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Mental Health Laws in India: An Analysis

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ABSTRACT: Human rights and underprivileged people's access to mental health care require supportive laws and policies. Both "hard" and "soft" laws pertaining to mental health care have been drafted on a global and regional level. It has been observed that new legislation and adjustments to existing ones are regularly required in the area of mental health treatment in India. Reforming mental health care has mostly been a reactive process thus far, but new laws and regulations provide the possibility of proactive change. A major obstacle to providing quality mental health care in India is a lack of appropriately trained human resources. A two-week forensic psychiatry course is required by postgraduate psychiatric standards, although this is inadequate to demonstrate the necessary competency. Consequently, forensic psychiatry necessitates the creation of a specialty. In addition, it's necessary to establish, plan, and manage forensic mental health services. It is necessary to have one or more forensic psychiatric institutes in India.

Keywords: Mental Health, Health, Treatment, Psychiatry, Law.

INTRODUCTION

The legal decriminalization of suicide is just a temporary solution; until otherwise demonstrated, all attempted suicides are presumed to be the result of mental illness. There should be no restrictions on the decriminalization of suicide in order to lessen stigma, promote transparency, and facilitate help-seeking. After the United Nations Convention on the Rights of Persons with Disabilities was ratified by India in 2007, the Mental Health Act 1987 was superseded by the Mental Healthcare Act 2017. An important development in Indian mental health law is the Mental Healthcare Act of 2017 (MHCA), which protects patients' autonomy, dignity, rights, and choices during mental health treatment. No one may be coerced into receiving mental health treatment under this Act, and inpatient admissions may be "independent" or "supported". The previous legislation's word "involuntary admission" has been replaced with "supported admission." The way the new Act is put into practice will be heavily influenced by state mental health authorities and mental health review boards. India's mental health treatment system is intended to be drastically changed by the 2017 Mental Healthcare Act. When it comes to treating PMI, the interaction between psychiatry and law is frequently relevant. Treatment for PMI frequently results in a reduction in the personal freedom of mental patients. Most nations have legal frameworks governing the treatment of individuals with mental illnesses. Ayurveda is not one of the many therapies in the literature that provide in-depth descriptions of various mental illnesses, even though there are many of them. The British created the system of caring for mentally ill people in India's asylums. After the British crown took control of the Indian government in 1858, a series of laws were passed quickly to regulate the treatment and care of mentally ill individuals in British India. Those were the laws:

a). The Lunacy (Supreme Courts) Act, 1858
b). The Lunacy (District Courts) Act, 1858
c). The Indian Lunatic Asylum Act, 1858 (with amendments passed in1886 and 1889)
d). The Military Lunatic Acts,1877.

The construction of mental asylums and the admission of mentally ill individuals were detailed by these Acts. At the time, India's insanity legislation were based on a British situation from the middle of the 1800s (Somasundaram *et al.,* 1984). A legislative foundation for the care of mentally ill individuals was established by the 1858 Acts. As the public's knowledge of the appalling conditions in mental health facilities grew among Indian intellectuals in the first ten years of the twentieth century, political consciousness and emotions of nationalism also grew. As a result, the Indian Lunacy Act of 1912 was passed. Growing public awareness of the horrific circumstances in mental health facilities throughout the first decade of the twentieth century, thanks to the work of Indian

intellectuals, has contributed to a rise in political consciousness and emotions of nationalism. However, the primary goals were to protect society from the threats presented by mentally ill individuals and to make sure that the general public was not able to enter these facilities. In these facilities, psychiatrists worked as full-time administrators. The Act also permitted judicial inquisitions for those with mental illnesses (Bhaumik 2013). The Universal Declaration of Human Rights was approved by the UN General Assembly after World War II. The Indian Psychiatric Society created the Mental Health Bill in 1950 to replace the outmoded ILA-1912. After a long and drawn-out process, the Mental Health Act of 1987 (MHA-87) was ultimate by passed in 1987.The following are the Act's main elements:

a) A changing understanding of mental illness and the adoption of a contemporary paradigm of care that prioritizes therapy and care giving above isolation.

b) The creation of a Federal/State Mental Health Authority to regulate and manage nursing homes and psychiatric hospitals and to advise the federal and state governments on mental health issues.

c) Admittance to a nursing home or mental hospital in extreme cases. The policies of voluntary admission and admission according to receiving orders were maintained.

d) The duties of the police and judiciary in situations involving PMI who are on the run or who have received inhumane treatment.e) Defense of PMI's human rights.

f) PMI property management and guardianship.

g) The Act's provisions regarding penalties for breaking them.

Since its launch, the MHA-1987 has drawn criticism in spite of all of its good qualities. It is said to be mostly focused on guardianship matters and PMI's licensing and admissions processes. The provision of mental health services and human rights concerns are not adequately addressed by this Act (Chanpattana *et al.* 2005). The Act and the Rules issued under it will never be properly implemented due to a multitude of incredibly complicated processes, flaws, and absurdities. Human rights advocates have questioned the constitutionality of the MHA, claiming that it imposes restrictions on individual freedoms without providing sufficient judicial review. In order to conform with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), MHA-87 is now being revised. It took almost thirty years for the President to approve this proposal (May 1987), and it wasn't until 1993 that it was signed into law. One benefit of the 1987 Mental Health Act (MHA) was its progressive definition of mental disease, which prioritized care and treatment above institutionalization. It underlined the need of protecting human rights, guardianship, and property management for people with mental disorders and contained precise procedures for hospital admission in exceptional circumstances.

The legal processes for guardianship, licensure, and admittance are the main areas of criticism directed at the MHA 1987 (Narayan *et al.,* 2011). This Act also did not adequately address the delivery of mental health services or human rights. Human rights groups have questioned the MHA 1987's constitutionality since it limits individual freedoms without providing a means of judicial review. Similarly, the MHA Regarding patient care and rehabilitation after hospital release, 1987 said nothing. In addition, carers and their families experience financial, social, and emotional pressure due to a shortage of treatment facilities. These complaints led to revisions in the MHA 1987, which culminated in the introduction of the Mental Health Care Bill 2013 in the Rajya Sabha (upper house of parliament) on August 19, 2013. This legislation does not yet become law, but it repeals the MHA of 1987.

Mental Health and Constitution of India

Article 21 of the Indian Constitution stipulates that an individual's life or personal freedom cannot be taken away from them unless it is done so legally. According to this article, the right to life and personal liberty includes "facilities for reading, writing, and expressing oneself in varied forms, freely moving about, and mixing and comingling with fellow human beings". Eleven A person who is of unsound mind and has been adjudged to be so by a competent court is ineligible to be registered on an electoral roll, as per Section 16 of the Representation of People Act, 1950. Accordingly, the individual is prohibited under the Constitution from holding public office, including that of President, Vice President, Minister, Member of Parliament, or State Legislature. The 1995 Persons with Disabilities Act (PDA 95) addresses full participation, equal opportunity, and protection of rights. PDA 95 was established in 1995 with the goals of preventing abuse and exploitation of handicapped individuals as well as inequality in the allocation of developmental advantages between those with disabilities and those without. It established an atmosphere free from obstacles and outlined the duties of the government, which included developing all-encompassing development plans and offering particular actions for the social inclusion of people with disabilities (Singh MP. In: Shukla's VN Constitution of India. 9th ed. Lucknow). Mental illness and mental retardation are likewise regarded as disabilities under PDA 95. Consequently, PMI are eligible for the advantages that the Act affords PWDs. While government employment has a 3% reserve provision, the PMI is not eligible for it. Additionally, this Act is being updated in light of the 2006 UNCRPD.

Provisions Of The Mental Health Care Bill (MHCB) 2013

Everyone has the right to get mental health treatment and therapy from government-run or supported programs under the MHCB 2013. Thus, in the event that a district mental health service is not accessible, a mentally sick patient will have access to resources and services

including free psychotropic medication, insurance coverage for mental illnesses, and funds for a private consultation. According to the MHCB 2013, treatment and rehabilitation will be provided in the least restrictive setting feasible, and patients' rights and dignity—especially those of low-income families—will be upheld. As a result of these recommendations, the financial and mental difficulties imposed on caregivers will be considerably eased (The Mental Health care Act, 2017).

The MHCB 2013 introduced two new concepts: advanced directives and nominated representatives. These allow individuals with mental illnesses to have more control over their treatment preferences in the event that they lose their mental capacity, as well as choosing a nominated representative to handle their affairs. National and state mental health organizations must be established, according to the legislation. Additionally, registration with the relevant state or federal mental health authority will be necessary for all mental health facilities (Gopikumar *et al.*, 2013).

A quasi-judicial commissioning committee on mental health reviews will evaluate the use of advance directives and their administration on a regular basis, offering recommendations to the government on how to protect the rights of individuals with mental illnesses. Although suicide is now illegal in India, this law suggests decriminalizing it. Decriminalizing suicide will lessen the burden on patients and carers as well as the strain on India's already overburdened judicial system. Suicide is a stressful social and legal issue (Dhandha, 2010).

Lastly, it is suggested that direct electroconvulsive therapy (ECT) be outlawed. That is, when ECT is used, only anesthesia and muscle relaxants will be allowed. This therapy is not available to minors.

The 2017 Mental Healthcare Act

The most commendable provision in the 2017 MHA is the legalization of suicide. The Act exempts the individual who attempted suicide from the penalties outlined in the Indian Penal Code (IPC) on the grounds that it was a result of mental stress or illness. In order to lower the frequency of suicide attempts in the future, it is the duty of the relevant governments to guarantee that the person who tried suicide receives the required care and protection. Throughout the preparation of the Act, the Indian Psychiatric Society (IPS) was contacted and invited on many occasions. Nonetheless, they were not permitted to participate in the Act's drafting. Reading down section 209 of the IPC will help with better suicide reporting (which would be beneficial from a legal and social standpoint), however the IPS has misgivings about the MHA, 2017, but it has stated explicitly that the legalizing of suicide (based on their recommendations) has been the single most significant improvement. Section 21(4) of the Act states that medical insurance (for treating mentally ill individuals) shall be given by insurers in the same manner as other insurances are for diseases. The Insurance Regulatory and Development Authority of India (IRDAI) has directed health insurers throughout the nation to cover mental illnesses under medical insurance policies, which is a very positive step.

The MHA, 2017 and the IPS worked together to successfully decriminalize homosexuality in India in 2018. Although the IPS's 2017 policy statement is closely aligned with the MHA, it has always maintained that "homosexuality is not a mental disease." The MHA, 2017 provisions and this IPS statement made it possible for them to be included in the ruling of this significant case. The non-discrimination provisions of the MHA, 2017 were included in the decision. Additionally, it was noted that section 377 was void because of its discrepancies with the MHA, 2017. The Mental Health Act of 2017's Section 29 mandates that the government develop and carry out programs that lessen stigma and raise public understanding of mental health issues. Section 30 requires the government to disseminate vital information on mental health to as many people as possible. As part of this dissemination, the MHA, 2017's provisions are also heavily marketed. Participation by pertinent public agencies in appropriate training and awareness campaigns on mental health issues is also required.

Principle 3 of the UN Principles is linked to Section 31, which strengthens the government's obligations by stating that it is the government's duty to guarantee that medical and mental healthcare personnel in public hospitals and jail cells receive sufficient training in compliance with internationally recognized standards. Consequently, MHA, 2017 has a more worldwide favors than MHA, 1987 (Narayan *et al.*, 2011).

As per MHA, 2017, an individual with a mental illness diagnosis who becomes embroiled in a court dispute (due to their exercise of rights under MHA, 2017) shall get the requisite legal aid to effectively prosecute their case. The Mental Health Act of 2017's Section 2(s) provides a wide definition of mental disease based on social and medical concerns. It broadly covers any major condition that has an impact on a person's thinking, mood, memory, orientation, or perception; it also substantially impairs and diminishes that person's sense of judgment and conduct. Such a person could struggle to identify and understand reality, as well as to do basic daily tasks. This concept of mental illness includes issues that arise from abusing drugs and alcohol. But "mental retardation" is not included in the definition of the word. A solid basis has been set for any potential legal problems that may emerge as a result of this legislation with the MHA, 2017's fair and medically sound definition.

"Advanced directives," which effectively grant a patient the capacity to exercise his right and offer directions for the care they desire for their sickness or the duration of their illness far in advance, can be issued in accordance with Section 5 of the Mental Health Act of 2017. They could also choose a spokesperson for this cause. The appropriate medical authorities need to carefully study and approve these instructions. Similar to the MHA, 1987, Chapter V of the MHA, 2017 explores the rights of individuals with mental illnesses. To safeguard patients' material, mental, social, and physical well, however, the rights outlined in the MHA, 2017 are

more comprehensive, robust, and expansive (Dutta *et al.*, 2001).

The MHA, 2017, include many welfare-related rights such as the freedom to refuse visits, emergency assistance, secrecy, medical insurance, and the right to be integrated into society without facing prejudice. Section 33 of the Mental Health Act of 2017 mandates the establishment of the Central Mental Health Authority. Section 45 requires the establishment of the State Mental Health Authority. These authorities will be in charge of creating and designing Mental Healthcare Programs and ensuring that the MHA, 2017, is successfully implemented.

Criticism Of MHA, 2017 And Suggestions

Despite the MHA, 2017's incredibly admirable features, the Act is lacking in a number of areas: The IPA and mental health professionals were undoubtedly considered in the preparation of MHA, 2017, but they were not included in the process. One of the 2017 MHA's most divisive and controversial portions is this one. There is no mention of a uniform procedure for granting advanced instructions in Section 5 of the Act. Due to the Act's exclusion of the procedure, uncertainty surrounds the right's exercise. The legislative goal of enabling the issue of advanced directives is undermined by such vague restrictions.

Remarkably, the MHA, 2017 has no provisions at all pertaining to the removal of a Nominated Representative. Furthermore, even if the representative's advice is not in the patient's best interests, medical personnel lack the authority to fire them. Even though this seems like a hurriedly drafted clause, personal contracts may be made between the parties to control the removal of a Nominated Representative in the event that it becomes necessary, even if it is a challenging barrier to overcome (The Mental Health care Act, 2017). Section 94 of the Mental Health Act of 2017 prohibits the use of electroconvulsive therapy as an emergency treatment to save a patient from dying or suffering permanent harm. For those with mental illnesses, this kind of therapy is a typical life-saving emergency treatment (particularly for those with higher suicidal inclinations). The MHA, 2017 has drawn criticism from a number of mental health professionals due to the fact that electroconvulsive treatment can assist in controlling and managing patients in emergency situations. Mental health professionals can jointly seek information from the Central and State Mental Health Authorities, enabling prompt investigation of the matter.

A standard set of credentials for mental health and medical professions is not provided by MHA, 2017. This degrades the quality of mental health services and raises concerns about the workforce's ability to handle the minds and brains of the nation in the hopes of recovery. It is imperative that this serious problem be looked at right now. Over time, nevertheless, appropriate modifications to the requirements for standards must be made (Kala 2013).

At this point, it is necessary to discuss a significant court ruling: Meenu Seth v. Binu Seth. The MHA, 1987 was already in effect in this case, which presented a challenge. The Delhi High Court dismissed the appeal, citing section 126 2(f) of MHA, 2017 as clear evidence that any disputes that were ongoing and unresolved in any Indian court under MHA, 1987 shall be covered by MHA, 1987, even if MHA, 2017 repealed MHA, 1987.

Mental Health Legislations In Other Countries

a) South Africa's rural villages and impoverished urban regions have a remarkably low number of psychiatrists or medical professionals with training and expertise in psychiatry.

b) The Italian Public Law of 1978 and the Mental Health Act of 1983 in England and Wales are noteworthy instances of a shift away from imprisonment and detention and towards integration and rehabilitation of individuals with mental disorders.

c) Japan enacted the Mental Hygiene Law in 1950, which encouraged the construction of mental hospitals and offered financial support to patients who were imprisoned without their will.

United Nations Convention For Rights Of Persons With Disabilities-2006 And Indian Laws

2006 saw the adoption of the UNCRPD. It was ratified by the Indian Parliament in May 2008. Laws and policies of nations that have ratified and signed the UNCRPD must be in compliance with it. India is presently revising its entire disability legislation as a result. The agreement signifies a change in perspective on how individuals with disabilities are treated, moving from social welfare to human rights. The new paradigm is predicated on the equality, dignity, and legal ability of all people. Article 2 of the treaty stipulates that PWDs would have equal access to the legal system in all spheres of life. The state is required under Article 3 to take reasonable measures to guarantee that individuals with disabilities can obtain support in the exercise of their legal rights. Article 4 demands measures to stop misuse of the assistance system that PWDs are obliged to utilize. The UNCRPD does not expressly forbid forced interventions, but it also does not allow for the compelled provision of mental health services. 22 In order to make changes to MHA 87, a draught Mental Health Care Bill - 2011 (MHCB) was produced. MHCB suggests creating a Mental Health Review Commission with state panels and registering mental health institutions as opposed to licensing them. The admissions procedure has undergone significant changes (Gangadhar *et al.*, 2013). The most significant aspect of the MHCB is that it makes the government responsible for creating mental health services, making them available to everyone, and taking the necessary action. The PMI provides strong protection for human rights, dedicating an entire chapter to the topic. A draught of "The Rights of Persons with Disabilities Bill, 2011 (RPWD Bill)" has been received by the Ministry of Social Justice and Empowerment (MSJE), and PDA 95 is also being modified. PWDs are entitled to the assistance they require in order to exercise their legal rights, but they are also free to alter, remove, or substitute any support

systems they may have. Restrictive guardianship has largely replaced plenary guardianship in practice. Of the intended 7% reserve for PWDs in government employment, 1% has been allotted to PMI. There are incompatible clauses in the RPWD Bill and the MHC Bill. Human rights activists predominated the RPWD drafting committee. Human rights activists feel that all PMIs should have complete legal authority, and that all mental hospitals should be forced to close and their forced institutionalization should be prohibited.

CONCLUSION

It is necessary to set aside enough money and make plans to expand the resources and expertise that mental health professionals and staff have access to. The Mental Health Act of 1987, the previous legislation, did not include a definition of mental illness. The expression "mentally ill person" means "a person who requires treatment for any mental disorder other than mental retardation." Substance use disorder (SUD) was not mentioned again after Chapter III. The current legislation, the Mental Health Care Act of 2017, officially classifies SUD as a mental illness. The MHCA, 2017's Section 89 is problematic since it allows for the treatment and admission of a person with a mental disorder without that person's agreement if a designated representative seeks it. The primary carer role is overlooked by the Act, which is within the family. Even medical professionals depend on the relatives of their patients. Therefore, appropriate family support is needed by the patient, the healthcare administration, and the practitioner. The government's mental health plan is likewise disregarded by the Act. The National Mental Health Program should have been created by every state and overseen by the state mental health authority, according to the Act. There are several strategies that may be applied to stay clear of the risks. Removing the mention of SUD from the definition of mental disease is one way to achieve this and extricate the idea of addiction therapy from the Mental Health Act of 2017. Many nations, including the United States, Australia (in many of its states), and New Zealand, have created separate laws for addiction and its treatment and have excluded drug abuse from their mental health laws because individuals who misuse substances behave differently and need different kinds of care. Schools, colleges, and other educational institutions should implement mental health programs. In India, a set budget ought to be set aside for the execution of these initiatives.

FUTURE SCOPE

Research simply means to search again. In this context this research paper talks about the various issues and challenges which are related to the mental health laws. Also this research paper tells about the relevance and adequacy of the legal provisions related to the mental health laws. But we can say that even after having so many legislations the problem and challenges related to mental health laws are still present. Due to this there is a scope to enact new laws related to mental health.

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