How to Cite:
Pandey, S., & Sahoo, S. (2022). Mental health law in India. *International Journal of Health Sciences*, *6*(S10), 456–462. Retrieved from
https://sciencescholar.us/journal/index.php/ijhs/article/view/13499

Mental health law in India

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Abstract---In India, the Mental Health Act 2017 was brought forth by replacing the Mental Health Act 1987, to remove the flaws that the previous version had. The new legislation allowed for decriminalisation of suicide in mentally ill patients, apart from clearly defining the term mental illness, and bringing in the Mental Health Authority. Despite the noteworthy provisions introduced in this legislation, it remains a point of criticism, which will be touched upon in this work. In addition to this, a brief overview of the manner in which the Australian jurisdiction deals with mental health, would also be covered.

Keywords---mental health law, health law, healthcare laws, mental health India, Mental Health Act 2017.

Introduction

When it comes to health, the term not only covers the physical health, but also encompasses mental health, along with spiritual and social dimensions. The WHO (World Health Organization) has recognized mental health and well being as being one of the most fundamental to having a quality life, which allows a person to experience life in a meaningful manner [1]. Considering that a person with mental health is not able to make decisions for themselves, it is different from the general health [2]. To put in perspective the problem of mental health, one can refer to the data associated with it. As per data of 2016, collected in a study undertaken by the National Institute of Mental Health and Neurosciences, India, in twelve states, nearly 1 in 40, and 1 in 20 individuals suffered from previous or present depression episodes. Here it is crucial to note that depression is just one of mental disorders prevalent in the nation. The survey put the mental disorder at 13.7% of Indian population [1]. Considering the massive burden of mental illness, proper framework and infrastructure is required to cater to this issue. To deal with the erstwhile flaws of Mental Healthcare Act, 1987, the Mental Healthcare Act, 2017 (MHA) was brought forth on 27th March 2017 [3]. The present work is focused on showing how this health law has catered to this aspect of healthcare, along with discussing its flaws, to make way for further amendments. In doing so,

comparison will be drawn with other jurisdictions to help in better understanding the manner in which mental health is dealt in Australia.

Mental Health Law in India

The MHA was passed after following the proper procedure, where after being passed in both the Lok Sabha and Rajya Sabha, it got its approval in April 2017 by the Honourable President of India [4]. As per the MHA, the mental illness is to be deemed as a substantial disorder of memory, orientation, perception, mood, or thinking, as a result of which, the individual has a grossly impaired judgement and is not able to meet the ordinary life demands, and covers the mental conditions which are associated with drugs or alcohol abuse. The erstwhile version of this act that was applicable before it, and was criticized for not recognising the mentally ill individual's rights, was rescinded with the advent of MHA. With this legislation, the Indian Penal Code 309 was also overturned, which earlier criminalized the mentally ill individuals who attempted suicide. The focus of MHA was to safeguard the rights of such individuals, where their treatment access was facilitated and making way for advance directive to be shared by them (the patient) that acted as a guide on the manner in which such a patient wanted to be treated for their illness [5].

To understand the manner in which the MHA has helped in bringing changes to the mental health in India, there is a need to look at its varied provisions. The first important provision is related to rights of the persons with mental illness. This provides that every individual has the right of accessing mental health care services in the nation. In addition to this, these services have to be affordable, accessible, convenient, and of good quality. The individuals with mental health have to be protected from inhuman treatment, have the right of complaining where there is shortfall in provisions, and even has the right of getting access to free legal services and even to their medical records. The individuals with mental illness are empowered with the right to make an advance directive, which helps them in deciding the manner in which they want to be treated for their illness, along with nominating the representatives that they make. To ensure that the same is not misused, the provision for the directive to be medical practitioner vetted has been put forth [6].

Basis MHA, the government has been mandated to set up Central Mental Health Authority at both state and national level. There is also a requirement put forth for all the mental healthcare practitioners and mental health institutes to be registered with the Mental Health Authority. The former set includes the psychiatric social workers, clinical psychologists, and the mental health nurses. The Authority will maintain, register, and supervise the mental health establishments' register; develop service and quality provisions as per established norms; maintenance of mental health professionals' register; receiving complaints regarding provision of services being deficient; and advising the government on mental health matters. The admission of individuals with mental illness is detailed in this act, which provides the process and procedure for admitting, treating, and subsequently discharging the individuals who are mentally ill [1].

With the introduction of MHA, as touched upon earlier, the suicide attempts were decriminalized for mentally ill patients. The government was given the duty of rehabilitating these individuals for making sure that they do not reattempt suicide. The individuals with such illness were barred from being subjected to ECT therapy, i.e., electroconvulsive therapy, without making use of anaesthesia and muscle relaxants. Apart from this, the use of this therapy was prohibited for minors. The MHA also put forth the responsibility on certain other agencies to further its prime objectives. For a police station, a police officer in charge has to report to Magistrate the reasons for believing that the mentally ill person was being neglected or ill-treated. The duty on police officer was also to take any wandering person in their custody, and to get them examined by the medical officer. Post the examination, such individual has to be taken to homeless person establishment, their residence, or a mental health establishment. Another noteworthy provision is the financial punishment, which provides that upon breaching the provisions of MHA, the individual would be fined INR 10,000, or be imprisoned for six months, or both. Where a repeat offender is noted, the fine ranges from INR 50,000-5 lakhs, and imprisonment of up to two years in jail, or both [1].

Critical Analysis

The MHA is a landmark legislation which has the aim of providing the mental healthcare services to individuals having mental illness. This legislation is aimed at providing the individuals with mental illness, a right, which pertains to living a life with dignity, wherein they are not harassed or discriminated against. There are both merits and demerits of the MHA as the main issue pertains to the same not being fully Indian. The MHA provides that the right to live life with dignity is given to patients with mental illness and that they will not be facing any discrimination based on caste, culture, religion, and sex. Apart from this, the legislation also provides that the individuals would have the right of confidentiality regarding their illness and even for their treatment. The ECT provision change has already been discussed. Apart from this, on such patients, sterilization cannot be performed and cannot be put in isolation or solitary confinement. The MHA furthers basis human rights for such individuals are well, including the right to be free from inhuman, degraded, or cruel treatment, the right to personal contacts and communication, and right to legal aid. Even though there are a number of rights given to these patients, the estimated expenditure which is required to meet the legal obligations, is not stated. Apart from this, it remains unclear on the manner in which the requisite funds will be allocated between state and central governments [1].

The MHA provides that the homeless individuals and the ones who are below the poverty line, will be provided with free quality treatment, even in such cases where they do not hold a BPL card. In a nation where mental illness is deemed equivalent to depression, it is obvious that the financial burden on government is way too high. To put this in perspective, the proposed healthcare expenditure for 2017-18 was 1.2% of the GDP. Across the globe, this has been the lowest, and since 2013-14, it has seen a constant decline [7]. The nation only spends around 0.06% on mental health care from its health budget, which is even lower than the spending made in this context by Bangladesh. As per the 2011 WHO report, the

developed nations spend more than four per cent of their budget on workforce, frameworks, infrastructure, and research of mental health [8]. Even though the MHA does bring in new provisions, there is an absence of rules or guidelines for the same to be implemented. Even with decriminalisation of suicide is a welcome move, there remains scope of the same being misused. An example of this is the dowry related attempted homicide or burning being twisted as an attempted suicide so as to avoid the required attention from it. The MHA also fails to address the cultural and socioeconomic factors that aggravate the mental illness in the nation, which includes the issues like superstition, discrimination, stigma, lack of awareness, and lack of access to healthcare.

A key aspect that has been given away with the 2017 variant of this act is that there is no provision available for a guardian being appointed for a mentally ill patient, which was indeed present in the erstwhile 1987 version of it. This discrepancy was noted in the case of *C. Raghuraman vs Unknown on 27 January, 2022* [9], wherein the Court noted that the decision given in *G. Nithyanandam vs. Tmt. D. Saritha and others* reported in 2013 3 LW 412 [10], became confusing. This is the reason why the judge had to return of petition as the same was filed by legal guardian of mentally retarded person was erroneous [11]. Reference was also made to the *Deepa Asani's* case reported in 2021 SCC Online 2148 [12], where it was noted that the repeal of 1987 variant left a vacuum regarding the appointment of legal guardian for such individuals. The court has not only intervened when it became necessary to remove the flaws of the 2017 version of the act, but has also intervened where it could see that it became crucial for the 2017 variant to be implemented without any further delay, as was seen in the case of *Kerala State Legal Services ... vs State of Kerala* on 5 February, 2021 [13] [14].

Comparison with Australia

As against India, the mental health laws are far more refined and adopt a more progressive approach, which show a focus on international trends pertaining to the human rights. The six states and two territories have been vested with the most legislation responsibility, resulting in preparation of several new mental health acts. There is also a model mental heath act, which promotes the common standards. For both India and Australia, UK remains a key influential aspect in their mental healthcare laws. And in both the jurisdictions, there is commonality of provisions like advance directives. However, the manner in which these are implemented are quite detailed in the Australian jurisdiction [15]. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) is a key aspect that is covered in the mental health legislation of both the jurisdiction as both India and Australia have adopted key principles of it [16]. In Australia, there are several regulations pertaining to ECT, one of which includes the need for the patient to be informed regarding the same being used on them and taking the relevant consent for its usage. Although, Tasmania is an exception to any special regulation pertaining to ECT [17].

It remains evident that there is a need to bring in provisions which could help in enhancing the skills and resources that are required for the workers and professionals in mental health field, along with making the requisite provisions for

the financial support. The 2017 version of MHA has been substantial in clarifying the meaning of mentally ill people, to cover even the ones who have been in this position due to substance use disorder. However, a key problem of MHA is that it allows for an individual having any mental illness to be treated or admitted without their consent, just on request of any nominated representative. Here, an ignorance is noted on the family assuming the primary caregiver role first. One cannot deny the fact that even the clinicians are reliant on the families. This means that having the proper support of family is crucial for the patient, healthcare administrator and for the clinician as well. There should have been provisions brought forth for mandating the implementation of National Mental Health Programme through this legislation in every state, which should have been made the responsibility of the local authorities to implement the same [18].

The next point of criticism for MHA is that it gives a very broad definition for mental illness, which in turn brings the increase in stigmatization of such illness. There was a need for creating a specific and a narrow definition on mental illness, so as to stop the people from having to witness or come across this stigma. The manner in which minors have to be managed, remains unclear in the MHA. In India, majority ECT is done directly. In order to get the support of an anaesthesiologist, high costs would have to be incurred. There would be a need to increase public education, effective audit processes, mobilization of resources, and professional training to make ECT accessible and available. A key aspect here is that suicide is decriminalized only for mentally ill patient, which is merely a band-aid solution. Rather, it should be decriminalized across the nation to remove stigma, for people to seek aid easily, and for being open. Then there is the issue of the MHA being silent on consistent method of providing advance directives. A nominated representative has no way of being removed in the MHA. Even the medial officers cannot dismiss such a representation, even when the same is not in patient's best interest. There is no set of qualifications specified for the mental health professionals in MHA, setting up low standards of mental healthcare [19]. This is a major flaw, which essentially outshines the very purpose of MHA. The MHA refrains any person from being chained [20]. However, the manner in which underqualified person can keep them in shackles, has not been covered in this legislation.

Conclusion and Future Developments

One cannot deny the fact that mental health is a crucial aspect that needs to be taken care of, in every jurisdiction. However, it is noted that despite the recent developments in this area, pertaining to the relevant laws, India has not lived up the expectations. The MHA 2017, which replaced the 1987 variant of this act, was introduced with a lot of hopes. The goal was to eradicate the shortfalls of the previous act, and to strengthen the manner in which the mental illness patients were protected. However, the criticism offered in the previous segments highlighted the need to amend the present act, so as to truly meet the purpose with which it was formed. Despite this, it cannot be denied that the MHA 2017 variant has been a landmark legislation, as it did bring in provisions to safeguard patients with mental illness. The ECT provisions, coupled with the proper definition and suicide provisions do aim at bringing a better set of rights for the mental illness patients. However, when it is compared to the more comprehensive

systems like that of Australia, the novice nature of the Indian legislation is reflected. This is because of the missing sophistication, coupled with the lack of funds, which even a nation like Bangladesh devotes more in comparison to India to deal with the mental health of the region. In short, it can be said that 2017 MHA has been a welcome move. Yet, the path to attaining good and comprehensive laws that care to the needs of mentally ill patients, is still a long way to go in the nation. There is a need to sit, introspect, and bring in a comprehensive set of provisions which can eradicate the problems stated above. In doing so, the necessary consultation of various stakeholder groups, particularity the ones on ground, and the ones who actually deal with the implementation of such provisions, should be taken into consideration.

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