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Mental healthcare act, 2017: a critical analysis on the protection of rights of the people with mental illness

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ABSTRACT

It's important to acknowledge that individuals, groups, and agencies often violate the human rights of individuals living with mental illness. However, it is crucial to recognize that these rights apply to all human beings, regardless of their race, sex, nationality, ethnicity, language, or religion. Human rights include the right to life and liberty, freedom from slavery, discrimination, and torture, freedom of speech and expression, as well as the right to work and education, among others. The Mental Health Care Act (MHCA) of 2017 has replaced the Mental Health Act (MHA) of 1987 in India to protect the rights and well-being of people with mental illness. The old Act was not sufficient in protecting the rights of the mentally ill, even though it served its purpose when it was created. As time passed and the focus shifted to the rights of the mentally ill, the 1987 Act fell short. The new Act aims to make mental healthcare services more humane and aligned with human rights standards, incorporating some novel ideas not present in its predecessor. However, only time will tell how effective these new ideas, concepts, and clauses will be in the Indian context. In this article, we will explore how the Mental Healthcare Act of 2017 safeguards the human rights of mentally ill people in India.

KEYWORDS

Mental health; Mental healthcare; Human rights; Mental illness; Depression

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Introduction

The Mental Health Care Act (MHCA) of 2017 has replaced the Mental Health Act (MHA) of 1987 to ensure the optimal protection of the rights and well-being of mentally ill people. In certain situations, mental health can differ from physical health since individuals with mental illnesses may not have the capability to make decisions independently. Regrettably, individuals who are affected by mental health problems often do not receive the appropriate medical assistance they need, as their family members tend to conceal their condition out of shame. It is estimated that more than 300 million people worldwide suffer from depression, which amounts to 4.4% of the world's population. A study conducted by the National Institute of Mental Health and Neurosciences reveals that in India, 1 in 40 individuals experience past episodes of depression, while 1 in 20 individuals experience current episodes. Despite the overwhelming number of individuals affected by mental health issues, there is still a lack of understanding of this condition in developing countries like India.

The World Health Organization (WHO) estimates that health involves physical, spiritual, mental, and social aspects and that mental health and well-being are essential to a fulfilling life. The WHO states that having good mental health allows individuals to find meaning in life, be creative, and participate actively in their communities. According to the WHO, mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community [1-4]. A study conducted by the National Institute of Mental Health and Neurosciences in India revealed that depression affects approximately 1 in 40 people with past episodes and 1 in 20 people with recent episodes. The lifetime prevalence of mental disorders is 13.7%, meaning that at least 150 million Indians require urgent intervention. Mental illness is particularly prevalent among vulnerable age groups such as adolescents and the geriatric population. Shockingly, mental health issues continue to be misunderstood in developing countries like India despite projections that mental illness will account for one-third of the global burden of mental illnesses over the next ten years [5,6]. Unfortunately, individuals, groups, and even governmental organizations often infringe upon the human rights of those with mental illness. Mental health is a multifaceted concept that involves a delicate balance of biological, psychological, emotional, and social factors. Achieving this balance results in a state of mental healthiness, which is associated with higher levels of life satisfaction and subjective well-being. It's essential to recognize that cultural, linguistic, ethnic, and religious backgrounds can significantly impact the interpretation and definition of mental health concerns [1-4,7]. The concept of mental health encompasses a complex interplay of biological, psychological, emotional, and social factors, with mental healthiness being the state of achieving balance and harmony among these aspects. Individuals with mental healthiness tend to experience greater life satisfaction and subjective well-being. It's worth noting that cultural, linguistic, ethnic, and religious backgrounds can influence the interpretation and definition of mental health issues. Unfortunately, empirical evidence confirms that individuals with a diagnosis of mental illness or related issues may face social stigma and be subjected to feelings of shame, humiliation, and loss of dignity [7].

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It is crucial for individuals to feel content with their living arrangements, work environment, community, and government protection to maintain long-term mental well-being. A society that prioritizes equality, justice, and democratic values can foster positive mental health among its members. Such societies place great emphasis on individual rights and benefits, thereby promoting the human rights of all members [2,3,7-9]. Human rights are the rights that are necessary for an individual's existence and living a dignified life. These rights are considered to be a natural law. The term 'human rights' specifically refers to the rights that every individual possesses simply because they are human. Mental illness can give rise to several issues that may cause significant violations of the fundamental rights of the affected individuals. People with mental illness require specific protection because they are vulnerable to challenges, difficulties, discrimination, and ill-treatment. Efficient and progressive legislation backed by vigilant governmental oversight can prevent human rights violations against mentally ill individuals. Implementing appropriate laws can create a more favorable environment for these vulnerable individuals [2,7-9].

It is a matter of great regret, mental illness can render individuals susceptible to many abuses, including physical and sexual assault, discrimination, stigma, limited access to healthcare, arbitrary detention in custodial settings, and denial of essential rights, such as self-determination in financial and marital matters. We can efficiently address and prevent these issues by enacting dedicated mental health legislation. Effective mental health legislation lays the groundwork for addressing crucial tasks such as integrating individuals with mental illness into the community, reducing stigma, guaranteeing top-notch care, and safeguarding their fundamental civil and other rights, including those associated with housing, education, and employment. Such legislation can be instrumental in cultivating a system and environment that supports these individuals rather than simply focusing on their care and treatment. Ultimately, the aim is to create a welfare-oriented atmosphere that provides aid and encouragement to those with mental illness [2,3,7-11].

Mental Healthcare Act 2017: Glimpses of Clauses and Provisions

Before 2018, the MHA (1987) governed mental healthcare in India. The 1987 Act made strides in destigmatizing terminology and revised supervision and admission procedures for those with mental health conditions. However, it was criticized for its inability to reduce stigma and address the issue of homeless individuals with mental illness. Additionally, the Act failed to reduce socially sanctioned detention customs and make public mental healthcare accessible to all. Furthermore, it did not adequately protect the human rights of mentally ill individuals concerning family, occupation, marriage, and social life. As India signed the Convention on Rights of Persons with Disabilities (CRPD) in 2006, creating more efficient mental health legislation became necessary, leading to the creation of the MHCA (2017). The MHCA (2017) includes a provision for establishing a Mental Health Review Board (MHRB), which will act as a quasi-judicial entity. Unlike the current system, patients can approach the board without the burden of navigating the legal procedure. The MHRB will address any issues related to admission, discharge, or violations of patient rights. Psychiatrists may be required to appear before the MHRB regarding a patient's care, and it is essential to maintain proper decorum and consider the intricacies of the legal system. Notably, the MHRB includes psychiatrists and other mental health professionals on its panel, a departure from the current legal process. [3,12-15] The MHCA, 2017 presents various positive aspects, and it has brought about notable changes compared to its forerunner, MHA, 1987. Yet, only time will reveal if this Act will truly be a game-changer in protecting the well-being and interests of those grappling with mental health concerns. In India, psychiatrists are often called upon to play dual roles as both treating physicians and expert witnesses for their patients. This presents a unique challenge as they must balance the principles of therapeutic alliance in the clinical setting with their obligation to assist the judicial system in delivering justice. It's important to note that their role in court is guided by court rules rather than clinical rules. This is in stark contrast to the Western developed world [14-16].

The Supreme Court of India has emphasized that judges need to be sensitive to the seriousness of mental health issues and avoid a “one-size-fits-all” approach when dealing with them. The court made this observation in a case where the State of Karnataka appealed against a High Court decision to dismiss a case of abetment of suicide against a government officer. Justices D.Y. Chandrachud and B.V. Nagarathna presided over the bench. The officer’s driver committed suicide a note was found stating that he was harassed by the officer, who had used his bank account to transfer ill-gotten wealth and convert black money into white. The High Court had quashed the charges against the officer, referring to the driver as a “weakling.” The High Court had also made it clear in the verdict that the dead man was under pressure, reasoning that he had met with friends and did not show any signs of being harassed or threatened. The High Court had ruled that the deceased’s behavior before his passing did not indicate that he was struggling with depression or any other mental health issues. Justice Chandrachud cited the work of behavioral scientists who have challenged the idea that all humans behave in the same way, stating that individual personality differences are reflected in people's behavior. The Supreme Court acknowledged that how individuals respond to threats, express emotions, and cope with various situations can vary significantly due to the complex nature of the human mind and emotions. The Supreme Court has noted that how an individual copes with a physical or emotional threat and expresses or refrains from expressing love, loss, sorrow, and happiness varies significantly due to the complex nature of the human mind and emotions. Justice Chandrachud, stated that using terms such as ‘weakling’ and measuring a person’s mental state by their outward behavior significantly reduces the gravity of mental health issues [17].

However, the issue of mental health in the legal profession needs to be addressed urgently and at the same time appropriately. The Madras High Court set an example of timely and appropriate judicial activism by considering a petition to establish a psychiatric wing for mental health treatment in prisons. The court recognized the lack of mental health treatment facilities nationwide and broadened the writ petition suo motu scope. The court appealed to various government departments to address India’s shortage of mental health infrastructure immediately. The High Court’s activism in raising crucial questions about the state of the mental health epidemic in India, especially in the present times, deserves

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appreciation. The High Court of Delhi has also stepped up to help mentally ill patients. The problem surrounding the mental health issue in the legal fraternity is also required to be dealt with on a war footing. An example of timely and appropriate judicial activism is the Madras High Court, which dealt with a petition to create a psychiatric wing for mental health treatment in prisons. The court took note of the lack of mental health treatment infrastructure across India. The High Court, while expanding the scope of the writ petition suo motu, pleaded with different government ministries and asked them to address issues surrounding the lack of mental health infrastructure in India immediately. The High Court's activism in raising crucial questions about the state of the mental health epidemic in India, especially in the present times, deserves appreciation. The High Court of Delhi has also come to the cause and rescue of mentally unwell patients [18].

Conspicuous Changes Made in the Mental Healthcare Act, 2017

A. Incorporation of broad definition of mental illness: 'A substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, especially characterized by sub-normality of intelligence' [Section 2(1) (s)] [19-22].

B. Defining capacity of mentally ill people: This Act recognized the decision-making capacity of mentally ill people regarding selecting treatment options and availing mental health services. This Act states that: 'Every person, including a person with mental illness, shall be deemed to have the capacity to make decisions regarding his mental healthcare or treatment if such person can understand the information which is relevant to decide on the treatment or admission or personal assistance and can appreciate any reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance as well as communicate the decision through speech, expression, gesture or any other means' [Section 4(1)] [19-22].

C. Provision of advanced directives: Under this Act, every adult 'shall have a right to make an advance directive in writing', specifying 'the way the person wishes to be cared for and treated for a mental illness,' 'the way the person wishes not to be cared for & treated'. An advanced directive is used only if the person ceases to have the capacity to make mental healthcare decisions and shall remain effective till the person regains the capacity to make decisions [19-22].

D. Nominated representatives: This provision is a unique feature of this Act. As per this Act person who is not a minor can appoint a nominated representative. The nomination shall be made in writing on plain paper with the person's signature or thumb impression. The person who is appointed as nominated representative shouldn't be a minor, capable of fulfilling his duties given to him under this act [19-22]. The order of precedence for the nominated representative is as follows :

a. The individual appointed as the nominated representative
b. A relative
c. A caregiver
d. A suitable person appointed by the concerned Board;
e. If no such person is available to be appointed as a nominated representative, the Board shall appoint the Director, Department of Social Welfare, or his designated representative, as the nominated representative.
f. The appointment of a nominated representative, or the inability of a person with mental illness to appoint a nominated representative, shall not be considered as the lack of capacity of the person to make decisions about his mental healthcare. In the case of minors, the legal guardian shall be their nominated representative.

E. Mental Health Review Board: This Act states that the State Authority shall constitute MHRB' [Section 73(1)]. The MHRB is a commendable feature of the Act, aimed at safeguarding the fundamental rights and privileges of individuals struggling with mental illness. Its responsibilities include the oversight of Advance Directives (ADs), the appointment of Nominated Representatives, the prevention of malpractice and improper treatment by Mental Health Professionals and Establishments, the consideration of nondisclosure of mental illness-related information, and the exploration of jails for information about mentally ill individuals [19-22].

a. District Judge, or an officer of the State judicial services or a retired District Judge (who shall be the chairperson of the Board)
b. The representative of the District Collector or District Magistrate or Deputy Commissioner where the Board is to be constituted
c. Two members of whom one shall be a psychiatrist and the other shall be a medical practitioner
d. Two members who shall be persons with mental illness or caregivers or persons representing organizations of persons with mental illness or caregivers or non-governmental organizations working in the field [Section 74(1)].

The powers and functions of the Board are as follows:

a. To register, review, alter, modify, or cancel an Advance Directive
b. To appoint a Nominated Representative
c. To receive and decide application from a person with mental illness or his nominated representative or any other interested person against the decision of medical officer or mental health professional in charge of mental health establishment' under Section 87 ('admission of minor'), Section 89 ('supported admission') or Section 90 ('supported admission beyond 30 days'); the Board has the power to dispose of an application challenging supported admission under Section 90 within a period of twenty-one days from the date of receipt of the application
d. To receive and decide applications concerning non-disclosure of information
e. To look at the complaints regarding deficiencies in care and services and ensuring proper care and treatment of the mentally ill individuals by Mental Health Professionals and Mental Health Settings
f. To visit and inspect prisons or jails and seek clarifications from the medical officer-in-charge of health services in such prison or jail

F. Decriminalization of suicide: This Act states that any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished. Government has to provide care, treatment,

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and rehabilitation to a person having severe stress and has attempted suicide and to reduce the risk of recurrence of attempt to commit suicide [Section 115(2)] [19-22].

G. Revised admission and discharge procedure for mentally ill persons: The MHCA, 2017 outlines four admission statuses: independent admission (voluntary admission), admission of a minor, supported admission (admission and treatment without patient consent), and supported admission beyond 30 days.

Independent admission refers to the admission of a person with mental illness who can make mental healthcare and treatment decisions or requires minimal support in making decisions [Section 85(1)].

For the admission of a minor [Section 2(1) (t)], the nominated representative of the minor shall apply to the medical officer in charge of a mental health establishment for admission' [Section 87(2)].

A person shall be admitted as a supported admission (admission & treatment without patient consent) upon application by the nominated representative of the person if:

i. The person has been independently examined on the day of admission or in the preceding seven days, by one psychiatrist and the other being a mental health professional or a medical practitioner, and both independently conclude that the person has a mental illness of such severity that the person (a) has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself or others (b) has recently shown or is showing an inability to care for himself to a degree that places the individual at risk of harm to himself.
ii. The person is unable to receive care and treatment as an independent patient because the person is unable to make mental healthcare and treatment decisions independently & needs very high support from his nominated representative in making decisions' [Section 89(1)].

Supported admissions must be notified to the MHRB within three days (for 'a woman or a minor') or seven days (for others) [Section 89(9)] [19-22].

Critical Assessment of MHCA, 2017

The MHCA (2017) is a significant milestone in India's mental health legislation, prioritizing patient autonomy, dignity, and rights. This new legislation represents a substantial shift in how mental healthcare is provided, focusing on protecting and promoting patients' rights during treatment. The Act allows for "supported" inpatient admissions, replacing previous involuntary admissions. Moreover, the law stipulates that a capacitous individual cannot be compelled to receive treatment for mental illness. The implementation of the new Act will be overseen by state mental health authorities and MHRB, which will play a crucial role in ensuring its effective implementation. While the MHCA (2017) preamble promises mental healthcare and services for those with mental illness and emphasizes the protection and promotion of their rights during treatment, there is room for improvement in terms of providing care in the community. Despite its patient-centric and rights-based approach, the legislation mainly addresses the rights of those with mental illness during hospitalization, with little mention of care for individuals in the community. It is a fact that the MHCA (2017) is heavily influenced by the Western model of legislation, which gives maximum importance to individual rights and autonomy in mental healthcare. However, this approach may come at the expense of considering the significant role that family members play in providing care for persons with mental illness (PMI). Unfortunately, the Act presumes mental healthcare providers and family members are the primary violators of PMI rights. In reality, family members often shoulder a significant burden and undergo isolation and frustration in caring for their loved ones. In India, where mental health professionals are scarce, families are often the critical resource for PMI care due to the tradition of interdependence and concern for loved ones in times of need. The act would benefit from acknowledging and fostering the contribution of family members' support in providing care [20-25].

Status of Human Rights of Mentally Ill People in India: An Active Judiciary, Statutory & Constitutional Provisions

The rights of every human being are fundamental and inviolable. All should have basic privileges, opportunities, and a secure environment. Regrettably, those with mental illness are among the most vulnerable members of society when infringing their human rights. In many nations, the situation regarding the human rights of individuals with mental illness is deplorable. In 1996, the WHO issued the guidelines for the promotion of human rights of persons with mental disorders to member countries, urging them to protect the fundamental rights of those with mental illness. This guideline enlisted 10 basic principles that should be incorporated into mental health legislation, thus:

1. Promotion of mental health and prevention of mental disorders
2. Access to basic mental health care
3. Mental health assessments following internationally accepted principles
4. Provision of the least restrictive type of mental health care
5. Self-determination
6. Right to be assisted in the exercise of self-determination
7. Availability of review procedure
8. Automatic periodical review mechanism
9. Qualified decision maker
10. Respect for the rule of law

This guideline, as well as the UN Convention on the Rights of the Persons with Disabilities (2006) has had a pivotal role in the formulation and enactment of the MHCA, 2017. In the past, some steps were taken to address the human rights of individuals with mental illness in India, e.g., 'The Bengal Enquiry (1818)', 'Investigation of Native Lunatics in Bengal (1840)', 'Mapother's Report of 1938', 'Moore Taylor's Report (1946)', 'The Bhore Committee Report (1946)', 'Mudaliar Committee Report (1962) or Health Survey and Planning Committee Report' and 'National Mental Health Programme in 1982', 'replacement of Indian Lunacy Act, 1912 with Mental Health Act, 1987', 'increased fund allocation for mental health in Five Year Plans (9th, 10th and 11th Five Year Plans)', 'implementation of District Mental Health Programme in more number of districts in the country' and 'Recommendations of Central Mental Health Authority of minimum standards of care in all the mental hospitals in the country (1999)'. In India, the judiciary has always been sensitive to the human rights of vulnerable segments of society like mentally ill people. The

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Supreme Court of India opined in the case of Chandan Kumar Bhanik vs. State of West Bengal (1988): "Management of an institution like the mental hospital requires a flow of human love and affection, understanding, and consideration for mentally ill persons; these aspects are far more important than a routinized, stereotyped and bureaucratic approach to mental health issues." The Supreme Court of India has played a pivotal role in safeguarding the human rights of mentally ill individuals and addressing their grievances in various cases, including Sheela Barse vs. Union of India, Rakesh Ch. Narayan vs. the State of Bihar, B.R. Kapoor vs. Union of India, PUCL vs. Union of India, and Erwadi Mental Asylum Fire Incident. Despite the existence of dedicated Acts such as the MHCA of 2017 or the earlier MHA of 1987, the violation of human rights of mentally ill individuals continues to persist in India due to a lack of public awareness and understanding. The National Human Rights Commission (NHRC) reports that many mental hospitals in the country have inadequate infrastructure and fail to provide basic amenities and services to the mentally ill. Furthermore, mentally ill individuals are often mistreated by their caregivers and family members, who fail to provide them with the necessary support and care. In many cases, they are abandoned by their loved ones and forced to live in mental asylums [26-29].

It is to be noted that issues on human rights are given utmost importance in the Constitution of India. The right to have a fulfilled and satisfying life for every citizen is enshrined in the Constitution of India (Article 21: Protection of Life and Personal Liberty). Subsequently, in many cases, the Honorable Supreme Court of India instructed the executive and policymakers to make the public health system available and accessible to each citizen because it is directly linked with Article 21 of the Constitution. Like any other citizen, mentally ill people also have the right to get optimal healthcare services and enjoy humane living conditions in mental health settings. The right to life in Article 21 of the Constitution does not talk about the mere survival of the citizens. Rather, it means every citizen has the right to live a dignified and meaningful life without basic amenities like health, education, a healthy living situation, and environment, it is not possible. Mentally ill persons are to be given rightful access to work and stay in their community, enjoy an optimal level of autonomy and privacy, and lead a normal family life. [20-23] Despite the increasing need for mental health services in India, the public mental healthcare system remains woefully inadequate. According to the National Mental Health Survey (NMHS-2016), approximately 150 million Indians require active interventions for their psychological issues. Unfortunately, the current public mental health system is insufficient, poorly distributed, and cannot meet the needs of those who require it [5,6].

The patient-clinician ratio in India is meager compared to developed nations or even many developing nations. As per the NMHS-2016, the number of psychiatrists in India varies from 0.05 in Madhya Pradesh to 1.2 in Kerala per lakh population, and annual budgetary allocation for mental health is only 1.3% of its total health budget [3,5,6]. In 2014, the Indian government proclaimed the first-ever National Mental Health Policy with the ambitious goal of providing universal psychiatric care to the population by the year 2020. The policy aimed to provide quality mental health services to a wide range of people through integrated care services. The guiding principles behind this policy were based on the ideals of universal access, equitable distribution of services, community participation, inter-sectoral coordination, and the application of appropriate technology. However, the present mental health scenario in India is not conducive to serving the actual needs of the population. There is a severe lack of mental health professionals in the country. For every 1000 people, there are only 0.7 physicians available, and there is only one psychiatrist for every 343,000 Indians. The numbers of other vital mental health professionals, such as clinical psychologists, psychiatric social workers, and psychiatric nurses, are also very disappointing. Fulfilling the goal of quality mental health care for all is impossible with these limited human resources. Not offering optimal clinical services to a large number of citizens is indeed a sign of human rights violation, and a welfare nation like India cannot afford to do it. The situation is dire, and urgent steps need to be taken to address this issue. The mental well-being of the population is a critical aspect of a developing country's progress, and the Indian government needs to prioritize the mental health sector to ensure a brighter future for its citizens [3,5,6,30-32].

Rights of Mentally Ill People Inscribed in the Act: An Interpretation of the Pros and Cons

The MHCA, 2017 mentions that every person shall have the following rights:

Right to access mental healthcare and treatment

Accessibility of optimal mental healthcare from the Government to the needy people, and there should not be any discrimination based on place of residence, geographical location, gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis.

Right to community living

Mentally ill people have the right to live in and be a part of society and not be segregated from it.

Right to protection from cruel inhuman treatment and degrading treatment

Mentally ill people have the right to live with dignity in a safe and hygienic environment with proper clothing, privacy, wholesome food, adequate sanitary conditions, facilities for leisure, education, recreation, and religious texts and they should not be exposed to cruel and inhuman treatment. They are to be protected from any sort of physical, sexual, and emotional abuse.

Right to equality and non-discrimination

Every mentally ill person shall be treated in the same manner as a person suffering from physical illness. The insurer shall make provision for medical insurance for the treatment of mental illness on the same basis applicable to the treatment of physical illness.

Rights to information

Information about the provisions of the MHCA, 2017, or any other Acts related to admission in a mental health setting, reviewing the admission, nature of illness and treatment plans, and side effects of treatments shall be given to mentally ill persons and his nominated representative. The language of communicating this information to the mentally ill people and their nominated representatives should be made

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understandable.

Right to confidentiality

All mental health professionals have to make sure that they should keep all the information obtained during the care and treatment of a mentally ill person as confidential. No photograph or any other information shall be released to media unless consent is given by the mentally ill person to do so.

Restriction on release of information in respect of mental illness

Everyone has to be respectful of the patient's right to privacy. Therefore, no photographs or any other means (e.g., electronic, digital, or virtual space) that could prove to be against the privacy of a mentally ill person taking treatment at a mental health establishment shall not be made public unless the concerned patient gives his consent to do so.

Right to access medical records

Mentally ill person to access his medical records, which may be prescribed to him.

Right to personal contacts and communications

Mentally ill people have the right to refuse and receive visitors, the right to receive and make a telephone call, send and receive an email.

Right to legal aid

Mentally ill people are entitled to get free legal assistance to exercise any of their rights given under this Act.

Right to make complaints about deficiencies in the provision of services

A person with mental illness or his nominated representative can complain regarding deficiencies to the medical officer or mental health professional, concerned board, or state authority.

The present Act is the replacement of MHA (1987), because MHA has some inherent or inbuilt drawbacks which can limit the autonomy and rights of the people with mental illnesses, e.g., 'markedly inadequate review processes or appeal processes for mentally ill individuals', 'absence of distinction or categorization of mental health settings (i.e., mental hospitals, psychiatric nursing homes, private general hospital psychiatry centers and convalescent homes)', 'exclusion of government mental hospitals from licensing', 'not including faith healing or traditional healing centers in the scope of the Act', 'not giving attention to choice or autonomy of the mentally ill individuals in relation to taking decisions on opting treatment measures', 'provisions of stringent measures for any act of denigration or defamation or wrongful portrayal of mentally ill people, mental illness and mental health interventions in popular culture and media', 'keeping mental health facility out from general healthcare settings', 'not much focus on community based mental health facility or making mental healthcare delivery system community centric', 'not making any effort to give importance to capacity of mentally ill people', 'inadequacy or failing to address stigma of mental illness' and 'not mentioning humane treatment and environment for mentally ill people'. The MHCA (2017), has some positive aspects that made this Act better than its predecessors (e.g., Indian Lunacy Act, 1912 and Mental Health Act, 1987).

This Act has given a comprehensive definition of mental illness, guaranteed the civic and human rights of mentally ill people, made mental health services accessible to all, emphasized the autonomy and decision-making capacity of mentally ill people, introduced novel provisions like Advanced Directives with regard to selection or rejection of psychiatric treatment and specifying the roles of the governmental system in overseeing the programmes and policies for the prevention of mental illness and promotion of positive mental health. However, this Act has some intricate limitations, e.g., not considering the rights of families and caregivers, their competence and guardianship, not mentioning the rights of non-protesting patients, not mentioning involuntary community treatment, being the overly ambitious and farfetched, highly legalized pattern of care, exposing clinical exercises and decisions to the judicial system or curtailing the clinical decision-making capacity of the treating clinicians which may have paradoxical consequences in the forms of 'barriers to care' [20-23].

This Act has given the importance of the rights of the mentally ill people, and shown respect to their decision-making abilities, autonomy, and personal choices by incorporating provisions like 'mentioning the capacity to make mental healthcare and treatment decisions', 'defining the process of determining mental illness as per the nationally or internationally accepted medical standards,' 'Advanced Directives', 'Nominated Representatives' and 'putting up an exhaustive list of the rights of mentally ill persons. But this Act can be counterproductive to address the rights of mentally ill people by reducing their right to get optimal treatment, and not getting suitable treatment at the right time due to the over-involvement of the judiciary. This way, this Act can limit the well-being of mentally ill people and deny their rights. Before 1947, mental health care in British India was governed by several legislations, including the Lunacy Acts and the Indian Lunacy Act. In 1987, the Republic of India introduced The Mental Health Act to replace its colonial predecessor, The Indian Lunacy Act of 1912. Unfortunately, The MHA of 1987 did not do enough to protect the rights of individuals struggling with mental illness. However, in 2018, this Act was repealed and replaced with The MHCA Act of 2017 by The Ministry of Law and Justice. While the MHA of 1987 did provide legal provisions for inpatient treatment of those with mental illness, it lacked an independent judicial review process for compulsory admission. Additionally, it did not ensure that mandatory treatment was the least restrictive option available to patients. Furthermore, the previous Act only applied to specialist mental hospitals and covered only a few individuals receiving mental health care in general hospital settings. However, it has already become obvious that the present MHCA (2017), also has some significant limitations, and those limitations can significantly affect the mental health needs of people and, at the same time, hamper the functions of the mental health care delivery system. The MHCA of 2017 has introduced various novel concepts, including mental health capacity, which is presently unclear and inadequately defined. According to the clause, individuals are assumed to possess the capacity and the authority to consent by default. If the supported admission provision must be employed, it is the responsibility of the attending mental health expert to demonstrate the contrary. The 'Advanced Directives' concept presents both an opportunity and a challenge. On the one hand, it empowers patients to make decisions and exercise

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autonomy, but on the other hand, it raises difficult questions about its applicability in India and the potential for misuse. Advanced Directives are essentially medical wills that outline treatment preferences in case a patient loses the capacity to consent. However, when the instructions in the Advanced Directives conflict with best practices or the proposed treatment is costly or complex to access, it can create additional challenges for healthcare professionals and put a strain on caregivers and families. One of the most significant challenges posed by the MHCA (2017), concerns allocating resources for mental health services and the revised structures enshrined in the Act. Given that India's mental health system is generally under-resourced, there are concerns regarding the suitability of a more legalistic approach to care, especially in light of potential delays resulting from lengthy judicial proceedings. Additionally, the new legislation could inadvertently create barriers to care, such as revised licensing requirements for general hospital psychiatry units, which were previously exempt from such standards. There is uncertainty surrounding how the Nominated Representative's responsibilities will affect the care of individuals requiring significant assistance in decision-making.

The MHCA (2017), may reduce the risk of coercion by mental health professionals, but appointed representatives could exert undue influence instead. This scenario could result in inexperienced individuals with conflicting interests having a solid impact on vulnerable individuals instead of trained professionals who are held to industry standards and regulations [23-25].

The previous MHA, enacted in 1987, primarily addressed the admission and treatment of individuals with severe mental illness in mental hospitals when they were involuntarily detained. However, the MHCA (2017) aims to regulate almost all mental health establishments, which could be avoided by focusing solely on mental healthcare institutions where patients are admitted involuntarily for treatment. The MHA of 1987 faced challenges in implementation due to limited resources, and the MHCA (2017) has yet to be introduced without addressing these issues. The definition of mental illness cited in the MHCA (2017) is also an important limitation of this Act. The MHA (1987) defines “Mental Illness” as a disorder affecting thinking, mood, perception, orientation, or memory that significantly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, including mental conditions related to substance abuse. However, it does not include mental retardation, which suggests a condition of stunted or incomplete development of a person’s mind, mainly in the form of subnormality of intelligence. As per this definition, the Act applies only to individuals whose thinking, mood, perception, orientation, or memory is substantially compromised impaired, limiting their judgment, behavior, capacity to interpret the reality, or ability to meet the ordinary demands of day-to-day life. At the same time, this Act does not apply to all PMIs but rather only to those who have severe mental disorders [21,23-25].

The Indian public mental health delivery system still has a long way to go to match international standards, where those in need of mental health services can receive prompt and essential care right at their doorstep. With a population of 1.4 billion, the nation faces a severe shortage of both human and material resources to address the growing mental health needs. While the Act serves as a clear indication of India's commitment to the clauses and recommendations outlined in the UNCRPD, only time will reveal the extent of its benefits, given its broad scope and philosophies [21-25,30-32].

Conclusions

The MHCA of 2017 is a crucial piece of legislation to ensure better care and promote social justice for the mentally ill in India. Globally, the rights of the mentally ill have been overlooked for too long, and it is still the case that many countries lack structured and up-to-date legislation to safeguard the rights of individuals with mental illness. The enactment of comprehensive and updated legislation is essential in protecting the fundamental rights of mentally ill people, and the present Act represents a significant step towards achieving this goal. The MHCA of 2017 introduces several novel provisions that could help to reduce human rights abuses and promote more excellent protection for this vulnerable segment of the population in India.

Disclosure statement

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