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MENTAL HEALTHCARE LAW IN INDIA: A SAILING SHIP OR A SINKING LIFEBOAT?

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ABSTRACT

The concept of mental health has secured mammoth credibility in the past few years, with focus being shifted towards enhanced mental health care professionals and facilities, and attention being paid towards a sounder mental and emotional health development of the youth and adults. However, the palpitating question persists: how far along has India travelled on this tumultuous journey to achieve the definitive aspiration of securing stable mental health across the country, for persons of every age group? Through the means of this paper, the author will endeavor to find an answer to this question by delving into the mental healthcare laws in India [The Mental Health Act, 1987 and The Mental Healthcare Act, 2017] coupled with the understanding of international [The Mental Health (Compulsory Assessment and Treatment) Act, 1992] as well as constitutional aspects in relation to mental health care laws. This paper wouldn't be inclusive enough without mentioning some vital case laws which further the central theme of this paper. Towards the end, a few proposals have been presented by the author which may prove assistive for bettering the mental health care law drafting and their implementation in India. The cornerstone of this paper is to view the concept of mental health from a legalistic and social microscope, at the national and international echelon.

KEYWORDS

Mental health; Mental health care; Mental healthcare professionals; The Mental Health Act, 1987; The Mental Healthcare Act, 2017.

INTRODUCTION

In contemporaneous times, the definition of "health" isn't confined to the mere physical health of a person, but also includes his/her mental, spiritual and emotional well-being. Possessing a stable mental health entails that a person can cope with the demanding adversities of life and remains calm, composed and collected in the face of a crisis. Further, a vigorous mental health also translates to the fact that a person can effectively use his/her resources to contribute to their community and achieve their highest potential. *Mental health*

isn't a concept of illness, rather a concept of wellness. Even though India is home to the second largest population in the world, it's still overflowing with social stigmas in relation to the concept of mental health. A cavernous investigation in the Indian mental health care laws will thus be undertaken by the author post interpreting the mental health care concept in a generic, global sense.

THE WORLD HEALTH ORGANISATION (WHO) AND MENTAL HEALTH

The largest and the most authoritative international institution which deals with the *"health of the world,"* is the WHO. The WHO provides a set of 10 basic principles[1] for the development of mental health care laws in different countries as well as the protection of the mentally ill patients around the globe. These principles have been derived from the *Principles for Protection of Persons with Mental Illness, 1991* as well as the *Improvement of Mental Health Care adopted by the UN General Assembly Resolutions, 1991*[2].These principles, in brief, are as follows:

1. The Prevention of Mental Disorders and the Promotion of Mental Health is the first principle, focusing upon implementing such measures which assist in the prevention of mental disorders with simultaneous measures being undertaken to promote the concept of mental health and eradicate the associated stigma. A sincere implementation of this principle becomes enormously necessary for a country like India where mental disorders are still viewed more as a "reckless attitude" and less as medical illness.
2. Any and everyone who requires basic mental health care should have rightful access to the same. This access means affordability in financial as well as geographical terms, across countries. This principle is most certainly dependent upon the existing resources in a country; however, immaculate efforts are required on part of the governments to ensure the dignity of the individual and allow him/her to access metal healthcare facilities which can help him/her to combat their illnesses. The focus should be upon developing a system which provides adequate care facilities (clinical as well as non-clinical) and improves the quality of life of the patient. The WHO has

*Symbiosis Law School, Pune
[1] Mental Healthcare Law:Ten Basic Principles, Division of Mental Health and Prevention of Substance Abuse, World Health Organization (1996), accessible at: https://www.who.int/mental_health/media/en/75.pdf.
[2] Resolution 46/119, Mental Health Care, UN General Assembly (1991).

also suggested that a component of mental health care should be included in the Primary Health Care centers, keeping the treatment culturally appropriate.

3. Assessment of mental health should be in consonance with internationally accepted standards. An example of the same can be the International Classification of Diseases-10 (ICD-10) of the WHO which provides a Classification of the Mental and Behavioural Disorders. The WHO suggests that clinical training for such diagnosis should also be carried out in a standard of internationally accepted formats and principles. The mental healthcare professionals should be careful to not base their diagnosis merely upon the economic, social or political standing of a person or simply on the basis of his/her past medical history. The effort should be to conduct novel assessments and relevant diagnosis which can help in the early detection and cure of the patient.
4. Patients of mental health disorders should be provided treatment opportunities which are the least restrictive or constrictive in nature. The slightest restrictive alternatives should be decided upon by considering the mental disorder of the patient, the available treatments for the disorder and the autonomy level required to undergo that treatment (including the patient's acceptance to undergo a particular treatment). Furthermore, necessary care should be provided to such patients who can potentially harm themselves as well as others due to their diagnosed conditions. Community and institution based mental healthcare treatment should be made available, no doubt, however, in cases where only the physical restriction of the patient is the instantaneous solution, the WHO enlists the following guidelines under this fourth principle:
   - All other alternatives of treatment should've been exhausted.
   - Regular observations as well as periodical assessment by approved healthcare workers should be carried out in these 'restrictive surroundings.'
   - It's indispensable to document the mental health history of the patient in the restrictive surrounding, and ensure that this treatment lasts preferably only for a limited period of time. This principle of the WHO seems to be deeply rooted in having a *socially sanctioned, rights based approach* towards mental illness which obliterates stereotypes as well as looks into the treatment aspect.

5. Self-determination and consent is one of the most critical principle provided by the WHO. The patient's consent for receiving any mental disorder treatment, should be free, informed and without any coercion or undue influence. The WHO mentions the concept of *"surrogate decision makers"* who can provide consent for patients who're incapable of doing so, albeit with a properly granted authority. The patient should be provided with all the relevant information in a verbal, written or sign-language format as is necessary for him/her to furnish an informed consent. In a country like ours, where individuals are mostly expected to conform to their family units, this principle becomes quite noteworthy.
6. A knowledgeable third party can assist the patient in exercising his/her right to self-determination in matters of ambiguity or confusion. These confusions can emanate due to language barriers or mere lack of general knowledge. An effort should be made to provide this third party assistance free of cost. In India, where the languages are diverse and the traditional education rates are low, such free third party assistance can make a key difference in the ways people can access and view mental healthcare.
7. A Reviewing Procedure should be reachable to any interested and/or concerned parties with regards to any decision implemented by the official or surrogate decision makers. If possible, a Review Board should be set up by the national government so as to provide these reviews in a timely, transparent manner; this review process should be guided by authorities possessing official and sufficient capacity.
8. An Automatic Reviewing System should be established for catering to all the interested parties. These reviews should happen automatically, at consistent intervals, by authorized officials. Furthermore, defaulting officials should be duly sanctioned.
9. The *decision makers* for the patient, for example, the official, or the *decision maker on behalf of the patient,* such as a friend, family member, etc. should be qualified and authorized to take decisions; they should be competent, knowledgeable, independent and impartial. A sufficient remuneration amount should be awarded to the official decision makers for rendering their services, however, in case they default or display any personal interest in the case, they should be disqualified from their positions,
10. The last, yet the most imperative principle highlighted by the WHO remains that all the decisions regarding the mental health care facilities and the implementation of mental health care legislations should be enacted and implemented while *respecting*

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and keeping in tandem with the law of the land i.e. there should be respect for the rule of law in a particular jurisdiction and the specific mental healthcare legislations should be in consonance with the general laws of the country, ensuring facile understanding of the law. This principle also includes informing patients about their legal rights and the judicial or administrative institutions under law, who will independently monitor the mental health care status in the country. To understand the last principle better, the mental healthcare legislation in our country have been analyzed in the further sections.

It's imperative to note that these ten basic principles as provided by the WHO work nearly as a **fundamental norm for mental health care administration and legislations all across the globe.** It's crucial that these inclusive principles are revered while drafting mental healthcare legislations for ensuring the rights of the mentally ill.

MENTAL HEALTHCARE IN INDIA- THE CONSTIUTIONAL VIEWPOINT

The Constitution of India is the Grundnorm on the basis of which other laws are formulated and enacted. While the Indian Constitution can't boast much about possessing direct mental health care based provisions, there are a few Articles which have a positive connotation with direct regards to the right of health and indirect relation to rights of mental health.

The Preamble of the Indian Constitution[3], seeks to ensure that Indian being a welfare state with a socialist ideology, would under Article 21[4], guarantee the right to life as well as the personal liberty of a citizen. The principle of democratic socialism is embedded deeply in our country, where the State assumes a paternalistic role. This, democratic socialism is what levies the responsibility upon the state, as ensured by the Preamble, to *provide for* and *advance* the healthcare conditions in the country.[5]

The Directive Principles of State Policy as enshrined in Part IV[6] of the Constitution further promote the scheme of public health and welfare.

Article 38[7] levies the responsibility upon the State to ensure social order for promoting public welfare.

[3] Preamble, The Constitution of India, 1949.
[4] Indian Const. art 21.
[5] P.M. Bakshi, Constitution of India (Universal Law Publishing Pvt. Ltd. 2003).
[6] Indian Const. part IV.
[7] Indian Const. art 38.

Article 39(e)[8] provides for the protection of the health of the workers, may it be women, men or children. It further states that no person should have to engage in occupations unsuited for their strength or age, or which could potentially be critically hazardous to their health. However, this provision of the Constitution is openly flouted when a massive number of underage children are employed in firecrackers industries or men have to stay underground for an unregulated and illegal number of hours at mining sites.

Article 41[9] of the Constitution charges the State with the duty to secure assistance, occupational and education rights for the sick and disabled. However, this Article additionally mentions that this assistance needs to be provided while being mindful of the State's economic and developmental constraints.

Article 42[10] states the duty of the State to ensure that a mother's and her infant's health are shielded from the predators such as unjust and inhumane working conditions. It's upon keeping this Article as the base point that the Maternity Benefit Act, 1961[11] and the Maternity Benefit (Amendment) Act,2017[12] have been drafted and implemented, guarding healthcare of the new mother, the expectant mother and the infant.

It is Article 47[13] which obligates the State to boost the standards of living as well as the nutrition level of the citizens- this obligation of the State should be treated as their primary responsibility.[14]

The village Panchayats and the Municipalities should take it upon themselves to improve and safeguard the public health- this is enshrined in Article 243 G[15] of the Constitution. The Panchayats and Municipalities would further be delegated with the requisite authority and powers to manage public health affairs. This Article assumes substantial relevance in relation to the current Corona virus pandemic that has viciously affected countries across the globe, including India. Assistance can be drawn from this Directive Principle, whereby the State can mandate the municipality officers and the Panchayat heads to work at the root levels to make sure that due sanitation measures are being pursued and social distancing is being maintained.

[8] Indian Const. art 39(e).
[9] Indian Const. art 41
[10] Indian Const. art 42.
[11] The Maternity Benefit Act, 1961.
[12] The Maternity Benefit (Amendment) Act, 2017.
[13] Indian Const. art 47.
[14] Javed v. State of Haryana, AIR 2003 SC 3057.
[15] Indian Const. art 243 G.

Fundamental Right and Health

The Directive Principles are non-justiciable rights and thus act as mere directives for the state, bereft of any enforceability. Hence, a diverse set of Articles have to be considered to maintain public health.

Article 21[16] quite famously states that a person shall not be deprived of his life or personal liberty, except in accordance to the procedure which is established by law. Herein, the "right to life" doesn't merely equate to an animal-like existence but to a life of dignity and decency- such a life should comprise of decent standards of physical as well mental health. Matters of mental health can be emboldened through the means of Article 21.

Furthermore, Article 23 is circuitously related to the concept of health. Article 23(1)[17] prohibits human trafficking, which in turn prohibits the spread of disease such as AIDS; thus, a pattern of public health guardianship can be observed. Article 24[18] also becomes essential since it deals with the concern of child labour and prohibits the employment of children in conditions which are hazardous and detrimental to their health. On the foundation of these constitutional provisions, several enabling and care giving legislations have been drafted to ensure the health and welfare of the citizens.

It's quite inopportune that none of the Articles in the Constitution neither directly deal with the subject of mental health care and nor advocate mental health care promotion by the State. However, with the available Articles of the Constitution, the judiciary has provided a broader interpretation to the concept of health, thereby securing the citizen's right to a life of dignity, which shall incorporate stable physical as well as mental health.

In ***Dr. Upendra Baxi v. State of Uttar Pradesh,***[19] the Apex court ordered a medical panel to be set up which shall duly examine the Agra Home inmates and submit a timely report. This report brought fore to the fact that thirty-three out of the fifty mentally ill patients had differing levels of mental illness which hadn't been examined during their admission into the facility. Therefore, the treatment that these inmates were recipients of was not tailored to their particular illness, thus leading to a flood of flawed treatments. Further, fourteen patients had been let out of the facility without assessing their mental state/status. Lamentably, many of

[16] *Supra* note 4.
[17] Indian Const. art 23(1).
[18] Indian Const. art 24.
[19] Dr. Upendra Baxi v. State of Uttar Pradesh, (1983) 2 SCC 308.

these patients didn't even possess sufficient financial resources to traverse back to their homes. The Supreme Court considered this to be a grave violation of the constitutional provisions which *ensured the right to life and public health to its citizens.* The actions of the facility members were deemed to be inappropriate and a rights based approach was adopted by the Supreme Court.

At this juncture, it's imperative to delve into an elaborate analysis with regards to specific mental health care legislations in India for understanding the preparedness level of our country in dealing with and handling mental health issues, which are only bound to multiply due to the lockdown imposition, owing to the Corona virus pandemic.

THE MENTAL HEALTH ACT, 1987[20] (MHA,1987)

The MHA, 1987 came into force in India in 1993 and replaced the Indian Lunacy Act, 1912. The aim of this Act was to institute **central authorities**[21] as well as **state authorities**[22] who would establish, license and supervise the administration of psychiatric hospitals. It intended to create a composite and compact legislation whereby the rights of the mentally ill could be protected and superior provisions could be enacted for their treatment and care. These Central and State government Authorities were responsible for providing advices to the central and state governments respectively.

Section 5[23] of MHA, 1987 mandated the institution and maintenance of psychiatric nursing homes and psychiatric hospitals. Further, section 17[24] and section 18[25] dealt with voluntary and a dignified admission and discharge, in and from the hospitals or the nursing homes, as the case may be. *Emphasis was applied upon the consent of the patient, for his admission and discharge.*

Section 23[26] of MHA, 1987 was incorporated to shift responsibility upon the police officers, since this section states that the police officers were bound to take into ***"protection"*** such individuals in the locality who *seem to be* mentally ill and are unable to take care of themselves. The Officer could also take into "protection" such people whom he believed to

[20] The Mental Health Act, 1987.
[21] The Mental Health Act, 1987 § 3.
[22] The Mental Health Act, 1987 § 4.
[23] The Mental Health Act, 1987 § 5.
[24] The Mental Health Act, 1987 § 17.
[25] The Mental Health Act, 1987 § 18.
[26] The Mental Health Act, 1987 § 23.

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be potentially detrimental to the society, owing to their mental health condition. However, arbitrary power wasn't attributed to the police officials since the person taken into "protection" had to be produced before the Magistrate within twenty-four hours.

Section 38[27] was included in the legislation by our experienced legislature, which enabled three visitors to check the conditions of the psychiatric wards and nursing homes, each month. The inspection included the examination of the patients' histories as well as the relevant medical certificates. The remarks of these visitors were duly recorded for further reviewing and facility improvement.

Section 39[28] also constitutes a part of this legislation. Incorporated in welfare-driven judicial wisdom, this section mandates the inspection of even those mentally ill patients who have been imprisoned and constrained. It should be noted that in an era where mentally ill patients were looked down upon in the society and faced the wrath of the lawmakers well as the prison authorities alike, MHA, 1987 stood as a beacon of hope for them, viewing them through a compassion lens.

Section 81[29] is quite possibly one of the most legislatively luminous sections of MHA, 1987 since it explicitly mentioned the fundamental human rights of a mentally ill patient in India. According to this section, mentally ill patients should be treated with dignity and should not face discrimination in any form. Further, such patients can't be exploited for research purposes on anyone's whims and fancies; rather, the consent for the same should be furnished by the patient (however, the guardians could provide the required consent on behalf of minors). Further, no communication made by and to a mentally ill patient in any psychiatric health facility can be interpreted openly by an outsider. This section is probably one of the most elevating, empowering and protective section of MHA, 1987 as it explicitly tends to the rights of the mentally ill. Chapter IX[30] of MHA, 1987 deals with the legal penalties and sanctions in case of violations of any provisions of the Act.

In totality, this Act was quite beneficial for the mentally ill patients of the erstwhile years as it endeavoured to protect them in every possible form.

However, MHA, 1987 shortly ceased to be relevant and assistive since the field of mental

[27] The Mental Health Act, 1987 § 38.
[28] The Mental Health Act, 1987 § 39.
[29] The Mental Health Act, 1987 § 81.
[30] The Mental Health Act, 1987, Chapter IX.

health and psychiatry developed and expanded by leaps and bounds. The plethora of transformations which had and were occurring in the field of mental health care and psychiatry could hardly be acknowledged within the ambit of MHA, 1987. The public demand for a new and refined mental health (care and regulation) legislation surged.

MENTAL HEALTH TO MENTAL HEALTH CARE: WHY WAS A NOVEL LEGISLATION NECESSARY?

As mentioned above, the demand for new mental health care law was rising. Below mentioned are a few points of criticism of MHA, 1987 which ultimately led to the enactment of a substantially streamlined and effective legislation:

- MHA, 1987 seemed to be missing out on the ten cardinal Principles as advocated by the WHO. Further, it also did not advocate much of the principles of the United Nations Convention on the Rights of Persons with Disabilities.[31] These considerations weakened MHA, 1987 in an international comparative aspect.
- Increased emphasis was laid upon the legal aspects of the handling of the mentally ill, as compared to the medical aspects. This was a major fallacy in the Act because without the considerations of psychiatrists, psychologists, counselors, etc., the legislation remained deficient and hollow.
- Barely any weight was provided to the family and the social unit of the mentally ill patient. Further, no community based psychiatric treatment was enabled. This discouraged several individuals from accepting their mental health woes- they feared to penetrate a system which was devoid of warmth and their family's care, lacking community representation.
- A major criticism also remains that Chapter IX of MHA 1987 was devoid of penal sanctions for those relatives and/or officers who made requests for *unnecessary detentions* of the patients admitted in the mental health facilities.
- Undue importance was laid upon the establishment of new mental health care facilities, without realizing that a superior alternative would instead be the improvement of the existing mental health care facilities.

[31] Article 4-32, United Nations Convention on the Rights of Persons with Disabilities, (2006), accessible at: http://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pd.

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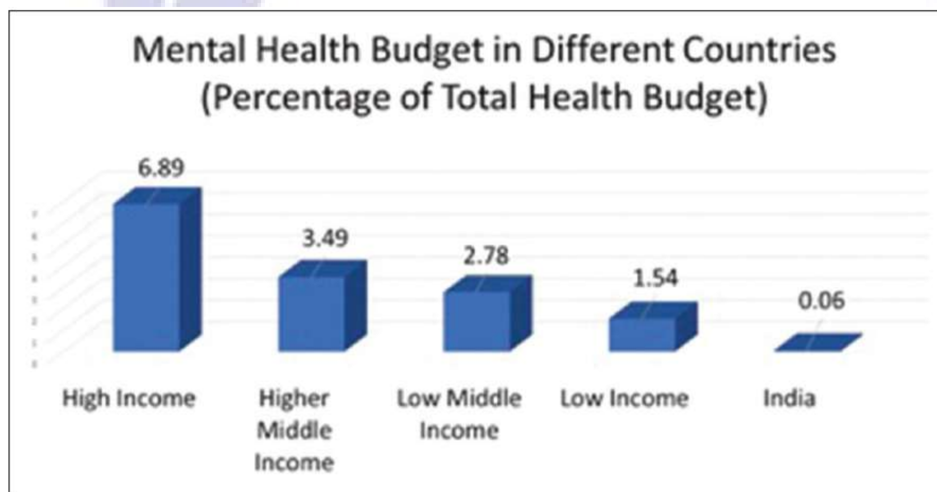
- Not a single provision of MHA, 1987 gave any rehabilitation guidelines, mandates or objectives for the mentally ill who had been discharged after a proper treatment. A single section prohibiting discrimination barely served any purpose.
- MHA, 1987 provided that a research could be conducted upon minors, by taking due consent from their guardian. The author believes this to be severely problematic from a human rights perspective.

THE MENTAL HEALTHCARE ACT, 2017[32] (MHA, 2017)- SOME IMPROVEMENTS, SOME LOST OUT OPPORTUNITIES



Source: Indian Journal of Psychiatry, Indian Psychiatric Society (2019) (http://www.indianjpsychiatry.org/viewimage.asp?img=IndianJPsychiatry_2019_61_4_415_262796_f2.jpg)

The data presented above is substantial evidence to depict that the expenditure made for the mental healthcare administration in India is dismal. A mere 0.6% of the entire budget being spent on the mental healthcare development in the country is quite a grim figure as one would expect it to rise after the implementation of MHA, 2017. Therefore, it's essential that the author deliberates upon MHA, 2017 and draws a comparison to its predecessor, MHA, 1987.

The Welcome Changes- MHA, 2017

[32] The Mental Healthcare Act, 2017.

1. The most commendable provision in MHA, 2017 is the decriminalization of suicide.[33] The Act assumes that the person who attempted to commit suicide was under mental stress and/or illness and therefore isn't liable for punishment under the Indian Penal Code (IPC). In fact, *duties have been levied upon the appropriate governments* to ensure that they provide the required care and protection to the person who attempted to commit suicide so as to reduce such instances in the future.

   The Indian Psychiatric Society (IPS) was invited and consulted at different junctures for deliberating upon diverse aspects of the Act. However, they weren't permitted to partake in the *drafting* of the Act. Thought the IPS has its fair share of reservations about NHA, 2017, it has explicitly stated that the decriminalization of suicide (based on their advice) has been the single most monumental change.[34] The IPS believes that reading down of the section 209[35] of the IPC will assist with enhanced reporting of suicide cases (which would be beneficial from a legal as well as social standpoint).[36]
2. Section 21(4)[37] of the Act provides that medical insurances should be provided for by the insurers (for treating the mentally ill patients), just at par with other insurances which are provided for any physical illnesses. The Insurance Regulatory and Development Authority of India (IRDAI), in a very optimistic step, has issued directives to health insurers across the nation to embrace the *segment of mental illnesses* in the medical insurance policies.[38]
3. The IPS and the MHA, 2017 have been a successful duo in the decriminalization of homosexuality in India in the year 2018. The IPS's position statement, while closely keeping in tandem with the MHA, 2017 has perennially been that, "homosexuality isn't a mental disorder." This statement of the IPS as well as relevant MHA, 2017 provisions carved their paths to be constituted as a part of the judgment in this landmark decision. The non-discrimination clauses[39] from the MHA, 2017 were

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[33] The Mental Healthcare Act, 2017 § 115.
[34] Jagadish, Furkhan Ali, Mahesh Gowda, Mental Healthcare Act 2017—The Way Ahead: The Opportunities and Challenges, 41, Indian Journal of Medical Psychology 113-118 (2019).
[35] The Indian Penal Code, 1860 § 209.
[36] *Supra* note 35.
[37] The Mental Healthcare Act, 2017 § 21(4).
[38] Health Insurance To Now Cover Treatment Of Mental Illnesses, QUINT (2018), accessible at::https://www.thequint.com/news/insurance-to-cover-mental-healt.
[39] The Mental Healthcare Act, 2017 § 18, 21.

incorporated into the judgment, while it was also noted that section 377[40], was unconstitutional in correspondence to the contradictions it possessed in relation to MHA, 2017.

4. Section 29[41] of MHA, 2017 obligates the government to plan and implement such programs which seek to promote the concept of mental health and reduce the stigma surrounding it.
   Section 30[42] ensures that the government disseminates significant information related to mental health as far and wide as possible. This dissemination also includes the widespread promotion of the provisions of MHA, 2017. It has also been mandated that relevant public authorities should undergo timely sensitization and training programs in connection to mental health care issues.
   Section 31[43] strengthens the responsibility of the government while stating that it's upon the government to ensure that medical mental healthcare professionals in public hospitals or in the prison cells should be adequately trained, matching up to internationally accepted standards- a link between this provision and *Principle 3 of the UN Principles* can be observed. Therefore, an enhanced international dimension has been affixed to MHA, 2017 as compared to MHA, 1987.
5. As per MHA, 2017, a person who's diagnosed with a mental disorder and is embroiled in a legal dispute (owing to the exercise of his rights accruing from MHA, 2017) would be provided the required legal aid to pursue their case.[44]
6. Section 2(s)[45] of MHA, 2017 provides an inclusive definition of mental illness, which is founded upon medical considerations and societal considerations. It roughly defines "mental illness" as any disorder of a substantial nature which relates to the mood, thinking, perception, memory or orientation of a person which severely affects and diminishes his/her sense of judgment and behaviours. Such a person may have difficulty in understanding and identifying reality and may also have difficulty in carrying out simple tasks of life. This definition of mental illness also includes the mental conditions which originate due to alcohol and drug abuse. However, the

[40] The Indian Penal Code, 1860 § 377.
[41] The Mental Healthcare Act, 2017 § 29.
[42] The Mental Healthcare Act, 2017 § 30.
[43] The Mental Healthcare Act, 2017 § 30.
[44] The Mental Healthcare Act, 2017 § 27.
[45] The Mental Healthcare Act, 2017 § 2(s).

definition excludes "mental retardation" from its ambit. With a balanced, medically sound definition in MHA, 2017, a solid ground has been set for any potential cases which may arise from this legislation.

7. Section 5[46] of MHA, 2017 provides for the issuing of *"advanced directives"* which essentially bestows the power upon a patient to exercise his right and furnish directives well in advance, with regards to the treatment they desire for their illness or for the remainder of their illness. They may also choose their *nominated representative* for this cause. These directives have to be appropriately vetted and approved by the relevant medical authorities.
8. Chapter V[47] of MHA, 2017 delves into the rights of the mentally ill patients, just like its predecessor, the MHA, 1987. However, the rights included in MHA, 2017 are more elaborate, empowering and liberal so as to ensure social, financial, physical and emotional safeguarding of the patients. Sections 18-28 of Chapter V[48] are the golden provisions of this Act. Right to confidentiality, right to emergency services, right to refuse visitors, right to medical insurance, right to be included into the society without prejudice and several other welfare-oriented rights have been incorporated under MHA, 2017.
9. The *Central Mental Health Authority* has to be established as under section 33[49] of MHA, 2017. Section 45[50] mandates the setting up of the *State Mental Health Authority*. These Authorities would be responsible for the planning and designing of Mental Healthcare Programs and the effectual implementation of MHA, 2017.

CRITICISMS OF MHA, 2017 AND THE ASSOCIATED PROPOSALS

Even with the tremendously laudable provisions of MHA, 2017, the Act lags behind in several aspects:

1. MHA, 2017, no doubt, took into consideration the viewpoints of mental healthcare professionals and the IPA; however, the IPA was excluded from the drafting process. This has been one of the most debated and criticized aspect of MHA, 2017.

[46] The Mental Healthcare Act, 2017 § 5.
[47] The Mental Healthcare Act, 2017, Chapter V.
[48] *Id.*
[49] The Mental Healthcare Act, 2017 § 33.
[50] The Mental Healthcare Act, 2017 § 45.

2. No standard procedure has been mentioned in Section 5 of the Act for the furnishing of advanced directives. Since the procedure is absent in the Act itself, ambiguity with regards to the exercise of the very right generates. Such hazy provisions deter the very legislative intent of providing the option of issuing advanced directives
3. Surprisingly, MHA, 2017 is devoid of even a single provision which deals with the removal of a *Nominated Representatives*. Furthermore, not even the medical officials possess the capacity to remove such a representative (even when their advices aren't in the best interest of the patient). This seems to be a hurriedly drafted provision and even though it poses a difficult hurdle to overcome, *personal contracts* can be entered into between the parties, which will regulate the potential removal of a Nominated Representative (when the need may be).
4. Via section 94[51] of MHA, 2017, e*lectroconvulsive therapy* has been banned as an emergency treatment to prevent the death of the patient or any irreversible harm that they may suffer. It's to be noted that this form of therapy is a classical lifesaving emergency treatment for the mentally ill (especially for those with higher suicidal tendencies).[52] This section of MHA, 2017 has been harshly criticized by several mental health professionals as electroconvulsive therapy could potentially be significantly assistive in controlling and managing patients in emergency situations.[53] A *collective appeal* by mental health professionals can be made in this regard to the Central and State Mental Health Authority who could then expeditiously look into the matter.
5. No standard set of qualifications have been provided by MHA,2017 for the medical mental health professionals. This reduces the standard of mental health care and makes one question the competency of the workforce in whose hands, the minds and brains of this country will be placed with trust and a hope of recovery. Immediate action is required to look into this critical loophole. However, for the longer run, proper amendments should be effectuated with regards to *standards qualifications.*

[51] The Mental Healthcare Act, 2017 § 94.
[52] Lancet, Efficacy and Safety of Electroconvulsive Therapy in Depressive Disorders: A Systematic Review and Meta-Analysis, UK ECT Review Groups, 799-808 (200).
[53] Manoj Kumar, Mental Healthcare Act 2017: Liberal in Principles, Let Down in Provisions, 30, Indian Journal of Medical Psychology 101-107 (2018).

An important judicial decision which needs to be mentioned at this juncture is that of ***Meenu Seth v. Binu Seth.***[54] The issue herein was that a case was already ongoing under the MHA, 1987. After MHA, 2017 came into effect, the appellants appealed that their case should proceed in tandem with the provisions of MHA,2017. However, the Delhi High Court dismissed the appeal and stated that even though MHA, 1987 has been repealed by MHA, 2017, section 126 2(f)[55] of MHA, 2017 clearly states that any cases which were ongoing and pending in any courts of India under MHA, 1987 will continue under the ambit of MHA,1987.

COMPARATIVE ANALYSIS WITH NEW ZEALAND: AN INTERNATIONAL OUTLOOK

- The Mental Health (Compulsory Assessment and Treatment) Act, 1992 (MCATA) is the primary act which deals with the mental healthcare framework in New Zealand.
  A guaranteed compulsory treatment as mentioned in this Act, provides a mentally ill patient with an opportunity to recover, rehabilitate in the society as well as take control of their own mental health. MCATA promotes this compulsory treatment by focusing on timely and regular consultation sessions between the "compulsory patients" and the mental health professionals.[56]
- Under the provisions of this Act, any person can request for a mental health assessment, which should be accompanied by a recommendation, provided by a registered medical practitioner.[57] Mental health professionals would have to invigilate the entire process and the support of family members throughout the entire process is permitted.
  When this is contrasted with the Indian legislation, such liberty in approaching the doctors and undergoing an assessment seems absent.
- A major guideline enlisted by the New Zealand Ministry of Health[58] mentions that even though there's a compulsory assessment which is permitted, the healthcare

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[54] Minu Seth v. Binu Seth, FAO No. 411/2017.
[55] The Mental Healthcare Act, 2017 §126 2(f).
[56] Soosay and Rob Kydd, Mental Health Law in New Zealand, BJ Psychology Journal (2016).

[57] Mental Health (Compulsory Assessment and Treatment) Act, 1992 § 8.
[58] Ministry of Health (2012a), *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act,1992,* accessible at: http://www.health.govt.nz/publication/guidelines-mental-health-compulsory-assessment-and-treatment-act-1992.

professionals still have to obtain the consent of a the patient wherever it's possible to do so. This consent should be "informed" and be obtained without undue influence or coercion.

- Part 6[59] of the MCATA mentions the eleven essential rights of the mentally ill patient:

  Right 1-The patients have the right to obtain information with regards to their rights as well as their legal status. They also possess a right to be made aware about the treatment that they're receiving under the Act; this information includes details about side effects.

  Right 2- This right ensures that the cultural and religious ideologies of the individual are respected during the assessment and treatment of mental disorders.

  Right-3- This right ensures that competent interpreters are provided by the State for interpreting and communicating on behalf of those who can't voice their concerns.

  Right 4- Herein, the treatment provided to the patients should conform to internationally accepted standards and match the treatment which is provided for any physical illness.

  Right 5- This provides that the patients be informed and notified about their treatments.

  Right 6- Ensures that the patients have the right to refuse or deny any video recording of them.

  Right 7- Asking for a second opinion from an independent psychiatrist is one of the major rights which have been attributed to the citizens of New Zealand.

  Right 8- This grants the patients with the power to consult any independent lawyer.

  Right 9- Assures the patient that his contact with his family and community will not be broken. This consideration seems to have been missed out on by the Indian legislature during the drafting of MHA, 2017.

  Right 10- This right relates to right 9 as it ensures that visitors and phone calls are allowed.

  Right 11-The patients also have the right to not only receive, but also send mails.

Though some of the above mentioned rights can be found in our legislative framework, it's noteworthy that a majority of them are either absent or not implemented efficiently.

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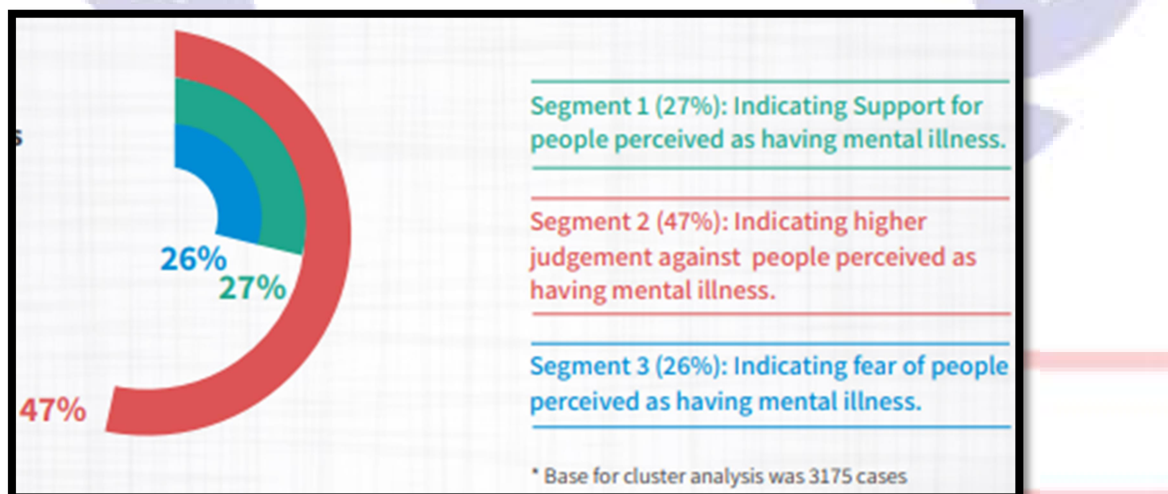
[59] Mental Health (Compulsory Assessment and Treatment) Act, 1992, Part 6.

In addition to the abovementioned Acts, the Bill of Rights Act, 1990 (which states the life and liberty of New Zealanders), the Human Rights Act, 1993 (makes discrimination illegal even on the basis of mental disability) and the Health and Disability Commissioners Act, 1994 (which provides an elaborate yet compact set of rights and states the importance of consent) work in full force to detect and prevent mental health disorders.

The provision of a *compulsory assessment* in New Zealand has led to the breaking of major stereotypes surrounding mental health disorders. If the Indian legislature could devise a model of a similar nature, it would ensure an enhanced reporting and treatment of mental disorders. However, it's to be noted the populations of New Zealand and India are starkly different and that a diverse and innovative set of measures need to be implemented in our country to bring our mental health legislation at par with international standards, so as to work in consonance with the WHO principles.

CONCLUSION

The author understands that even though the current mental health care legislation in India is not of a golden quality, it has showcased significant improvement as compared to its predecessor, MHA, 1987.



Source: The Three Segments of General Public based on their Attitude Towards Mental Health, TLLLF NATIONAL SURVEY REPORT (2018) ([1]https://www.thelivelovelaughfoundation.org/downloads/TLLLF_2018_Report_How_India_Perceives_Mental_Health.pdf.)

The data presented above explicitly depicts that a chunk of the issues are rooted in the society itself. A metamorphosis in the mindset at an individual level is the need of the hour and blatantly shifting the entire burden on the legislature would be redundant. If consistent, sincere efforts are not directed towards an empathetic acceptance of mental disorders in our country, the benefits of the available legislation cannot be availed and the stigmas attached to mental disorders can never be discarded, A conscious effort on part of the citizens, the legislature as well as the executive agencies would be massively beneficial for improvement in the perception of the concept of mental health care in India.