Page 646 - 652 **DOI:** *https://doij.org/10.10000/IJLSI.111346*

INTERNATIONAL JOURNAL OF LEGAL SCIENCE AND INNOVATION

[ISSN 2581-9453]

Volume 4 | Issue 1

2022

Mental Healthcare Act, 2017

SANJANA RATKAL[1]

ABSTRACT

India has been facing the worst mental health crisis in a very long time. Within the pandemic itself, the situation has worsened. With suicide rates increasing and the treatment of any individual with mental illness with hostility or belittlement, mental health as a legal concept is more needed now than ever. This article looks at the Mental Healthcare Act of 2017 and analyses how much farther we are yet to go.

I. INTRODUCTION

Health encompasses the composite union of physical, spiritual, mental, and social dimensions according to the World Health Organization (WHO), which recognises that "mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful, become creative and active citizens."

Mental health is significantly different from general health as in certain circumstances, mentally ill people may not be in a position to make decisions on their own.[2]

On march 27th of 2017, the Mental Healthcare Act 2017 was passed, which got its approval from the Honourable President of India in April 2017.

The Act rescinds/revoked the existing Mental Healthcare Act 1987, which had been widely criticised for not recognising the rights of a mentally ill person and paving the way for isolating such dangerous patients.

The Mental Healthcare Act 2017 aims to provide mental healthcare services for persons with mental illness. It ensures that these persons have a right to live life with dignity by not being discriminated against or harassed. There are many positive/constructive aspects to this bill, but it is not without its shortcomings; it is not foolproof in the Indian context.

The Act has played a massive role in allowing for accessibility to mental health sufferers and provides mental health services to all. This right is meant to ensure that services be accessible, affordable, and of good quality.

It also mandates the provision that mental health services be established and available in every district of the country.

However, keeping in mind the already inadequate medical infrastructure at district and subdistrict levels, the financial burden to be borne by the state governments will be huge

[1] Author is a student at VIT Chennai, India.

[2] Mental Healthcare Act 2017: Need to Wait and Watch, Abhisek Mishra and Abhiruchi Galhotra, 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5932926/

 [ISSN 2581-9453]

unless the central government allocates a larger portion of the budget to incur the expenditure.

Yet even during the pandemic, when the mental health crisis is at its most critical, the paltry amount designated towards medical health facilities during the budget 2021 is unfortunate.

In our country, where mental illness is considered equal to depression, the obvious financial burden on the government will be too high. For the financial year 2017–2018, the proposed health expenditure of 1.2% of the gross domestic product in India. It is among the lowest in the world, and the public health expenditure has consistently declined since 2013–2014. India spends 0.06% of its health budget on mental health care, which is significantly less than what Bangladesh spends (0.44%). Most developed nations spend above 4% of their budgets on mental health research, infrastructure, frameworks, and workforce, according to a 2011 WHO report.

II. EXCERPTS FROM THE ACT

Section 3 (3)

"Mental illness of a person shall not be determined on the basis of–

(a) political, economic or social status or membership of a cultural, racial or religious group, or for any other reason not directly relevant to the mental health status of the person;

(b) non-conformity with moral, social, cultural, work or political values or religious beliefs prevailing in a person's community."

Section 3(4) "Past treatment or hospitalisation in a mental health establishment though relevant, shall not by itself justify any present or future determination of the person's mental illness."

Section 3(5) "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 has been declared as such by a competent court."

III. CHANGES FROM THE 1987 ACT

Mentally ill persons often lack the ability to make sound decisions and do not always have a relative to speak for them on their behalf. In such a situation, treating physician is the best to take decisions because patients or their nominated representatives have limited knowledge on mental health and mental illness. Hence, from a physician perspective, this new directive will definitely lengthen the time of admission of mentally ill persons.

The Act further recognises the right to community living; right to live with dignity; protection from cruel, inhuman, or degrading treatment; treatment equal to persons with physical illness; right to relevant information concerning treatment, other rights and recourses; right to confidentiality; right to access their basic medical records; right to personal contacts and communication; right to legal aid; and recourse against deficiencies in the provision of care, treatment, and services.

The Act assures free quality treatment for homeless persons or for those who belong below the poverty line (BPL), even if they do not possess a BPL card.

The newly introduced decriminalisation of suicide is definitely a welcome move. There

could be very much a possibility of misuse of this bill, but it is still a step in the right direction, according to many.

Not everything is sunshine and rainbows, however. In developing countries like India, persons with mental illness and their situations are being aggravated by socioeconomic and cultural factors, such as lack of access to healthcare, superstition, lack of awareness, stigma, and discrimination. The bill does not direct any provisions to address these factors. The mental healthcare bill does not offer much on prevention and early intervention.

While the new Act makes several provisions, it provides no guidelines or rules of implementation.

IV. LEGAL POINT OF VIEW

While on the one hand, a psychiatrist would be most concerned over the patient's mental diagnosis and the patient's welfare, the court tends to focus more on the competency of said patient, how much of a risk they can be and more on the welfare of society rather than the welfare of the person.

Prior to the 2017 act, India was governed by the mental health act of 1987, which focused n exactly that legal perspective, thus inviting scathing critiques from many. However, legislations drafted after the eighties tend to give some stress on the rights of people with mental illnesses also.[3]

The 2017 Act envisages the right of the patients to access a range of mental healthcare facilities that weren't allowed to them prior to 2017.

In case these services are not available, a person with mental illness (PMI) is entitled to compensation from the state. Various rights such as the right to community living, right to confidentiality, right to access medical records, right to protection from cruelty and inhumane treatment, and right to equality and non-discrimination are all ensured by the law. It does not make distinctions amongst the PMI on the basis of poverty though all destitute and homeless PMI are entitled to free mental health treatment. It restricts electroconvulsive therapy (ECT) without anaesthesia and any type of ECT to children and also restricts psychosurgery.[4]

What the 2017 legislation changed was that it bestowed upon PMI a certain autonomy over themselves. Through an advance directive which is a written statement, the person can explain "how they want to be cared" and "how they should not be cared for" in case they become incapacitated because of the mental illness.

Further, any person (except minors) has the right to choose a Nominated Representative (NR) to assist the patient with treatment-related decisions.

Moreover, any information relating to a PMI undergoing treatment in a Mental Health Establishment (MHE) shall not be released to the media without the consent of the PMI.

[3] Indian legal system and mental health, Choudhary Laxmi Narayan , Deep Shikha, Jan 2015 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3705679/

[4] India: Mental Healthcare Act: A Legislation for The People, Sahil Sood, 06 August 2020, https://www.mondaq.com/india/healthcare/972410/mental-healthcare-act-a-legislation-for-the-people

The media also need to restrain themselves from depicting or disclosing the identity of the PMI during reporting in specific cases that come to media attention. The right to privacy is maintained under the Act.

V. MENTAL HEALTH LEGISLATION IN OTHER COUNTRIES

- In the rural areas and poorer urban areas of South Africa, there are very few psychiatrists or medical practitioners with knowledge and experience of psychiatry.
- The Italian Public Law enacted in 1978, and the Mental Health Act of 1983 in England and Wales are prominent examples of a shift from custody and incarceration to the integration and rehabilitation of persons with mental disorders.
- In Japan, the Mental Hygiene Law was enacted in 1950 and encouraged the development of psychiatric hospitals and ensured financial support for patients who were admitted involuntarily.

VI. PROHIBITIONS AND PUNISHMENTS

MHCA, 2017 restricts the procedures such as sterilisation (of men or women when intended as a treatment for mental illness), unmodified ECT, seclusion, and chaining. The Act also regulates research on PMI and the use of restraints and neurosurgical treatment for them

. According to Section 309 of the Indian Penal Code, 1860, "Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to 1 year or with fine, or with both".

The government has a duty to provide care, treatment, and rehabilitation to a person having severe stress and who attempts to commit suicide to reduce the risk of recurrence of such an attempt. Punishments prescribed under the Act are too harsh, and there is no provision to assess whether a contravention is accidental, due to practical difficulties, or deliberate.

The relationship between psychiatry and law most often comes into play at the time of treatment of PMI.

Treatment of PMI often involves curtailment of the personal liberty of psychiatric patients. Most of the countries in the world have laws regulating the treatment of psychiatric patients. Though there are elaborate descriptions of various forms of mental disorders in various treatises in Ayurveda, the care of the mentally ill in the asylums in India is a British innovation.

VII. HISTORY

After the Second World War, the Universal Declaration of Human Rights was adopted by the UN General Assembly.

Indian Psychiatric Society submitted a draft Mental Health Bill in 1950 to replace the outmoded ILA-1912. Mental Health Act (MHA-87) was finally enacted in 1987 after a long and protracted course.

The main features of the Act were as follows.

- Definition of mental illness in a progressive way and introducing the modern concept of their treatment with

stress on care and treatment rather than on custody.

- Establishment of Central/State Mental Health Authority to regulate and supervise the psychiatric hospitals/nursing homes and to advise Central/State Governments on Mental Health matters.
- Admission in special circumstances in psychiatric hospitals/nursing homes. Provisions of voluntary admission and admission on the reception orders were retained.
- Role of Police and Magistrate to deal with cases of wandering PMI and PMI cruelly treated.
- Protection of human rights of PMI.
- Guardianship and Management of properties of PMI.
- Provisions of penalties in case of breach of provisions of the Act.

Though having many positive features, the MHA-1987 had been the target of criticism right since its inception. It is alleged to be concerned mainly with the legal procedure of licensing, regulating admissions and guardianship matters of PMI.

Human rights issues and mental health care delivery were not adequately addressed in this Act.

UNCRPD was adopted in December 2006. It was ratified by the Parliament of India in May 2008.

Countries that have signed and ratified the UNCRPD are required to bring their laws and policies in harmony with it. Therefore, this led to all the disabilities laws in India being put under a process of revision.

The convention marked a paradigm shift in respect of disabilities from a social welfare concern to a human rights issue. The new paradigm is based on the presumption of legal capacity, equality and dignity. According to article 2 of the convention, PWD will enjoy legal capacity on an equal basis for all aspects of life.

Laws in respect of the PMI are presently at crossroads as most of them are under revision to bring them harmony with the UNCRPD-2006.

Human rights activists are pressing for legal capacity to PMI in absolute terms, whereas psychiatrists are in favour of retaining provision for involuntary hospitalisation in special circumstances.

It must be emphasised that the ultimate aim of any legal provision should be the welfare of the PMI and the society at large.

Mental health is different from general health as in certain circumstances, mentally ill people may not be in a position to make decisions on their own. Those who suffer rarely get access to appropriate medical treatment as their families try to hide their condition out of a sense of shame.

VIII. STATISTICS

Common mental disorders (CMDs), including depression, anxiety disorders and substance use disorders, are a huge burden affecting nearly 10.0% of the population.

Depression was reported to be higher in females, in the age group of 40-49 years and among those

residing in urban metros. Equally high rates were reported among the elderly (3.5%).[5]

In 2013, 36 million years of healthy life were lost to mental illness in China, and 31 million in India. Estimates now suggest that by 2025, 39.6 million years of healthy life will be lost to mental illness in China (10 per cent increase) and 38.1 million in India (23 per cent increase).

A report by the World Health Organisation (WHO) revealed that 7.5 per cent of the Indian population suffers from some form of mental disorder. Mental illnesses constitute one-sixth of all health-related disorders, and India accounted for nearly 15% of the global mental, neurological and substance abuse disorder burden.[6]

Over 300 million people are estimated to suffer from depression, equivalent to 4.4% of the world's total population. According to a study conducted by the National Institute of Mental Health and Neurosciences, 1 in 40 and 1 in 20 people are suffering from past and current episodes of depression in India.

IX. CHALLENGES

- The need for services and efforts, not to mention finance distribution to reduce the treatment gap
- There is also a prevalent scarcity of specialists within the field due to a lack of scope. As per reports of 2016, for every 100,000 people in India, there are 0·3 psychiatrists, 0.12 nurses, 0.7 psychologists and 0.07 social workers, while the desirable number is anything above 3 psychiatrists and psychologists per 100,000 people. [7]
- Training of primary health care doctors and general physicians to be better equipped to handle situations where sensitivity is integral is not paid as much attention as it needs.
- A poorly informed public and the taboos against seeking any psychiatric help[8]

X. WAY AHEAD

- Increase public and professional awareness and intervene to reduce stigma and ease the burden of discrimination;
- Extend and strengthen existing systems of primary care to deliver health services for these disorders;
- Make cost-effective interventions available to those who will benefit;
- Conduct operational research to demonstrate the cost-effectiveness of specific treatments and health services in local settings;
- Create national centres for training and research
- Mental health services should be accessible, equitable and affordable
- Government should downsize large psychiatric hospitals

[5] National Mental Health Survey of India, 2015-16, http://www.indianmhs.nimhans.ac.in/Docs/Summary.pdf
[6] WHO Report on mental health 2016
[7] WHO report
[8] Mental Health Care and Human Rights, D Nagaraja Pratima Murthy 2008, https://nimhans.co.in/wp-content/uploads/2019/06/Mental_Health_Care_and_Human_Rights.pdf

- Human resources for mental health must be systematically enhanced through both short-term and long-term strategies
- There should be a national database of services and human resources available for mental health care in the country, and this should be periodically updated.
- The State and Central Governments should follow a stepped care approach to mental health services
- Aftercare rehabilitation and reintegration within the society
- Mental health must be converged with the social, education, labour and legal sectors. Translational research must be encouraged in all areas
- Law review and reform needs to occur periodically
- Limitations imposed on the mentally ill in the area of insurance should be rectified
- The mental health care of vulnerable groups like children, the elderly, women subject to domestic violence should receive priority attention.

XI. CONCLUSION

According to the numbers, 56 million Indians suffer from depression, and another 38 million Indians suffer from anxiety disorders.

That mental health has a stigma attached to it is an unavoidable factor within Indian society itself. Media gossip antagonising actresses over the suicide of another actor by means of black magic is far more believable than that an actor may have suffered from depression to the masses. Merely citing a temporary shift in mood against a complete absence of a deeper and more psychological understanding of the concept is unfortunately what is done.

If we are to start anywhere, we must first start with erasing the negativity surrounding mental illnesses. The taboo must be destroyed, and people should be freely allowed to speak up and seek health without fearing what people would say or fearing that their conditions would be chalked up to laziness or being called inconsequential or fake by society.

Mental illnesses are still illnesses, and the way you would rest your body when suffering a physical ailment, the brain too needs that rest.

Mental health is real, and it sees no privilege or nationality; it sees no race or gender. Anyone can be mentally ill, and they are all equally deserving of treatment.

In spite of this big burden of mental health issues, unfortunately, it continues to be misunderstood in developing countries like India. The new Mental Healthcare Act 2017 rescinds/revoked the existing Mental Healthcare Act 1987, which had been widely criticised for not recognising the rights of a mentally ill person.[9]

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[9] Mental Healthcare Act 2017: Need to Wait and Watch, Abhisek Mishra and Abhiruchi Galhotra, 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5932926/