Editorial

The Mental Healthcare Bill 2016: Exotic in nature, quixotic in scope… but let's take the plunge, shall we?

The initial draft of the Mental Healthcare Bill (MHCB) was introduced in the Rajya Sabha on 19 August 2013, and was passed with many amendments by that house on 8 August 2016.[1] It is awaiting approval by the Lok Sabha at the time of writing this editorial. If passed, it will become the Mental Healthcare Act, 2016 after receiving assent from the President of India.

The MHCB was drafted to address the inadequacies of the existing Mental Health Act, 1987, but more importantly, and as emphasized in its preamble, because it was felt 'necessary to align and harmonize the existing laws' with the principles of human rights as enunciated in the United Nations Convention on Persons with Disabilities (UNCRPD) to which India is a signatory since 1 October 2007.

Thus, by its very conception, the MHCB is a 'rights-based' instrument, aimed to empower persons with mental illnesses with several facilities as a matter of right and not just dole or sympathy. It also empowers them with the right to choose or refuse certain treatments in advance, and to nominate their 'representatives' who can take decisions on their behalf when they are ill and when they lack the capacity to decide for themselves. On the other hand, when they are judged to have the capacity to understand the pros and cons of their choices, their wishes have to be respected even if they appear contrary to what the doctor or the family thinks is best for the person. If they are 'supported' in their admission (meaning thereby detained in the hospital against their will for involuntary treatment), they have the right to challenge that decision in a prescribed manner. Finally, they have a right not to be prosecuted for making a suicide attempt any longer, with the presumption that any person attempting suicide was under severe stress and hence needs help, not punishment. Along with these rights-based provisions, there are provisions mandating the government to help persons with mental illness with essential medicines and other facilities in the community, along with creating infrastructure and human resources to prevent, detect and treat mental illnesses.

Since its inception, the MHCB has attracted both accolades and brickbats, perhaps the latter more than the former, though an early World Report in *The Lancet* hailed it as a 'Mental health bill set to revolutionize care in India'.[2] Not surprisingly, most of the criticism has been from psychiatrists, whose mandate it is to treat people with mental illnesses. Many critiques have been published in the *Indian Journal of Psychiatry* (IJP), the official journal of the Indian Psychiatric Society (IPS), as well as in other psychiatry journals.[3–6] An entire 2015 issue of the *Indian Journal of Social Psychiatry* (the official journal of the Indian Association for Social Psychiatry, IASP) was devoted to the bill and included nine invited articles by eminent psychiatrists of India examining critically different aspects of the MHCB.[7] An editorial in the July–September 2016 issue of *IJP* focused on the shortcomings of MHCB 2016.[8] The writers of this article, while applauding the positive aspects, identify 13 'challenges' in the present version of the MHCB and offer 'remedies' to some of these. The media is also abuzz with news of the MHCB in the offing, because of articles appearing in print and electronic media including one by the present Union Health Minister.[9]

Given this background, we are deliberately avoiding discussion on issues that have been debated between psychiatrists and policy-makers. We believe there are other conceptual and pragmatic issues concerning MHCB 2016 that need to be put in perspective.

First, the need for 'doing something, and doing something urgently' to improve mental healthcare in India is evident by the 'National Mental Health Survey of India, 2015–16' document.[10] Nearly 150 million Indians are in active need of interventions for their mental illnesses. About 1% of the population reported a high suicidal risk. While common mental disorders (depression, anxiety, substance use disorders) affected nearly 10% of our population, severe mental illnesses (psychoses, bipolar disorder) affect nearly 1% of the population. Mental illnesses caused substantive disabilities and the treatment gap varies from 28% to 83%; the figures for bipolar disorder, major depression, psychotic and neurotic disorders being as high as 70%, 85%, 75% and 83%, respectively.

Unfortunately, to solve these problems the MHCB borrows heavily from western concepts and mental health Acts of western countries, especially of the UK. There are several Acts, both in England and Scotland, which refer to detention of patients, capacity of patients to decide for or against a particular treatment intervention, and patient rights in general. The MHCB appears to combine all of these into one single power-packed document. In doing so, it has become quite 'exotic' (of foreign origin), but perhaps also 'quixotic' (with fantastic but unrealistic plans).

A closer look at MHCB 2016 reveals that in the process of making it 'comprehensive', its drafters have made some compromises on clarity of focus. Currently, we can only argue this using the example of the Mental Health Act, 2007 (MHA 2007) of England and Wales. MHA 2007 is only for 'detained' patients (community treatment orders also being applicable only after a patient has been admitted under Section 3 of MHA 2007); is developed around, and focuses on, admission to hospitals; and uses 'risk management' as the basic criteria for detention. Though there are components/sections related to patient rights, these are driven by the western concept of 'individual autonomy'.[11] On the other hand, MHCB 2016 has been envisaged for all patients with 'mental disorders', irrespective of their admission status; is developed around, and focuses on, all types of patients (i.e. those in the community, outpatient clinic and hospital-based); and uses 'human rights' as the main concept running through its various components. Additionally, risk assessment-cum-management is only a small component (in case of supported admissions).

At first look, MHCB 2016 appears to be simplistic and linear in concept as MHA 2007. However, the intricacy is reflected in that 'rights' and 'risks' have been incorporated from two different frameworks, which are for different populations and with different underlying concepts, e.g. risk is not a parameter for consideration in the outpatient, community and non-supported admission setting. This is cognitively dissonant keeping in view that there is a clause for 'suicide attempt' to be decriminalized, and self-harm and suicides are significantly more prevalent in the community.[12]

Further, MHCB 2016 is being implemented with the presumption that it will be applicable across the country irrespective of geographical, cultural and resource variations. The MHCB does relax some of the deadlines for the northeastern states, but this does not seem to be enough. Disparities exist in rural and urban areas, in different states and in different terrains and also need to be addressed.

We hold that the main problem with MHCB 2016 is that western concepts have been incorporated without appropriate adjustments to the traditional Indian concepts of family, collectivistic society with its focus on 'mutual interdependence' as the driving value system rather than the western value of 'personal autonomy and independence'.[11] India, as a society, is undergoing a rapid acculturation process,[13] and coupled with the vast geographical, literary-cum-cultural rural–urban divide, and the availability of (mental health) resources make one wonder whether 'unitary' concept of implementation and delivery of MHCB 2016 will be a 'reality' or a 'quixotic dream'.

Finally, and in agreement with many other critics,[4–6] we feel that the inclusion of general hospital psychiatric units (GHPUs) under the ambit of the 'Mental Health Establishment' in the purview of MHCB will defeat its purpose by discouraging general hospitals to have psychiatry units. This could push back psychiatry care to a bygone era. Further there is the risk of there being utter chaos if the momentous paperwork and time–effort–energy needed for detention and tribunals are attempted to be carried out in GHPUs with the heavy rush of patients. In the UK, where both the authors have worked, psychiatrists cry foul if they have more than 5–6 patients per outpatient clinic or in the

ward. The system is different in the UK because much time is used up in paperwork and administrative work related to the MHA. In India the system will collapse if such pressure mounts with hundreds of patients and inadequate infrastructure and resources. Worryingly, the desperation to complete the paperwork may foster less-than-ideal practices. A possible domino effect can cause more harm than help people with mental illness, thus further marginalizing and stigmatizing mental healthcare.

While we appreciate the efforts made by the IPS to negotiate certain minimum and 'doable' changes in the MHCB (such as keeping a provision where GHPUs can be brought out of the definition of Mental Health Establishment as defined in the MHCB, increasing the representation and say of psychiatrists in the administrative bodies to be constituted under the MHCB, etc.), we are not sure if these amendments would actually be implemented, and, if so, in what form. Hence, eventual acceptance of the MHCB by psychiatrists and the IPS may be the best option. It may be more appropriate and realistic if the focus is now shifted and goals are reset to deal with what we are likely to have! Practical issues related to the Act will be known only after the MHCB is implemented on the ground.

It may be potentially more productive to adopt a four-pronged approach. First, a dialogue must be initiated with policy-makers of the relevant ministries regarding the process of development of a Code of Practice (a guidance to all who will be using the new Mental Healthcare Act on how they should proceed when undertaking duties under the new Act), akin to the Code of Practice developed for the Mental Health Act, United Kingdom, 2008.

Second, emphasis should be laid on training for skill development. The MHCB does mention some timelines, but elaborate and specific action plans are required to prepare the system before the MHCB is implemented.

Third, negotiations should be started with the Central and state governments to identify the lack of resources and ensure their availability with proper budgeting to implement the provisions of the MHCB.

Last but not the least, the practical implementation of MHCB 2016 will lead to situations with potential for legal recourse. This will generate legal perspectives, leading to modification of provisions of the MHCB, thereby achieving what IPS has been advocating.[8]

Section 125 of MHCB 2016 vests the Centre with the 'power to remove difficulties' that may occur in the implementation of the Act. This would allow for remedial action related to limitations of infrastructure, geographical location and cultural diversity.

We hope our theoretical misgivings will lead to pragmatic solutions.

Declaration

This editorial expresses the personal opinion of the authors and does not have any connection with the official stand taken by the IPS, IASP or any other professional organization.

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