FOR IPS MEMBERS: FOR URGENT ATTENTION & RESPONSE

MENTAL HEALTH CARE ACT 2017:
PROPOSAL FOR AMENDMENTS

IPS OFFICE BEARERS:

Dr Gautam Saha President	Dr NN Raju Vice- President	Dr TSS Rao Hony Gen Sec	Dr Kshirod Mishra Treasurer	Dr Om Prakash Singh Editor
	Dr PK Dalal Past President	Dr Vinay Kumar Past Hony Gen Sec	Dr Mukesh P Jagiwala Past Treasurer	

PATIENTS RIGHTS TASK FORCE
Organising Chairperson: Indira Sharma; Organising Secretary: Shruti Srivastava
Dr. Kazi Md Rezaul Karim; Dr (Major) Nand Kishore; Dr Sandeep Grover

---

Dear All,
You are aware that there is great dissatisfaction with the MHA 2017. The best option available to us is to go for amendments. The Indian Psychiatric Society has decided to send a 'Proposal for Amendments to the MHA 2017' to the Govt of India.
Please find herewith a draft of the proposal.
In view of your vast expertise and experience, we most humbly urge you to please spend your valuable time and go though the proposal. Please give your concrete suggestions for modifications if any.
It will be highly appreciated if your reply is received within 15 days.

PATIENTS RIGHTS TASK FORCE
Organising Chairperson: Indira Sharma; Organising Secretary: Shruti Srivastava
Dr. Kazi Md Rezaul Karim; Dr (Major) Nand Kishore; Dr Sandeep Grover

---

THE MENTAL HEALTHCARE ACT 2017: A PRESSING NEED FOR AMENDMENTS

The Mental Healthcare Act (MHA)-2017 has been driven by activists, who highlighted the plight of persons with mental illness (PwMI) over the years by way of human rights violation, and campaigned for justice via an appropriate legislation. The primary objective of MHA 2017 is to acknowledge the Rights (Rs) of patients with mental illness and to address the same.

On 16 September 2013, a delegation of the Indian Psychiatric Society (IPS), comprising 6 psychiatrists, and headed by Prof Dr Indira Sharma, the then President of IPS, on invitation from the government, attended the meeting of the Standing Parliamentary Committee, for finalizing the draft of the Mental Health Care Bill. Suggestions from the delegation (IPS) were submitted for consideration on 16.9.2013 (initial report), & thereafter on 27.9.2013 (revised report) after discussing with the executive council of IPS.

The MHA 2017 came into force on 7th April 2017. However, there has been dissatisfaction from almost all sectors. 27 petitions have been filed in the Courts. The main objection is that by focussing on the Rs of PwMI, their basic need, to be treated, is being compromised. The IPS, the largest association of mental health professionals in Asia, with over 6000 members is deeply concerned, as denial of treatment to persons with mental illness, especially those with severe mental illness (SMI), is having very serious repercussions on, not only the patients, but also on their families and on the society at large.

The best that can be done by IPD is to plead for amendments in the MHA2017. Thus an 'Open Forum' on "*Mental Health Care Act 2017: Proposal for Amendments*" was organized by the Task Force on Patient's, Rights, IPS, under aegis of IPS, on Zoom platform, on 15.7.2021, 7:00 to 9:00 PM. The organizing Chairperson was Prof Dr Indira Sharma, Former Professor & Head, Department of Psychiatry, Institute of Medical Sciences, BHU, & Co-person Prof Dr Shruti Srivastava, Professor of Psychiatry, Department of Psychiatry University College of Medical Sciences, Delhi. The detailed program of the forum is given above:

The forum was well attended. It witnessed lively fruitful discussions on the MHCA 2017. The main highlights of the discussion.

MENTAL HEALTH NURSE

CHIS2*(1)(q)* "mental health nurse" means a person with a ~~diploma or degree in general nursing or diploma or degree in psychiatric nursing~~ recognised by the Nursing Council of India established under the Nursing Council of India Act, 1947 and registered as such with the relevant nursing council in the State;

Suggestion: May be amended as:
"mental health nurse" means a person with a **degree in psychiatric nursing or degree in general nursing with a diploma in psychiatric nursing**, recognised by the Nursing Council of India established under the Nursing Council of India Act, 1947 and registered as such with the relevant nursing council in the State;

MENTAL HEALTH ESTABLISHMENT (MHE)
*"MHE" means any health establishment, …meant for the care of PwMI…, where PwMI are admitted and reside at, or kept in, for care, treatment, convalescence & rehabilitation, …; & includes any general hospital or general nursing home; … (*CHII 2.(*1)(p).*

"No person or organisation shall establish or run a mental health establishment unless it has been registered with the Authority under the provisions of this Act." (CHX 65 *(1)*) Authority means the State / Central Mental Health Authority.

It is submitted that:
General Hospitals, including medical teaching institutions, provide excellent non-stigmatising comprehensive health care (including mental health care) to a large section of the society.
They would be required to follow the rigorous mandate of the MHA 2017 for registration, once the Act is notified. This may deter many from maintaining psychiatric services. All medical staff working in these hospitals are registered with the National Medical Commission (NMC) or with the other respective

medical councils. The latter may regulate the functioning of general hospitals, including medical teaching institutions.

Suggestion (s):

1. Definition of MHE should not include general Hospitals, including medical teaching institutions. (appropriate changes should be made in CH1**2.** (1) (p) as given below:

   MHE as defined in CH1S2**.** (1) (p): :
   "mental health establishment" means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; **but does not include** ~~and includes~~ **teaching medical institutions**, any general hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person; but does not include and a family residential place where a person with mental illness resides with his relatives or friends;
2. It should be made mandatory for all general hospitals, including medical teaching institutions, both government and private, to provide services for PwMI along with treatment for physical illness. (May inserted in CH V S18, *(1)(a))*
3. The Central Government may by notification exempt "*general hospitals, including medical teaching institutions, both government and private*", from the requirement of registration under the Act. (Ref to CH X S 65, *(2)).*

DEFINITION OF MENTAL ILLNESS;

It is submitted that:

1. Contradictory definitions of mental illness have been given in the Act. In Chapter I the definition of a mental illness means:
   "*a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, 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, specially characterised by subnormality of intelligence;"* (CHI 2. *(1)(s)*)
   This definition is of a '*Serious Mental Disorder*' (Reference: Mental Health Act of the State of New Brunswick of Canada), with exclusion of mental retardation.

   On the other hand in Ch II 3. *(1)* mental illness includes all mental illnesses mentioned in the ICD (International Classification of Mental and Behavioural Disorders, World Health Organisation (WHO));

2. 1) International classifications (DSM-5 (Diagnostic & Statistical Manual of Mental Disoders-5th Edition) and ICD-11) use the term '*mental disorder*' & not '*mental 'illness'* to avoid any controversy, and both have included mental retardation. The equivalent terms for mental retardation in DSM -5 is

"*intellectual disability*" under the category '*Neuro-developmental disorders*'; and in ICD-11 is "*intellectual developmental disorder* ".
2) Restricting definition of mental illness to SMI would restrict the applicability of the Act & exclude a vast chunk of PwMI.
3) The ICD-11 & DSM-5 are used by allopathic doctors & are unsuitable for AYUSH doctors.

Suggestion:
For AYUSH doctors the definition of mental disorder, which corresponds to the above definition, but utilizes terminologies for mental and behavioural symptoms in AYUSH, needs to be clearly spelled out and documented in the MHCA 2017, for each medical disciplines: Ayurveda, Yoga, Unani, Siddha & Homeopathy separately.

MENTAL HEALTH CAPCITY:
Mental Health Capacity (MHC) is the capacity to make mental healthcare and treatment decisions:
CH II 4. : Every person, including a person with mental illness shall be deemed to have capacity to make decisions regarding his mental healthcare or treatment if such person has ability to-

(a) understand the information that is relevant to take a decision on the treatment or admission or personal assistance; or
(b) appreciate any reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance; or
(c) communicate the decision under sub-clause (*a*) by means of speech, expression, gesture or any other means. (CHII 4.)

It is submitted that:
Assessment of MHC based on above criteria would be flawed on 4 accounts.

1) In a person with active psychosis, MHC is impaired (ie judgement is impaired), irrespective of the severity of symptoms , and a formal assessment may give a false positive result
2) Second, MHC assessment cannot be done in many PwMI on a cross-sectional basis by direct verbal questioning. MHC has also to be inferred by behavior.
3) MHC in most patients with SMI is not static. It could be absent today, then impaired thereafter for a few days, and then could be intact for the next few days.

Suggestions:

1) First, all 3 conditions should be simultaneously met with.
2) MHC should be assessed on the basis of history (from available sources) and examination of patient. The time period covered should be the previous 10 days. Further, when there is doubt about MHC being intact, the (working) decision should be that it is probably impaired and patient should be given the benefit of doubt and treated.

ADVANCE DIRECTIVE
Ch III: Every person, who is a major, has a right to make an '*Advance Directive*' (AD) in writing, specifying the way the person wishes / or does not wish to be cared for and treated for a mental illness (MI); & may be made irrespective of his past MI &/ or treatment for the same. The AD shall be invoked only during the period when the person's MHC is impaired because of mental illness (when such person ceases to have capacity to make

mental healthcare or treatment decisions). It shall be the duty of the psychiatrist in-charge to treat the person with MI, in accordance with his AD. The AD shall not apply to emergency treatment. There is provision for the psychiatrist/care-giver to approach the Mental Health Review Board (MHRB) if the AD is not suitable.

It is submitted that:

1. AD is a hypothetical illogical concept, because: 1) imagining that a person has mental illness at some later time is very much different from actually having it at a later time. 2) It is the doctor, & not the patient, who has the expertise to evaluate and then decide on the best treatment (based on the patient's clinical profile), and communicate the same to patient/ patient's family, who may agree/ disagree to it.

2. Although a mental health professional shall not be held liable for any unforeseen consequences on following a valid AD ((CH II, 13, *(1)*).). The latter is a paradoxical situation as it amounts to harming the patient by following his AD, even when the doctor could have saved the patient using his own judgment. For eg, a patient, who has prohibited ECT, and or hospitalization in his AD, presents in a manic or depressed state, may not be hospitalized despite the family's request for in-patient treatment. This could have disastrous consequences for the patient, family and others.
3. Developed countries like England have narrated several cases where ADs had become a hindrance by law and not permitted emergency psychiatric treatment to patients suffering from mental illness.

Suggestion:
AD may be deleted from MHCA 2017.

NOMINATED REPRESENTATIVE
Ch IV: Every person, who is not a minor, has a right to nominate one or more individuals (not minor(s)), in order of precedence, as *Nominative Representative*s (NRs). The nomination shall be in writing on plain paper with the person's signature/ thumb impression. The NR would act as the guardian of the patient as per provisions of MHA.

It is submitted that:
The provision of NR may be problematic because:

1) A PwMI, with persecutory delusions against his family, may like to avoid his close relatives and nominate someone else as NR. Besides, for ulterior motives friends or distant relatives may befriend the PwMI, so as to be nominated as NR; and more so if the person with MI is a rich. After being nominated the NR may exploit the PwMI.
2) The NR may not have the time and commitment to devote for arranging the care/ caring needed for the PwMI.
3) Most PwMI have family members willing to cooperate with the medical team in the care of the patient so, as such, there would be no need for nominating a NR in the vast majority of cases.

Suggestions:
Every person, who is not a minor, shall have a right to appoint a NR subject to the condition that:

1) a near relative (first degree relative) is not available, or
2) there is evidence that the near relative is not interested, or
3) there is evidence that the near relative is likely to harm the person with MI.

RIGHTS OF PERSONS WITH MENTAL ILLNESS

CH V mentions 11 Rights of persons with MI. These are Rs to:

1. Access mental healthcare.
2. Community living
3. Protection from cruel, inhuman & degrading treatment & R to live with dignity)
4. Equality & non-discrimination
5. Information
6. Confidentiality
7. Restriction of release of information in respect of MI
8. Access medical records
9. Personal contacts & communication
10. Legal Aid
11. Make complaint about deficiency in provision of services.

Suggestion:

All the above Rs may be accepted, though with some modifications.

CH V **18**. *(1)* Right to access mental healthcare:

Suggestions:

The range of services should include:

1. Services to sedate restrain & transport persons with mental illness or suspected mental illness to a Mental Health Establishment (MHE) or govt. hospital for assessment and management as an emergency / in-patient/ out-patient treatment.
2. Supported (involuntary) treatment on outpatient basis with the consent of the guardian/ NR
3. Indoor facilities should have provision for stay of 1-2 relatives with the patient & / family wards.
4. Home based rehabilitation should be preferred to community based rehabilitation.
5. Marriage, wherever feasible, shall be the preferred pathway to home-based rehabilitation. Marriage fulfills all the rehabilitation needs of PwMI, is economical, & with least stigma.

PROTECTION FROM CRUEL, INHUMAN & DEGRADING TREATMENT & R TO LIVE WITH DIGNITY

CHV20 (2)(f): "*Every person with mental illness shall be protected from cruel, inhuman or degrading treatment in any mental health establishment and shall have the following rights, namely:*

(f) to not be forced to undertake work in a mental health establishment and to receive appropriate remuneration for work when undertaken"

(j) *to wear own personal clothes if so wished ….*

It is submitted that:

1) Asking patients to undertake work in a MHE is not cruelty, because doing work is part of healthy life-style.
2) Not allowing women to dress appropriately as per cultural norms amounts to depriving a woman of her femininity, which impedes psychosocial rehabilitation.

Suggestion:

1) PwMI, admitted in a MHEs / Government hospitals, should be encouraged to do work such as self-help skills, & others, as considered appropriate. The establishment should be liable to pay the PwMI a reasonable sum if money is generated from the work.
2) Women should be allowed to dress appropriately in MHEs. Eg, wear jewellery (artificial) (ear ring, necklace, ring, watch) and have light makeup (bindi, *sindur*, *mangalsutra* etc.
3) Right to marriage:
    1. The institution of marriage is the dignified path for fulfilling one's sexual & other needs.
    2. Marriage laws (Hindu Marriage Act 1955, Special marriage Act 1954 and others) have put restrictions on the marriage of persons with mental illness. This is despite the fact that: 1) UDHRs, 1945 (to which India is a signatory) had declared the right to marry and have a family, as a Universal Human Right.
    3. The prognosis of severe mental illness (SMI) has improved steadily over the past 5 decades. Many patients with SMI are living happily with their spouses.
    4. It is emphasized that marriage of most persons with mental illness is feasible.
    5. Recent court judgements that have disallowed divorce on the ground of SMI is evidence that marriage and SMI (schizophrenia) are not incompatible. The Supreme Court bench of Justice Singhvi & V. Gopala Gowda in 2013 ruled that "*man cannot dump wife on ground of schizophrenia*", "*schizophrenia is a treatable, manageable disease which can be put on a par with hypertension and diabetes*". In fact, it is submitted that often it is easier to treat schizophrenia than to treat diabetes & hypertension & related complications because they are silent killers linked to life style, change of which is most challenging.

    Suggestion:
    1. There is a dire need to amend the marriage laws, giving all PwMI the R to marry.
       The recommendations in this regard have been sent to the Ministry of Law, Health & National Commission of Women, by the Indian Psychiatric Society on 14.1.2014.
    2. "*Right to marriage*" may be included in MHCA 2017.

RIGHT TO ACCESS MEDICAL RECORDS
All PswMI shall have a right "to access their basic medical records as may be prescribed." (CHV 25. (1))

Suggestion:
Replace by:
All inpatients should be provided with discharge summary. Outpatients and emergency patients may be given a summary of patient's medical record on payment. (CHV 25. *(1)*)

RIGHT TO INFORMATIOM
As per the MHA 2017 CHV 22 *(1)(2)(3)*
(1) A PwMI "&" his NR have rights to the following information:
    (a) the provision of this Act or ….law …under which he has been admitted, …, & the criteria for admission under that provision;
    (b) "of his right to make an application to the concerned "Board" for a review of the admission;"
    (c) the nature of the person's mental illness and the proposed treatment plan which includes information about treatment proposed and the known side effects of the proposed treatment;
    (d) receive the information in a language & form that such person receiving the information can understand.

(e) the medical officer or “MHP” in charge of the establishment and if not satisfied with the response;

(2) ……it shall be the duty of the medical officer or psychiatrist in-charge of the person’s care to ensure that full information is provided promptly…

RIGHT TO LEGAL AID

As per MCA 2017, 27 *(1) (2)*

(1) A person with mental illness shall be entitled to receive free legal services to exercise any of his rights given under this Act.

(2) It shall be the duty of magistrate, police officer, person in charge of such custodial institution as may be prescribed or medical officer or MHP in charge of a MHE to inform the PwMI that he is entitled to free legal services under the Legal Services Authorities Act, 1987 or other relevant laws or under any order of the court if so ordered & provide the contact details of the availability of services.

RIGHT TO MAKE COMPLAINTS ABOUT DEFICIENCY IN PROVISION OF SERVICES

As per MCA 2017, 28 *(1) (2)*

(3) Any PwMI or his NR, shall have the right to complain regarding deficiencies in provision of care, treatment and services in a MHE to,—

(i) the medical officer or “MHP” in charge of the establishment and if not satisfied with the response;

(ii) “the concerned Board and if not satisfied with the response;”

(iii) the State Authority.

(2) The provisions for making complaint in sub-section (1), is without prejudice to the rights of the person to seek any judicial remedy for violation of his rights in a MHE or by any MHP either under this Act or any other law for the time being in force.

It is submitted that:

Such provisions are impractical & would be impediments to the development of a doctor-patient relationship.

Suggestion:

Please refer to suggestions given below.

1. Delete CHV, 27.

   Patient / NR/ guardian should first complain to the medical officer / psychiatrist in-charge or Head of Department, who would look in the matter & if necessary resolves the problem via the Ward committee/ Hospital Board. If patient is still not satisfied the Hospital Board can be approached. If still not satisfied the hospital board may suggest further options, State Authority or Legal Services Act. Contact details may be provided by the Board.

   Only after exhausting the local system of redressal should the PwMI/ NR/ guardian approach the State Authority/ services under Legal Services Act.

MENTAL HEALTH REVIEW BOARD (Ch XI)

The Mental Health Review Board (MHRB) has 6 persons; Chairperson, a District Judge, Representative of District Collector/ District Magistrate; Deputy Commissioner (1), psychiatrist (1), medical practitioner (1), & PwMI / Care giver of PwMI/ NGO representatives (2)

The MHRB has been assigned several clinical duties such as reviewing complaints relating admission and treatment including electroconvulsive therapy (ECT) within a specified the frame

It is submitted that:

1) A clinical decision (relating to medical treatment) taken by the MHRB (chaired by a legal expert (District Judge), with 4 non-medical members & only 1 expert (psychiatrist), cannot be valid. In legal language it would be *ultra vires*, meaning "*beyond the powers'*. The decision has to taken by a medical expert from psychiatry.
2) Clinical situations can be extremely challenging demanding immediate decisions & implementation.

Suggestions:
Redressal should be speedy & at the place where the problem arises.

Thus following are proposed:

1. A 2-tier system, A WARD COMMITTEE (WC) & HOSPITAL BOARD (HB), should replace the MHRB
2. Every hospital should have a *Ward Committee*, a *Hospital Board* & a *Mechanism* for regular redressal and suggestions from consumers of medical care, regarding matters relating to patient care.

WARD COMMITTEE

The WC should comprise 2 (preferably 3 persons) (psychiatrist In-charge+ 1 psychiatrist + 1 psychiatrist/MHP), all from the same hospital, for a speedy decision of the admission and treatment.

HOSPITAL BOARD

The HB should comprise 3 members (preferably 5 persons) Superintendent (or In-charge) of the Hospital/ MHE, psychiatrist In-charge of the case, Head of the Department of psychiatry +/ 2 employees. (Doctor/MHP)

MECHANISM FOR REGULAR REDRESSAL AND SUGGESTIONS

1. DISPLAY of INFORMATION & REDRESSAL
   Name of the authority (Medical Superintendent / Dy Medical Superintendent/ In-charge of hospital), to who complaints or suggestions can be made, along with contact details should be displayed prominently at various places in the hospital and at the hospital website.
2. "Complaint cum Suggestion" boxes can be fixed in the outdoor & indoor sections of the Hospital. The boxes should be opened periodically and place before the WC where they should be read out, discussed and appropriate action taken on them by the WC / Hospital Administration. The same should be documented.
3. REGULAR MEETINGS
   Regular meetings of indoor patients & their attendants should be convened on weekly/monthly basis with the medical officer as chairperson & mental health nurse as co-chairperson in the ward. Patients/ attendants may present their complaints, problems and suggestions in the meetings. Thereafter suitable action may be taken. Minutes of the meeting & action taken should be documented.

REDRESSAL OF COMPLAINTS BY HOSPITAL AMINISTRATION

The Hospital administration (WC & HB) should attend to grievance (s) within a time frame.

If the PwMI is not satisfied he shall convey so to the Administration. It shall then be the duty of the Administration or in-charge of the MHE/ Government hospital to inform the PwMI/NR/ Guardian that can approach the State Mental Health Authority. He is also entitled to free legal services under the Legal Services Authorities Act, 1987 or other relevant laws or under any order of the court if so ordered and provide the contact details of the availability of services.

As far as possible the proper channel should be maintained as given belo:
Medical 0fficer/ psychiatrist-In-charge > Head of Department/ WC > HB > SMHA/ Legal Services under Legal Services Act

CENTRAL MENTAL HEALTH AUTHORITY (CMHA) (CH VII)

1. Composition
   The Central Mental Health Authority (CMHA) has 20 (18±2) members.
   1) The Chairperson is Secretary or Additional Secretary to the Government of India (GOI), Department of Health & Family Welfare—*ex officio*;
   2) 4 Joint secretaries (*ex officios*) to the GOI, from the Departments of Health & Family Welfare, Ayurveda, Ayush & Yoga; Department of Disability Affairs of the Ministry of Social Justice & Empowerment& from Ministry of Women & Child Development
   3) Director General of Health Services (DGHS), *ex officio*;
   4) Directors of the Central Institutions for Mental Health
   5) Other representative from the relevant Central Government Ministries or Departments
   6) MHP (a psychiatrist from ayurveda, or homeopathy, or unanani or siddha),
   7) Clinical psychologist, psychiatric social worker, mental health nurse, one each
   8) Representatives of PwMI, and of care givers of PwMI, NGOs providing service to PwMI, 2 each
   9) 2 persons representing areas relevant to mental health, if considered necessary.
2. All questions shall be decided by a majority of votes by the members present & in the event of an equality of votes, the chairperson shall have a second/casting vote.
3. All decisions of the CMHA Authority shall be authenticated by the signature of the chairperson

It is submitted that:

1. Composition:
   1) The Chairperson of the CMHA is a non-medical person from the administration sector. It would not be possible for a non-psychiatrist to understand the complexities of mental illness and the related issues & do justice.
   2) There is no psychiatrist from allopathy in the CMHA. This would defeat the very purpose of the CMHA.
   3) Inclusion of 4 representatives, 2 PswMI & 2 care-givers of PwMI, would go increase the stigma of the representatives, and infringe upon their right(s) to privacy. As per the Act, every PwMI has a right to privacy (CH V S20(d)). Further, it is duty of the appropriate government to ensure that the programmes to reduce stigma associated with mental illness, are planned, designed, funded and implemented in an effective manner (CH VI S30(b)). The Act also states that "*No person or authority shall classify a person as a person with mental illness, except for purposes directly relating to the treatment of the mental illness or in other matters as covered under this Act or any other law for the time being in force*".
   4) High rates of life-time and point prevalence of mental disorders have been reported. However, the real figures are likely to be much higher as in clinical practice about 50-75 % psychiatric morbidity

(present/ past) is being noted in the families of PwMI seeking treatment. Thus in all probability the members of the CMHA would either have a current/past history of mental illness, or a family member with mental illness, so as such the member would representative of a PwMI or as a care-giver of PwMI. It is another thing that the CMHA member would like to keep the information confidential (& he has a right to do so).

2. All decisions cannot be taken by voting, especially clinical decisions. Decisions have to be based on merit.
3. Authentication of decisions of the CMHA by the sole signature of the chairperson would amount to belittling the powers/significance of other members.

Suggestions:

1. Composition:
    1) Chairperson: Directors of the Central Institutions for Mental Health1
    2) 4 Joint secretaries (*ex officios*) to the GOI, from the Departments of Health & Family Welfare, Ayurveda, Ayush & Yoga; Department of Disability Affairs of the Ministry of Social Justice & Empowerment& from Ministry of Women & Child Development5
    3) Director General of Health Services (DGHS), *ex officio*; 6
    4) Other representative from the relevant Central Government Ministries or Departments7
    5) Clinical psychologist, psychiatric social worker, mental health nurse, 1each 10
    6) Psychiatrists 6 (3 from Government (service, teaching, administrative,1 each) & 3 from Private (consultant practice, having own private MHE, employed in private MHE), with 15 years of experience. 16
    7) Two persons representing NGOs which provide services to PwMI. 18
    8) Two persons representing areas relevant to mental health, if considered necessary.20

    Note: Representatives of PwMI, and care giver of PwMI, NGOs providing service PwMI have not been included,

CENTRAL MENTAL HEALTH AUTHORITY	
MHCA 2017	Suggested
1. Secretary or Additional Secretary to the Government of India (GOI) in the Department of Health and Family Welfare—chairperson *ex officio*;	Directors of the Central Institutions for Mental Health—members *ex officio;*
2. Joint Secretary to the GOI in the Department of Health & Family Welfare, in charge of mental health—member *ex officio;*	Yes
3. Joint Secretary to the GOI in the Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy— member *ex officio;*	Yes
4. Director General of Health Services— member ex officio	Yes
5. Joint Secretary to the GOI in the Department of Disability Affairs of the Ministry of Social Justice and Empowerment— member ex officio;	Yes
6. Joint Secretary to the GOI in the Ministry of Women & Child Development— member ex officio;	Yes
7. Directors of the Central Institutions for Mental Health—members *ex officio;*	1 psychiatrist from government sector (Administrative)

8. such other *ex officio* representatives from the relevant Central Government Ministries or Departments;	Yes
9. one MHP as defined in item (*iii*) of clause (*r*) of sub-section (*1*) of section 2 having at least fifteen years experience in the field, to be nominated by the Central Government—member;	1 psychiatrist from government Sector (Service)
10. one psychiatric social worker having at least fifteen years experience in the field, to be nominated by the Central Government—member;	Yes
11. one clinical psychologist having at least fifteen years experience in the field, to be nominated by the Central Government—member;	Yes
12. one mental health nurse having at least fifteen years experience in the field of mental health, to be nominated by the Central Government—member;	Yes
13. two persons representing persons who have or have had mental illness	1 psychiatrist from government sector (teaching); 1 Psychiatrist from private sector (OPD Consultant)
14. two persons representing care-givers of persons with mental illness or organisations representing care-givers, to be nominated by the Central Government—members;	1 psychiatrist from private sector. (Own MHE); 1 psychiatrist private sector (Employed in MHE)
15. two persons representing NGOs which provide services to persons with mental illness, to be nominated by the Central Government—members;	Yes
16. two persons representing areas relevant to mental health, if considered necessary	Yes

2. All decisions should be taken after discussion with the members by the Chairperson on the basis of merit of the case.
3. All members should sign on the minutes (including the resolutions) of the meeting. (This would authenticate the decisions taken).

STATE MENTAL HEALTH AUTHORITY (CH VIII)

1. Composition:

   The State Mental Health Authority SMHA comprises 17 members:

   1) Chair person: Secretary or Principal Secretary in the Department of Health of State Government—chairperson *ex officio*; 1
   2) 2 Joint secretaries *ex officios* (Department of Health & in-charge of mental health, Social Welfare, of the State Government)3
   3) Director of Health Services or Medical Education—*ex officio*44
   4) such other representatives from the relevant State Government Ministries or Departments- *ex officio*;5
   5) Head of any of the Mental Hospitals in the State or Head of Department of Psychiatry at any Government Medical College6
   6) one eminent psychiatrist from the State not in Government service 7

7) A non-allopathic doctor (of ayurveda, homeopathy, unani or siddha), clinical psychologist, psychiatric social worker, mental health nurse, one each
8) Representatives of PwMI, and of care givers of PwMI, NGOs providing service to PwMI, 2 each15
9) Representatives NGOs providing services PwMI 17

2. All questions shall be decided by a majority of votes by the members present and in the event of an equality of votes, the chairperson shall have a second/casting vote.
3. All decisions of the SMHA Authority shall be authenticated by the signature of the chairperson or in his absence any other member authorised by the State Authority in this behalf.

It is submitted that:

1. Composition:
   1) The Chairperson is a non-medical person from the administrative sector. It would be difficult for a non-Psychiatrist to understand the complexities mental illness and related issues & do justice.
   2) There are only 2 psychiatrists. This will defeat the basic purpose of SMHA
   3) There are problems in including PwMI or care-givers of mental illness as mentioned above (Refer to CMHA)
2. All decisions cannot be taken by voting, especially clinical decisions. Decisions have to be based on merit.
3. Authentication of decisions of the CMHA by the sole signature of the chairperson would amount to belittling the powers/significance of other members.

Suggestions:

1. Composition
   1) It is proposed to have a Senior psychiatrist (Head of any of the Mental Hospitals in the State or Head of Department of Psychiatry at any Government Medical College) should be the chairperson of the SMHA
   2) Of the 16 members, 7 should be psychiatrists.
2. All decisions should be taken after discussion with the members by the Chairperson on the basis of merit of the case.
3. All members should sign on the minutes (including the resolutions) of the meeting. (This would authenticate the decisions taken).

STATE MENTAL HEALTH AUTHORITY	
MHA 2017	Suggestion
Secretary or Principal Secretary in the Department of Health of State Government—chairperson *ex officio*;	Head of any of the Mental Hospitals in the State or Head of Department of Psychiatry at any Government Medical College,;
Joint Secretary in the Department of Health of the State Government, in charge of mental health—member *ex officio*;	Yes
Director of Health Services or Medical Education—member *ex officio*;	Yes
Joint Secretary in the Department of Social Welfare of the State Government—member *ex officio*;	Yes
such other *ex officio* representatives from the	Yes

relevant State Government Ministries or Departments;	
Head of any of the Mental Hospitals in the State or Head of Department of Psychiatry at any Government Medical College,	1 psychiatrist from government sector (Administrative)
one eminent psychiatrist from the State not in Government service	Yes (Psychiatrist from Private Sector (Employed in MHE)
one mental health professional as defined in item (*iii*) of clause (*q*) Of sub-section (*1*) of section 2 having at least fifteen years experience	1 psychiatrist from government Sector (Service)
one psychiatric social worker having at least fifteen years experience	Yes
one clinical psychologist having at least fifteen years experience	Yes
one mental health nurse having at least fifteen years experience	Yes
two persons representing persons who have or have had mental illness, to be nominated by the State Government—member;	1 psychiatrist from government sector (teaching); 1 Psychiatrist from private sector (OPD Consultant)
two persons representing care-givers of persons with mental illness or organisations representing care-givers, to be nominated by the State Government—members;	1 psychiatrist from private sector. (Own MHE); 1 psychiatrist private sector (Employed in MHE)
two persons representing NGOs which provide services to PwMI	yes

ADDMISSION TREATMENT & DISCHARGE
WHO WILL ADMIT: CH XII
The MHCA 2017 provides for Independent and supported admission for treatment of MI.
An Independent admission to a MHE is made on a request by a PwMI, with unimpaired MHC, on his free will.

> *On receipt of such request under sub-section (1), the medical officer or MHP in charge of the establishment shall admit the person to the establishment …..*(CHXII 86. *(2)*)
> *The medical officer or MHO in charge of a MHE shall discharge from the MHE any person admitted under section 86 as an independent patient …. (*CHXII 88*. (1))*

An involuntary admission (supported admission) is made on a request by the NR of a PwMI, with impaired MHC

> *The medical officer or MHP in charge of a MHE shall admit every such person to the establishment, upon application by the NR of the person, under this section* (CHXII 89 *(1))*

It is submitted that:
As per the provision even non-medical personnel (mental heal nurse, Psychiatric social worker, or clinical psychologist) can admit PswMI.

Suggestion:
Replace *Psychiatrist* for MHP in CHXII 85 *(2) & 89 (1)*

WHO SHOULD BE ADMITTED FOR TREATMENT?
An Independent admission to a MHE is made on the request of a PwMI, with unimpaired MHC, on his free will.
Involuntary admission (supported admission): CH XII
A supported admission of a PwMI to a MHE can be made, on an application by the NR of a PwMI,
(1) (a) …the person has a MI of such severity that the person:
- (i) has recently threatened or attempted or is threatening or attempting to cause body harm; or
- (ii) has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or
- (iii) 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

(b) admission to the MHE is the least restrictive care option possible in the circumstances; &
(c) the person is …. unable to make mental healthcare and treatment decisions independently ….

The limitations of involuntary admission are:
1) There is no provision for admission to a MHE if there is a risk of '*destruction of property* even when MHC is impaired.
2) If on assessment MHC is unimpaired the patient cannot be admitted even when there MI poses a is risk of self-harm; or gross neglect of self-care leading to risk of self-harm; or there is risk of harm to others because of violent behavior.
3) There is no provision for admission to a MHE even when there is a clear '*Need*' for treatment if MHC is not impaired. It is submitted that the presence of a SMI, by itself, justifies the '*need*' for admission as it is well established that SMI can pose risks to self and others, may cause severe impairment and result in disability if not treated promptly. Thus if treatment of the person with SMI is not possible/ difficult on OPD basis / or treatment on OPD basis has not yielded the desired results, the person with SMI should be admitted for treatment. The law should make provisions for the same.
4) As MHC in is PwSMI is not static, as explained above. Besides, antipsychotics, antimanucs and antidepressants may take 30 days or more to be effective. Thus weekly assessment of MHC to determine when patient should continue to admitted for treatment, is unscientific and would be a major hindrance to treatment of PwMI.
5) Persons addicted to, or abusing addictive substances, deserve special attention. They continue to do so despite the knowledge that intake of the substance is harmful; and may manifest symptoms of SMI during phases of withdrawal and intoxication, during which they may indulge in violence (emotional, physical, sexual & verbal), destruction of property & crime. Generally they do not seek treatment. They are a great burden to themselves, their families & community at large. Their MHC would be found to be unimpaired during the lucid phase so as such cannot be treated on involuntary patients. In present times, effective treatments are available for detoxification and further treatment of persons addicted to substances (including alcohol, opium, brown sugar), but such treatments are generally done on in-patient basis.
6) Not treating persons with SMI would defeat the primary objective of the MHA 2017, meeting the need ffor treatment.
7) Not treating persons with SMI would amount to violation of Constitutional Right to Life, of the PwMI, because life means life with dignity. (Article 21)

8) Not treating persons with SMI would amount to violation of Constitutional Right to Life of others because PwMI may pose risk to family members and community (Article 21)
9) Further, it may be note that R to life and personal liberty (Article 21) is not absolute, it can be curtailed according to procedure established by law, if it encroaches on the Rs of others
10) In the MHA 1987 there was a provision for "*Admission under special circumstances*" if there was a clear '*need'* for treatment "*if the medical officer in charge is satisfied that in the interest of the mentally ill person it is necessary to do so."*

Suggestion:
Following provision may be added in CHXII (Between section 88 & 89)

Ch IX II S 89 (8)
"(8) In case where the consent has been given under subsection (7), the medical officer or the mental health professional in-charge of the MHE shall record such consent in the medical records & review the capacity of the patient to give consent every seven days)"

If on assessment MHC is found to be intact, he would have to be discharged., Thereafter shall not be admitted for 7 days. If admission is required he will be considered in accordance wiith S 90
unless seen by 2 psychiatrists
Is submitted that:
These provisions are most unscientific. & would pose great risk to patient and others
May be deleted

9) Admission of person with mental illness persons under certain special circumstances
    1. Any person with mental illness who does not, or is unable to, express his willingness for admission as a voluntary patient, may be admitted and kept as an inpatient in a psychiatric hospital or psychiatric nursing home on an application made in that behalf by a relative or a friend of the mentally ill person if the medical officer-in-charge is satisfied that in the interests of the mentally ill person it is necessary so to do:

    2. Any person against whom there is a complaint of domestic violence because of mental illness / substance abuse disorder under the Protection of Women from Domestic Violence Act, 2005, may be admitted as a involuntary patient if the medical officer-in-charge is satisfied that in the interests of the mentally ill person it is necessary so to do, Request in this regard have been sent to the Ministry of Law, Health & National Commission of Women, by the Indian Psychiatric Society on 14.1.2014.

RESPONSIBILITIES OF THE FAMILY
It should be the duty of the parents/ guardian/ family members to get family members with mental illness treated. In the MHA 1987 there was a provision to enforce the same:

MHA 1987

" Part III ***Reception orders***
25. ***Order in case of mentally ill person cruelly treated or not under proper care and control***

(1) Every officer in charge of a police station, who has reason to believe that any person within the limits of his station is mentally ill and is not under proper care and control, or is ill-treated or neglected by any relative or other person having charge of such mentally ill person, shall forthwith report the fact to the Magistrate within the local limits of whose jurisdiction the mentally ill person resides.
(2) Any private person who has reason to believe that any person is mentally ill and is not under proper care and control, or is ill-treated or neglected by any relative or other person having charge of such mentally ill person, may report the fact to the Magistrate within the local limits of whose jurisdiction the mentally ill person resides.

(3) If it appears to the Magistrate, on the report of a police officer or on the report or information derived from any other person, or otherwise that any mentally ill person within the local limits of his jurisdiction is not under proper care and control, or is ill-treated or neglected by any relative or other person having the charge of such mentally ill person, the Magistrate may cause the mentally ill person to be produced before him, and summon such relative or other person who is, or who ought to be in charge of, such mentally ill person.

(4) If such relative or any other person is legally bound to maintain the mentally ill person, the Magistrate may, by order, require the relative or the other person to take proper care of such mentally ill person and where such relative or other person willfully neglects to comply with the said order, he shall be punishable with fine which may extend to two thousand rupees."

Suggestion:
CH XIII B may be inserted
The above provision may be inserted in chapter XIIIB in MHA 2917

PROHIBITED TREATMENTS

XII 94. Emergency treatment
(1) Notwithstanding anything contained in this Act, any medical treatment, including treatment for mental illness, may be provided by any registered medical practitioner to a person with mental illness, either at a health establishment, or in the community, subject to the informed consent of the NR, where the NR is available, and where it is immediately necessary to prevent—

(a) death or irreversible harm to the health of the person; or includes transportation of the person with mental illness to a nearest MHE for assessment.
(b) the person inflicting serious harm to himself or to others; or
(c) the person causing serious damage to property belonging to himself or to others where such behaviour is believed to flow directly from the person's
Explanation.—For the purposes of this section, "emergency treatment" includes transportation of the person with mental illness to a nearest MHE for assessment.

(2) Nothing in this section shall allow any medical officer or psychiatrist to give to the person with mental illness medical treatment which is not directly related to the emergency treatment specified under sub-section *(1)*
(3) Nothing in this section shall allow any medical officer or psychiatrist to use ECT as a form of treatment.
(4) The emergency treatment referred to in this section shall be limited to seventy-two hours or till the person with mental illness has been assessed at a mental health establishment, whichever is earlier:

It is submitted that:
A ban on providing non-emergency treatment during the emergency period is not justified. Further, the prohibition of ECT during emergency of 72 hours is a paradoxical provision because ECT is generally indicated in emergency situations ((a) (b) (c) mentioned above) and should be given as early as possible, preferably within 48 hours.

Suggestion:
1. Insert:

(1) Notwithstanding anything contained in this Act, any medical treatment, including treatment for mental illness, may be provided by any registered medical practitioner or psychiatrist to a person with mental illness, either at a health establishment or in the community, subject to the competency of the medical officer or the psychiatrist and the informed consent of the guardian or NR.

2. Delete:

~~*(2) Nothing in this section shall allow any medical officer or psychiatrist to give to the person with mental illness medical treatment which is not directly related to the emergency treatment specified under sub-section (1)*~~

CH XII 95

(1) Notwithstanding anything contained in this Act, the following treatments shall not be performed on any person with mental illness—

(a) ECT without the use of muscle relaxants and anaesthesia;

(b) ECT for minors;

(2) Notwithstanding anything contained in sub-section (*1*), if, in the opinion of psychiatrist in charge of a minor's treatment, ECT is required, then, such treatment shall be done with the informed consent of the guardian and prior permission of the concerned Board.

CH XII 96

(1) Notwithstanding anything contained in this Act, psychosurgery shall not be performed as a treatment for mental illness unless—

(a) the informed consent of the person on whom the surgery is being performed; &

(b) approval from the concerned (b) Board to perform the surgery, has been obtained.

It is submitted that:
1. Prohibition of ECT without the use of muscle relaxants and anaesthesia is contrary to medical evidence. ECT with anaesthesia exposes the patient to the risk of anaesthesia, which could be hazardous in some medically compromised patients & may even prove to be lethal. On the other hand Modified ECT (modified intravenous benzodiazepines like diazepam, which also results in muscle relaxation), or direct ECT is safer.
2. Prohibition of ECT to minors is contrary to medical evidence. Acute and catatonic schizophrenia often presents during adolescence, and may have devastating influence on patients if not promptly treated. Such patients may have limited response to medication, but respond rapidly to ECT; which is life saving.
3. Prohibition on psychosurgery as a treatment for mental illness, again, is contrary to medical evidence. In modern times psychosurgery as such is not used as a treatment for mental illness. However, with

technological advancements more evidence is accumulating suggesting the role of brain lesions in major mental illnesses; and some of these lesions may be amenable treatment by psychosurgery. Besides, Stereotactic surgery (psychosurgery), which is non-invasive, is now available. A good response is seen in such cases when the decision to operate is based on expert knowledge and experience.

4. The MHRB giving approval for ECT to the minor, or for psychosurgery, would be *ultra vires* (Beyond the power) as the Chairman of the Board is a legal expert, not a medical expert of mental illness (psychiatrist). The "Ward Committee may decide on ECT for minors & for psychosurgery". For deciding on psychosurgery should co-opt 2 neurosurgeons, out of which one could be the neurosurgeon in-charge of the case.

Suggestion:
Delete:
"*CH XII 95* ***(1) (a)(b) & (2) &*** *CH XII 96* ***(1) (a)(b)"***

RESTRAINT OF PATIENTS
CH XII 97.
(5) The nominated representative of the person with mental illness shall be informed about every instance of restraint within a period of twenty-four hours.
(6) A person who is placed under restraint shall be kept in a place where he can cause no harm to himself or others and under regular ongoing supervision of the medical personnel at the MHE.
(7) The MHE shall include all instances of restraint in the report to be sent to the concerned Board on a monthly basis
*(9)*The Board may order a MHE to desist from applying restraint if the Board is of the opinion that the MHE is persistently and willfully ignoring the provisions of this section

It is submitted that:
1. Physical restraints are limited used. The reliance is on chemical restraint.
2. It is practically not possible inform the guardian/ NR about every instance of restraint within a period of twenty-four hours.
3. The MHE can document all instances of restraint in the medical records. These can be accessed by the Hospital Board.
4. There is no justification for sending a report of restraints on a monthly basis to the MHRB, because the Chairperson of the MHRB is a legal expert, not a mental illness expert. A decision the use of restraints in PwMI by the MHRB would be *ultra vires*.
5. In no place safety is absolute. The patient can always find a way to harm himself/others. Quick recovery by prompt treatment is the solution.

Suggestion:
1. Delete:
   (5)
2. Replace:
   (6) A person who is placed under restraint shall be kept in a place where he can cause ~~no~~ **<u>least</u>** harm to himself or others and under regular ongoing supervision of the medical personnel at the MHE.
3. Replace:
   *(7)*The MHE should document all instances of restraint in the medical records. These can be accessed by the Hospital Board

Insert:

*(9)*The **Hospital** Board may order a MHE to desist from applying restraint if the Board is of the opinion that the MHE is persistently and willfully ignoring the provisions of this section

Summary:

- It needs to appreciated the very purpose of the Act is being defeated by the over ambitious effort to be fair to P with MI.
- Its needs to be appreciated that, Rs are never absolute.
- Rs of Ps, Rs of Family, Rs of mental professionals to practice their profession with dignity & without fear, & Rs of Community at large, are all at stake
- Optimal balance between of Rs is the solution.

PATIENTS RIGHTS TASK FORCE

Organising Chairperson: Indira Sharma; Organising Secretary: Shruti Srivastava

Dr. Kazi Md Rezaul Karim; Dr (Major) Nand Kishore; Dr Sandeep Grover

---