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The Mental Healthcare Act, 2017: The Contemplations to be Addressed

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ABSTRACT

The Mental Healthcare Act, 2017 replaced the Mental Health Act, 1987. The new Act aims to align and bring harmony between the existing legislation with that of Convention on Rights of Persons with Disability and its optional protocol ratified in 2007 by India. The law has been praised as being revolutionary as well as an obstacle to adequate patient treatment. The new Mental Healthcare Act, 2017 represents a major leap forward in principles and has the rights and privileges of mentally ill people maintaining humanistic fervour. The new Act has several positive features like making advanced directive, aims to balance mental disorders with that of physical disorders and regulates the mental health establishments providing mental healthcare facilities. It also helps to define the role of police in ensuring protection of patients. Insurance providers were instructed not to discriminate against people having mental disease and one of the substantial steps taken is the decriminalization of suicide. This Act also has significant limitations. Indeed, some of these limitations directly contradict the values and principles stated in the Act. The restrictions can prevent from realizing the revolutionary principles of this new Act. There are glaring shortfalls and omissions in the name of adapting global principles to the Indian context. There are also various compromises made. It is unwilling to establish strong systems which provide the resources to implement the human rights agenda that is supposed to be enshrined in the new Act. This research paper not only focuses on the positive and the negative aspects related to the Mental Healthcare Act, 2017 but at the same time is focusing on the suggestive aspects which can be addressed in the mental health sector for effective implementation. Keywords: Mental Health, Mental Healthcare Act, 2017, Convention on Rights of Persons with Disability

I. INTRODUCTION

The legal evolution and exploration of the Mental Health sector from the path of "Mental illness'' to "Mental health,'' from "mental asylums" to "mental health institutes'' is an affirmative journey. The first legislation in the soil was the Lunacy Act of 1912 which was later amended to be called Mental Health Act of 1987. The focus of these two previous

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legislations was primarily on treatment, regarding admission, discharging of diagnosed individuals and regulations for psychiatric institutions among several others. Later on it was found that the 1987 Act could not sufficiently safeguard the rights of Mentally-ill people and hence there was a need for tectonic change in this sphere. Later on The Mental Health Care Act, 2017 replaced the 1987 law and legally ensured that every person is having the right to access mental healthcare and medical-treatment. The ambit of the new Act was also expanded by ensuring free treatment to those people who are homeless and to those people who are living under the poverty line and not possessing BPL card. The Act is vocally talking about those people who are having mental illness are having the right to live with human dignity and in getting access to the care and facilities and there shall not be any discrimination based on gender, sexual-orientation, religious belief, cultural aspects, caste-based prejudices, political social beliefs, class or disability. This new law also de - criminalizes suicide and is being treated as serious stress for those who attempt it and is not therefore tried and punished under section 309 of the Indian Penal Code which has been scrapped down.

According to World Health Organization, one in four people has mental illness and the rate is alarming globally. Mental disorders account for 12 % of the global modern diseases and will increase 15% by 2020. As such it has become crucial and need of the hour to think profoundly about the rights of the people having mental illnesses. Mental health if delicately observed is not only confined within the periphery of physical and psychological well-being but is also carrying the attribute of social-wellbeing. But it is a fact that people suffering from mental illnesses are vulnerable to various stigmas, cruelty, neglect and ridicule, as such the legal responsibility in this regard is immense.

II. MENTAL HEALTH AND THE JUDICIAL INTERPRETATIONS

The exploration by the Supreme Court in addressing and redressing various issues related to this field came with new insights. In *B.R Kapoor v. UOI*[2] *and PUCL v. UOI* the proper maintaining and facilities available in the hospitals dealing with mental diseases was explored and *R.C Narayan v. State of Bihar*[3] was mainly concerned about the Ranchi Mental Asylum.

In *Legal Aid Committee v. State of MP*[4] , the Supreme Court intervened for improving the facilities of the Gwalior Mental Asylum and this particular case particularly dealt with the subject of health of which mental aspect is an integral part, which comes as a vital principle mentioned under the Concurrent list in the Indian Constitution, which empowers both the

[2] AIR 1990 SC 752
[3] AIR[2003] SC 2363
[4] SCC 1994 (5)27

Union and states to implement various measures including the authority to legislate. In *Sheela Barse v. UOI*[5] , the Apex Court held that the access of non-criminal mentality ill-persons to imprisonment is completely illegal and against the constitutional principle. In *Chandan Kumar Banik v. State of West Bengal*[6] the Apex Court addressed the inhumane state in which mentally-ill persons were dwelling in mental health hospital. The Court ordered the ending of the practise of tying up the mental health patients those who were not physically controllable with iron chains. Such practise was denounced by the Supreme Court and ordered proper medical treatment for them. Sadly, 26 patients died in Erwadi because they had been tied to their beds when the entire building was saturated by fire. The government's failure caused them tragically. After the tragedy, the Indian National Human Rights Commission, mandated pursuant to section 12 of the Law on Human Rights in 1993, advised all the Chief Ministers to certify that people with mental disease should not be held in chains, be they government institutions or private bodies.

The mental Health Care Act 2017 defines “mental illness” as a substantial disorder of ‘thinking, mood, perception, orientation or memory’ which grossly impairs judgement, behaviour, and capacity to recognize reality or ability to meet the ordinary demands of life. The Act talks about Right to access Mental Health Care and treatment. According to the Section 115 of Mental Healthcare Act (MHCA), 2017, suicide attempters are presumed to have severe stress, not to be punished and the government should have duty to provide care, treatment, and rehabilitation to reduce the risk of recurrence.

III. THE NEW ACT AND THE INTERNATIONAL NORMS

The new Act adhered the UN Human Rights treaty as per the international norms. In the year 2007, India ratified “Convention on Rights of Persons with Disability” which initiated the inception of the Act. A World Health Organization report estimating 50 million Indians have suffered depression shows that mental health is neglected. The Mental Health Care Bill was originally introduced by the UPA in August 2013, replacing the 1987 Mental Health Law, to put the law in accordance with the UN Convention obligations. The Bill was reintroduced in the 16th Lok Sabha led by NDA with 134 amendments. The revision of the UPA II bill creates grave doubts as to whether the object is met. The act recognizes mental disease as a ' clinical problem, ' for which only medicines and clinical procedures can provide treatment. The substantial issues like prevention of mental illnesses and promotion of mental well-being have been neglected and the research in this field shows that in cases related to mental

[5] AIR 1983 378 6 1995
[6] Supp (4) Supreme Court Cases 505

illnesses, only at an advanced stage medical intervention occur.

The definition currently in the Act defining 'mental health professional' is restricted to clinical psychiatrists and professionals who are holding postgraduate degree in Ayurveda, Homeopathy, Siddha-Unani- all on the clinical side. The inclusion of non-allopathic fields is laudable, but it is still unclear why psychotherapists and psychoanalysts were excluded as illness is also result of one's social setting and for preliminary treatment qualified psychotherapists, counsellors and psychoanalysts are needed. The Act also proposes an 'advanced medical directive' through which the individuals can dictate how they "wish to be'' and "wish not to be treated'' and nominating member who can take decisions on their behalf in case they lose their mental capacity. For periodic review and effective implementation of the Act, the Act itself provides for the Constitution of an expert committee but neither the Act nor the rules define constitution, procedure and terms of reference of the Committee. The transparency of such a body of tremendous importance should be there and at the same time be subjected to public scrutiny.

IV. IMPORTANT ASPECTS OF THE MENTAL HEALTHCARE ACT, 2017

The Mental Health Act 2017 as it is intended to offer the mental healthcare-facilities to mentally ill people, it makes sure that these people should have the right to live a dignified life without discrimination or harassment. This Act has several positive / constructive aspects, but it is not without its failings in the actual Indian context. Few of these can be discussed here. (A)Progressive Inclusions This Act gives the right to live a dignified life without unfairness or discrimination on the basis of sex, beliefs, cultural background and caste. Each person is entitled to confidentiality in respect of his or her illness and treatment[7] . According to the new measures, the ECT (Electroconvulsive Therapy) must not be carried out without anaesthesia and the minors are excluded from ECT.[8] Sterilization in these patients shall not be carried out, nor shall they be placed in solitary confinement or seclusion.[9]

(B) Mental Wellbeing and Healthcare This Act enables everyone to have access to mental wellbeing and healthcare. This right is intended to ensure accessibility, affordability and decent quality of care. It also requires the establishment and availability of mental health care in every district level. But again, with the already insufficient medical infrastructure of districts and sub-divisions, the financial strain to be borne by state governments will be colossal if the central government does not allocate a larger part of the budget to the

[7] Section 23. (1), The Mental Healthcare Act, 2017
[8] Section 95, The Mental Healthcare Act, 2017
[9] Section 97, The Mental Healthcare Act, 2017

expenditure. Therefore in the districts and subdivisions, the medical infrastructure should be improved through explicit mentioning in the Act.

(C) The Advance Directive The notion of an advance directive[10] has been taken from the West that provides patients far more power to determine on certain cases for their own treatment. Furthermore, local indicators such as existing mental health resources and lack of understanding of psychiatric illness in India were not taken into consideration in contrast to the developed nations. People with mental illness, with severe mental disorders often lose the ability to make sound decisions and often do not have a relative who speaks for them. In such scenario, it is important that the treating doctor to take decisions because patients or their nominees have limited knowledge about mental health and mental illnesses.

V. CLARITY AS THE NEED OF THE HOUR

The Act also acknowledges the right to dwell in a community[11]; the right to live with respect and dignity, to safeguard against both cruel, inhuman-treatment, proper care of mentally ill individuals with physical illness or disability[12], the right to pertinent information on treatment and includes other rights and remedies like the right to privacy, the right to access to basic healthcare records[13] , the right to personal contacts and right to communication, the right to legal treatment. However, there is no approximation of the expenditure necessary to fulfil the obligations under the law nor is it clear why and how the funds will be allotted between the Union and the state governments. So there should be proper and explicit mentioning of all these substantial procedures.

VI. INSUFFICIENT HEALTH EXPENDITURE

The Act also ensures that homeless or those belonging to the poverty line (BPL), receive free good quality treatment, even if they do not have a BPL card. Even in our own part of the world, where mental illness is regarded as depression, the government's economic burden in this regard is far too high. The suggested health expenditure in India for the financial year 2017- 2018 was 1.2 percent of gross domestic product. It is one of the lowest in the world and expenditure on public health has decreased steadily since 2013-2014. India spends 0.06% of its health budget for ensuring mental healthcare, which is much less than what Bangladesh spends (0.44%).[14] According to the 2011 report of the WHO, most developed nations expend

[10] Section 5, The Mental Healthcare Act, 2017
[11] Section 19, Right to Community Living
[12] Section 21 (1) (a)
[13] Section 25
[14] 4 Abhisek Mishra, Abhiruchi Galhotra, Mental healthcare Act 2017: Need to wait and watch, International

more than 4 percent of even their own budgets on studies, infrastructure, methodologies and workers in mental health. Even though the new Act contains several provisions, does not provide strict guidelines or implementing rules.

VII. DECRIMINALISATION OF SUICIDE

The introduction of the new suicide decriminalisation[15] is certainly a welcome move. There can be a lot of aspects of this Act which can be misused. But again a case of attempted homicide can be twisted as an attempted suicide in instances of dowry and does not show necessary attention to be addressed under this Act. In developing nations such as with India, socio-economic and cultural considerations such as paucity of access to health care, superstition, lack of knowledge, stigma and discrimination aggravate the conditions and situations of the individuals with mental disorders. There are no provisions in the Act to discuss these aspects. The new Act on mental health offers little prevention measures and early intervention and as such these issues are to be mentioned in an effective way to face the challenges in this regard from the Indian context.

VIII. CHALLANGE OF THE STAKEHOLDERS

There are generally many components in the Act that mentally ill people, their families, caregivers, professionals, healthcare providers and others concerned about it can consider to be welcome steps. Furthermore, it also appears ambitious and presents all stakeholders with an enormous responsibility and challenge for its efficacious application. The new regulation also seeks to be over-inclusionary in its approach, which extends far beyond its legislative limits, and despite the good intent behind it, it would be a challenge to stakeholders that whether the content of the Act is legislation, program, policy or even a guideline for treatment.

IX. THE OVERLOOKED CULTURAL ASPECTS

This Act looks closely at the hypothesis that MHC providers and members of the family are the primary violators of mentally ill people's rights which is disappointing. On the other hand, the Act does not really take into consideration the positive contribution of family members, the burden of caregivers, isolation, exasperation and stigmas suffered by the family members having mentally ill member/s. The Act is virtually silent about the position of family members in providing medical care and their contribution. In India, the family is the key resource for the care of mentally ill patients which is not present in the West and as such

Journal of Applied and Basic Medical Research 15 Section 115, Mental healthcare Act 2017

[15] Section 115, Mental healthcare Act 2017

without seeing families as primary violators, though in some cases they may be, the empowerment of such families can be done by rendering proper awareness and facilities. Same motive also applies for the MHC providers by empowering them and not by delineating them as primary violators. For two reasons, families take on the role of primary caregivers rather than primary-violators. Firstly, this is because of the Indian culture of interdependence and concern in adversities for close and dear people. Secondly, there is a lack of qualified mental health professionals for the majority of the population and as there is substantial dearth in this field, clinicians therefore rely on the family members not only to know about the conditions of the mentally ill patient but also to come in contact with such patients by bringing them to the Mental Health centres or clinics. Therefore, the patient, clinicians and healthcare administrators need sufficient family support. Unfortunately, this Act does not encourage the need to provide care to family members. People with mental disorders/illness can repeal, change/amend or can do cancelling of advanced directives several times a day, and family members will find it hard to deal with these circumstances. The advance directive can only be amended or overruled by the Mental Health Board. To facilitate treatment, this must be actually done in a very short time (24-48 h). If the patient wrote expensive treatment/care or in private hospital (which family cannot afford) in advance, who will be able to bear the cost of expensive treatment is the question. Given the required human resources (medical and judicial), economic constraints and our combined efforts in the local community to treat mentally ill patients, our Indian population is not prepared for these advanced directives. In particular, data from research studies do not endorse the use of advance directives in persons with mental illness (Cochrane review). Before introducing this advance directive, it was necessary to carry out even more research on this topic in our population. This advance directive paves the way for more disputes and a huge burden on the financially unsound family members. Some of the critics as such advised to keep the advance directive out of the scope of the Act. The Cochrane database of systematic review of advance treatment guidelines for people with mental disorder revealed that really quite few statistics are available to try to make definitive recommendations. This certainly did not have its intended benefit even in the West. The Indian conditions are pretty hasty and ill-conceived to hurry into legislation on this count.

X. THE MENTAL HEALTH REVIEW BOARDS

The mental health review boards at district level, which are quasi-judicial bodies supervising the effective and efficient application of the MHC delivery system, may bring in new barriers to treatment delivery and delays which are caused unnecessarily due to dearth of people

engaged under the same and lack of other resources connected to it for operating at every level of the district. Needless to say, mental health care is actually taking an ugly turn according to several critics similar to western countries, in which involuntary mental health care is being frequently argued in the courts. The function of such Boards seems to have become a lengthy, extensive and expensive judicial process. These boards of review must have a time limit (< 72 h) for decision-making. Due to a lack of sensitivity and time-taking processes, the mainstream judicial system is unable to handle such complaints and is also clogged with an enormous dependence on mainstream cases. The boards must break away from prolonged legal proceedings. Conversely, the first level of examination might be an autonomous hospital review board that can resolve these difficult issues in a cost-effective and time-effective way at the door of the patient. It would therefore be prudent to create consumer-friendly (independent) hospital boards using local resources in each hospital. This hospital board of the MHC could consist of independent psychiatrists / mental health professionals, family caregivers and patients who have recovered. Another alternative is to create a visitor board at each hospital (in harmony with the Mental Health Act, 2017) to carry

XI. CONCLUSION

It is prudent for policymakers to take account of culture of the country, new scientific advancements in the sector of mental health, to assess the needs of patients and families that are not met, to take measures to narrow the gap in treatment, to take measures to increase the resources of the workforce and to build skills among health professionals / workers in the field of mental health, and provide a comprehensive health care system and thus the need for the hour is a substantial change in the legislation, which can address the healthcare needs at all basic levels of prevention (primary, secondary and tertiary levels) and by safeguarding the fundamental human-rights of mental health patients, health-workers and of their own family members.

In developed nations, mental health systems are focused on preventative and early intervention. The Ireland government's vision statement on mental health care policy says that service providers should cooperate and facilitate recovery and reintegration through the provision of accessible, extensive and community - based mental health services. In the wider context of healthcare provisions, the systems are becoming more costly day by day and the government can be greatly relieved by a system dealing with health-protection rather than just disease-care. Needless to say, in our healthcare delivery system, there is underinvestment in health security and disease prevention. Since the new national health policy focuses on a

healthier India, preventive strategies must be developed. The need for an hour is also cost-effective preventive and early intervention in the case of mental illnesses. There are several challenges currently facing us, such as the ability to access professionals, inexpensive and high-quality treatment for people with mental illness and assisting their family members in this regard. There is also a lack of skilled professionals, as the main worry in this respect is the acute shortage of the same. In India, people with mental illness continue to suffer from about 2.5 crore to 6.25 crore. India has 4,000 properly trained psychiatrists, compared to 12,500 requirement. There are 3,000 psychiatric nurses and 2,000 clinical psychologists. The Government should enable more psychiatric nursing courses as such. According to the ICMR (Indian Council of Medical Research) study, the rate of psychiatric illness or disorders in children between the 4 and 16 years of age was approximately 12 percent in India and despite all these problems, only 550 doctors pass out each year in the psychiatric discipline. The shortage of psychiatrists and social workers in psychiatry is 67% and 96% respectively. Each four-lakh population has far less than one psychiatrist. Psychiatric care is important. In psychiatric care, the ideal nurse-patient ratio should be 1:5. The tele-nursing possibilities could be researched. More psychiatric nursing training courses should be allowed by the government. Despite a lot of prejudices surrounding mental health in the Indian Society, it is a matter of concern that mentally ill people are seen to be different from those who are physically ill. Though India got several laws time to time dealing with the same, and most recently the Mental Healthcare Act of 2017 has been passed, still it is unfortunate that social stance when it comes to mental health is not seen with humanistic spirit. Though law is said to be an instrument for social change, and to many it is an established fact but unless and until more social awareness is promoted, the ultimate goal in this regard cannot be achieved. The recent 2017 Act gave a concrete approach, which is the outcome of various evolutionary processes starting from the British era to the present scenario, the recent Act also at the same time incorporated multiple provisions which are human rights based and especially addressing the core issues dealing with the mental health sector with an inclusive strategy. Moreover, as Health is in concurrent list, the cooperation between the Union and the State Boards should be boosted. There has been a significant shift from predominant seclusion or custodial care as in the Indian Lunacy Act of 1912 (when effective treatment was deficient) to the Mental Health Act of 1987 (which focused primarily on the treatment and care of mentally ill people with tangible efforts to reduce stigma and cater for their human rights) to the current Mental Healthcare Act, 2017 (which focuses primarily on human rights). It is undoubtedly a great leap in its extent from the act of 1987. It is an effort to absorb radical

views and principles that the global community is now endorsing. But the narrow interpretation of a' mental healthcare professional' definition involves conflict, which leads to debate among psychotherapists, advisors and psychoanalysts. In the amended draft' Advance Directive,' there is no clear procedure. Once a person has been hospitalized, society calls him insane or mad. The Act did not provide for society to be educated against such misconceptions. The Act does not contain the complete list of available treatment options so that the individual person can take a decision without asymmetry of information. The constitution, procedure and terms of reference for a Committee of Experts made for periodic examination and effective implementation of the same are not defined either by the Act or by the regulations. Although this legislation makes it easier for patients to discharge, it does not make provisions for patients after their discharge. There was a great deal of stress on admission and treatment in the hospital. This tends to increase healthcare costs again. Home treatment provisions are not made. No doubt it has been a critical step in treating mental illness by the Mental Healthcare Act, 2017 but in existing Act there are many gaps and it is substantial to fill those gaps. It will then be able to ensure the right of individuals related to mental health and help to comply with the UN Convention and other stakeholders. The right to treatment for those seeking mental health care under the new law also empowers them to refrain from being treated. It enables those who are mentally ill to refuse or seek treatment. This law makes it more difficult to treat people who do not accept mental illness. This clause could eventually add to the issues. It will be a question of discussion for many decades if the new Act represents an "improvement" of the prior act and largely depend on the role of the interested parties. However, the new Act is based solely on a radically different paradigm than previous times and is also a reflection of the emergence of human-services-based frameworks in all spheres.

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