Guest Editorial

Mental Healthcare Act 2017 – *The way ahead: Opportunities and Challenges*

Milton Friedman *"One of the great mistakes is to judge policies and programs by their intentions rather than their results."*

(Milton Friedman; 1914-1986)

INTRODUCTION

The new Mental Healthcare Act (MHCA) of 2017[1] has been a milestone in the way mental health care is to be delivered in the country. There is a lot of anguish about the MHCA, primarily for three reasons:

1. The lawmakers did not trust psychiatrists in the drafting of the act
2. The Indian Psychiatric Society (IPS) was not taken on board, unlike in the case of the Mental Health Act (MHA), 1987
3. The caregivers' rights and burden of care are not adequately addressed.

When the Consumer Protection Act of 1986 was introduced, clinicians had a lot of apprehensions and quite frankly, fear of the misuse of law, which made most of them become defensive in the way they practice medicine. However, there is a need to learn from this and not let the history repeat itself. The MHCA is a reality that needs to be accepted and we need to adapt to comply with the new act.

WHAT WAS THE NEED FOR THE NEW LAW?

The MHA of 1987[2] had not been able to adequately protect the rights of the persons with mental illness. Although, back in the day, the act was able to achieve what it was intended to, as time passed and more focus was put on the rights of the mentally ill, the MHA 1987 simply did not have the answers to the questions being raised.

The United Nations Convention on the Rights of Persons with Disabilities 2006 (UNCRPD)[3] defines the rights of persons with disabilities and the obligations of the state toward persons with disabilities. It mandates the signatories to provide the following rights to persons with disabilities: The right to accessibility, including the information technology; the rights to live independently and to be included in the community;[4] the rights to personal mobility,[5] habitation and rehabilitation;[6] and the rights to participate in political and public life and cultural life, recreation, and sports.[7]

The convention also mandated all parties to raise awareness about the human rights of persons with disabilities[8] and ensure access to roads, buildings, and information.[9]

The convention had eight governing principles:[10]

1. Respect for inherent dignity; individual autonomy, including the freedom to make one's own choices; and independence of persons
2. Nondiscrimination
3. Full and effective participation and inclusion in society
4. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity.
5. Equality of opportunity
6. Accessibility
7. Equality between men and women
8. Respect for the evolving capacities of children with disabilities and respect for the right of children to preserve their identities.

Though the MHA 1987 addressed some of the above principles, it fell short of being fully compliant with the UNCRPD resolution. The human rights groups started questioning the constitutional validity of the MHA 1987, as some provisions were interpreted as a curtailment of the personal liberty of the mentally ill. There was no provision of a proper review by any judicial body to oversee and address the issues at the ground level. The MHA 1987 provided that the research on mentally ill can be carried out by the consent of the caregiver,[11] which violated the human rights of the mentally ill. There was a stigma attached with mentally ill admitted in mental health establishments (MHEs), which the MHA 1987 was unable to address. Also, the MHA 1987 did not specify any defined role for the appropriate governments in mental health care delivery.

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To address these issues and be compliant with UNCRPD, the Government of India, as a participant in the UNCRPD, had two choices in front of it: either to amend the MHA 1987 to fully comply with the UNCRPD resolution, or draft a new bill in its entirety to govern the way mental health care gets delivered in the country. The Ministry of Health and Family Welfare (MoHFW), in its better judgment, chose the latter path.

ROLE OF IPS IN MHCA 2017

The MHA of 1987 was conceived, piloted, and drafted by the IPS. However, during the drafting process for new MHCA 2017, IPS was not taken on board. Although invited for the consultation process at different stages, the IPS was not assigned any significant role in the drafting of the new act. IPS had raised concerns and apprehensions about various provisions in the new act that is believed to be not in the best interest of the mentally ill, which unfortunately did not receive any attention.

The MoHFW, for reasons best known to them, entrusted the job of drafting and conducting the initial consultation process to a psychiatrist who is not even an ordinary member of the IPS. This act was primarily driven by human rights activists and nongovernmental organizations (NGOs), with very little involvement from organizations of professions who are major stakeholders in the delivery of mental health care.

However, the act is now formalized and in effect from May 29, 2018. There is a need to accept this reality and adapt.

WELCOME CHANGES

The IPS welcomes a lot of changes this new act has brought in and the effect the act is having on the mental health care in our country. To begin with, the rights of the mentally ill are clearly defined. Persons suffering from mental illnesses have been afforded a lot of freedom and right over choosing the type of medical treatment, where they would like to be treated, and the duration of their treatment. They now have the rights to stay in the community instead of being confined to an establishment, to hold a job, to health insurance, and to live with dignity. This is a commendable attempt to reduce the stigma plaguing the mentally ill. Affording equal rights to the mentally ill, irrespective of their gender, class, religion, region, and even sexual orientation, is another step in the right direction.

DECRIMINALIZING SUICIDE

Attempt to commit suicide is not a crime but a cry for help. The biggest change and the most commendable one in the MHCA 2017 is that of decriminalizing suicide.[12] A person who attempts suicide shall be presumed to be suffering from mental stress or illness at the time of the act and will not be punished under the Indian Penal Code (IPC). The IPS is proud to have taken the initiative in this change and in bringing about the change of mindset which ultimately resulted in decriminalizing suicide. This will not just improve reporting of suicide but will also help in discovery and treatment of the undetected mentally ill. This will also go a long way in decreasing the legal and procedural burden on an already traumatized family of a person who attempted suicide.

INSURANCE FOR MENTAL ILLNESS

The new act grants the persons with mental illness to have mental health insurance similar to those with physical illnesses[13] and mandates the government and the private insurance companies to provide mental health insurance on par with physical illnesses. Insurance Regulatory and Development Authority of India has already issued a welcome directive to health insurers to include mental illnesses in medical insurance policies.[14]

Ayushman Bharath has been a landmark initiative from the Government of India. Ayushman Bharath has accepted 17 of the 21 proposals from IPS and National Institute of Mental Health and Neuro Sciences (NIMHANS). The prices are reasonable for both the psychiatrists and the patients. However, private psychiatry has not been included in Ayushman Bharath; but the hope is there that in the near future, private psychiatry too will be recognized.

The new act also mandates and clearly defines the duties of the government.[15] The appropriate government has the duty to provide community living facilities, like shelter homes, halfway homes, etc. In a reasonable period of time, the government has to ensure that the quality of mental health services is on par with the internationally accepted standards.

As per the new act, the mentally ill patients are entitled to receive free legal aid when it comes to any legal disputes from exercising the rights accorded to them by the act.[16]

ROLE OF IPS AND MHCA IN SCRAPPING SECTION 377 IPC

The IPS has to be commended for its continued efforts to bring equal rights and a life of dignity for the Lesbian, Gay, Bisexual, Transgender, Questioning/Queer (L.G.B.T.Q) community and to get the section 377 of IPC repealed.[17] The position statement from IPS was accepted by the Supreme Court and various provisions of the MHCA 2017 were quoted in the judgment. Justice Nariman quoted the nondiscrimination clauses from the MHCA. Justice Chandrachud quoted extensively from the act and also commented against "Conversion Therapy" which never really had any basis in psychiatry. Justice Indu Malhotra also pointed at the inherent contradiction between the rights protected by the MHCA 2017 and Section 377 of IPC.

The IPS and MHCA playing a role in the landmark judgment that repealed section 377 of IPC are in itself a small victory. This should motivate the IPS and the professional community to continue fighting the social maladies plaguing our society.

OPPORTUNITIES AHEAD

The IPS, in collaboration with other agencies, is striving to improve the quality of academic and postgraduate training in the country. IPS has been insisting the erstwhile Medical Council of India (MCI) on including psychiatry as an independent subject and not just an offshoot of general medicine in the MBBS curriculum.

There is a need to strive to improve the quality of mental health service so that they reach the international standards as mandated by the MHCA. A lot of work also needs to be done to remove the stigma associated with mental illness and the mentally ill.

NEW CHALLENGES

The MHCA 2017 has introduced a lot of new concepts like the mental health capacity,[18] which as of now is ambiguous and ill defined. As per the clause, everyone by default is presumed to have the capacity and the right to consent. It is the responsibility of the treating mental health professional to prove otherwise if the provision of supported admission has to be invoked.

In the absence of any clear guidelines from the MoHFW regarding the assessment of mental health capacity, perhaps it would be helpful to refer to McArthur's Competence Assessmentt Tool for Treatment.[19] Institute of Human Behavior and Allied Sciences also has come up with an informal mental health capacity assessment proforma, and NIMHANSwill soon come out with its own guidelines.

Advance directive (AD)[20] is a form of medical will which the mental health professionals have to follow in case of nonemergency when there is a loss of capacity to consent for treatment. This throws up new challenges to the professionals when the instructions in the AD are not in alliance with the best practice guidelines or when the treatment proposed is expensive or in a setup which is far to reach. This can put an extra burden on the caregivers and the family.

Similarly, the concept of the nominated representative (NR)[21] has been introduced. In the United Kingdom, "NR" stands for nearest relative who would make decisions on behalf of the mentally ill in case of loss of capacity to consent. However, the MHCA defines NR differently. Any person nominated by the patient can be the NR once ratified by the Mental Health Review Board (MHRB). This person needs to be consulted for all treatment-related decisions and his/her opinion supersedes that of the nearest relative. Again, this can throw up a lot of challenges to the treating professional and may also strain the Indian family system, and affect the family dynamics of patients and caregivers.

In view of all the challenges, there is a need to adapt the way psychiatry is practiced. There is a big need to engage with the media, police, NGOs, human rights activists, etc. It is imperative that they are seen as partners and taken on board. Mental health professionals need to actively write articles on mental health in periodicals, appear in debates, and conduct regular workshops and education programs on mental health and the MHCA for police, media, and NGOs.

WHAT NEXT?

In light of the new laws, there are two options:

1. Get defensive by getting cautious, being very guarded in the way psychiatry is practiced, cutting down on the number of admissions, focusing more on outpatient care, etc., However, this is not recommended as this may lead to an increased burden of mental illness on the society and higher suicide rates and overall, undo the years of good work that has been done and take us back by decades
2. The rational choice would be to accept and move forward, and reinvent ourselves. The most important change would be to reconnect with the patients. Psychiatrists need to refocus from giving

more attention to the caregiver and the family, and should make the patients the central figures in the management plans. Gone are the days of a patriarchal way of practicing medicine or top-down relationship between the doctor and the patient. There is an urgent need to make the patient a party in all decision-making processes. We need to have better communication with patients, family, NR, media, NGOs, and human rights groups.

There is a need to find creative solutions to problems that may arise as a result of the new act. More ffrequent monitoring on an outpatient basis, more house visits, constant communication, and mobilizing Mental Health Professionals for door-to-door visits to increase contact and bridge the gap between patients and mental health services is the way forward.

There is a big need to popularize and advertize the availability of psychiatric emergency services, options of pick-up from homes, and psychiatric ambulances. We need to focus on suicide prevention strategies, especially for those who are the most vulnerable, like the farmer groups.

There is still a lot of scope left to popularize and destigmatize psychiatry among the general population and even our own medical community. Perhaps, more awareness programs and cross-specialty scientific programs need to be conducted to demystify psychiatry.

HOW TO CHANGE AND ADAPT?

Mental health professionals need to be well aware of the MHCA and other relevant legislations like the Protection of Children from Sexual Offences, Narcotic Drug and Psychotropic Substances Act, MCI (Professional conduct, Etiquette, and Ethics) guidelines for good practice, etc., The process of obtaining consent should be thorough, and we should strive to get a written informed consent, which is preferably handwritten by the patient in their native language, with signatures of witnesses, NR, etc., whenever possible.

We should be careful while selecting patients for home visits and pick up from homes. There is a need to document care at every step, as the courts presume that care was not provided if it was not documented. We should respect the AD and the wishes of the patient and the NR, even if those are not in their best interest. At the same time, we should offer them options which are based on evidence and help the patient make an informed choice.

MANAGING A MENTAL HEALTH ESTABLISHMENT

MHEs need to be fully compliant with the new act. There are extensive guidelines about running an MHE which need to be followed, beginning with the renewal of the license from state mental health authorities, registering as an MHE. There is an urgent need to conduct self-audit, assess mental health capacity of all inpatients, and to take their consent for continued admission. If they do not consent for a stay, discharge planning has to be done with the help of family members, and the patients and caregivers have to be educated about alternatives like shelter homes, half-way homes, etc., which the appropriate government has to provide. There is a need to educate the patients about their rights in accordance with the new act. We need to educate families and orient them toward the MHCA. The staff has to be trained to respect the rights and liberties of the patients. The establishments have to be made "least restrictive." There is also a need to upgrade the MHEs to meet internationally accepted standards in accordance with the International Society for Quality in health care. Applying and procuring National Accreditation Board for Hospitals and Healthcare Providers (NABH) accreditation would be the way forward. However, one needs to be aware of the disparity between MHCA and NABH as to how care has to be provided. For instance, guidelines given by MHCA and NABH on the use of physical and chemical restraints differ. NABH guidelines state that the attendants be immediately informed about the reasons for restraint, while MHCA gives the establishment a window of 24 h to inform the NR. Also, MHCA mandates all MHEs to inform the MHRB, in a monthly report, about all instances of restraints,[22] while NABH does not mandate any such reporting.[23]

All MHEs should prepare for audits and visits from the MHRBs. As and when the state mental authorities start forming MHRB, the implementation of the new act will kick in at the ground level. There is a need to liaise with independent psychiatrists and have them conduct independent evaluation and assessment for all supported admissions. Although suicide has been decriminalized, any abetment to commit suicide or suspicion of homicide attempt should be reported to the authorities.

SAFEGUARD FROM LITIGATION

To protect ourselves from legal hassles and potential litigations, there is a need to have extensive documentation at every step. Written and informed

consents should be taken for every management plan, and every care provided should be documented. There is a need to have professional indemnity insurance with legal counsel coverage.

To reduce potential liability, avoid the urge to make a definitive diagnosis in the first visit itself. Always try to obtain second and third opinions from independent psychiatrists. Mental health professionals need to be consistently updated, maintain competence by attending relevant continuing medical education (CME), be aware of legal aspects of psychiatry, and understand their role as an expert witness when summoned.

BURDEN ON MENTAL HEALTH SERVICES

The effect of MHCA on the health services and the burden it might cost the exchequer are yet to be formally estimated. The Kerala Health Department estimates the cost of MHRB at Rs 1 crore per year per Board; the Karnataka Health Department could only allot a measly 5 lakh Rs from its budget to implement the MHCA. Time will tell whether the mental health services will get more expensive, while everyone starts complying with the MHCA.

What would be the financial and emotional burdens on the families? Will MHCA cause more legal hassles to mental health professionals, mentally ill, and the families? What is the accountability of an NR? Will the MHCA be an additional burden on an overloaded judiciary? These are some of the questions which perhaps will be answered over time.

CHANGING SCENARIO

In medicine, usually new and ground-breaking research, academic developments, and novelties influence the changing trends in clinical practice. However, in psychiatry, the recent trends have been influenced by legal issues like rights of the mentally ill and new regulations on establishments which treat them, rather than by research on illness and treatment. Perhaps, once we get past the rights-based issues, which were much needed, the focus should be on research on illnesses and treatments to get psychiatry on par with other specialties in medicine.

CONCLUSION

MHCA 2017 comes out to be a praiseworthy effort for addressing the long-standing problems encountered by patients and clinicians in the sector of mental health. This act has the potential to bring a radical change in the way mental health care is delivered in our country. Even though some sections of the act have been criticized, it is still more humane and appropriate in the current scenario. Perhaps, with future amendments in some necessary areas, this act can prove to be a blessing to the mental health care system.

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