Mental Health Care Act 2017: Current Trends and Challenges in India

Deependra Yadav[1]*, Dr. Namrata Yadav[2]

[1]*Research Scholar, Raffles University, Jaipur d.deepuyadav@gmail.com
[2]Assistant Professor of Law Raffles University, Jaipur Yd.namarata11@gmal.com

ABSTRACT
The Mental Health Care Act (MHCA) of 2017 represents a significant advancement in the evolution of mental health legislation in India. It was implemented to align Indian legislation with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), initiating a substantial transformation in the perception and treatment of mental illness in the nation. The MHCA 2017 shifts away from a predominantly custodial approach to safeguard the rights of individuals with mental illness, enhance access to high-quality mental healthcare, and reduce stigma and discrimination. This paper examines the prevailing trends influencing the implementation of the MHCA 2017, together with the substantial barriers hindering its proper application. This study paper will comprehensively address these topics while evaluating the provisions of the existing Act and identifying its deficiencies in protecting, serving, caring for, and rehabilitating its intended beneficiaries.

Key Words-: Mental Health Care Act (MHCA) Of 2017; United Nations Convention On The Rights Of Persons With Disabilities (UNCRPD); Mental Illness; Rehabilitate.

INTRODUCTION

The Indian government endorsed the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2007. Indian legislation must comply with this convention. The 1987 Mental Health Act was superseded by the amended Mental Health Act, which incorporated 134 revisions and did not comply with the requirements set by the UNCRPD. The Act's preamble clearly states its aim to protect, promote, and enhance the rights of individuals with mental diseases during their receipt of mental health care services.

A 2011 survey by the World Health Organization indicates that over 36% of the Indian population experiences severe depressive episodes. A 2017 poll indicates that 14% of Indians are estimated to have mental health illnesses, 20% are at risk of developing depression, and at least 10% require urgent medical attention. The mentioned number is solely meant to underscore the necessity of this new Act. A treatment discrepancy of 80% to 90% indicates that a minimal percentage of individuals in need of mental healthcare are receiving it. This results from insufficient knowledge, stigmatization, and accessible professional resources. The increase in underlying mental health concerns, including aggressive and violent behavior, excessive substance use, suicidal thoughts and attempts, marital discord, and divorce rates, indicates that a paradigm shift may be required to prioritize the development and delivery of suitable mental health services in India. (1)

Unfortunately, the Act does not acknowledge the substantial contributions of family members, the challenges faced by caregivers, and the loneliness, frustration, and hostility that individuals with mental illness impose on them. The Act fails to delineate the obligations and contributions of family members regarding caregiving. In India, families typically assume the major caregiving responsibility for two reasons. This is mostly attributable to India's interconnected society and the compassion extended towards friends and family facing hardship. Secondly, a significant section of India's population requires the support of more mental health professionals due to a deficiency of skilled and qualified workers.(2) Unfortunately, the Act fails to emphasize the necessity of offering medical help to family members.

To understand the current trends and challenges, it is crucial to first outline the key provisions and guiding principles of the MHCA 2017(3)

- The Act establishes the rights to mental health care, community living, freedom from harsh, inhuman, and degrading treatment, access to information, confidentiality, and legal aid. It prioritizes the individual with a mental illness in the decision-making process for their treatment and care.
- The Act's provision for advance directives, enabling individuals to articulate their care and treatment preferences in the case of future mental illness and to designate a representative for decision-making, is a significant aspect. This fosters autonomy and self-determination.
- The decriminalization of suicide attempts. The Act acknowledged that attempted suicide signifies emotional suffering rather than a criminal offense, so abolishing its criminality under Section 309 of the Indian Penal Code. This motivates individuals in need to pursue assistance without the fear of encountering legal consequences.
- The Act establishes fundamental standards of care and service provision by delineating and governing mental health

establishments. It mandates the registration of these establishments and their subjection to ongoing oversight.

- The Act established Central and State Mental Health Authorities to implement and oversee its provisions, register mental health facilities, and address complaints.
- The Act underscores the government's obligation to deliver inexpensive and readily accessible mental health treatments across all tiers, including basic care.
- The Act advocates for the establishment of community-based mental health services to diminish dependence on institutionalization and enhance the social integration of individuals with mental illness.
- The Act prohibits discrimination against individuals with mental illness in various domains, including work, education, and housing.

The Mental Health Care (MHC) Bill, 2016, was enacted in India on August 8, 2016, and, with approval in the Lok Sabha, will repeal the Mental Health Act of 1987. The legislation seeks to protect, promote, and actualize the rights of individuals in the delivery of mental health care and services. The legislation primarily concerns the rights of hospitalized individuals with mental illness who remain silent about their care in the community. This new framework aims to ensure that mental health services are accessible, affordable, and user-friendly, emphasizing the importance of informed consent and patient autonomy. Additionally, it provides for the establishment of a central mental health authority to oversee the implementation of these rights and improve the overall quality of care. The legislation underscores the shift from psychotic diseases to common mental problems and from mental institutions to primary healthcare facilities.(4)

The revised bill includes several significant advancements, including the decriminalization of attempted suicide, a detailed enumeration of the rights of individuals with mental illness, and the mandate for insurers to offer medical coverage for mental illness treatment on par with physical ailments. The bill specifies the "duties of appropriate government," encompassing the planning, design, and implementation of mental health programs, including initiatives for promotion, prevention, suicide reduction, and stigma relief. These initiatives aim to create a more inclusive approach to mental health care, ensuring that individuals receive the support they need without the fear of discrimination. By prioritizing mental health alongside physical health, the legislation seeks to foster a society where seeking help is normalized and encouraged.

The measure employs an overly expansive approach that surpasses its legislative limits, complicating stakeholders' ability to determine if the contents relate to law, programs, regulations, or treatment guidelines. The bill neglects to account for the significant contributions of family members, the challenges encountered by caregivers, and the isolation, frustration, and violence endured as a result of mental illness. In India, family members serve as the principal resource for the care of those with mental illness, and the bill fails to emphasize the importance of supporting these family members in providing treatment.(5)

MENTAL HEALTH: PAST AND PRESENT

The British enacted the Lunacy Act in 1858, marking the inaugural mental health legislation in India. Authors A Kiranmayi, U Vindhya, and V Vijayalakshmi elucidate the protracted duration preceding the British enactment of mental health legislation. Historically, mental health in India was perceived through an orientalist lens.

The "low prevalence" was ascribed to the nation's "oriental philosophy of life," less urbanization and industrialization, and robust familial connections, since numerous persons perceived mental illness to be significantly less prevalent in India compared to Western countries. Unlike interventions for promotion or prevention, illness treatment constitutes a substantial segment of mental health endeavors. (6)

According to Prateeksha Sharma(7)), the viewpoints and approaches to mental health vary across industrialized and underdeveloped countries. Sharma concludes that developing countries, particularly India, exhibit deficiencies in the enactment of suitable legislation and the formation of a more inclusive community for individuals with mental health issues, as compared to peer support systems in mental healthcare in the United States. The formation of such a community ensures that the rights of individuals with mental health disorders are progressively protected. Notwithstanding the progress achieved by expatriates, activists, and mental health service consumers in the developed Western world in advocating for their rights, inclusion, and dignity, significant disparities persist in social bargaining power, wage negotiation capabilities, and community acceptance compared to analogous movements in developing or underdeveloped regions. The latter have generally arisen due to the backing of professional, educated, and socially influential groups that enact changes most beneficial to their goals and operating tactics. In the Western world, psychiatry has transitioned its focus to "recovery," but in India, the aim is to tackle the "treatment gap in mental healthcare."

RETHINKING HOLISTIC APPROACHES IN PUBLIC HEALTH: THE DISTINCT NATURE OF MENTAL HEALTH

This Article emphasizes the unique characteristics and challenges inherent in mental health discourse while analyzing the necessity of distinguishing mental health from broader public health initiatives. advanced understanding of mental health that transcends its classification as merely a public health issue. advocates for a people-centered, comprehensive

approach to mental health that recognizes its distinct sociopolitical context and the necessity for specialized terminology. The comprehensive nature of public health programs, which tackle a wide array of health concerns, is increasingly recognized. However, within this holistic viewpoint, mental health requires a distinct paradigm. The objective of this article is to elucidate the differences between mental and general health, highlighting the importance of addressing mental health as a separate entity.(8)

THE INADEQUATE MENTAL HEALTH CARE BILL

The Mental Health Act of 2016 is the government's comprehensive initiative to tackle mental health challenges in India. It supplanted the Indian Lunacy Act of 1912 with its implementation in 1993. However, it possesses significant disadvantages. K. S. Jacob notes that the measure is still evolving.

Incorporating mental retardation into the category of mental illness proved hard. The implementation of this regulation was arduous due to the amalgamation of diverse treatment and rehabilitation facilities and the necessity for uniform criteria. The ratio of one psychiatrist for every ten beds exemplifies the criticizedand unrealistic minimum criteria. A notable drawback was the exclusion of government hospitals from the licensing process. Furthermore, the statute exempted other hospitals that involuntarily admitted individuals with mental diseases. The implementation was further obstructed by the subpar performance of state and national mental health authorities, attributable to insufficient funds and resources.

Numerous individuals assert that family members are significant resources, especially within the Indian framework of community care for individuals with mental illness. Consequently, unless proven otherwise, family members may be considered the inherent guardians. The notion of a "Nominated Representative" fundamentally threatens the integrity of the Indian family system. The core concept of advance directives is that they become applicable when the individual in question experiences mental illness. The statement possesses an excessively broad sense, as there exist numerous mental disorders with varying degrees of severity. An advance directive must specify care instructions for each condition, including the management of schizophrenia. This advance directive imposes significant burdens on family members and is likely to incite an increase in litigation. Furthermore, the general public struggles to understand the concept, leaving relatives vulnerable to exploitation and misconduct. "The Act assumes that patients, including individuals with paranoid psychosis, possess the intelligence to select the most appropriate treatment for themselves." Advance directives should be removed from the Act for the following reasons.(9)

LACK OF RESOURCES

The Mental Healthcare Act in India is a rights-based legislation impeded by insufficient funding, a scarcity of mental health experts, and inadequate infrastructure, especially in semi-urban and rural regions. Ignorance, stigma, prejudice, and social isolation are the primary factors contributing to the Act's challenges. The present NMHP budget constitutes merely 0.06% of the overall healthcare budget, in contrast to 5% in affluent nations. A primary worry is the deficiency of money and qualified mental health practitioners. Only two out of ten affected individuals pursue medical assistance, indicating a deficiency in awareness of mental health issues in India. Moreover, a treatment gap exists that hinders numerous individuals from obtaining mental health care.(10)

THE STATE AVOIDING STATUTORY RESPONSIBILITY

The new Act imposes obligations on family members by permitting mentally ill individuals to choose "nominated representatives" as proxy decision-makers. This may jeopardize relationships and lead to subsequent relapse. Individuals without family or caregivers encounter challenges in obtaining essential care within mental health facilities. The Act mandates that a district Mental Health Review Board designate a Nominated Representative within seven days. To guarantee equitable access, direct authority for proxy decision-making may be conferred.(11)

CURRENT TRENDS SHAPING THE IMPLEMENTATION OF THE MHCA 2017

***Several trends are currently shaping the implementation and impact of the MHCA 2017*:(12)**

- ***Increased Awareness and Advocacy:*** Awareness of mental health concerns in India is increasing, driven by media coverage, celebrity endorsements, and activism from mental health professionals, NGOs, and individuals with personal experiences. This heightened knowledge has fostered a more favorable atmosphere for addressing mental health issues and advocating for improved services, in accordance with the MHCA's goal of diminishing stigma.
- ***Emphasize Community Mental Health:*** Consistent with the Act's focus, there is a progressive transition towards the establishment and enhancement of community-based mental health services. This encompasses efforts such as the District Mental Health Programme (DMHP), which seeks to deliver mental healthcare at the primary healthcare tier. The emphasis is on early identification, intervention, and rehabilitation within the community, hence minimizing the necessity for prolonged institutionalization.
- ***Integration of Mental Healthcare with General Healthcare:*** Initiatives are in progress to amalgamate mental healthcare with general healthcare services. This entails educating primary healthcare physicians and other healthcare professionals to recognize and address prevalent mental diseases. This integration is essential for enhancing access to mental healthcare, particularly in rural and marginalized regions.

- ***Digital Mental Health Initiatives:*** The proliferation of technology has resulted in the advent of digital mental health platforms that provide online counseling, therapy, and support services. Although these efforts show potential for enhancing access to mental healthcare, their regulation and conformity with the principles of the MHCA 2017 remain in a state of ongoing development.
- The courts has significantly influenced the interpretation and enforcement of the rights of individuals with mental illness under the MHCA 2017. Significant rulings have underscored the necessity of informed consent, the entitlement to community life, and the imperative for deinstitutionalization. Public interest litigations have advocated for improved enforcement of the Act.
- ***The evolution of advance directives:*** Although the notion of advance directives is relatively new in India, there is an increasing recognition and acceptance of its significance in fostering autonomy. Initiatives are underway to raise awareness and offer help on the creation and registration of advance directives.
- **Emphasize Capacity Building:** Acknowledging the deficit of mental health practitioners, there is a growing focus on capacity building across many tiers.

Significant Challenges in the Implementation of the MHCA 2017(13)

Despite the progressive nature of the MHCA 2017 and the positive trends, several significant challenges hinder its effective implementation:

- ***Resource Constraints:*** A major issue is the inadequate distribution of financial and human resources for mental health. Mental health routinely receives insufficient funding from the health budget, leading to a shortage of mental health professionals, facilities, and essential medications. The lack of resources severely limits the availability and quality of mental healthcare services. The mental healthcare infrastructure in India is critically inadequate. There is a lack of sufficiently equipped mental health facilities, especially in community environments.
- ***Stigma and prejudice:*** Despite increased knowledge, stigma and prejudice around mental illness endure in Indian society. Such prejudice hinders individuals from accessing support, obstructs their social integration, and creates barriers to employment, education, and housing. Alleviating stigma requires continuous public awareness campaigns and changes in societal perceptions.
- ***Inconsistencies in Implementation:*** The execution of the progressive components of the MHCA 2017 has been slow and uneven across states. Inconsistencies are present in the formation and functioning of state mental health authorities, the accreditation of mental health facilities, and the implementation of community-based programs.
- ***Inadequate Awareness of Rights and Provisions:*** Many individuals with mental illness and their families are unaware of their rights and the regulations outlined in the MHCA 2017. This lack of knowledge limits their ability to assert their needs and secure the support they deserve.
- ***Obstacles in the Implementation of Advance Directives:*** While advance directives are crucial for promoting autonomy, their execution faces challenges related to awareness, legal clarity, and the processes for registration and execution during mental health crises. It is important to make sure that the MHCA 2017 works well with other laws and policies about disability, guardianship, and social assistance to create a complete system for mental healthcare.
- ***Intersectoral collaboration and clear directives:*** An extensive system for data collection and monitoring of mental health services is crucial for the effective planning, execution, and evaluation of the MHCA 2017. The current data infrastructure for mental health in India is insufficient, obstructing the capacity to assess progress and identify areas for improvement.
- ***Addressing the Needs of Vulnerable Populations:*** Special attention must be directed toward meeting the mental health needs of vulnerable populations, including children and adolescents, women, the elderly, marginalized communities, and individuals affected by trauma and violence. Tailored interventions and accessible services are essential to address their particular challenges.

Strengthening the Implementation of the MHCA 2017(13)

To ensure the effective implementation of the MHCA 2017 and realize its vision of equitable and rights-based mental healthcare for all, the following steps are crucial:

The government must substantially augment the budgetary allocation for mental health to rectify the resource Deficit and enhance infrastructure, workforce, and service delivery.

- ***Human Enhancing Resources:*** It is imperative to invest in the training and recruiting of mental health experts across all fields. Exploration of innovative techniques to attract and retain professionals in underserved regions is essential.
- ***Effective Implementation Mechanisms:*** State governments must prioritize the development and efficient operation of State Mental Health Authorities and formulate explicit instructions for the execution of the Act's provisions.
- ***Campaigns for Public Awareness and Stigma Reduction:*** Ongoing and culturally attuned public awareness initiatives are essential to address stigma and discrimination related to mental illness and to encourage help-seeking behavior.
- ***Capacity Building and Training:*** Extensive training programs for healthcare professionals, law enforcement personnel, educators, and other stakeholders are essential to guarantee a rights-based approach to mental healthcare.
- ***Advancing Community-Based Services:*** It is essential to invest in and expand community-based mental health programs, particularly the integration of primary care, to enhance accessibility and diminish dependence on institutional

facilities.

- ***Operationalizing Advance Directives:*** It is essential to establish and disseminate explicit standards and accessible methods for the creation, registration, and implementation of advance directives.
- ***Enhancing Data Systems:*** Developing a comprehensive national mental health data system is crucial for tracking trends, assessing programs, and guiding policy decisions.
- ***Inter-sectoral Collaboration***: Effective cooperation among the health, social welfare, education, law enforcement, and other pertinent sectors is essential for addressing the social determinants of mental health and providing comprehensive care.
- ***Empowerment of Individuals with Lived Experience:*** Actively engaging individuals with lived experience and their families in the development, implementation, and assessment of mental health services can yield invaluable insights and guarantee that treatments are centered on the individual.

CONCLUSION

The Mental Health Care Act of 2017 signifies a substantial progress in the promotion of mental health and rights in India. Nonetheless, obstacles including financial insufficiency, inadequate infrastructure, stigma, and implementation shortcomings endure. Realizing the complete potential of the MHCA 2017 requires continuous effort, enhanced funding, and cooperation among all stakeholders. Policymakers must account for local culture, incorporate recent advancements in mental health science, assess patient and family needs, identify areas for improvement, amend provisions to rectify treatment deficiencies, implement reforms to enhance workforce resources and skill development among mental health professionals, facilitate comprehensive healthcare services, foster positive attitudes toward patients, and obtain requisite financial support through budget allocations to ensure effective enforcement of the Act, which aims to integrate progressive ideas and principles from the global community. A 2016 poll revealed that at least 10% of Indians necessitate rapid medical attention, with 14% facing mental health issues. Mental health accounts for less than 0.06% of India's health expenditure, although the country has only 3,827 registered psychiatrists, well below the required 13,500.

SUGGESTIONS

- A mental healthcare establishment is required to adhere to a comprehensive set of guidelines, including the renewal of its license from state mental health authorities, registration as a mental health-care establishment, and the immediate necessity of conducting a self-audit to evaluate the mental health capacity of all inpatients
- Each stage necessitates comprehensive documentation. The care provided must be documented, and written and informed consents should be obtained for each management plan. Legal counsel coverage should be included in professional indemnity insurance.
- The next step is to establish constant communication, increase house visits, and mobilize mental health professionals for door-to-door visits to help develop contact and bridge the gap between patients and mental health services. This will be necessary to further monitor all outpatients.
- There is still a significant amount of awareness that needs to be disseminated in order to destigmatize and popularize psychiatry among the general population. Perhaps, in order to demystify psychiatry, it is necessary to implement additional awareness programs and cross-specialty scientific initiatives.
- Reconnecting with patients is the most critical modification that must be implemented. Psychiatrists must reorient their attention from prioritizing the caregiver and family members to making patients the central figures in the management plans.
- If this Act is to be implemented, the government must allocate a minimum of 5% of the total healthcare budget to mental healthcare.

REFERENCES

1. *Rao GP, Math SB, Raju MS, Saha G, Jagiwala M, Sagar R, Sathyanarayana Rao TS. Mental Health Care Bill, 2016: A boon or bane? Indian J Psychiatry. 2016 Jul-Sep;58(3):244-249. doi: 10.4103/0019- 5545.192015. PMID: 28065999; PMCID: PMC5100113.*
2. *Medical Council of India. Code of Ethics Regulations. [Last accessed on 2016 Aug 18]. Available from: http://www.mciindia.org/RulesandRegulations/CodeofMedicalEthicsRegulations2002.aspx*
3. *Sarin A, Murthy P, Chatterjee S. Psychiatric advance directives: Potential challenges in India. Indian J Med Ethics. 2012;9:104–7. doi: 10.20529/IJME.2012.031.*
4. *Math SB, Srinivasaraju R. Indian psychiatric epidemiological studies: Learning from the past. Indian J Psychiatry. 2010;52(Suppl 1):S95–103. doi: 10.4103/0019-5545.69220.*
5. *Avasthi A. Preserve and strengthen family to promote mental health. Indian J Psychiatry. 2010;52:113–26. doi: 10.4103/0019-5545.64582.*
6. *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.*
7. *Math SB, Srinivasaraju R. Indian psychiatric epidemiological studies: Learning from the past. Indian J Psychiatry 2010;52:S95–103.*

8. *Pattanayak RD, Sagar R. Health insurance for mental health in India: A welcome step toward parity and universal coverage. J Ment Health Hum Behav 2016;21:1–3.*
9. *Saranya D, Sujit KK, Adarsh T. Forensic Psychiatry, the Mental Health Care Bill: Change and Appraisals. Department of Psychiatry, K G Medical University, Lucknow.*
10. *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.*
11. *Antony JT. Mental Health Care Bill-2016: An illusory boon; on close reading it is mostly bane. Indian J Psychiatry 2016;58:363–5.*