



SHAPING TOMORROW'S LEADERS. TODAY.

MENTAL HEALTH BILL 2016

The Mental Health Care Bill 2016 is *watershed legislation aimed at safeguarding the rights of individuals suffering from mental illness. It also strengthens and promotes the protection of such individuals.* This bill repeals the outdated law: Maternal Health Act 1987. India ratified the *UN Convention on Protection on the Rights of Persons with Disabilities* in 2007. The convention *binds the signatories to reform and align their domestic laws as per the provisions.* This bill is a significant step in that direction due to its progressive and remarkable features.

HISTORY

The earliest citing of *Mental disorders in India are from Vedic Era (2000 BC - AD 600).*

- Charaka Samhita (400–200 BC), an ayurvedic textbook describes various factors of mental stability. It also has instructions regarding how to set up a care delivery system.
- In the same era, in South India Siddha was a medical system. The great sage Agastya, one of the 18 siddhas contributing to a system of medicine included the Agastiyar Kirigai Nool, a compendium of psychiatric disorders and their recommended treatments.
- In Atharva Veda there are descriptions and resolutions about mental health afflictions.
- In the Mughal period, the *Unani system of medicine* was introduced by an Indian physician Unhammad in 1222. Then existed form of psychotherapy was known as *ilaj-i-nafsani* in Unani medicine¹.

EARLY LEGISLATION

The *first law in relation to mental illness in British India was the Lunatic Removal Act 1851*, which ceased in 1891. This law was mainly enacted to regulate the transfer of British patients back to England. After the takeover of Indian administration by the British crown in 1858, many laws were introduced for the care of people with a mental illness, including:

- The Lunacy (Supreme Courts) Act 1858
- The Lunacy (District Courts) Act 1858
- The Indian Lunatic Asylum Act 1858 (with amendments passed in 1886 and 1889)

¹ https://en.wikipedia.org/wiki/Mental_health



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- The Military Lunatic Act 1877

Under these Acts, patients were detained for an indefinite period in poor living conditions, with little chance of recovery or discharge. This led to the introduction of a bill in 1911 that consolidated the existing legislation and led to the **Indian Lunacy Act (ILA) 1912 (Somasundaram 1987)**. The ILA 1912 was essentially the first law that governed mental health in India. It brought in fundamental change for the management of asylums, which were later termed mental hospitals. However, this act focused on the protection of public from those who were considered dangerous to society (i.e. patients with a mental illness). The ILA 1912 neglected human rights and was concerned only with custodial sentences.

As a result, the **Indian Psychiatric Society suggested that the ILA 1912 was inappropriate and subsequently helped to draft a Mental Health Bill in 1950** (Trivedi, 2002). It took more than three decades for this bill to receive the President's assent (in May 1987); it was finally implemented as an Act in 1987. The advantage of the **Mental Health Act (MHA) 1987** was that it defined mental illness in a progressive way, placing emphasis on care and treatment rather than on custody. *It provided detailed procedures for hospital admission under special circumstances and emphasised the need to protect human rights, guardianship and the management of the property of people with a mental illness.*

The criticisms of the MHA 1987 are mainly related to the **legal procedures of licensing, admission and guardianship. Also, human rights and mental health care delivery were not adequately addressed** in this Act (Narayan et al, 2011). Human rights activists have questioned the constitutional validity of the MHA 1987 because it involved the curtailment of personal liberty without the provision of a review by any judicial body. The MHA 1987 was also **silent about the rehabilitation and treatment of patients after their discharge from hospital** (Dhandha, 2010). In addition, insufficient treatment facilities posed financial, social and emotional burdens on carers and family. These criticisms led to the amendment of the MHA 1987, which eventually culminated in the Mental Health Care Bill 2016².

² http://www.rcpsych.ac.uk/pdf/PUBNS_IPv13n3_65.pdf



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WHAT IS MENTAL ILLNESS

- A disorder of mood, thought, perception, orientation and/or memory.
- Includes mental conditions associated with the abuse of alcohol and drugs, but excludes mental retardation (e.g. Down's syndrome).

EXAMPLES OF MENTAL ILLNESS

Name	Symptoms
Paranoia	Patient has deep conviction that everyone, including his or her closest family members, wants to injure or destroy him
Heavy Depression	Patient feels that life is so dreary and unhappy that it is better to commit suicide.
Anorexia	Person has an intense fear of gaining weight. He severely restricts food intake and usually becomes extremely thin.
Phobia	intense and persistent fear of a specific object for example telephone, spiders etc.
Obsessive-Compulsive Disorder(OCD)	Common obsessions include fears of contamination from germs, doubts about whether doors are locked or appliances are turned off, hoarding vast amounts of useless materials, and repeating words or prayers internally. Such persons keeps repeating same activity over and over again.
Schizophrenia	A person with schizophrenia has difficulty telling the difference between real and unreal experiences, logical and illogical thoughts, or appropriate and inappropriate behaviour. He avoids social contacts, hears voices inside his that command him to act in strange or unpredictable ways.
Dementia/Alzheimer's Disease	In the early stages, patient experience some memory loss then to a decrease in thinking ability such as decision making. Later such patient cannot perform daily activities or recognize his



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	loved ones, because of damage in brain cells.
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HIGHLIGHTS OF THE BILL

- **Rights of persons with mental illness:** Every person shall have the *Right to access mental health care and treatment from services run or funded by the government.* The right to access mental health care includes affordable, good quality of and easy access to services. Persons with mental illness also have the Right to equality of treatment, protection from inhuman and degrading treatment, free legal services, access to their medical records, and complain regarding deficiencies in provision of mental health care
- **Advance Directive:** A mentally-ill person shall have the *right to make an advance directive that states how she/he wants to be treated for the illness during a mental health situation and who her/his nominated representative shall be.* The advance directive has to be certified by a medical practitioner or registered with the Mental Health Board. If a mental health professional/ relative/caregiver does not wish to follow the directive while treating the person, he can make an application to the Mental Health Board to review/alter/cancel the advance directive
- **Central and State Mental Health Authority:** The bills aims to set up these bodies to
 1. Register, supervise and maintain a register of all mental health establishments
 2. Develop quality and service provision norms for such establishments
 3. Maintain a register of mental health professionals
 4. Advise the government on matters relating to mental health
 5. Train law enforcement officials and mental health professionals on the provisions of the Act
 6. Receive complaints about deficiencies in provision of services
- **Mental Health Establishments:** Every *mental health establishment has to be registered* with the relevant Central or State Mental Health Authority. In order to be registered, the establishment has to fulfil various criteria prescribed in the Bill
- **Mental Health Review Commission and Board:** *It will be a quasi-judicial body that shall periodically review the use and the procedure for making advance directives and advice the government on protection of the rights of mentally ill persons.* The Commission with the concurrence of the state governments, shall



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constitute Mental Health Review Boards in the districts of a state. The Board will have the power to (a) register, review/alter/cancel an advance directive, (b) appoint a nominated representative, (c) adjudicate complaints regarding deficiencies in care and services, (d) receive and decide application from a person with mental illness/his nominated representative/any other interested person against the decision of medical officer or psychiatrists in charge of a mental health establishment

- **Decriminalising suicide:** A person who attempts suicide shall be *presumed to be suffering from mental illness* at that time and *will not be punished* under the Indian Penal Code.
- **Prohibiting electro-convulsive therapy:** Electro-convulsive therapy is allowed *only with the use of muscle relaxants and anaesthesia*. The therapy is prohibited for minors.
- **Insurance facilities:** The bill mandates the insurance companies to provide *medical insurance to mentally ill individuals on the same grounds as physically ill people*. Thus, it respects the right of mentally ill on the basis of equality
- **Inhumane Treatment:** The bill *identifies the inhumane and degrading treatment of mentally ill people as crime* and tackles the issue of mentally ill forcibly admitted to the hospital against his will.³

KEY ISSUES AND ANALYSIS

- There are concerns that the *new bill is too ambitious and unrealistic, given the lack of infrastructure, staff and resources*, and may not therefore be able to deliver what is proposed. The average number of psychiatrists in India is only 0.2 per 100 000 population, compared with a global average of 1.2 per 100 000 population. Similarly, the figures for psychologists, social workers and nurses working in mental healthcare are 0.03, 0.03 and 0.05 per 100 000 population in India, compared with global averages of 0.60, 0.40 and 2.00 per 100 000, respectively (World Health Organization 2005)
- This bill *has an over inclusive definition of mental illness*, which will have a significant impact on stigma. A better approach would be to have a precise and restrictive definition of mental illness because then the vast majority of patients would not have to face stigma-related problems

³<http://www.prsindia.org/uploads/media/Mental%20Health/Bill%20Summary-Mental%20Health%20care%20bill.pdf>



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- The bill is ***not clear about the management of minors***. A minor can be admitted only in exceptional circumstances, but these ***circumstances are not made entirely clear***
- In India, ***nearly half of all administrations of ECT (Electroconvulsive Therapy) are direct, which limits its use***. Services are, though, being upgraded. Modified ECT is more expensive than direct ECT and anaesthetist back-up for psychiatric units is mostly not available yet. The positive outcome of this move could be a shift in the focus towards the ***development of better set-ups for modified ECT in the long term***. Mobilising resources, greater public education, training of professionals and robust audit procedures should be urgent national priorities to help make the modified ECT available and accessible. This will address the concerns raised by various human rights organisations and will safeguard the rights of patients. Concerns were raised that many provisions of the Bill could have a negative impact in psychiatric treatment.⁴
- The bill ***decriminalises suicide but more as a stop-gap arrangement***, by creating a presumption of mental illness in every case of attempted suicide unless proved otherwise. Suicide should be completely decriminalised, without any conditions attached, which would help reduce stigma, create openness and make it easier to seek help.
- The present Bill could make psychiatrist uncomfortable, as it is ***bringing in too much control***.
- Concerns with Mental health care decisions in the hands of non-experts. ***Mental Health Review Board, which has six members out of which only one is a psychiatrist***
- The over inclusive ***definition of mental illness*** might harm the large chunk of psychiatric patients who might feel stigmatised
- The bill ***is silent about the expenditure needed***. It does not provide details of sharing expenses between centre and states
- Public Health being a state subject will put ***immense financial pressure on states*** for implementation
- Centre bringing such a ***law on state subject will impact the cooperative federalism model***
- Doesn't ***ban compulsory treatment for psychological condition which goes against the spirit of UN Convention on Rights of People with Disability***

⁴ <http://indianexpress.com/article/explained/new-mental-health-bill-provisions-rajya-sabha-2964545/>



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- The Bill mandates the central and state governments to ensure access to mental health services in every district. These will include outpatient and inpatient services, hospitals, and community-based rehabilitation establishments. However, the *financial memorandum of the Bill does not estimate the expenditure required to meet the obligations under the Bill nor does it provide details of the sharing of expenses between the central and state governments*. Without the allocation of adequate funds, the implementation of the Bill could be affected. The Standing Committee examining the Bill had noted that public health is a state subject. Since several states face financial constraints, the central government might have to step in to ensure funds for the implementation of the law

WAY FORWARD

- The Mental Health Care Bill has some unprecedented measures aimed towards a sea change for the betterment regarding access to treatment for the mentally ill across the country and particularly so for the underprivileged.
- The issues with the bill have to be resolved. States need to be consulted before finalising it as act.
- Care has to be taken that the Bill does not create impediments in psychiatric treatment in the country.
- It must be ensured that the large chunk of psychiatric patients is able to avail mental health care facility without any stigmatic feeling and hindrance.

CONCLUSION

The MHB 2016 is a step towards improving access to mental health services and bringing the law in line with international mental health legislation and human rights standards. The bill is a significant improvement over the existing MHA 1987, bringing about protection and empowerment of persons with mental illness. However, further discussion and debates are ongoing about its perceived shortcomings. Effective implementation will require a substantial change in the system currently in place and will need an extensive input of staff and finance. There are certain loopholes in the MHCB 2016 which question its applicability and meaningfulness for the Indian population. As admission procedures, treatment options and decision-making would become legalised and bureaucratized, certain experts are apprehensive that the bill will likely increase the stigma and hesitation to seek treatment from mental health professionals, due to cultural, educational and social factors, particularly in rural India. But at the same time, the revised legislation could mark a start of a new era for anti-stigma campaigns; it could lead to greater allocation of resources to mental health, and



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the training and retention of mental health professionals, including psychiatrists, psychiatric nurses and other allied professions.