shri/Smt/Km/Ms._____is ordinarily a resident at the address given above.
5. This certificate entitles the holder to change name and gender in all official documents of the holder.

Date Signature of the District Magistrate

Place Seal

Form – 4

[See rules 2(e) and 7(1)]

Form of certificate of identity for change of gender to be issued by District Magistrate under Rule 6 of the Transgender Persons (Protection of Rights) Rules, 2020 read with section 7 of the Transgender Persons (Protection of Rights) Act, 2019

Photograph of the certificate holder District Magistrate to attest the photograph

1. On the basis of the application submitted to the undersigned along with a medical certificate from the Medical Superintendent or Chief Medical Officer (name of the Hospital and complete address), it is to certify that Shri / Smt./ Km/ Ms. (name) son/ daughter / ward of Shri/ Smt. (name of the parent or Guardian) of (complete residential address of the applicant) has undergone medical intervention to change gender.
2. His/ Her birth name is_____.
3. This certificate is issued in terms of the provisions contained under Rule 6 of the Transgender Persons (Protection of Rights) Rules, 2020 read with section 7 of the Transgender Persons (Protection of Rights) Act, 2019.
4. It is also certified that Shri / Smt/ Km/ Ms. is ordinarily a resident at the address given above.
5. This certificate entitles the holder to change name and gender in all official documents of the holder.
6. Such change in name and gender and the issue of this certificate shall not adversely affect the rights and entitlements of the holder of this certificate.

Date Signature of the District Magistrate:

Place Seal

Form – 5

[See rules 2(g) and 5(4)]

Form of Identity Card Front side of identity card

State Emblem

State Government of (name of the State) Office of the District Magistrate

Transgender Identity Card

Photograph of the Card holder

Identity card number

Name

Mother's name@

Father's or Guardian's name @

Gender Transgender

Date of birth **or** dd/mm/yyyy

Age as on the date of application for issue of ___years

Identity card Reference number of certificate of authority on the basis of which this card is issued

Back side of the identity card

Present address

Card issue date

Signature of the issuing authority

Designation

Seal of the issuing authority

Issued under Section 6*/7* of the Transgender Persons (Protection of Rights) Act, 2019 and under Rule See rules 2(g) and 5(4)] of Transgender Persons (Protection of Rights) Rules, 2020

*** Strike out whichever is not applicable**

@ only in case the applicant is a minor child

Form – 6

[See rules 2(g) and 7(4)]

Form of Identity Card Front side of identity card

State Emblem

State Government of (name of the State) Office of the District Magistrate

Identity Card

Identity card number

Photograph of the Card holder

Name

Mother's name@

Father's / Guardian's name@

Gender Male /Female

Date of birth **or** dd/mm/yyyy

Age as on the date of application for issue of ___years

identity card Reference number of certificate of authority on the basis of which this card is issued

Back side of the identity card

Present address

Permanent address

Card issue date Signature of the issuing authority

Designation

Seal of the issuing authority

@ Only in case of a minor child

Illustrative list of official documents referred to in_____

S No	Name of the official document
(1)	Birth certificate
(2)	Caste/ Tribe certificate
(3)	Any education certificate issued by a school, board, college, university or any such academic institution
(4)	Election Photo Identity Card
(5)	Aadhaar Card
(6)	Permanent Account Number (PAN)
(7)	Driving Licence
(8)	BPL ration card
(9)	Post Office bank/ Bank Pass book with photo
(10)	Pass port
(11)	Kisan Pass book
(12)	Marriage certificate
(13)	Electricity / water/ gas connection paper
(14)	Property papers,
(15)	Vehicle registration
(16)	Service book, employment papers
(17)	Identity card related to bar,
(18)	Policy papers

Chapter 13

Fitness to work: concepts and future development

Barikar C Malathesh, Shalini S Naik, Sydney Moirangthem, Suresh Bada Math

Highlights

- "Fitness to work" is dynamically influenced by the interaction of "demands of the work" and "abilities of the worker"
- There is no legislation for "fitness to work" assessment in India. However, Rights of Persons with Disabilities (RPWD) Act, 2016 deals with job related issues faced by disabled persons
- National Medical Council has prescribed fitness assessment for any illness, in its Professional conduct, etiquette and ethics regulations of 2002

Introduction

THE DEFINITION OF DISABILITY has evolved over years. Initially it was more clinical, but the current definition, as per United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) emphasises the role of attitudinal and environmental barriers in causing the disability. Similarly, the definition of fitness to work is also not clinical; rather it is dynamic in nature. Assessment of fitness to work is done to determine if an individual is fit to perform the job that is assigned to him without putting himself or herself or others at risk of harm, be it physical or psychological (1). "Fitness to work" is dynamic in nature because it is constantly influenced by the two other dynamic factors: "demands of the work" and "abilities of the worker". So, it is very essential to know the nature of the work that the employee is employed in and the abilities of the employee to decide if a particular person is fit to be employed in a particular job.

Historically "fitness to work" was initially used after the industrial revolution took place in 1700s. But it was restricted to merely observing absence of any major illnesses or deformity only. In 19th century the first legislation, British Factory Acts was introduced to mandate any sort of physical examination for industrial workers and it was still in rudimentary phase and did not provide any protection for labours those got injured or sick because of his job. In 1987 Workmen's Compensation Act was introduced in Britain which mandated providing compensation to any job-related injury / sickness, gradually similar legislations were enacted all over the industrialised world. To fulfil the above mandate companies started to collect a prescribed amount per year as premium and they would charge higher premium for someone who is at risk of injuring himself. Gradually people with any form of chronic illness, history of sick leaves or any form of incapacity started facing discrimination at recruitment process or even after being recruited. Additionally, pre-employment physical examination was introduced to minimise people with disability or who are likely to develop disability as it would save the compensation amount the industry

would have to pay out in case of disability later on. Similar principles were used during world war 2 in 1939 for the recruitment of army personnel (2).

The year 1944 marks a significant milestone when a report submitted to The American Medical Association (AMA) mentioned that health examinations should be used to achieve physical and mental wellbeing of the employee rather than to unfairly exclude / remove them from work. It led to formation of US War Manpower Commission in 1944 that made a novel attempt rehabilitating disabled people by identifying the jobs suitable for them depending upon their abilities and matching it with the work activities of the job. The next major step was taken by Dr B Hanman, who pointed out that the traditional medical examination for determining fitness has its own limitations and he brought in concepts of "Physical demand analysis" and "Functional capacity assessment". He criticised the vague descriptions that are commonly used in fitness assessments such as 'no heavy lifting', 'light duties only' etc, as these terms can mean differently to different people including the examiner, examinee, and employer. He was also of the opinion that the people from disabled category might be vastly different in their abilities, so the assessment of functional capacity of each individual needs to be tailored for that individual (2). Slavenski pointed out the limitations of traditional fitness assessments such as not basing them on analysis of job requirements, are informal and inconsistent, and how little scope the examinee has to demonstrate his capabilities.

Such a fitness assessment would lead to more unemployment, reduced productivity of the society and increase financial burden to the governments for the welfare of the unemployed. As the governments started realising the aforementioned issues, governments across the globe made it mandatory not to discriminate people based on illness or disability during recruitment, hiring, employment, compensation etc. The concept of fitness for work assessment too has got evolved over the years and assessment of mental health became part of fitness for job evaluation. Any disturbances in mental health, even before the diagnosis of a syndromal disorder, is likely to disturb the efficiency of an individual to dispense his / her job responsibilities and those who are going through the episode of mental illness are likely to have significant impairment in occupational functioning. Lincoln was the first person to describe mental health criteria in fitness assessment. His criteria's were concerned with motivation to work and career potential rather than examinee's mental health. As per his criteria, people with history of mental illness (PMI) were unemployable (3). As per the AMA 1973 guidelines, PMI with 'impaired judgment' during medical examination are considered unemployable. Both the above principles are against the human rights' codes and other labour organisation laws.

Psychiatric evaluations of fitness for work are generally done when the employee shows significant drop in work performance, goes on unauthorised leave or if there are significant disturbances in the behaviour in the form of aggression, disruption or any unusual work (4). Mental disorders are cited as reason for approximately 40% sickness absenteeism and they amount to 35% of the disability benefits (5–7).

Fitness to work assessment can be done either before employment or during employment. When it is done as part of pre-employment there are high chances that those with some form of disability, even if it does not affect their work capacity, are likely to face discrimination and get rejected at the recruitment

process itself as it was done in the past. This discrimination is against human rights and rights of persons with disabilities. As per Rights of Persons with Disabilities (RPWD) Act, 2016 certain jobs are reserved for those with disabilities, but this applies only to the government jobs. On the other hand, in private / unorganised sectors there is no such reservation, and they are likely to use the pre – employment fitness assessment to discriminate people with disability. In this chapter we are restricting the discussion to only post-employment fitness to work assessment.

Importance of "work" in "life"

Work is defined as "an activity in which one exerts strength of faculties to perform: (a) sustained physical or mental effort to overcome obstacles and achieve an objective or result; (b) the labour, task, or duty that is one's accustomed means of livelihood; (c) a specific task, duty, or function, or assignment often being a part of phase of some larger activity". Even though work and health are closely related, health is not always required to be in perfect condition for being employed and work doesn't always deteriorate the health. Interestingly, work plays a vital role in everyone's life. When work is not a part of regular employment, it will still help the individual through several domains other than monetary needs, such as identity, recognition, sense of purpose, source of self-worth, opportunity to develop his or her skills, feeling of autonomy, sense of independency, maintaining relationships etc. These domains hold therapeutic value in individual's physical and mental wellbeing. The person who is workless is likely to have higher mortality rates, higher long-term illnesses like hypertension and diabetes, sense of worthlessness and poor mental health whereas a person who is employed in a work is likely to have better social integration, better quality of life and better mental health. Hence, the government across the globe must try to integrate people with disabilities into work by taking necessary steps and thereby reducing the overall morbidity related to mental illness.

Relation between mental illness and job performance

Table 13.1 summarizes several ways through which mental illness can affect the work performance. Table 13.2 mentions assessment of psychological dysfunction due to illness, job and other factors.

Illness related factors

Mental illness affects one's ability to perform a job through multiple pathways. The "diagnosis" of the illness significantly influences the ability. A person with depression might not be suitable to jobs such as bus driver, train driver, flight pilot as there are incidents of suicides while they are in charge of a vehicle / flight. A person suffering from anxiety disorder might not be fit to drive a vehicle since he can lose judgment at the height of anxiety and end up with a road traffic accident. A person with uncontrolled psychosis is not fit for any of the risky jobs where there is treating to the safety of himself or others. These issues are discussed in detail further in the article.

Legal frameworks available in different countries

One of the very first legal bodies that was related address the issues of labours / workers is International Labour Organisation (ILO), which was established in 1919. In the initial years ILO was setup to address effect of colonisation on labour industry, but gradually with awareness of rights of labours ILO too

started addressing the rights. Till date there are 189 conventions that have been adopted by ILO. "Vocational Rehabilitation and Employment (Disabled Persons) Convention" is one such convention which was adopted in 1983. Article 3, 4 and 5 of the above convention mandates the ratified governments to promote employment opportunities for disabled persons in open market. During the same period United Nations declared 1981 as the "International year of disabled". In 1993 United Nations came out with standard rules on equalization of opportunities for persons with disabilities, though it was not a legally binding instrument it represented strong moral and political commitment of the government to attain equalisation of opportunities for persons with disabilities. In line with the above global legal statutes different countries have passed different legislations to protect employment rights of disabled.

Table 13.1: Impact of mental illness on work performance

Psychological domain	Affected in	Its effect on work
Cognitive abilities	Mental retardation, head injury, depression, schizophrenia	Low intelligence, poor academic abilities, Impaired memory, Poor executive skills
Psychomotor speed	OCD, Depression	Slowness in work
Reliability	Cluster B personality disorder, Depression, Somatization disorder, Agoraphobia	Person might be irregular work there by impairing job performance
Motivation to work and dutifulness	Cluster B personality disorder, Depression	Might not be motivated enough to do work and might be manipulative and miss the deadlines
Interpersonal relationships	Cluster B Personality disorders, Bipolar affective disorder, Schizophrenia	Might not be able to take orders from supervisors, might not get along with co-workers and juniors
Being honest and truthful	Anti-social Personality Disorder and borderline personality disorder	Might start lying at work and put the blame on others for missing deadlines.
Ability to handle stress	Schizophrenia, Post Traumatic stress disorder, Acute stress disorder, anxiety disorders, depression	Might get relapse of the illness When the work pressure mounts and go on long leaves
Impaired Judgment	Psychosis, Mania	Might put oneself and others at risk

Canada, United States of America & United Kingdom

Section 15 of Canadian Charter of Rights and Freedoms, which is part of Canadian constitution, clearly spells that there should not be any discrimination based on any disability in any of the government programmes, further section 15(2) of the same document mandates promotion of programs aimed at improving employment opportunities for people with disabilities. Canadian Human rights act of 1977, amended in 1985 prohibited any form of discrimination against people with disabilities. Employment Equality Act was passed in 1995 advocates to abolish any form of discrimination against disabled people at workplace. Another legislation preserving the rights of disabled is "Accessible Canada Act" which was passed in 2019 after ratifying UNCRPD (8–10). In USA the Americans with Disabilities Act of 1990, further amended in 2008 prohibits any form of discrimination against people with disabilities. This legislation also prohibits any form of discrimination against people with disabilities. Any person who has taken leave under Family and Medical Leave Act can be asked to get the fitness to work certificate in the prescribed format. When the employer sends the employee for fitness to work assessment, employer can mention the list of essential job functions that employee should possess (11,12). The legislation which protects the rights of disabled in UK is The Equality Act of 2010. As per this legislation no one can be terminated from job because of a disability and no one can be rejected during recruitment process because of a disability (13,14). The above legislations broadly speak about preserving rights of persons with disabilities and making modifications in the working environment to suit people with disabilities. There is no specific legislation dealing with return to work in Canada and United Kingdom.

Table 13.2: Multifactorial assessment of dysfunction due to illness

Illness related factors	*Job related factors:*
Diagnosis	Risk to other
Duration of illness	Risk to self
Course of Illness	High responsibility jobs
Medications	*Other factors*
Any disability	Familial support
Risk of violence / self-harm	Medication supervision
Symptom profile & residual symptoms	

India

There is no legislation directly dealing with fitness to work assessment, but the legislation that is concerned with job related issues of disabled persons is Rights of Persons with Disabilities (RPWD) Act, 2016. Even though "fitness to work" assessment is not done exclusively for people with disability (PWD), majority of them will have some form disability leading to work impairment. Section 20 of RPWD act specifically deals with the issues of employment in PWD, as per which any government servant who

acquires any form of disability during service cannot be dispensed and demoted, but he/she should be given a post that is appropriate for him/her. Now to understand if the existing job would be appropriate or what sort of job would be suited for this person, he needs to undergo fitness assessment.

Even though none of the above legislations directly speak about the assessment of fitness to work, all of these indirectly point towards inclusive environment for persons with disabilities and to ensure the same, fitness assessment is essential.

Past studies conducted on fitness assessment

There are multiple studies that have been conducted on fitness for job assessment in different employment areas. A study conducted on fitness for work assessment referral in a general hospital of India has found that the most common reason for referral was absenteeism and most common diagnosis among the referral was substance used disorder. It was interesting to note that only 22% were unfit for job rest were either immediately fit to resume or were temporarily considered unfit till next evaluation. Almost half of those who were unfit had organic mental condition, which was unlikely to improve so had to be considered unfit. There was no structured tool used for assessment of fitness (15). Another cross-sectional study conducted at Dammam on 116 fitness to work referral also had similar percentage of people being considered unfit, which was 20%. The unfit group had more cases of psychotic spectrum, more likely to be on antipsychotics, longer duration of illness, more hospitalisation days and more frequent hospitalisation. There was no structured tool used in assessment of fitness, but they had selected few items from WHO Health and Performance Questionnaire (16). Another study conducted in India found that 17% were considered unfit for work and almost 40% has no psychiatric illness at all (17). These studies suggest that generally majority of the examinees will not be having active psychiatric illness and majority of the referrals tend to be fit for duty. But there is no standard and validated assessment method used in any of these studies. There is need to develop a tool for structured assessment for fitness to work.

Who examines the patient for fitness assessments?

Whenever a person is asked to get the fitness to work evaluation done it is quite obvious that they will first approach their treating psychiatrist. Most of the disability evaluations generally do not require expertise in forensic psychiatry, but when it comes to assessing the fitness to work forensic experience comes handy because of dynamic nature of the concept itself. Past studies have suggested that donning the dual role of forensic psychiatrist and treating psychiatrist leads to ethical conflicts, as the primary duty of forensic psychiatrist is welfare of the state and treating psychiatrist is welfare of the patient (18,19). Having a dedicated forensic psychiatrist for fitness to work assessment is a distant dream in India as there is shortage of psychiatrists. Alternately, a general adult psychiatrist who is not treating psychiatrist of the patient can perform the assessment.

General principles while conducting fitness for duty evaluation

Initiation of assessment process

Majority of fitness evaluations in India are initiated with the employer making an official request, through a letter, to one of the government psychiatrists / psychiatry department/ psychiatry institutes.

If the individual working in any of the institute requests for a fitness certificate he/she should be instructed to obtain a request letter from his employer for the same. After receiving the request, the concerned psychiatrist who is supposed to conduct the fitness assessment, should ideally clarify reason for referral and the timeframe within which the report should be submitted. Psychiatrist in charge should explain the examinee about the need of collateral information, from whom it will be collected, the charges of the assessment (hospital charges), to whom the report will be sent. Then consent should be obtained from examinee for examining him/her, for contacting his/her employer / supervisor and for sending the report to the concerned authorities. Few authorities want the report to be sent in a confidential manner, the same should be clarified with employer and conveyed to the examinee and stated while obtaining the informed consent. The psychiatrist should also ensure that he or she has clear idea about the questions for which the employer needs the answers. Just mentioning the name of the illness is not going to serve any purpose so the assessment should address the specific questions for which employer needs clarification. The employers who send regular referrals for fitness assessment will have fair bit of idea with respect to questions for which they need answers from the psychiatrist. But an employer who is sending his employee for the fitness assessment first time will not have clear idea and will not be able to frame the questions to the psychiatrist properly. In such situations the psychiatrist with the help of psychiatric social worker may contact the referral agency and clarify the reason for referral (see tables 13.3 and 13.4) and can also obtain patient's work performance report, his or her job description, any disciplinary action taken against him or her and supervisors' observation which led to fitness referral. Following this, the time frame required for the assessment should be conveyed to the referring agency.

Table 13.3: Patient's health conditions where fitness to work assessment are needed

a. Patient's health condition might be a limit the performance of the job.
b. Patient's health condition may get deteriorated because of the work profile.
c. Patient's condition might not be suitable for certain jobs, putting them at unreasonable risk of injury.
d. Patient's condition might put co-workers at risk of injury.
e. Patient's condition might put the community at risk

Table 13.4: Timelines when the fitness to work assessment is required

a. Being recruited for the first time into a job
b. Being transferred to a new job, including promotion
c. Returning to work after major illness or injury
d. After prolonged absence
e. As a part of periodic review
f. Significant change in the employee's behaviour which has resulted in significantly reduced work performance.

Conducting examination

Following above the psychiatrist can initiate the detailed evaluation of patient's illness. While conducting the assessment the psychiatrist should do objective examination without keeping in mind the outcome and the consequences by using neutral and non-confrontational approach. The patient should be informed that the typical doctor-patient relationship doesn't exist here and the psychiatrist is providing his services for the state and not to the patient (20). The privacy of the patient should be given utmost importance. A disclosure should be made that the complete confidentiality will not be maintained as the assessing psychiatrist is supposed to send the assessment report to the referring agency. It would be better to conduct the examination in inpatient setting where there will be adequate time to conduct the details examination and adequate observation too can be done with respect to the behavioural disturbances that are noted by the employer. At no point of examination, empathy or any other psychotherapeutic skills should be used to manipulate the patient or other informants so as to obtain the information. The above conduct is considered unprofessional and unethical (19). If at any point of time, the psychiatrist suspects malingering then the focus of discussion must highlight discrepancies in the facts but an argumentative approach should never be used (21).

Data collection Phase

In addition to the usual details that are collected during any psychiatric interview, there are few additional details that should be collected carefully. Those details include work history, collecting collateral information by significant others and performing psychometric testing wherever necessary. In addition to usual illness details, the details about the event which resulted in current referral for fitness assessment should be obtained in detail. Work history should include the level of patients functioning at workplace before the current referral, the event and the work impairment that led to the referral. Any discrepancy between the patient's version and the employer version of events leading to referral should be adequately explored. In case of unauthorised long absenteeism, the reason for being absent, the efforts made by patient to inform his employer about his absenteeism and efforts made by the patient to re-join work should be enquired.

The patient's medical, family, social and legal history should be enquired. Document any recent or past exposure to stressful events, presence of current/ past psychiatric symptoms, any psychiatric treatment in the past, history of substance use and any psychiatric treatment details. Explore patient's personality traits, coping strategies and frustration tolerance. Explore any behavioural disturbances in the past that occurred at the workplace, if present what was the action taken by the employer in the past. Using multiple sources of information helps psychiatrist reach accurate diagnosis.

Specific work-related assessment

Merely arriving at psychiatric diagnosis is never sufficient in fitness assessment, as it doesn't provide sufficient evidence for presence of impairment or disability. None of the diagnostic categories translate to complete disability or impairment in a specific domain (table 13.1), so it is essential to carry out further examination of specific domain which is "key domain" as per their job profile. After reaching the psychiatric diagnosis it is very essential to ascertain if the patient has reached full remission of the illness

or not. If the patient has not reached full remission, then a rough approximation of likelihood of remission should be made. If the illness is not likely to show any further improvement, then specific job-related assessment should be done at that point itself. If the patient is likely to improve further, specific job-related fitness assessment can be done at a later point and the same should be informed to the employee by providing a temporary unfit certificate to the patient. If the patient has improved or stabilized with partial improvement or unlikely to improve any further, then the psychiatric fitness assessment should be conducted. This assessment should be tailored for each patient as per their job profile and specific "key domains" (given in table 13.1) should be assessed in dept depending upon their job profile. General rule of thumb is to first understand the high responsibility tasks that are involved in their job and then to assess impairment in the "key domain" can affect those high responsibility tasks. We would like to discuss common referrals that come for fitness to job assessment and the key domains of assessment in those patients.

Clinical case scenario 1

In a bus driver referred for fitness assessment, the high responsibility task is driving the vehicle safely so that he doesn't meet with accidents. For driving vehicle safely, the person should have adequate concentration, quick reflexes, adequate judgment and no active hallucinations / delusions. In such cases the person should be checked for impaired concentration, slowness in reaction time, impaired judgment etc. If the referred bus driver has OCD, he might find it difficult to touch the parts of the bus as he might feel that the parts are contaminated. If the reaction time slow because of depression, psychosis then he/ she might end up with accidents due to reduced speed of reflexes. If the Driver has active delusions / hallucinations he might put others at risk of accidents because of impaired social judgment.

Clinical case scenario 2

In a bank officer sent for fitness assessment, the high responsibility task involves handling the finances of the customers. He/she should be evaluated for any persistent cognitive deficits as he is likely to handle big financial amounts and any mistake in calculations will lead to mishandling the money of customers. If the person is working in a very busy bank branch, we should expect him to work at reasonable pace. If the person has slowness because of psychosis or medication, or because of depression then it is likely to disrupt the work and cause inconvenience to the customers.

Clinical case scenario 3

In an army person or a police officer sent for fitness assessment, high responsibility task involves handling the firearm. In such cases we should look for any illness related factors that can cause mishandling of firearm leading to harm to himself or others. If he/she is suffering from depression with active suicidal ideas, he/she might use firearm to commit suicide. If the person has active persecutory delusion or if he/she is in manic phase he/she might use firearm to kill someone else because of impaired judgment. If the person is having cluster B personality disorder with significant impulsive behaviour, then he/she might use firearm as an impulsive reaction to minor stressful events.

Clinical case scenario 4

If a peon sent for fitness referral, the high responsibility task is shifting the documents appropriately from one officer to another officer. If he/she is suffering from active delusions / hallucinations the document might get misplaced. If he or she has cognitive deficits the document shifting might get slowed down. There is no significant financial loss or harm to anyone even if the document gets misplaced.

Each clinical case scenario highlights domain that specifically needs to be assessed in accordance to their job profile. Other than illness related domain, we should also assess the medication related side effects and make the necessary adjustments in medication so that it doesn't cause significant impairment at work. For example, a surgeon having tremors as side effect of medication is likely to face significant impairment compared to a psychiatrist having the same. Another common domine that needs assessment in almost all fitness referrals is stress tolerance and the amount of stress present at the workplace, as excessive psychological stress can cause relapse of almost all psychiatric illnesses.

Writing the report

The fitness assessment report should be detailed, comprehensive, address the specific questions raised by referring agency and should not include unnecessary details that are not related to the fitness assessment outcome. The sensitive personal information can be omitted if it is not directly related to fitness assessment outcome such as history of marital discord, history of extramarital affairs, sexual orientation etc. Mentioning the diagnosis is questionable as doing so will cause breach in the privacy of the patient. The referral is for the assessment of fitness to work, so the same can be mentioned without revealing the details of the illness.

Report should consist of three important sections. Initial section of the report should contain the reason for referral, the specific questions raised by the referring agency, warning on the limitations of confidentiality and list out the informants / documents used in preparing the document. Second section should include the examinee's version of the events that led to the current referral; the employers version of the events that led to the referral; psychiatric, medical, personal and any other significant history; and finding of mental status examination. It must also include brief report of the interviews done with other persons such as family members, work supervisors etc.

Third section should include the diagnosis (if patient agrees), the specific impairments in the "key domain" and how it might affect the work efficiency, the likelihood of improvement or no improvement in future, the recommendations about the treatment and fitness opinion. The opinion on fitness to work should be on whether he or she is fit for current job; if fit, does he or she require any modification in the work environment; if unfit, then is it permanent or temporary dysfunction and what sort of jobs he or she can perform. When patient is considered fit, it is also prudent to describe behavioural abnormalities that are likely to be present, so that the employer finds it easy to accommodate the employee at workplace. Psychiatrist should also mention if patient needs re-examination after a specific period as there is likelihood of change in his/her condition. If the reduced work performance and fitness assessment referral was because of a maladaptive personality trait, and not related to illness related impairment, the same should be clearly mentioned in report. A logical explanation should be given with

regard to how patient is fit for the duty or unfit for the duty. Any early warning signs and symptoms should be clearly mentioned in the report, so that the employer refers the patient at the earliest in case of relapse or exacerbation.

Fitness certificate format

National Medical Council has prescribed a fitness format as per Professional conduct, etiquette and ethics regulations of 2002 (22). But this format is a general format for any illness and not specifically tailored for psychiatric fitness assessment. There are few drawbacks of using this format for psychiatric fitness assessment like mandate to mention the illness name, no provision for mentioning the key domains assessed no provision for explaining in detail why the person is considered unfit for a job. The implications of mentioning a physical illness and a psychiatric illness are completely different because of stigma that comes along with psychiatric illness. We propose a new format for reporting the psychiatric fitness evaluation, which is in appendix 13.1.

Conclusion

There is neither legislation nor established guidelines on the procedure of carrying out the fitness to work assessment and certification. Inclusion of both performance (i.e., functional testing) and non-performance (i.e., self-reported disability, social assessment) measures provides comprehensive information about an individual's ability to return to work. Fitness to work assessment may help the employer and the employee; however, it must be directed at the job in question. In all circumstances, it will be a good practice to fulfil the legal right 'reasonable accommodation' of a person if has disability within the definition of the RPWD Act, 2016.

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Appendix 13.1

Fitness to work assessment report template

i. This is to certify that a person named Mr/Ms_____
aged ___, with identification marks _____
working as _____ _____ at _____
has been referred by _____
for the evaluation of fitness to work as _____

ii. This referral is made because of the below observation the employer
   a.
   b.
   c.
   d.
   e.

iii. We would like to declare that the confidentiality of the patient's illness and disability will not be maintained, as the report is being sent to the referring agency.

iv. In preparing the below report following individuals were interviewed and following documents were reviewed.
   a.
   b.
   c.
   d.
   e.

v. As per Mr/Ms _____ he/she has been referred for fitness assessment for the following reasons.
   a.
   b.
   c.
   d.
   e.

vi. The history of illness and treatment were collected by interviewing the following persons and reviewing the following records
   a.
   b.
   c.
   d.
   e.

vii. Following above step, it was found that (relevant psychiatric, medical, personal history and physical and mental status examination findings to be mentioned below) _____

viii. After obtaining above history and mental status examination it was found that the person is suffering from _____ (to be revealed if patient agrees otherwise ICD code to be used). The illness is likely / unlikely to improve / worsen in future.

ix. Reassessment of the patient would be done after _____ as it is likely that the patient's condition would change. (strike off if not applicable)

x. The key domines in carrying out his job profile include _____ _____

xi. Explain the impairment in the key domines and how it is likely to affect the work efficiency of the employee below _____

xii. Because of the above facts we consider that Mr / Ms _____ is currently temporarily / permanently, fit / unfit to work as _____ _____

xiii. The employees' psychiatric condition has got stabilised / is likely to change in future, because of which the reassessment is advised after _____ / not advised.

xiv. If unfit for current job, please recommend few points about what job he would be able to carry out or what modifications he would require at the workplace _____ _____

xv. Any other recommendations including recommendations about medications and follow up visits should be mentioned below _____ _____

xvi. I Dr. _____ certify that the examination of Mr / Ms _____ _____ was carried by me and I certify that the examination was done in a non-judgmental approach at the request of _____

The above fitness opinion is applicable only for the current illness; any new onset of symptoms or behavioural disturbances would require a fresh referral for another assessment.

Place_____, Date _____

Signature_____

Name and Registration number of the psychiatrist_____

Chapter 14

Protection of Women from Domestic Violence Act, (PWDVA) 2005

Prakyath R Hegde, Bhavika Vajawat, Shalini S Naik, Suresh Bada Math

Highlights

- World over, 1 in 3 women are victims of physical and sexual violence by their partners and 40% of homicides against women are committed by their intimate partners.
- Women with mental illness (MI) are at risk for Domestic Violence (DV) and abuse in turn has an impact on developing a psychiatric illness. Thus, they are dual victims of both MI and DV
- Psychiatrists can address by identifying DV, ensuring their safety, offering psychological assistance and empowering them to handle DV through legal and societal means.

Introduction

DOMESTIC VIOLENCE (DV) is a serious, preventable, public health concern experienced by 40% of the women at the hands of their partners worldwide (1). Any form of behaviour, actual or threatened, by a male member in the household to gain control or power over a woman who could be his wife, girlfriend, or any other female member constitutes DV. Momentum for the policy intervention in this regard came after the General Assembly of the United Nations passed the "Declaration on the Elimination of Violence against women" in 1993 (2). Following this, DV was extensively researched which led to more data on the prevalence, pathways, causes and systematic mechanisms for redressal. DV is ubiquitous affecting all socio-economic and cultural strata and is often committed by the ones who are assumed to have a protective role in the family. In India, until recently there was no separate civil law to address the specificities of this complex problem. In September 2005, the "Protection of Women from Domestic Violence Act, (PWDA) 2005" was enacted, which guaranteed the rights of women are protected and upheld (3).

Extent and nature of domestic Violence

The actual incidence of domestic violence is difficult to measure. It's largely underreported for the fear of the consequences, societal stigma, economic reason, denial and even unawareness. Denial and unawareness that they are trapped in the DV cycle (figure 14.1) leads to under-representation of the problem. The abuser will initially charm the victim, and isolate her from her support system. Following this, to exercise a sense of control the abuser starts abusing, and subject her to violence. This follows a reconciliation phase, following which the abuser again charm her and isolate her, to continue with the incessant cycle of domestic violence.

Official statistics are maintained which has its limitation in measuring the actual extent of DV. Limitations are because of methodology in the collection of data, which is usually self-reported or through reports on crime. "National Family Health Survey (NFHS) is a large-scale, multi-round survey conducted in a representative sample of households throughout India, which collects self-reported responses for spousal violence. In 4th NFHS (2015-16) (4), 30% of married women reported to have experienced spousal violence (physical and sexual) and 4% have experienced it during pregnancy. Only 14% sought help to stop domestic violence. This could be an under-estimate as women may prefer not to disclose that she was abused and even minimise the amount of violence she has suffered.

Abuser-victim-duo follows a course of interaction that culminates into domestic violence as depicted in figure 14.1.

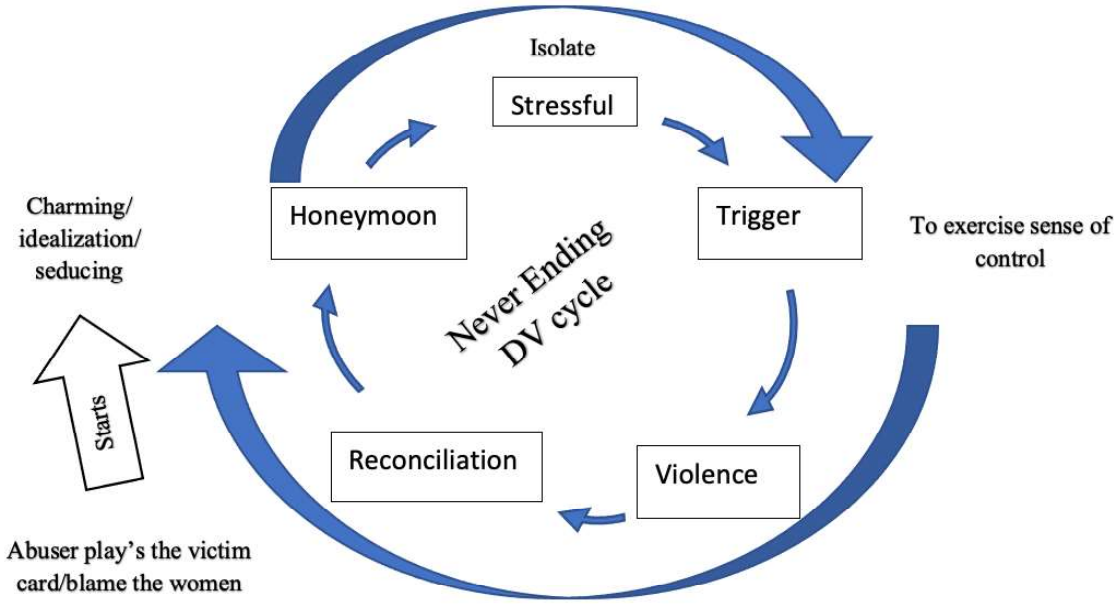

Figure 14.1: Incessant cycle of domestic violence

NCRB (National Crime Records Bureau) periodically collects data related to crimes from all the states across the country. As per NCRB 2019, 30% of the crimes against women are registered under Section 498A of the IPC, which deals with 'cruelty by husband or his relatives (5). This shows that the problem of domestic violence is significant, making a large portion of crimes against women.

Globally 1 in 3 women are a victim of physical and sexual violence by their partners. As much as 40% of homicides against women are committed by their intimate partners. Additionally, 6% of women reported that they are sexually abused by men other than their partner.

COVID-19 pandemic has led to uncertainty, unemployment, frustration and an increased time spent at the household because of nationwide lockdown. This has led to increased exposure of women to abusive partners, leading to an escalated prevalence of DV globally, including in India. 5th NHFS (2019-2020) has released data for 22 states/Union Territories (UT) recently. In this, seven of the 22 states/UT's have shown an increase in the prevalence of spousal violence since the last survey(6).

Systemic reviews have shown a higher prevalence of DV's among persons with all types of psychiatric disorders (7). Cross-sectional studies done in India, have shown that two-thirds of the spouses of persons with alcohol dependency were victims of DV (8). Patients with schizophrenia are at a higher risk of DV against them and also reported higher rates of psychopathology (9). This shows that both mental illness in the victim and the perpetuator plays a role in increased prevalence in this subset of the population.

Types of Domestic Violence

Broadly DV can be divided into physical abuse, emotional abuse, sexual abuse, economical abuse or even controlling behaviour.

Table 14. 1: Types of Domestic Violence

Physical abuse *includes hitting, slapping, or beating on trivial issues or without any reason. It can range from single or repeated assaults to even death.*
Emotional abuse *includes insulting, threatening to separate from the children, stalking, acting out on infidelity-related doubts, and intimidation.*
Sexual abuse *includes sexual coercion, refusing to use contraceptives and deliberately passing on STD.*
Economical abuse *includes restricting access to the finances and other resources to which she is entitled.*
Controlling *behaviour includes isolating from friends and families, depriving them of their support system, not giving freedom of choice, making the victim believe that she is incapable of surviving alone.*

Risk factors for Domestic Violence

The causes of DV are multi-factorial and can be divided into environmental factors, victim factors, and perpetrator factors (see table 14. 2). Mental illness in both the victim and the perpetrator is a risk factor for DV. Women with mental illness have to bear the brunt of being a victim of DV and that of mental illness, which is termed as "Double disadvantage".

Table14. 2: Risk Factors for Domestic Violence

Environmental factors	Victim factors	Perpetrator factors
Socio-cultural traditions	Young age	Low income
Weak community sanctions	Low education	Low education
Patriarchal societal norms	Financial dependency	Recent job loss
Poverty and weak legal and criminal justice system	Separated/divorced marital status	Antisocial personality & Substance abuse
Decreased outside access (e.g.: COVID -19 pandemic)	Exposure to violence as a child – Parental violence	Exposure to violence as a child– Parental violence, Sexual abuse

Health consequences of DV

Women bear various health consequences of DV which have been discussed under the following headings:

(i) **Physical consequences**: Physical injury can be both a consequence of direct injury from the assault or may lead to chronic medical illnesses. Victims of DV reported a higher prevalence of musculoskeletal pain, gastrointestinal disorder, gynaecological disorder, and sexually transmitted diseases (STDs). A study done by WHO in 2013 has found that abused women are 1.5 times more likely to have STDs. Unintended pregnancies, abortion, and various menstrual disorders like pelvic pain and dyspareunia are reported in victims of DV. Abused women are twice more likely to have an abortion.

(ii) **Mental health consequences**: The relationship between mental illness and DV is bidirectional (see figure 14.2). While persons with psychiatric illness themselves are a risk factor for DV, it is also a result of abuse, leading to a vicious cycle of psychiatric illness and abuse. Additionally, survivors of DV are at a higher risk of developing depression, anxiety, suicide, somatoform disorder, and sexual dysfunctions.

(iii) **Risky behaviour**: In both the perpetrator and the victim high-risk sexual behaviour in the form of decreased use of the condom, multiple sex partners can occur, in addition to abuse of substance use.

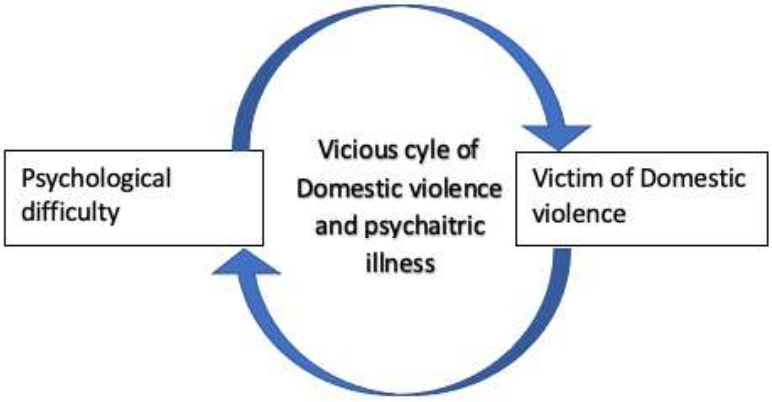

Figure 14.2: Vicious cycle of domestic violence and psychiatric illness.

Legislature on Domestic Violence

India has adopted the "Convention on the Elimination of All Forms of Discrimination against Women" and the "Universal Declaration of Human Rights", both of which ensure that women are given equal rights as men and should not be subjected to any kind of discrimination (10). Article 15(3) gives power to the legislature to make special provisions for women and children. To exercise this power, the Protection of Women from Domestic violence Act was passed in the parliament in 2005 (3).

The term "Domestic Violence" is defined in the act as any conduct done against the woman by a partner or a spouse and his relatives which has affected the wellbeing of the woman. Both omissions of care such as neglect and commission of abuse are accounted as domestic violence. It includes the actual abuse and even the threats of abuse whether physical, sexual, verbal, emotional or economic. Although primarily it is meant to protect wife or female live-in partner, it extends to women who are sisters, widows, or mothers and any woman living in the same household. It further includes unlawful demand for dowry to the woman or her relative.

The salient feature of the Protection of Women from Domestic Violence Act 2005 (3)

- The Protection of Women from Domestic Violence Act came into force on 26th October 2006 by the Ministry of Women and Child Development.
- DV includes not only actual abuse but also the threat of abuse and includes physical, sexual, verbal, emotional and economic abuse.
- Only a woman can be an aggrieved person under the law and should be in a domestic relationship with the respondent/abuser.
- Although reporting of DV is not mandatory, any person who has a reason to believe that the DV has happened can report to the information officer.
- The act caters to the woman's right to reside in the matrimonial or shared household, irrespective of her title in the household.
- The act provides for the appointment of protection officers to assist the woman with her legal aid, safe shelter, and also medical examination.
- The act considers a breach of protection order by the respondent as a cognizable and non-bailable order which is punishable with imprisonment for a term that may extend to one year or with a fine that may extend to twenty thousand rupees or both.
- Economical abuse in the act would include deprivation of financial resources she is entitled under any law or custom. Even restricting access to the resources, or disposing of household effects, which a woman in a relationship is entitled to be considered as abuse as per the act.

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Assessment Tools

Many tools have been designed to screen for DV. The most widely used tool in research and medical literature for DV is Conflict Tactics Scale (CTS-2) which is a 39-item to evaluate intimate partner violence. Other common tools include the Partner Violence Screen(PVS), the Women Abuse Screening Tool(WAST), the Two-Question Screening Tool and the abuse assessment screen(AAS), which are short survey tools making their usage practical in a clinical setting. Centre for women's Studies and Development Research Institute, Rajagiri College of Social Sciences, Kochi has developed a tool for domestic violence against women in the Kerala interview schedule (11). The interview schedule covers mainly victim profile, type of violence, reasons for the violence, nature, manifestations, frequency and consequences.

STEPWISE APPROACH TO DOMESTIC VIOLENCE
Whenever Domestic Violence is suspected: Domestic Violence should be suspected in all patients who presents with an inconsistent explanation of the injury, delay in seeking treatment, and poor adherence to health advice.
Assessment of intimate domestic violence: In patients suspected to have domestic violence, the patient should be interviewed in privacy. At all stage, confidentiality should be ensured, unless there is a serious danger, where reporting may be necessary.
Offer support: The first consideration when DV is disclosed is to offer support. It's done by empathizing, acknowledging, and expressing continued support to the victim.
Ensure safety: It should be immediately followed by ensuring the safety of the survivor. Often the survivors deny their danger. So, it becomes important that their fears and concerns should be addressed, to have a plan in place for their safety.
Empowerment of the victim: Empowerment of the survivor by providing information about the provisions in the law, and facilitating her ability to make her own decisions should be done. She should be educated about her rights and empowered to assert her rights to live with dignity.
Assessment and treatment for Mental Health: Irrespective of whether the woman has a clinical disorder or not, it's important to assess for mental health problems and provide support. Specifically, a woman should be assessed for Anxiety, depression, and PTSD, Substance use, Suicide risk, somatoform disorder, and Sexual Dysfunction. Once a comprehensive assessment is done, a specific treatment plan for the mental health problem should be initiated from the first visit itself.
Referral to Legal Aid Clinic: A referral to Legal Aid clinic is helpful in providing assistance with reporting and guidance about the need for reporting. It helps to seek protection legally and to issue a warning to the perpetrator. As per MHCA-2017, section 27, all persons with mental illness have the right to access free legal aid (12).
Liaison with other professionals: If the women need temporary shelter, it's useful to have a network of NGOs, police personnel, and lawyers, so that women can access them easily. Referral to a social worker to assess her support system and strengthen her support can be done.
Reporting to the protection officer: Severe DV will require the clinician to report to the DV protection officer, preventing the perpetrators from contacting the patients. As per MHCA 2017 section 23, which deals with confidentiality, its prudent to "release of Information if it is necessary to protect any other person from harm or violence", thereby ensuring the safety of the patient (12)

Conclusion

Women form a higher proportion of domestic violence victims and often do not exit the abusive domestic relationships due to lower political-social and economic decision-making power. The Protection of Women from Domestic Violence Act (PWDVA), instituted in 2005, is legislation aimed at protecting women from violence in domestic relationships and providing a simplified procedure for women to access civil and quasi-criminal remedies.

Resources in India

https://wcd.nic.in/document/domestic-violence

Telephone resources	
Women helpline (WHL) for domestic abuse	181
Women Helpline – Women in Distress	1091
Lawyer's collective women rights initiative (LC WRI): Legal Aid cell for Domestic Violence cases	(011) 24373993/ 24372923 010
All India Women's Conference	10921
Shakti Shalini	10920
Action India	011-26692700
SAARTHAK	011-26853846
Saheli (Saturday only)	011-24616485
Jagori	011-26692700
Nirmal Niketan	011-27859158
Nari Shakti Samiti	011-23973949

Video link: https://youtu.be/hS6RdsiIpWM

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