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# Legislative Commentary: The Mental Healthcare Act, 2017

TARSH KHANNA[1]

## ABSTRACT

*A Hamletian Dilemma- To Mercy or not to mercy. What are the responsibilities of the state when it decides to punish a person for a crime? The debate whether to retain or abolish the provision of mercy petition is unending. The negative implications of the provision have, in multiple cases, led to a public and media outcry for failure in the administration of justice, such as in the case of Afzal Guru, Nirbhaya, etc. This article traces the expediency of the powers to grant pardon prescribed in the Indian constitution, and the jurisprudence developed in the court of law. The article commences with the origin and the history of the provision, then explains its scope and intricacies. Furthermore, it justifies the necessity of the provision in spite of its repercussions, in the modern civilized society.*

## I. INTRODUCTION

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. In a welfare society, the state needs to make all efforts for social inclusion and provide opportunity and equal participation so that a democratic society benefits when all its members participate fully in the community affairs.[2] The Government of India ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2007.[3] The convention requires the laws of the country to align with the convention. There was a perceived and felt need for a new act to suit the changing times and also a need for it to be in line with the UNCRPD.[4] Hence, the lawmakers harmonized the national legislations such as the Mental Health Act, 1987[5] and Persons with Disability Act, 1995 with the UNCRPD.

[1] Student of Symbiosis Law School, Pune, India.

[2] Rao GP, Ramya VS, Bada MS. The rights of persons with disability bill, 2014: How "enabling" is it for persons with mental illness? Indian J Psychiatry 2016;58:121-8

[3] Narayan CL, Shikha D, Narayan M. The mental health care bill 2013: A step leading to exclusion of psychiatry from the mainstream medicine? Indian J Psychiatry 2014;56:321-4.

[4] Mental Healthcare Act, 2017. Available from: http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20Healthcare%20Act,%202017.pdf.

[5] Math SB, Murthy P, Chandrashekar CR. Mental health act (1987): Need for a paradigm shift from custodial to community care. Indian J Med Res 2011;133:246-9.

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The National Mental Health Survey was undertaken as a large scale, multicentred national study on the various dimensions and characteristics of mental health problems among individuals aged 18 years and above, across 12 Indian states during 2014–2016. As per the survey, overall weighted prevalence for any mental morbidity was 13.7% lifetime morbidity and 10.6% current morbidity.[6] In this regard, Government of India started to make efforts to improve the mental health services in the form of formulating the National Mental Health Policy (NMHP), 2014 and Mental Healthcare Act (MHCA), 2017. The latter was enacted with the support of all parties in both Houses of the Parliament (notified on May 29, 2018).[7]

## II. Salient Features Of The Act

MHCA 2017 is heavily influenced by the western model of legislation. It is based on individual rights, is patient centric, and gives the individual total autonomy over them, which comes in the way of the treatment unless the patient gives informed consent. On a closer look, this act is premised on a hypothesis that the mental healthcare providers and family members are the main violators of the rights of the PMI, which is unfortunate. Key measures include

- new definitions of 'mental illness' and 'mental health establishment';
- revised consideration of 'capacity' in relation to mental healthcare
- 'advance directives' to permit persons with mental illness to direct future care;
- 'nominated representatives', who need not be family members;
- the right to mental healthcare and broad social rights for the mentally ill;
- establishment of governmental authorities to oversee services;
- Mental Health Review Boards to review admissions and other matters;
- revised procedures for 'independent admission' (voluntary admission), 'supported admission' (admission and treatment without patient consent), and 'admission of minor';
- revised rules governing treatment, restraint and research; and
- de facto decriminalization of suicide.

Key challenges relate to resourcing both mental health services and the new structures proposed in the legislation, the appropriateness of apparently increasingly legalized approaches to care (especially the implications of potentially lengthy judicial proceedings), and possible

[6] Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, *et al*. National Mental Health Survey of India, 2015-2016: Summary. Bengaluru: National Institute of Mental Health and Neurosciences; 2016.
[7] Rao GP, Math SB, Raju MS, Saha G, Jagiwala M, Sagar R, *et al.* Mental health care bill, 2016: A boon or bane? Indian J Psychiatry 2016;58:244-9

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paradoxical effects resulting in barriers to care (e.g. revised licensing requirements for general hospital psychiatry units). There is ongoing controversy about specific measures (e.g. the ban on electro-convulsive therapy without muscle relaxants and anaesthesia), reflecting a need for continued engagement with stakeholders including patients, families, the Indian Psychiatric Society and non-governmental organisations. Despite these challenges, the new legislation offers substantial potential benefits not only to India but, by example, to other countries that seek to align their laws with the United Nations' Convention on the Rights of Persons with Disabilities and improve the position of the mentally ill.

MHCA 2017 is heavily influenced by the western model of legislation. It is based on individual rights, is patient centric, and gives the individual total autonomy over them, which comes in the way of the treatment unless the patient gives informed consent. On a closer look, this act is premised on a hypothesis that the mental healthcare providers and family members are the main violators of the rights of the PMI, which is unfortunate. On the other hand, the act does not take into account the family members' significant contribution, caregivers' burden, and the isolation and frustration they undergo because of PMI. The act does not acknowledge or foster the contribution of family members' support and will in providing care. Unlike the west, in India, the family is the key resource in the care of PMI. Families assume the role of primary caregivers for two reasons: first, because of the Indian tradition of interdependence and concern for near and dear ones in adversities. Second, there is a paucity of trained mental health professionals required to cater to the vast majority of the population.[8] Hence, even the clinicians depend on the family. Thus, having adequate family support is the need of the patient, the clinician, and the healthcare community will be providing with all the other requirements for the patients. The previous legislation, 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). This could be avoided by legislation focusing only on mental healthcare institutions where patients are admitted for treatment against their will. Mental Health Act, 1987 was not implemented across the country because of a severe shortage of resources. However, MHCA 2017 has been introduced without addressing the issues which haunted the Mental Health Act, 1987.[9] his article focuses on the strengths and weaknesses of this legislation

## III. Beneficial Provision Of The Act

The heart and soul of this legislation are in Chapter 5 which safeguards the patients' right to

[8] Avasthi A. Preserve and strengthen family to promote mental health. Indian J Psychiatry 2010;52:113-26
[9] Antony JT. A decade with the mental health act, 1987. Indian J Psychiatry 2000;42:347-55

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access a range of mental healthcare facilities (such as inpatient and outpatient services; rehabilitation services in the hospital, community, and home; halfway homes; sheltered accommodation; and supported accommodation). If the services are not available, PMI are entitled to compensation from the state. 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. The act seeks to ensure that mental healthcare facilities are available to all. Those below the poverty line, whether in possession of BPL (below poverty line) card or not, the destitute, and the homeless will be entitled to free mental health treatment. The act provides the right to confidentiality and protection from cruel, inhumane, and degrading treatment, in addition to the right to live in a community and avail free legal aid. It bans electroconvulsive therapy (ECT) without anaesthesia and any type of ECT to children and restricts psychosurgery.

A PMI has the right to confidentiality with respect to his/her mental health status, mental health care, treatment, and physical health care. All health professionals providing care or treatment to a PMI shall be obligated to keep such information which has been obtained during care and treatment confidential, except to the nominated representatives (NRs) to enable them to fulfil their duties and to other health and mental health professionals to enable them to provide appropriate care and treatment to the PMI and to protect any other person from harm or violence. The act, by including institutions belonging to other alternative health systems in the definition of MHEs, has made uniform regulations in establishing and regulating mental healthcare delivery services. The act regulates both public and private mental health sectors. This legislation revolves around "autonomy" and gives every person the right to make an advance directive. This is a written statement which explains "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, the person (except minors) can also choose a NR to assist him/her with treatment-related decisions. Any information relating to a PMI undergoing treatment in a MHE shall not be released to the media without the consent of the PMI. The right shall also apply to all information stored in electronic or digital format in real or virtual spaces. The media also need to restrain themselves from depicting or disclosing the identity of the PMI during reporting in specific cases that go to the media. Under the act, there is a provision for involuntary admission with the support of the NR and also appeals can be made to the Mental Health Review Board (MHRB), which will also review all admissions that extend beyond 30 days.

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## IV. Analysis & Conclusion

MHCA of 2017 focuses mainly on the human rights of PMI. It is prudent for the lawmaker to account for the culture of the land, newer scientific developments in the mental health field, analyze the met-unmet needs of the patients and families, and make provisions to bridge the treatment gap. There is also a need to make provisions to enhance the resources and skill building among professionals/workers in the field of mental health, to provide comprehensive healthcare services, to promote mental health and well-being, and to make provisions for adequate financial support/budget (for plan and nonplan expenditures). The need of the hour is a law that can be implemented in practice and can cater to the health needs at all levels of prevention (primary, secondary, and tertiary) while also protecting the rights of the family, professionals, and end users. There is an urgent need to amend the existing law to convert it from an aspirational law into a law of action.

When it comes to the negatives, the act is highly loaded with the rights-based ideology and in this respect is similar to the mental health legislations of many western countries. However, the resources those countries have are many folds higher than those of India. Implementation of MHCA 2017 will face challenges due to the scarcity of resources. There have also been serious doubts raised about workforce, economics related to implementation, and political will for successful implementation of the act. The major limitation is lack of resources, especially in the semi-urban and rural areas. There are logistic issues such as poor infrastructure, inadequate mental health workforce, low budget for mental healthcare, and lack of mental health resources in general healthcare settings. If minimum mental health services are not available in the district where the patient resides, such persons are entitled to access any other mental health services in the district, and the costs of treatment at such establishments will be borne by the appropriate government.

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