The Mental Health Care Bill 2013: A Critical Appraisal

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ABSTRACT

The Mental Health Care Bill – 2013 has been introduced in Rajya Sabha and is now waiting for enactment. The Bill entails unprecedented measures to be undertaken by the Government ensuring everyone right to access mental health care and treatment from services run or funded by the Government. The Government is to meet the man-power requirement of mental health professionals according to international standard within a period of ten years. Various rights of persons with mental illness have been ensured. All the places where psychiatric patients are admitted and treated including the general hospital psychiatry units (GHPU) are to be registered as mental health establishments. Unmodified ECT has been banned and ECT to minors can be given only after approval from the Mental Health Review Board. This article advocates for exemption of GHPU from the purview of the Bill, taking into consideration impediment created in the treatment of vast majority of psychiatric patients who retain their insight into the illness and seldom require involuntary admissions. It is also advocated to reconsider ban on unmodified ECT and restriction placed on ECT to minor which are very effective treatment methods based on scientific evidence. In our country, family is an important asset in management of mental illness. But requirement of seeking approval from the Board in many of the mental health care decision may discourage the families to be proactive in taking care of their wards. The Board and Mental Health Authorities at the central and the state levels are authorized to take many crucial decisions, but these panels have very few experts in the field of mental health.

Key words: *General hospital psychiatry units, Mental Health Care Bill - 2013, Persons with mental illness*

In the early half of the twentieth century, mental health laws were primarily concerned with the custodial aspect of mental illness, and human rights aspects were hardly taken care of. Large scale violation of human rights during Second World War resulted in worldwide outcry which led to campaigns to recognize and uphold rights of all groups of persons. The newly formed United Nation Organization rose to the need of time and the Universal Declaration of Human Rights was adopted by the UN General Assembly in 1948.[1] Indian Psychiatric Society (IPS), the representative body of psychiatrists in India since 1948, realized the need of revising the archaic Indian Lunacy Act, 1912 and making a new law in accordance to this declaration. It is frequently alleged that psychiatrists are least concerned with the human rights of persons with mental illness; but as a matter of fact, the IPS has always remained in forefront in the struggle for betterment of conditions of mental asylums (as they were called then) and also for the human rights of persons with mental illness. After due deliberations, the IPS prepared and presented a draft Mental Health Bill in 1950 to the government for consideration.[2] Due to various reasons, it could not be enacted for a long period of time and the actual enactment process started in the 1970s, finally leading to the Mental Health Act, 1987 (MHA-1987). The Act came into operation after notification in 1993. It is rightly said that the MHA-

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1987 was conceived, drafted and piloted by Indian Psychiatric Society.[3]

CURRENT PROCESS OF AMENDMENT

India signed the United Nations Conventions on the Rights of Persons with Disabilities (UNCRPD) in September 2007 and the Indian Parliament approved it in May 2008. The purpose of the UNCRPD is to promote, protect and ensure full and equal enjoyment of all human rights and fundamental freedoms by all persons with disability (PWD) and to promote respect for their inherent dignity.[4] After signing the UNCRPD, it became imperative for the Government of India to revise all the disabilities laws in the country to make them compliant to the UNCRPD. The Ministry of Health and Family Welfare initiated the process of amendment of the MHA-1987 with technical help from Indian Law Society, Pune. After more than 3-year-long process, which involved consultation over several drafts, the ministry prepared the Mental Health Care Bill, 2013 (MHCB).[5] It was introduced in the Rajya Sabha in August 2013. The Parliamentary Standing Committee on Health Related Matters submitted its report with suggestions of some minor changes in November 2013.[6]

POSITIVE FEATURES OF THE MENTAL HEALTH CARE BILL

It is worth mentioning that psychiatrists have been apprehensive that psychiatric treatment and mental health care would be adversely affected by a number of provisions of the Bill. But it must also be realized that this is one of the most proactive type of legislation and has many positive and land mark features which, if properly and genuinely implemented, are set to revolutionize mental healthcare services in our country. Main positive features are summarized as below.

Availability of good quality mental health services

The Bill ensures right of every person without discrimination to access affordable and good quality mental health services which are to be made available by the Government in sufficient quantity and easily accessible geographically. The Government is also mandated to provide for a range of services required by persons of mental illness (PMI) and has to ensure that no persons shall have to travel long distances to access mental health care. The mental health services are to be integrated into general health services and are to be made available in each district. Half-way homes, sheltered accommodations, supported accommodations, rehabilitation establishments and services, services to support family of PMI, child and old-age mental health services etc. are also to be established. All these services are to be made available in all the general hospitals run or funded by the Government. Basic and emergency mental health care are to be made available at all community health centres levels. The Central Government has to place annual reports in the Parliament and the state government to do it in the state legislatures describing the progress made towards achieving access to mental health care in the country.

Duties of the Government

The Government has also been assigned duties to plan, design and implement programmes for promotion of mental health and prevention of mental illnesses and to create awareness about mental health, particularly programmes to reduce stigma which are to be adequately funded. Provisions of the Act are to be given wide publicity through public media. Government officials including police officers and other officers are to be given periodic sensitization and awareness training on the issues addressed by this act.

Human resources requirement of mental health services

The appropriate Government have also been assigned duties to take measures to address human resources requirement of mental health services by proper planning and the internationally accepted guidelines for number of mental health professionals on the basis of population are to be met within a period of ten years. All the medical officers in public health establishments and in jails are to be trained to provide basic and emergency mental health care.

Human rights of the PMI

Special emphasis has been given to the human rights of PMI. All PMI have the right to live in, be part of and not segregated from society. They have the right to live with dignity in a safe and hygienic condition with adequate provisions of privacy, leisure, recreation, education and religious practices. They have the right of equality in treatment, protection from inhuman and degrading treatment. PMI or their nominated representatives have been ensured the right to information regarding their admission, nature of their illness and treatment plan after their admissions and the right to appeal for review of their admission. They have the right to confidentiality in respect of their mental health care and treatment and information regarding their mental illness and treatment cannot be released without their consent except in certain specified circumstances. All PMI have right to access their medical records, which can be withheld only in case of likelihood of serious harm to the PMI or any other person. All PMI admitted in Mental Health Establishments (MHE) have the right to personal contact and communication. All PMI

have the right to free legal services to exercise any of the rights under this Act. Any PMI or his nominated representative has the right to complain about deficiency in services to the medical officer in charge of the MHE or to the State Mental Health Authority or to that Mental Health Review Board.

Decriminalization of suicide

In case of suicide, the person will be presumed, unless otherwise proved, to have severe stress at the time of the attempting suicide and thereby not liable to be prosecuted under section 309 of Indian Penal Code. The Government has also been assigned duties to provide care, treatment and rehabilitation of such person and to plan and implement public health programmes to reduce suicides and attempted suicides in the country. This provision of decriminalization of attempt of suicide has been welcomed by all.

Emergency admissions

There is provision of emergency admission on any bed in the country up to a period of 72 hours (120 hours for the north-eastern states) and the psychiatric treatment, except electro-convulsive therapy (ECT), can be initiated by any registered medical practitioner, if there is danger to patient's health or the patient is violent or suicidal. This provision fills a major lacuna overlooked by the architects of the previous law, which made transporting a disturbed patient illegal, except under court order.[3]

NEGATIVE FEATURES OF THE MHCB

Concerns have been raised that many of the provisions of the Bill would have negative impact in psychiatric treatment. Antony states that the present Bill would make every psychiatrist quite uncomfortable, seeking the kind of measure it is bringing in to control this group of medical professional.[7] Antony also feels that the over-inclusive definition of mental illness would harm the large chunk of psychiatric patients who will feel stigmatized, but he favours inclusion of profound mental retardation in its ambit. He calls for a restrictive definition of mental illness and penal provisions for officials responsible for non-implementation of different mental health measures under this Bill.[7] Kala is apprehensive about negative impact of large scale countrywide post-admission review in almost all cases of involuntary admissions.[3] Narayan *et al.* strongly advocated exemption of all general hospital psychiatric units from the purview of the Act.[8] Some of the negative features feared to have negative impact on psychiatric treatment are summarized as below.

General Hospital Psychiatry Units (GHPU)

The Bill requires any health establishment where PMIs are admitted or kept in for care, treatment, convalescence and rehabilitation to be registered as Mental Health Establishment (MHE), which would then be bound by all the rules framed under the Bill by the Mental Health Authorities. The provision of 'License' under the MHA-1987 has been replaced by 'registration'. But it is only a cosmetic change of nomenclature, as all the MHE shall have to fulfil the stiff norms and guidelines framed by the authorities. Under the MHA-1987, *"any general hospital or general nursing home established or maintained by the Government and which also provides for psychiatric services"* were excluded from the definition of psychiatric hospital/psychiatric nursing homes, making them exempted to obtain license under the Act. Thus general hospital psychiatry units (GHPU) in the government sector were exempted, but GHPU in private sector did not enjoy this exemption. In the present Bill all such establishments, whether private or government, have been brought under the ambit of definition of MHE. Licensing provisions are always perceived as a major hurdle in establishment of services, which are already precariously scarce in our country. Scarcity of mental health care can be imagined by the fact that the state of Bihar with a population of about 100 million did not have a single licensed psychiatric hospital/psychiatric nursing home with admission facility till few months back. Admission facility has been started in the lone Government psychiatric hospital at Koelwar near Patna only recently. Licensing requirement under the MHA-1987 has already harmed the private general hospital psychiatry because both corporate and charitable hospitals have stopped having psychiatry beds as it invited licensing and visit by members of the visitor board which were perceived as harassing.[9]

Exclusion of GHPU in government establishments only from the definition of psychiatric hospital/psychiatric nursing home has led to an anomalous situation in respect of psychiatry indoor units in medical colleges, both in government sector and in the private sector. Medical Council of India stipulates establishment of psychiatric indoor units with prescribed number of beds in all the medical colleges under its guidelines. But the medical colleges, both government and private, cannot do it without attracting the provisions of the MHA-1987.

Under the MHA-1987, psychiatry indoor units in government medical colleges are not regarded as psychiatric hospitals/psychiatric nursing homes. Under the same Act, involuntary admissions can be made only at a psychiatric hospital/psychiatric nursing home. Thus any involuntary admission made in psychiatry units in a government medical college is illegal under the MHA-1987.

All the private medical colleges who have psychiatric indoor units under the MCI guidelines are to get licence under the MHA-1987 as they are regarded as psychiatric hospitals/psychiatric nursing home and it is illegal for them to function without a license. But psychiatry indoor units are functioning, at least on paper, in most of the medical colleges, though it is a matter of curiosity that how many of them have obtained the license under the MHA-1987.

After the proposed MHCB comes into force, all the medical colleges, in government as well as in the private sector, would have to get registered as MHE without which they cannot have psychiatry indoor units which is necessary under the MCI guidelines. Will it be a desirable situation?

In fact, it is desirable that all the GHPU, both in teaching and non-teaching hospitals should be exempted from the purview of the MHCB. The GHPU are very important assets in psychiatric care as they are easily accessible and people get benefit from these units without any feeling of stigma. General hospital psychiatry movement has been described as one of the success stories of post-independence psychiatry scene in the country.[9] GHPU has been described as an important milestone in the development of Indian Psychiatry.[10] It is also referred to as slow and silent change, but in many ways a major revolution in the whole approach to psychiatric treatment in our life time.[11] Requirement of registration as MHE for all GHPU would have a dampening effect on their establishment and hardly anyone would be interested in opening them. As a result these facilities in private sector would remain almost non-existent. Even government hospitals will be discouraged to establish GHPU in their set-up. Already existing government general hospitals with GHPU would be burdened with requirement of registration as MHE. But exemption of GHPU from the purview of MHCB will encourage all the general hospital to establish psychiatric indoor units making these widely available. As GHPU are always open to public scrutiny, the question of violation of human rights and their exploitation would not arise. Friends and relatives of PMI can anytime visit these units or even may stay with them. Antony also holds the view that definition of MHE should include only the places where the patients are treated without presence of bystanders.[7]

Incorporation of the provision of exemption of GHPU would require only a slight modification in the definition of MHE in the MHCB. It is true that if the GHPU are exempted from the definition of MHE, involuntary admissions would not be technically possible in these hospitals. Taking consideration of the interest of vast majority of psychiatric patients, we should accept this situation. In emergency situations, admissions up to 72 hours can still be made in these units and after that the concerned PMI may be transported to any MHE. Any GHPU, which desire to provide for involuntary admission also, might be given the option of getting registered as MHE. Medical colleges with psychiatry indoor units according to MCI guidelines, even though restricted only to voluntary admissions, would get sufficient number of patient for MBBS teaching. PG teaching in psychiatry might require posting for few months in a MHE to get training on all types of patients.

Imposing ban on unmodified ECT and restrictions on ECT to Minors

Electro-convulsive Therapy (ECT) is a very useful method of treatment in many acute and chronic psychotic conditions, many of which occur for the first time during childhood and adolescence. But unmodified ECT has been prohibited in the Bill. It seems to be based on popular perception and sentiment rather than scientific evidence. Such a ban would stop the ECT from being administered at small and remote places, where anaesthetic support is not available even for routine surgery. In our country lack of resources is the rule rather than exception. Even many district hospitals do not have anaesthetists. Severe restriction has been placed on the use of ECT to minors in the Bill, where prior approval from the Mental Health Review Board has to be obtained. This also appears to be based on sentiments rather than on scientific evidence. The requirement of approval from the Board is fallacious, as ECT is an emergency and often life-saving procedure and it will be a great burden on the families or the treating psychiatrist to obtain approval from the Board so quickly. In fact any idea of prescribing or prohibiting any particular form of treatment in mental health legislation is anachronistic and improper. IPS and other professional associations of psychiatrists have opposed these bans on ECT. IPS has also prepared and published a position statement in this respect giving elaborate information about the unmodified ECT.[12]

Marginalization of families of persons with mental illness

In our country, where manpower resources in mental health care are extremely scarce, family is a very important asset in management of mental illness. In many cases family will have to move to the Board to get approval of mental health decisions and involuntary admissions. Provisions of nominated representatives and advance directives has also put limitation on the role of the families and may put the PMI and his family on opposite side of the fence. It may damage goodwill and bonding in the families. It will also make families less willing to be as proactive in the treatment of their wards as at present, which will be an unmitigated disaster.[3] This may lead to disruption in the families

and untreated PMI may go on aimless wandering and may become unnecessary violent leading to disruption in the society.

Mental health care decisions in the hands of non-experts

Mental Health Review Board, which has six members out of which only one is a psychiatrist, is vested with vast powers to take decisions in respect of mental health care as also to regulate the professional conduct of psychiatrists.[7] Moreover, Mental Health Authorities both at central and state levels have been assigned duties to set norms and standards, to register and to keep a close eye on functioning of the MHE. In both these authorities, there are only two or three psychiatrists among more than twenty official and non-official members. All these provisions constitute an elaborate system of making crucial decisions in the field of mental health in the hands of non-experts.

Increased paper works in psychiatric treatment

Elaborate regulatory and appellate provisions of admissions in MHE will constitute a lot of clerical and paper works in the management of MHE and the treating psychiatrist will have to cope with a great burden in this respect in his day to day functioning. Even psychiatrists working outside the MHE will have to do a lot of paper works due to various provisions like advance directive, nominated representatives and requirement of approval from the Board for taking many of the treatment decisions. As a result a private psychiatrist may be less willing to take up psychiatric cases requiring paper works and formalities and the ultimate sufferers would be the PMI themselves on this count.

CONCLUSION

The MHCB has some unprecedented measures aimed towards a sea change for the better, regarding access to treatment for the mentally ill across the country and particularly so for the underprivileged.[3] But it is to be taken care that the Bill does not create impediments in psychiatric treatment in the country. It must be emphasized that psychotic disorders or the major psychiatric disorders constitute only a small group among the psychiatric disorders. Even many of the psychotic disorder patients retain their insight into the illness. Therefore, care must be taken that this large chunk of psychiatric patients is able to avail mental health care facility without any stigmatic feeling and hinderance. Families are great asset in management in mental illnesses and care should be taken not to marginalize them.

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