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Mental health laws in India: A critical analysis

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***Abstract*---**Supportive legislation and policies are needed for human rights and mental health treatment for disadvantaged people. Internationally and regionally, both "hard" and "soft" legislation relating to mental health treatment have been drafted. In the field of mental health care in India, amendments to existing laws and the formation of new laws are frequently necessary and have been seen. So far, mental health care reform has primarily been reactive, but current legislation and policies provide the prospect of proactive change. One of the most serious issues in providing good mental health treatment in India is a shortage of qualified human resources. While postgraduate psychiatric standards prescribe a two-week forensic psychiatry course, this is insufficient to establish the essential competency. As a result, forensic psychiatry requires the development of a specialisation. In addition, forensic psychiatric services must be created, organised, and maintained. In India, one or more centres of expertise in forensic psychiatry are required.

***Keywords*---**mental health, health treatment, psychiatry.

Introduction

Suicide is decriminalised under the law, but only as a stopgap measure, with a presumption of mental disease in all attempted suicide instances unless proven differently. Suicide should be completely decriminalised, with no limits, to help reduce stigma, enhance openness, and make it easier to seek help. Following India's adoption of the United Nations Convention on the Rights of Persons with Disabilities in 2007, the Mental Healthcare Act 2017 replaced the Mental Health Act 1987. The Mental Healthcare Act of 2017 (MHCA) safeguards patients' autonomy, dignity, rights, and choices during mental health treatment, and thus represents a significant advancement in Indian mental health legislation. This new law marks a fundamental shift in the way mental health treatment is

provided, as it aims to preserve and promote people's rights while delivering mental health care. Under this Act, no one can be forced to seek mental health treatment, and inpatient admissions can be 'independent' or 'supported.' The term 'supported admission' replaces the term 'involuntary admission' from prior legislation. State mental health authorities and mental health review boards will have a big say in how the new Act is implemented. The 2017 Mental Healthcare Act aims to radically overhaul India's mental health care system. The relationship between psychiatry and legislation frequently comes into play when it comes to treating PMI. Personal liberty of psychiatric patients is commonly reduced as a result of PMI treatment. The majority of countries have laws controlling the care of mentally ill people. Despite the fact that there are thorough accounts of different mental disorders in various treatises in the literature, Ayurveda is not one of them.[1] The care of mentally ill patients in India's asylums was invented by the British. Following the British crown's capture of India's government in 1858, a flurry of laws were enacted in quick succession to control the care and treatment of mentally ill persons in British India.[2] These laws were:

- 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)
- The Military Lunatic Acts, 1877.

These Acts outlined the procedures for constructing mental asylums and admitting mental patients. The insanity statutes in India at the time were based on a mid-nineteenth-century British scenario. The 1858 Acts established a legal framework for the treatment of mentally ill persons.[3] Indian intellectuals' increased public awareness of the terrible circumstances in mental health institutions throughout the first decade of the twentieth century fostered rising political consciousness and nationalistic feelings.[4] The Indian Lunacy Act of 1912 was adopted as a result. Rising political consciousness and nationalistic feelings are fueled by Indian intellectuals' greater public knowledge of the heinous conditions in mental health institutions throughout the first decade of the twentieth century.[5] Nonetheless, the main focus was on safeguarding society from the dangers posed by mentally ill persons, as well as ensuring that no ordinary person had access to these institutions. Psychiatrists were employed as full-time authorities in these hospitals. The Act also authorised judicial inquisitions for mentally sick individuals. Following World War II, the United Nations General Assembly adopted the Universal Declaration of Human Rights. To replace the obsolete ILA-1912, the Indian Psychiatric Society developed a Mental Health Bill in 1950. After a long and drawn-out process, the Mental Health Act of 1987

[1] Somasundaram O, Kumar MS. Changing patterns of admission in a state mental hospital. Indian J Psychiatry. 1984;26:317–21

[2] Banerjee G. The Law and Mental Health: An Indian Perspective. 2001. [Last accessed 2012 Jun 21]. Available from: http://www.psyplexus.com/excl/lmhi.html

[3] Somasundaram O. The Indian lunacy act, 1912: The historic background. Indian J Psychiatry. 1987;29:3–14

[4] Banerjee G. The Law and Mental Health: An Indian Perspective. 2001. [Last accessed 2012 Jun 21]. Available from: http://www.psyplexus.com/excl/lmhi.html

[5] Somasundaram O. The Indian lunacy act, 1912: The historic background. Indian J Psychiatry. 1987;29:3–14

(MHA-87) was ultimately passed in 1987. The following are the Act's main elements:

a) A evolving definition of mental disease, as well as the introduction of a modern treatment concept that emphasises care and therapy rather than confinement.
b) Establishment of a Federal/State Mental Health Authority to oversee and supervise psychiatric facilities and nursing homes, as well as provide mental health recommendations to the federal and state governments.
c) In exceptional circumstances, admission to a psychiatric facility or nursing home. Both voluntary admission and admission based on reception orders were preserved.
d) The police and magistrate's roles in cases of wandering PMI and PMI who have been treated cruelly..
e) Protection of human rights of PMI.
f) Guardianship and Management of properties of PMI.
g) Provisions of penalties in case of breach of provisions of the Act.

Despite its numerous positive attributes, the MHA-1987 has received criticism since its inception. It's reported to be mostly concerned with PMI's licencing and admissions procedures, as well as guardianship issues. This Act does not effectively address human rights issues or mental health service delivery.[6] Due to a plethora of extremely complex processes, defects, and absurdities, the Act, as well as the Rules promulgated under it, will never be successfully implemented.[7] Human rights activists have questioned the MHA's constitutional legitimacy, alleging that it restricts personal liberty without allowing for adequate judicial examination.[8] MHA-87 is currently being amended to comply with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

This measure took more than three decades to get the President's consent (in May 1987), and it was only passed into law in 1993. The Mental Health Act (MHA) of 1987 had the advantage of defining mental illness in a progressive manner, emphasising care and treatment over institutionalisation. It included specific processes for hospital admission in unusual cases and emphasised the need of safeguarding human rights, guardianship, and property management for persons with mental illnesses.

The MHA 1987 is criticised mostly for the legal procedures of licence, admission, and guardianship. Human rights and the delivery of mental health treatment were also not effectively addressed in this Act[9]. Human rights organisations have questioned the constitutional legitimacy of the MHA 1987 since it restricts personal liberty without the opportunity of judicial review. Similarly, the MHA

[6] Narayan CL, Narayan M, Shikha D. The ongoing process of amendments in MHA-87 and PWD Act-95 and their implications on mental health care. Indian J Psychiatry. 2011;53:343–50

[7] Dutta AB. The Long March of Mental Health Legislation in Independent India; Dr.L.P.Shah Oration delivered at IPS-WZ Conference at Goa. Goa Psychiatric Society; 2001. [Google Scholar]

[8] Dhandha A. Status Paper on Rights of Persons living with Mental Illnessin light of the UNCRPD, in Harmonizing Laws with UNCRPD, Report prepared by the Centre of Disability Studies. Human Right Law Network. 2010 May [Google Scholar]

[9] Narayan C. L., Narayan M. & Shikha D. (2011) The ongoing process of amendments in MHA-87 and PWD Act-95 and their implications on mental health care. *Indian Journal of Psychiatry*, 53, 343–350

1987 remained silent on patient rehabilitation and care following discharge from the hospital.[10] In addition, a lack of treatment facilities puts financial, social, and emotional strain on caregivers and their families. As a result of these criticisms, the MHA 1987 was revised, culminating in the Mental Health Care Bill 2013, which was introduced in the Rajya Sabha (upper house of parliament) on August 19, 2013. The MHA of 1987 is repealed by this measure, but it has yet to become law.

Mental Health and Constitution of India

The Indian Constitution Article 21 of India's constitution states that no one may be deprived of his or her life or personal liberty unless in accordance with legal procedures. According to this article, "facilities for reading, writing, and expressing oneself in varied forms, freely moving about, and mixing and comingling with fellow human beings" are included in the right to life and personal liberty.[11] According to the Representation of People Act, 1950 (sec 16), a person is disqualified for registration in an electoral roll if he is of unsound mind and stand so declared by a competent court. As a result, the person is ineligible to hold public posts such as President, Vice President, Ministers, Members of Parliament, and State Legislatures under the Constitution. 1995 Act on Persons with Disabilities (Equal Opportunity, Protection of Rights, and Full Participation) (PDA 95). PDA 95 was created in 1995 to eliminate discrimination in the distribution of developmental benefits between disabled and non-disabled people, as well as to prevent abuse and exploitation of disabled people (PWD). It created a barrier-free environment and specified the government's responsibilities, which included formulating comprehensive development policies and providing specific measures for the integration of PWDs into society. Under PDA 95, mental retardation and mental sickness are also considered disabilities. As a result, the PMI are entitled to the benefits provided by the Act to PWDs. There is a 3% reserve provision in government employment, but it is not available to the PMI. This Act is also being revised in light of the UNCRPD 2006.

Provisions of the Mental Health Care Bill (MHCB) 2013

Under the MHCB 2013, everyone has the right to receive mental healthcare and therapy from government-run or funded services. As a result, if a district mental health service is unavailable, a patient with mental illness will have access to services and facilities such as free psychotropic medication, mental illness insurance coverage, and money for a private consultation. Treatment and rehabilitation will be available in the least restrictive environment possible, and patients' rights and dignity, particularly those from low-income families, shall be protected, according to the MHCB 2013. As a result of these recommendations,

[10] Dhandha A. (2010) Status Paper on the Rights of Persons Living with Mental Illness in Light of the UNCRPD. In *Harmonizing Laws with UNCRPD*. Report prepared by the Centre of Disability Studies Human Rights Law Network. [Google Scholar]

[11] Singh MP. In: Shukla's VN Constitution of India. 9th ed. Lucknow: Eastern Book Company; 1994. p. 165

the financial and mental difficulties imposed on caregivers will be considerably eased.[12]

Advanced directives and nominated representatives are two new concepts introduced by the MHCB 2013, which give people with mental illnesses more control over how they want to be treated in the future if they lose their ability (i.e., mental capacity), as well as who will be their nominated representative to manage their affairs. The law calls for the creation of national and state mental health bodies. Every mental health facility will also be required to register with the appropriate central or state mental health authority.

A quasi-judicial mental health review commissioning committee will assess the usage and processes for giving advance directives on a regular basis and advise the government on how to preserve the rights of mentally ill people. Suicide is still a crime in India, but this law proposes that it be decriminalised[13]. By decriminalising suicide, the stress caused by societal and legal factors can be reduced, easing the strain on patients and caregivers while also reducing the impact on India's already overcrowded legal system.

Finally, it is advocated that direct (unmodified) electroconvulsive treatment (ECT) be prohibited[14]. That is, only muscle relaxants and anaesthesia will be permitted when ECT is employed. Minors are not permitted to get this treatment.

Criticism of the MHCB 2013

Given the lack of infrastructure, manpower, and resources, there are fears that the new law is too ambitious and unrealistic, and that it will not be able to accomplish what is planned[15]. In India, there are just 0.2 psychiatrists per 100,000 people, compared to a global average of 1.2 psychiatrists per 100,000 people. Similarly, the numbers of psychologists, social workers, and nurses working in mental health treatment in India are 0.03, 0.03, and 0.05 per 100,000, respectively, compared to global averages of 0.60, 0.40, and 2.00 per 100,000[16].

Second, this measure contains an overly broad definition of mental illness, which would significantly increase stigma. A preferable way would be to establish a specific and narrow definition of mental illness since this would prevent the great majority of people from having to deal with stigma[17]. The bill is unclear on how minors should be managed. Only under extreme situations may a minor be accepted; however, these criteria are not totally obvious[18]. Nearly half of all ECT administrations in India are done directly, limiting their utility. However, services

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[12] Gopikumar V. & Parasuraman S. (2013) Mental illness, care and the bill: a simplistic interpretation. *Economic and Political Weekly*, 48(9), 69–73. [Google Scholar]; Kala A. (2013) Time to face new realities: Mental Health Care Bill, 2013. *Indian Journal of Psychiatry*, 55, 216–219. [Europe PMC free article] [Abstract] [Google Scholar]

[13] Bhaumik S. (2013) Mental health bill is set to decriminalise suicide in India. *BMJ*, 347, f5349

[14] [14] Narayan C. L., Narayan M. & Shikha D. (2011) The ongoing process of amendments in MHA-87 and PWD Act-95 and their implications on mental health care. *Indian Journal of Psychiatry*, 53, 343–350

[15] Antony J. (2014) Mental Health Care Bill 2013: a disaster in the offing? *Indian Journal of Psychiatry*, 56(1), 3–7

[16] World Health Organization (2005) *Mental Health Atlas*. WHO.

[17] Antony J. (2014) Mental Health Care Bill 2013: a disaster in the offing? *Indian Journal of Psychiatry*, 56(1), 3–7

[18] Narayan C. L., Narayan M. & Shikha D. (2011) The ongoing process of amendments in MHA-87 and PWD Act-95 and their implications on mental health care. *Indian Journal of Psychiatry*, 53, 343–350

are being enhanced[19]. Modified ECT is more costly than direct ECT[20], and anaesthesiologist support for psychiatric hospitals is rare. In the long run, this change might result in a shift in emphasis toward the creation of improved set-ups for modified ECT. To assist make the improved ECT available and accessible, national goals should include mobilising resources, increased public education, professional training, and effective audit processes. This will meet the concerns expressed by numerous human rights organisations while also protecting patients' rights.

The measure decriminalises suicide, but only as a band-aid solution, by establishing a presumption of mental disorder in all attempted suicide cases unless proven differently. Suicide should be decriminalised totally, with no restrictions attached, in order to remove stigma, increase openness, and make it simpler to seek aid.

On August 19, 2013, the Rajya Sabha introduced the Mental Health Care Bill, 2013. The Mental Health Act of 1987 is repealed by this bill. The government ratified the United Nations Convention on the Rights of Persons with Disabilities in 2007, according to the Bill's Statements of Objects and Reasons. The Convention requires that the country's legislation be in compliance with it. Because the present law does not sufficiently protect the rights of people with mental diseases or encourage their access to mental health treatment, a new bill was introduced. The key features of the Bill are:

*Rights of persons with mental illness**:*** Persons with mental illnesses have the right to get mental health treatment and care from government-run or funded services. The ability to acquire services that are both economical and of good quality, as well as having simple access to them, is part of the right to mental health care. In addition, people with mental diseases have the right to fair treatment, protection against harsh and degrading treatment, free legal assistance, access to their medical records, and the ability to protest problems in mental health care.
*Advance Directive**:*** A mentally sick individual has the right to write an advance directive that specifies how he wishes to be treated for his disease in the event of a mental health emergency, as well as who his designated representative will be. The advance directive must be certified by a physician and recorded with the Mental Health Board. If a mental health professional, relative, or caretaker refuses to follow the directive while treating the patient, he or she can petition the Mental Health Board to have the advance directive reviewed, changed, or cancelled.
*Central and State Mental Health Authority**:*** These administrative bodies are in charge of (a) registering, supervising, and maintaining a register of all mental health establishments, (b) developing quality and service provision norms for such establishments, (c) maintaining a register of mental health professionals, (d) training law enforcement officials and mental health professionals on the Act's provisions, (e) receiving complaints about service deficiencies, and (f) advising the government on matters relating to mental health.

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[19] Chanpattana W., Kunigiri G., Kramer B. A., et al. (2005) Survey of the practice of electroconvulsive therapy in teaching hospitals in India. *Journal of ECT*, 21, 253–254
[20] Gangadhar B. N. (2013) Mental Health Care Bill and electroconvulsive therapy: anesthetic modification. *Indian Journal of Psychological Medicine*, 35, 225–226

Mental Health Establishments: Every mental health facility must be registered with the appropriate federal or state agency. The establishment must meet a number of requirements set out in the Bill in order to be registered.
The bill also lays out the steps for admitting, treating, and releasing mentally ill people. Except when he is unable to make an autonomous decision or conditions exist that make a supported admission necessary, the decision to be admitted to a mental health facility should be made by the person with the mental illness as much as feasible.
Mental Health Review Commission and Board: The Mental Health Review Commission will be a quasi-judicial body that will regularly assess the use of advance directives and the process for obtaining them, as well as advise the government on how to protect the rights of mentally ill persons. The Commission will establish Mental Health Review Boards in each of the state's districts, with the agreement of the state governments.
The Board will have the authority to (a) register, review, alter, or cancel an advance directive, (b) appoint a nominated representative, (c) adjudicate complaints about care and services deficiencies, and (d) receive and decide an application from a person with mental illness, his nominated representative, or any other interested person, challenging the decision of the medical officer or psychiatrists in charge of a mental health establishment.
Decriminalising suicide and prohibiting electro-convulsive therapy: Suicide attempts are believed to be the result of mental disease at the time and are not punishable under the Indian Penal Code. Electro-convulsive therapy is only permitted when muscle relaxants and anaesthesia are used. Minors are not permitted to get counselling.

The Mental Healthcare Act, 2017

The legalising of suicide is the most laudable provision in the 2017 MHA.[21] The Act assumes that the person who tried suicide was under mental stress and/or sickness, and hence is not subject to the Indian Penal Code's penalties (IPC). The appropriate governments have been entrusted with the responsibility of ensuring that the person who attempted suicide receives the necessary care and protection, in order to reduce the number of suicide attempts in the future. At several points throughout the Act's development, the Indian Psychiatric Society (IPS) was invited and consulted. They were not, however, allowed to contribute to the Act's formulation. Though the IPS has misgivings about the NHA, 2017, it has said expressly that the legalising of suicide (based on their recommendations) has been the single most significant improvement. Reading down section 209 of the IPC, according to the IPS, will help with better suicide reporting (which would be beneficial from a legal and social standpoint).

Medical insurance (for treating mentally ill people) should be supplied by insurers, according to Section 21(4) of the Act, in the same way as other insurances are provided for illnesses. In a highly encouraging move, the Insurance Regulatory and Development Authority of India (IRDAI) has issued directions to health insurers across the country to include mental diseases in medical insurance coverage.

[21] The Mental Healthcare Act, 2017 § 115

In the year 2018, the IPS and the MHA, 2017 were a successful pair in decriminalising homosexuality in India. While closely aligned with the MHA, the IPS' policy statement in 2017 has always maintained that "homosexuality is not a mental disease." This IPS statement and the applicable MHA, 2017 provisions paved the way for them to be included in the verdict in this important decision. The MHA, 2017, non-discrimination clauses were incorporated into the ruling. It was also observed that section 377 was invalid due to the inconsistencies it had with MHA, 2017.

Section 29 of the Mental Health Act of 2017 requires the government to create and implement initiatives that increase mental health awareness and minimise stigma. Section 30 mandates that the government communicate critical mental health information as widely as feasible. The provisions of the MHA, 2017, are also widely promoted as part of this dissemination. It is also required that relevant public authorities participate in timely awareness and training initiatives related to mental health issues.

Section 31 bolsters the government's responsibilities by stating that it is the government's responsibility to ensure that medical and mental healthcare professionals in public hospitals and prison cells are adequately trained in accordance with internationally accepted standards—a link can be seen between this provision and Principle 3 of the UN Principles. As a result, when compared to MHA, 1987, MHA, 2017, has a greater international character.

According to MHA, 2017, a person diagnosed with a mental disease who is involved in a legal dispute (as a result of exercising his rights under MHA, 2017) would be supplied with the necessary legal assistance to pursue their case. Section 2(s) of the Mental Health Act of 2017 offers a broad definition of mental illness based on medical and societal concerns. It generally defines any significant disorder affecting a person's mood, thinking, perception, memory, or orientation, and seriously affecting and diminishing his or her sense of judgement and behaviour. Such a person may have difficulties comprehending and identifying reality, as well as carrying out simple living duties. This definition of mental illness covers problems that develop as a result of alcohol and drug misuse. The term, however, excludes "mental retardation" from its scope. With a balanced, medically sound definition in the MHA, 2017, a firm foundation has been laid for any prospective legal disputes that may arise as a result of this legislation.

Section 5 of the MHA, 2017 allows for the issuance of "advanced directives," which essentially gives a patient the ability to exercise his right and provide directions for the care they want for their disease or the remainder of their illness well in advance. They may also designate a representative for this cause. These directions must be thoroughly reviewed and authorised by the proper medical authorities.

Chapter V of the MHA, 2017, delves into the rights of mentally ill people, just as its predecessor, the MHA, 1987. However, in order to protect patients' social, financial, physical, and emotional well-being, the rights defined in the MHA, 2017 are more thorough, forceful, and liberal. Sections 18-28 of Chapter V of this Act

are its most important provisions. The MHA, 2017, has included the right to confidentiality, emergency services, the freedom to decline visits, medical insurance, the right to be included in society without discrimination, and a variety of other welfare-related rights. The Central Mental Health Authority is required by Section 33 of the Mental Health Act of 2017. The State Mental Health Authority must be established under Section 45. The development and design of Mental Healthcare Programs, as well as the successful implementation of the MHA, 2017, would be the responsibility of these authorities.

Criticisms of MHA, 2017 and Suggestions

Even with the enormously commendable provisions of the MHA, 2017, the Act falls short in various areas:
MHA, 2017, surely took mental healthcare professionals' and the IPA's perspectives into account; yet, the IPA was excluded from the drafting process. This has been one of the most contentious and criticised sections of the 2017 MHA. Section 5 of the Act makes no mention of a consistent method for providing advanced directives. Because the method is not included in the Act, doubt regarding the exercise of the right arises. Such ambiguous rules undermine the legislative objective of allowing for the issuance of advanced directives.

Surprisingly, there isn't a single provision in MHA, 2017 that deals with removing a Nominated Representative. Furthermore, not even medical officials have the power to dismiss such a representative (even if their counsel is not in the best interests of the patient). Although this appears to be a hastily worded provision, personal contracts can be entered into between the parties to regulate the potential removal of a Nominated Representative, despite the fact that it is a difficult obstacle to surmount (when the need may be).

Electroconvulsive therapy has been outlawed as an emergency treatment under section 94 of the MHA, 2017 to prevent the patient's death or irreversible injury. This type of therapy is a traditional life-saving emergency treatment for mentally sick people (especially for those with higher suicidal tendencies). Several mental health specialists have slammed this section of the MHA, 2017, because electroconvulsive therapy can help control and manage patients in emergency situations. Mental health specialists can make a joint request to the Central and State Mental Health Authorities, which could investigate the situation quickly.

MHA, 2017, does not provide a common set of qualifications for medical and mental health professionals. This lowers the standard of mental health care and calls into question the workforce's competency in entrusting the country's minds and brains to them in the hopes of recovery. To investigate this significant flaw, immediate action is essential. In the long run, however, proper adjustments to standards qualifications should be made.

An important judicial decision that needs to be mentioned at this juncture is that of *Meenu Seth v. Binu Seth*[22]. The problem in this case was that a case was already in progress under the MHA, 1987. Following the implementation of MHA

[22] FAO No. 411/2017, High Court of Delhi

2017, the appellants requested that their case be handled in accordance with the provisions of MHA 2017. Despite the fact that MHA, 1987 was abolished by MHA, 2017, the Delhi High Court dismissed the appeal, stating that section 126 2(f) of MHA, 2017 clearly indicates that any issues that were continuing and pending in any Indian court under MHA, 1987 will continue to be covered by MHA, 1987.

Mental Health legislations in other countries

a) There are extremely few psychiatrists or medical practitioners with knowledge and experience of psychiatry in South Africa's rural communities and poorer metropolitan areas.
b) The Mental Health Act of 1983 in England and Wales, as well as the Italian Public Law issued in 1978, are notable examples of a change away from custody and incarceration and toward integration and rehabilitation of people with mental illnesses.
c) In 1950, Japan passed the Mental Hygiene Law, which supported the building of psychiatric facilities and provided financial assistance to involuntarily confined patients.

United Nations convention for rights of persons with disabilities-2006 and Indian laws

The UNCRPD was adopted in December of 2006. The Indian Parliament ratified it in May of 2008. Countries that have signed and ratified the UNCRPD are required to align their laws and policies with it. As a result, India's whole disability legislation is currently being revised. The pact marks a shift in the treatment of people with disabilities from a social welfare issue to a human rights issue. The new paradigm is based on everyone's legal capacity, equality, and dignity. According to article 2 of the treaty, PWDs would enjoy equal legal competence in all areas of life. Article 3 mandates that the state take reasonable steps to ensure that people with disabilities have access to assistance in exercising their legal rights. Article 4 calls for safeguards to prevent abuses of the system of support required by PWD. There is no explicit prohibition of forced interventions in the UNCRPD, but neither does the Convention permit compulsory mental health care.[23] The process of modifying MHA 87 began, and a draught Mental Health Care Bill – 2011 (MHCB) was created. MHCB proposes that mental health facilities be registered rather than licenced, and that a Mental Health Review Commission with state panels be established. Significant modifications have been made to the admissions process. The MHCB's most important feature is that it holds the government accountable for establishing and providing mental health services to all individuals, as well as taking appropriate action. Human rights are well-protected in the PMI, with a whole chapter devoted to the subject. PDA 95 is also being changed, and a draught of "The Rights of Persons with Disabilities Bill, 2011 (RPWD Bill)" has been received by the Ministry of Social Justice and Empowerment (MSJE). According to Section 18 of the proposed bill, PWDs will have legal capacity on an equal footing with others in all aspects of life, and any legislation, rule, byelaw, custom, or practise that imposes disqualification on the

[23] Dhandha A. Status Paper on Rights of Persons living with Mental Illnessin light of the UNCRPD, in Harmonizing Laws with UNCRPD, Report prepared by the Centre of Disability Studies. Human Right Law Network. 2010

basis of disability will become unenforceable. PWDs have the right to get the help they need to execute their legal rights, but they also have the flexibility to change, modify, or abolish any support system they have. Plenary guardianship has mostly been phased out in favour of restricted guardianship. PMI has been allocated a 1% quota out of the planned 7% reserve for PWDs in government posts. The MHC Bill and the RPWD Bill have irreconcilable clauses. The drafting committee of the RPWD was dominated by human rights campaigners. A group of human rights advocates believes that every PMI should have full legal authority, and that compulsory institutionalisation and the closure of all mental institutions should be outlawed. They say the MHCB makes no assumption of universal capacity and has no plan to help people make educated decisions about their own lives. They've even urged that MHA 87 be repealed totally, and that the issue be addressed by a reworked and comprehensive RPWD Bill under MSJE's control.

Conclusion

There is a need to create preparations to improve the resources and skills of mental health professionals/workers, as well as to provide enough financial support/budget. The previous law (the Mental Health Act of 1987) didn't provide a definition of mental illness. A "mentally ill person" was defined as "a person who requires treatment for any mental disorder other than mental retardation." Except in Chapter III, no mention of substance use disorder (SUD) was made elsewhere. The current act, the Mental Health Care Act of 2017, has included SUD in the definition of mental illness. A flaw in the MHCA, 2017, is Section 89, which allows a person with mental illness to be admitted and treated without his agreement if a chosen representative requests it. The Act overlooks the fact that the family is the primary caregiver. Even clinicians are reliant on their patients' families. As a result, the patient, the practitioner, and the healthcare administrators all require proper family support. The Act also ignores the fact that the government has a mental health programme. The Act should have required all states to develop a National Mental Health Program and made the state mental health authority responsible for it. There are a number of approaches that can be used to avoid the hazards. One method to do this is to remove the concept of addiction therapy from the scope of the Mental Health Act of 2017, by removing the reference to SUD from the definition of mental disease. Many countries, like the United Kingdom, Australia (in many of its states), and New Zealand, have kept drug abuse out of their mental health legislation and passed distinct laws for addiction and its treatment since people with substance misuse act differently and require different treatment. Mental health programme should be started at educational institutions, schools and colleges. A fixed budget should be allocated to implement such programmes in India.

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