Mental Health Care Bill, 2016: A boon or bane?

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INTRODUCTION

On August 8, 2016, the Mental Health Care (MHC) Bill, 2016 was passed in the Rajya Sabha. If the Bill is passed in the Lok Sabha, then it repeals the Mental Health Act, 1987. The Government of India ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2007. The Convention requires the laws of the country to align with the Convention. The new Bill was introduced as the existing Mental Health Act, 1987 does not fulfill the obligations of the UNCRPD.

The preamble of the MHC Bill, 2016 clearly depicts that this legislation is to protect, promote, and fulfill the rights of such persons during delivery of MHC and services. The Bill is progressive and rights based in nature. The whole dedicated Chapter (v) on “Rights of the persons with mental illness” is the heart and soul of this legislation. However, the Bill mainly focuses on the rights of the persons with mental illness only during treatment in hospital and it is completely silent about the care of the persons with mental illness in community. MHC priorities need to be shifted from psychotic disorders to common mental disorders and from mental hospitals to primary health centers. Increase in invisible mental problems such as suicidal attempts, aggression and violence, widespread use of substances, and increasing marital discord and divorce rates emphasizes the need to prioritize and make a paradigm shift in the strategies to promote and provide appropriate mental health services in the community.

There are several significant positive developments in the new Bill. First, there is a mention of decriminalization of attempted suicide. It is specifically stated that there is a presumption of severe stress in person with attempted suicide and such person shall not be tried and punished under the said code. Moreover, it is highlighted that the appropriate Government will be bound not only to provide care, treatment, and rehabilitation of such persons but also to take measures to reduce its recurrence. This is an important and progressive step which will have positive implication throughout the country.

Second, there is a detailed description on “Rights of person with mental illness.” This is highly significant step to make the Bill as patient-centric. There is a mention of the right to access MHC and treatment at affordable cost, good quality which is acceptable to person with mental illness, their family members, and caregivers. The onus will be on appropriate Government to make such provisions for range of services including outpatient and inpatient services, half-way homes, sheltered accommodation, supported accommodation, hospital- and community-based rehabilitation, free cost of medicines, specialized services of child and adolescent, and old age mental health. The appropriate Government will ensure necessary budgetary provisions for effective implementation along with integration of mental health services into general health care at all levels of health.
Every person with mental health illness will have right to protection from cruel, inhuman, and degrading treatment. Third, the key feature in this new Bill is the provision for medical insurance for treatment of mental illness at par with physical illness by all insurers. Mental health insurance has remained a neglected area for long. This new feature will have huge and significant impact for the persons with mental illness, family, and caregivers. Fourth, the new Bill clearly describes the “Duties of appropriate Government.” This is a unique feature as the appropriate Government will have responsibility to plan, design, and implement programs for mental health such activities related to promotion, prevention, reduction of suicide, stigma. The important aspect will also to address the human resource needs which include training of medical officers and other persons.

There are many other favorable aspects of this new Bill, which are beyond the scope of description here. In general, there are several features which may be seen as welcome step by persons with mental illness, their family, caregivers, professionals, care providers, and significant others. However, it seems ambitious and poses a huge responsibility and challenge to all stakeholders for its effective implementation.

The new Bill tries to be overinclusive in its approach stretching beyond its legislative limit, and despite noble intentions behind it, it would be a challenge for the stakeholders whether the contents of the Bill are legislation, program, policy, or even a treatment guideline. There are highly qualified and accountable bodies to design a program or to recommend the treatment guidelines.

There is a need to draw a distinction between the act and the rules, while the former is stable and constant over the years and latter are subject to change. The major task would be to effectively formulate the Rules which take into the account the opinions of all stakeholders and in the best interest of the person with mental illness.

On a closer look, this Bill premises on a hypothesis that the MHC providers and family members are the main violators of the rights of the persons with mental illness, which is unfortunate. On the other hand, the Bill does not take into account of family members’ significant contribution, caregivers’ burden, isolation, frustration, and violence they undergo because of persons with mental illness. The Bill is silent on the role and contribution of family members in providing care. Unlike the West, in India, family is the key resource in the care of patients with mental illness. Families assume the role of primary caregivers for two reasons. First, it is because of the Indian tradition of interdependence and concern for near and dear ones in adversities. Second, there is a paucity of trained mental health professionals required to cater to the vast majority of the population; hence, the clinicians depend on the family. Thus, having an adequate family support is the need of the patient, clinician, and the healthcare administrators. Unfortunately, that Bill does not foster the need to support the family members in providing care.

The Mental Health Act, 1987 legislation focused on admission and treatment of persons with severe mental illness in mental hospitals when they were detained against their will. However, the MHC Bill, 2016 tries to regulate almost all the MHC establishments. This could be avoided by legislation focusing on MHC institutes, where patients are admitted against their will for treatment. The Mental Health Act, 1987 was not implemented across the country because of severe shortage of resources; however, a new MHC Bill, 2016 has been introduced without addressing the issues which haunted the Mental Health Act, 1987. Although there are many positive aspects of the MHC Bill, 2016, the negative aspects have severe and negative impact of the MHC in India. This article focuses on the shortcomings of the MHC Bill, 2016.

MENTAL HEALTH CARE BILL, 2016: CHALLENGES AND REMEDIES

Definition of mental health establishment
National Mental Health Programme (NMHP) (National policy) advocates integration of mental health into general and primary health care. However, the Bill mandates all the establishments to take license for treating patients; this may come in the way of integrating mental health into general health and, thus, the implementation of the policy. Many private hospitals and nursing homes may refuse to treat patients with mental illness reporting that they do not have license to do so. Hence, the proposed Bill should be in line with the NMHP (Mental health policy). To encourage treatment in general hospitals, they need to keep those establishments out of the purview of licensing.

The proposed Bill enthusiastically moves forward (without acknowledging the available meager resources) to protect and promote human rights of persons with mental illness by mandating licensing of the mental health establishments. There are many hostels, prisons, jails, juvenile home, child protection centers, reception centers, centers for destitute, beggars’ home, religious places such as temples, churches, and dargahs, and faith healers need to take license to keep persons with mental illness. This will defeat the purpose of the Bill and will invite “license raj” of harassing the MHC providers. It would be prudent to keep the general hospital psychiatry units and nontreatment providing centers to be kept out of the purview of licensing.

Capacity to make mental health care and treatment decisions
This issue of capacity to make MHC and treatment decisions is inadequate and may have dangerous consequences.
because person with mental illness may refuse treatment due to (a) absent insight, (b) severe mood symptoms, and (c) his/her symptoms are coming in the way of decision-making. Family members usually find it difficult to manage individuals with serious mental illnesses, who have no insight, and usually, they refuse admission and treatment. This clause by default considers that everyone has capacity and one has to prove that person with mental illness lacks capacity before initiating involuntary treatment. One has to approach the mental health board to take permission to initiate involuntary treatment. There is no scope to take guardians’ consent to initiate involuntary treatment under the new Bill. This will add an enormous burden to family members and MHC providers in treating involuntary patients with severe mental disorders.\[12]\] This clause is either to be deleted or to be considered informed consent from the parents and family members, or two doctors (preferably one of them is a psychiatrist) opinion is taken to initiate involuntary treatment. This can help the patient and also the family members in providing timely care.

The Supreme Court of Canada has dealt similar issue in a well-known celebrity case referred as “Canada’s Beautiful Mind” that a law that allows a person with a mental illness to be incarcerated indefinitely in a “hospital” because needed psychiatric treatment cannot, by law, be provided is not justifiable in a caring democratic jurisdiction.\[13]\] Hence, the new Bill needs to make provision for treatment (involuntary) in all supported (involuntary) admissions through informed consent from the parents and/or by family members to restore liberty by treatment. It has been stated very rightly that in the regulation of involuntary treatment, a balance must be found between duties of care and protection and the right to self-determination.\[14]\]

**Advance directives**

Person with mental illness may revoke, amend, or cancel advanced directives many times in a day, and family members will be finding difficult to handle such situations. Only the mental health board has powers to amend or overrule the advance directive. This needs to be done in very short time to enable the treatment (24–48 h). If patient has written costly treatment or private/corporate hospital (which family cannot afford) in advance directives, then who will bear the cost of costly treatment? Considering the available human resources (Medical and Judicial), economic constraint, and our collective community efforts in treating patients with mental illness, our Indian population is not ready for such advanced directives. Above all these, research studies data do not support the use of advance directives in person with mental illness (Cochrane review). It would be prudent to do more research in this area in our population before to introduce this advance directive.\[15]\]

This advance directive operates on the basic premise that “if a person develops mental illness” Which mental illness?

If multiple illnesses occur? If it becomes comorbid with physical illness? What severity? Under what circumstances? Above issues are wide open and threaten each individual. If an MHC provider writes an advance directive, he/she needs to write for each disorder “if I develop mania,” “if I develop schizophrenia,” like a textbook, how he/she should be cared or not to be cared. This advance directive will welcome more litigations and heavy burden on family members. It is advisable that advance directive needs to be kept out of the purview of the Bill.\[16]\] The Cochrane database of systematic review on advance treatment directives for people with severe mental illness reported that there are too few data available to make definitive recommendations to introduce it.\[17]\] Even in the West, this has certainly not had its intended benefit. For the Indian reality, to be rushing in with legislation on this count is rather hasty and ill conceived.\[14,18]\]

**Nominated representative**

A person with mental illness may revoke his/her decision of nomination of a representative as he/she suffers by reason of severe mental illness coloring his/her perception, alter many times in a day too. (1) Only mental health board has powers to overrule the nominated representative. (2) This needs to be done in very short time to enable the treatment. (3) If nominated representative is requesting for costly treatment (which family cannot afford), then who will bear the cost of costly treatment: is it family? or nominated representative? or the State? (4) Considering the available human resources (Medical and Judicial), economic constraint, and our collective community efforts in treating patients with mental illness, our Indian population is not ready for such a departure from family as a caregiver to a patient chosen nominated representative. (5) This nominated representative breaks the Indian family system who cares and bears the brunt of patents unpleasant behavior and still willing to support his/her treatment.\[17]\] Ultimately, family may disown the patient and which may have serious consequences in the form of abandoning the patient and wandering mentally ill at large, which defeats the very purpose of the Bill in protecting the patient.

Family members are the true value and assets in the Indian context to provide community care for persons with mental illness. Hence, family members are the natural guardians until proven otherwise. This “Nominated Representative” breaks the very backbone and fabric of our society “the family.” In all most, all the cases, family members are the caregivers this needs to be fostered and enhanced. This clause on Nominated Representative needs to be removed from the Bill.\[16]\]

**Mental health review boards**

The district-level mental health review boards, which are quasi-judicial bodies overseeing the effective implementation of the MHC delivery system, could introduce
new hurdles for treatment delivery and unnecessary delay. This could be simply because of nonavailability of judicial workforce and other resources to operate at every district levels. If these issues are not addressed, this may cause delay in initiating treatment, which may cause enormous amount of stress on the care providers. Delay in addressing the issue can defeat the purpose of the Bill. If these boards do not operate on day-to-day basis at each hospital level, then this can cause serious adversarial impact on the MHC of the person. Unfortunately, MHC is taking an ugly turn similar to western country where involuntary MHC is argued in the court of law. MHC is becoming a tedious, prolonged, and costly judicial proceeding. These mental health review boards need to have time limit (<72 h) to take decision, especially with regard to capacity to consent for treatment issues. The mainstream judicial system is incapable of handling such complaints because of lack of sensitivity and also being clogged with a huge pendendency of mainstream cases.\textsuperscript{12} These boards need to move away from tardy judicial process/procedures.

Alternatively, the first level of review could be independent hospital review board, which can address those contentious issues in a cost-effective and timely manner at the patient’s doorsteps/hospital. Hence, it would be prudent to create consumer-friendly (independent) MHC hospital boards at every hospital using local resources. This MHC hospital board could be comprised of independent psychiatrist/mental health professionals, family caregivers, and recovered patient. Another alternative is to create a board of visitors at each hospital (along the lines of Mental Health Act, 1987) to perform similar functioning.

**Right to confidentiality**

The Bill also gives power to nominated representative to unlimited access to the records of the persons with mental illness. Mental health professionals have expressed reservations over sharing of information, describing it as “breach of confidentiality,” as per the Medical Council Ethics, 2002.\textsuperscript{16} However, according to the Bill, information regarding MHC needs to be shared with the nominated representative. This issue impinges on the fundamental rights - “right to privacy.” Hence, there is a need to introduce a clause that information shared will be only with family members and will be in verbal form only. Written documents or medical records will be shared only with patients/legal authorities on obtaining a written request.

**Punishment for contravention of any of the provisions of the Bill/rule**

Punishments are too harsh and there is no provision for whether contravention is accidental or due to practical difficulties or deliberate. Medical personnel is already covered under various legislations such as Consumer Protection Act, MCI, and civil and criminal laws for any medical negligence. There are various other commissions such as Human Rights Commission, Women Commission, and Child Welfare Committee to protect the rights of the persons with mental illness. Unlike the other patients, behavior and responses of mentally ill are different, especially in patients with paranoid delusions. Such people are likely to complain against hospital/doctors or other personnel which he may feel true because of his/her illness but are not true. This litigation-based MHC can give rise to a defensive practice, and tendency to avoid care of such patients will only harm such patients and their family members. This will also increase the cost of MHC.

There should be a provision for an independent expert committee/mental health board at hospital levels to review such complaints, and only complaints which have prima facie found to be true should be referred to the District Mental Health Board. Otherwise, there will be innumerable complaints making the hospital authorities/doctors and other personnel spend more time in the District Boards than in hospital treating patients.

**Discharge planning**

The psychiatrist is expected to be responsible for patient care and treatment in the future after discharge. This clause is idealistic but may not be possible in custodial care (involuntary patients), destitute patients, and voluntary admissions, wherein only the patient can be briefed or counseled regarding the future treatment. The ultimate decision of continuing treatment or not is the choice of the patient. Discharge planning should not be considered as negligence as it is not possible without active cooperation of the patient and family members. If the law makers are very serious about this issue of “the continuity of care,” then they should enable the MHC providers and family members by introducing the Compulsory Community Treatment Order. Unfortunately, the Bill is silent on the much-needed community treatment order. Inclusion of compulsory community treatment orders may play a significant role in providing care for the chronically ill patients and also better the lives of the family members and caregivers. Availability of community treatment order to the family members and caregivers enables them to provide continuous care. The community treatment order brings relief to families of person with mental illness, encourages use of less restrictive forms of inpatient treatment, reduces violence, prevents unnecessary criminalization, and brings greater stability to the lives of the seriously mentally ill. Hence, there is a need to have a community treatment order in place. The New York’s Compulsory community treatment order is comprehensive and can be adopted with minor modification suitting our society and resources. Implementation of such law can bring in continuity of care after discharge.

**Permission for research**

The Bill mandates State Mental Health Authority to grant permission for research. Too many regulations
Role of family members during admission and treatment

The Bill undermines the role of family members played in providing care in hospital environment. The Bill needs to make provisions that at least one family member needs to be present with the patient during inpatient treatment. There is a high need that family members need to be involved in the provision of the care. This process not only protects patient’s rights but also protects family members getting involved in active treatment processes such as psychoeducation, supervised medication, and family therapy to be cotherapist and also in rehabilitation process which makes huge difference in continuity and outcome of the treatment. \(^7\) If there are no family members, the medical board (comprising two mental health professionals) will waiver of the requirement of family member. Hence, there should be emphasized on such admissions along with their relative (by blood, marriage, or adoption) to encourage family support during acute crisis which provides moral, emotional, physical support to the ailing person with mental illness. \(^7\) Not involving family members will drive the mental hospital to the 19\(^{th}\) century of overcrowding and institutionalization syndrome. Many institutions such as NIMHANS (Bengaluru), DIMHANS (Dharwad), and many other centers for excellences across India have popularized the concept of family participation during inpatient care.

A clause needs to be introduced wherever involuntary inpatient treatment is required, by default one family member needs to accompany and be with the persons with mental illness during inpatient treatment. The duration for inpatient criteria for supported admission needs not apply when family members are physically present in the ward (24/7) and participate in treatment and decision-making process. A separate category for admission with family members needs to be introduced and promoted. Promote family support system to provide solace to the ailing minds that have been proved beyond doubt in Indian scientific research across the country.

Management of properties of persons with severe mental illness is completely absent. Rehabilitation and integration of homeless mentally ill into the community and management of their assets and properties are completely absent. There is a need to have this issue of management of properties of persons with severe mental illness to be addressed in the proposed Bill.

Treatment/intervention

The treatment and intervention procedures need to be as per the national professional guidelines. The board needs to take the professional bodies opinion in case of conflict in treatment and intervention procedures. Electroconvulsive therapy (ECT) is a form of treatment recognized for depressive patients with high degree of suicidal ideas/attempt and acutely agitated and disruptive patients. In emergency treatment, ECT is a form of treatment and in children has been banned in the Bill. If this clause is not removed, effective treatment will be lost to the patient whose life can otherwise be saved. \(^1\) Further, ECT is usually given in acutely ill patients. Waiting for the Board’s approval for ECT in minors or emergency is withholding the much-needed treatment. Treating psychiatrist needs to have the right to decide about emergency treatment with the consent of family members. The Bill should not prohibit or apply ban on medically acceptable procedures.

Lack of resources

The drafted Bill is highly loaded with the rights-based ideology, which is similar to the western society whose resources are much more, in fact, many folds than India. The issue in our society with regard to the feasibility of implementation of the MHC Bill is the scarcity of resources. \(^2\) There have been serious doubts raised about the availability of resources such as workforce and money and also political will for successful implementation of the Bill. The major setback is lack of resources, especially in the semi-urban and rural areas. There are logistic problems such as poor infrastructure, inadequate mental health workforce, low budget for MHC, and siphoning of the available mental health resources to general health care. \(^3\) In addition, lack of knowledge regarding mental health among the policymakers, stigma, discrimination, and isolation adds to the challenges. If minimum mental health services are not available in the district where the patient resides, then that such person is entitled to access any other mental health service in the district and the costs of treatment at such establishments in that district will be borne by the appropriate Government. This compensation based mental health issues can lead to false claims and many of them siphon of the existing meager resources. Instead of discussing the compensation, the Bill needs to focus and make provisions and includes a well thought through and detailed road map in the Bill for improving mental health workforce on similar lines of Mental Health Act of 2007 in the UK. The Bill needs to introduce clauses for development of workforce within a given time frame.

There is also an urgent need to introduce Psychiatry at the undergraduate level (MBBS) so that every graduated doctor should learn to treat mental illnesses. This responsibility needs to be entrusted to a particular agency for implementing and monitoring the progress of workforce development. The need of the hour is in addressing major challenges such as lack of mental health workforce, financial aid, and stigma, which are the major threats to developing comprehensive psychiatric services in the community. \(^4\)
Provision of budget
The Bill is silent and does not mandate the State to allocate budget for smooth functioning of State Authority or respective district boards. Similarly, the workforce resource for implementing the Bill is highly scarce both in the judiciary, Paralegal and also in the area of mental health treatment. Hence, training of workforce needs to be considered to fill the existing gap. The Bill should mandate provision of adequate resources for proper functioning of these constitutional bodies.

CONCLUSION
There has been a major shift from predominant seclusion or custodial care as in the Indian Lunacy Act, 1912 when the effective treatment was deficient; to the Mental Health Act of 1987 that mainly focused on the treatment and care of mentally ill with some tangential efforts to reduce stigma and cater for their human rights; to the present MHC Bill of 2016 that focuses mainly on the human rights of persons with mental illness and their institutionalization, thereby affecting the care of the persons with mental illness. With the present Bill, there lies an imminent danger of heralding the stigma and scare of mental ill patients along with institutionalization syndrome that plagued the prescientific era. It is prudent for the policymakers to account for the culture of the land, newer scientific developments in the mental health field, analyze the met-unmet needs of the patients and family, make provisions to bridge the treatment gap, make provisions to enhance the workforce resources and skill building among health professionals/workers in the field of mental health, provide comprehensive health-care services, promote healthy attitudes toward such patients, and make provisions for adequate financial support/budget (for plan and nonplan expenditures) while making law of the land. The need of the hour is a law that can be implemented in practice that can cater to the health needs at all levels of prevention (primary, secondary, and tertiary levels of prevention) while protecting the human rights of the mental health workers as well as the end-users and their relatives.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

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