The Mental Health Care Act 2017

Question Answer Guide for stakeholders

Amrit Bakhshy
SAA, Pune

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Written by:

Amrit Bakhshy

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Abhay Kele, director

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Preface (Second Version)

I was requested to do a booklet guide on MHCA 2017 in a Question Answer format which was included in a book on MHCA 2017, of which I was a guest editor, brought out last year by the Society for Mental Health Awareness Research and Teaching and Training-SMARTT, a body of the mental health professionals in Pune. It was a compilation of 189 questions and answers and formed Section Two of the book. I have been sharing soft and hard copies of the booklet with the families of the persons with the mental illness and the mental health professionals interested in understanding the Act.

SAA is hosting the All India Conference of Caregivers of Persons with the Mental Illness on 10th September 2019, which is the birthday of SAA's founder Late Dr. Jagannath Wani, who was a caregiver of his wife. One of the three sessions in the Conference is on "Disabilities Laws in India: Advantages and Disadvantages for Families of Persons with Mental Illness". The session will have focus on MHCA 2017. We have decided to distribute among the participants an updated version of the booklet-Question Answer Guide on the Act which will be a useful reading for them. CMHA and SMHAs have still to make Regulations under sections 122 and 123 of the Act. Some states have yet to form SMHAs. States have also not yet adopted/notified State Rules. Further updating will be required once State Rules and Central/State Regulations are notified.

Care has been taken to avoid repetitiveness in questions. But some part repetitiveness might have crept in. Readers may please bear with it.

The first version was written keeping in view the relevance to the mental health professionals. The second version is focused on what is more relevant to the family caregivers. I hope the family caregivers and other stakeholders find it as a useful resource.

Amrit Bakhshy
9881190000
4th September 2019

Preface

As a caregiver and as a representative of an NGO working for PwMI and their families, the writer had the priviledge of participating in deliberations and consultations related to the drafting of the different versions of the Mental Healthcare Bill. He was also a part of the team involved in drafting the Rules. MHCA 2017 is a classic act for mental health care, which is compliant with UNCRPD and provides rights and benefits to persons needing mental health care and treatment.

This booklet is an endeavor by a caregiver activist, with no legal background, to explain the Act in an easy to understand language, in an objective question answer format. Questions cover the entire gamut and periphery of the Act. There are questions, seeking clarity, interpretations, explanations and replies based on apprehensions, doubts, disagreements and misinformation. Readers may find some questions hypothetical, rudimentary, pointless or just an expression of anger and disagreement. There are questions, which are not directly related to the provisions in the Act but were asked on twitter, raised in media, seminars, conferences and workshops on MHCA 2017; these are included to give a wider perspective to the readers. Readers will note that there are disproportionately large number of questions on Advance Directive and Nominated Representative which are areas of concern for caregivers and also MHPs.

Answers are culled from the Act itself and from the Central and the State Rules to avoid subjectivity. Answers to some questions are, however, based on common analytical and theoretical jurisprudence and based on the writer's own perception, understanding and interpretation.

The Booklet is mainly for stakeholders, who, have no legal background and need help in understanding the various provisions of the Act. Knowledgeable readers and professionals may find some questions elementary or of little relevance, which they may choose to skip. Readers may also have different views and different interpretations. Some more clarity will emerge when the Regulations are notified. In due course CMHA and SMHA will come out with clarifications and case law will also develop over the years.

Wherever possible, sections from the Act and Rules have been quoted at the end of the answers. The quoted numbers in brackets indicate the section, the sub-section and the clause of the Act respectively, on which the answers are based.

Amrit Bakhshy

Acronyms used

- Act : Mental Healthcare Act 2017
- AD : Advance Directive
- BPL : Below Poverty Line
- CMHA : Central Mental Health Authority
- CMO : Chief Medical Officer
- CRPD : Convention on Rights of Persons with Disability
- ECT : Electroconvulsive Therapy
- IPS : Indian Psychiatric Society
- LGBTQ : lesbian, gay, bisexual, transgender
- MHA : Mental Health Act
- MHC : Mental Health Care
- MHCA : Mental Healthcare Act 2017
- MHE : Mental Health Establishment
- MHP : Mental Health Professional
- MHRB : Mental Health Review Board
- MO I/C : Medical Officer In charge
- MOHFW : Ministry of Health and Family Welfare
- NR : Nominated Representative
- PSW : Psychiatric Social Worker
- PwMI : Person(s) with Mental Illness
- PwD : Person(s) with Disability
- RCI : Rehabilitation Council of India
- RMP : Registered Medical Practitioner
- RPwDA : Rights of Persons with Disability Act
- SOR : Statement of Objects and Reasons
- SMHA : State Mental Health Authority
- UNCRPD : United Nations Convention on Rights of Persons with Disability

Background

1. How have the Laws in India, related to PwMI, evolved over the years?

Early Laws

In 1851 the East India Company passed the first law in the country "Lunatics Removal Act" to regulate the repatriation to England of British nationals with mental illness for treatment. This was followed by the British Government in India passing a number of laws for mentally ill persons as under:

- The lunacy (Supreme Court) Act (34 of 1858)
- The lunacy (District Courts) Act (35 of 1858)
- The Indian Lunatic Asylums Act (36 of 1858)
- The Military Lunatics Act (11 of 1877)
- The Indian Lunatic Asylums (Amendment) Act (18 of 1886)
- The Indian Lunatic Asylums (Amendment) Act (20 of 1889)

The above Acts led to establishment of mental asylums for keeping the mentally ill who were considered dangerous to the society.

The Indian Lunacy Act, 1912

The Viceroy Council decided in 1911 to consolidate the lunacy laws enacted during the period 1858 and 1889 and to bring these laws in line with the English law, the Lunacy Act 1890 as amended by the Lunacy Act 1891. Accordingly, the Indian Lunacy Act, 1912 was passed; which ended the management of mental hospitals with the IG Prisons and led to psychiatrists' appointment in mental hospitals. The Act provided safeguards against wrongful detention and criteria for certification of the mentally ill by the magistrate.

The Mental Health Act, 1987

In 1949 the IPS in its annual conference sought enactment of a new mental health act and appointed a committee to prepare a draft of the proposed act. In 1959-60 the Govt. announced its intention to amend the 1912 Act but nothing substantial was done in the next two decades. In 1981, the Government introduced the Mental Health Bill in the Parliament. The Bill was passed by the Lok Sabha on 19th March, 1987

and the Rajya Sabha on 22nd April, 1987. The President's assent on 22nd May, 1987 made it the Mental Health Act, 1987. The Act was notified only in April 1993.

The Mental Health Act, 1987 was acknowledged as a progressive act in tune with changing times. Its salutary features included incorporation of modern concepts of mental illness and treatment. It acknowledged the role of psychiatrists, simplified the rules of admission and discharge and provided for protection of human rights of the patients. It also provided for supervision of psychiatric hospitals by creating the Mental Health Authority, and penalties for violation of provisions of law. It contained provisions regarding restrain, admission and discharge but did not pay attention to proper care and treatment.

Mental Healthcare Act 2017

The decision to amend the Mental Health Act 1987, to align and harmonise it with the UNCRPD, was taken in a meeting of stakeholders called by the MOHFW on 22nd January 2010. The first draft was released on 28th February 2010. The second draft was put in public domain in mid-June 2010. Both the drafts were widely discussed and debated by the stakeholders.

After the second draft was circulated, it was realised that there were multiple amendments and many repealed sections which made the Act look clumsy and difficult to read and understand. The better course would be to repeal and replace the existing Act with a new Act. It was, then decided by the Government, at the time of the third draft, to draft a new bill.The Bill was passed by the Lok Sabha on 27th March 2017 and Rajya Sabha on 30th March 2017. It received the President of India's Assent on the 7th April 2017.

2. What was the need to have a separate act for mental illness? There are no such acts for other illnesses?

Many countries in the World, mostly erstwhile British Colonies, have separate laws for persons with mental illness, In British India separate laws were passed for persons with mental illness, then called lunatics, to keep them in lunatic asylums away from the community as they were a risk for others. These lunatic asylums, consisting of closed barracks, were generally in the neighbourhood of jails, outside the cities and were under the control of the Inspector General of Police. Slowly the concepts changed and the process of reforms started. Today, we believe

that persons with mental illness should live in the community and the rights taken away from them through laws framed in mid nineteenth and early twentieth century should be restored and they should enjoy the same rights as the others with physical illnesses. The current act provides them protection of their rights related to their illness and treatment in accordance with UNCRPD.

3. In what way is MHCA 2017 different from MHA 1987?

MHA, 1987 was enacted to regulate the admission and treatment of PwMI to psychiatric institutions and for the management of their property and affairs. Over the years, the provisions in the MHA 1987 were considered inadequate to protect the rights of the PwMI and promote access to mental health care. The need was voiced for a new Act to protect, promote and fulfill their rights related to mental healthcare and services.

MHA 1987 mixed healthcare and social care issues, whereas MHCA 2017 covers only the healthcare related aspects and does not go into the questions of guardianship and civic and political rights. The MHCA 2017 stresses on community based care and half way homes, voluntary admissions, and inherent decision making capacity.

4. When did the MHCA come into force?

Section 1(3) of the Act provided that it should come into force on such date as the Central Government might, by notification in the Official Gazette, appoint; or on the date of completion of the period of nine months from the date on which the Mental Healthcare Act, 2017 receives the assent of the President.

The intention was that the Act should be notified immediately after it got President's assent. If that did not happen the Act would stand notified after 9 months (in Mental Health Care Bill 2013, it was 3 months) of president's assent on 7th January 2018.

As the stakeholders awaited the Act to come in to effect by default on 7th January 2018, the Government making use of the lacuna in the language of the section 1(3), (omission of the phrase "whichever is earlier") surprised the stakeholders by issuing a notification on 2nd January 2018, stating that the Act would come into force on 7th July 2018. The 6-month extension in time was notified by the Government, presumably as the rules were yet to be finalized. The second surprise

came on 29th May 2018, when the Government rescinded their notification of 2nd January 2018 and appointed 29th May 2018 as the date on which the Act would come into force, presumably as the Rules got finalized by then. The Rules were also notified simultaneously.

5. What is UNCRPD that India signed and ratified? In what way did it make obligatory for the Government to enact a new mental healthcare act?

The Preamble of the MHCA 2017 states that as India has signed and ratified the UNCRPD, it is necessary to align and harmonise the existing laws with the Convention.

UNCRPD is the human rights convention concerning persons with disabilities including PwMI. It contains rights of PwDs aimed to improve their access to society, education and employment. UNCRPD was adopted by the General Assembly of the UNO on 13th December 2006, which India signed on 30th March 2007, the day it was opened for signature. India ratified it on 1st October 2007. It came into force on the 3rd May 2008, the day it was signed by the 20th member state.

By signing the CRPD, India committed to the international community that it would follow the principles and ideas of the convention and would not do anything which might violate human rights of PwDs. Through ratification of the CRPD, India committed that it shall take legislative, administrative, adjudicative, and programmatic measures to implement the provisions in the convention towards the promotion, and protection of human rights, including fundamental freedom of PwDs.

6. What objectives are achieved through this Act?

The objectives listed are as under:

Protecting and promoting rights of PwMI during delivery of health care in institutions and community.

- Ensuring health care, treatment and rehabilitation of PwMI in the least restrictive environment and in a manner that does not intrude their rights and dignity
- Preference to community based solutions in the vicinity of the residence of the PwMI instead of institutional solutions.

- Providing treatment, care and rehabilitation to improve the capacity of the PwMI, to develop their full potential and to facilitate their integration into the community.
- Regulating the public and the private mental health sectors within a rights' framework.
- Improving accessibility to mental health care through sufficient provision of quality public mental health services and non-discrimination in health insurance.
- Establishing a mental health system integrated into general health care
- Promoting principles of equity, efficiency and active participation of all mental health stakeholders in decision making.

(SOR)

7. What are the significant features of the MHCA 2017?

Important features in the Act are summarized below:

- Empowerment of the PwMI, providing them with mental health and treatment related rights, and access to healthcare and treatment without discrimination, including human rights and safeguards, which fulfil India's obligations related to the UNCRPD.
- Setting out minimum standards to improve the conditions in MHEs in the country.
- Provision for appeal by a person admitted in an MHE and his rehabilitation and reintegration with families and community in non-medical settings.
- Fixing responsibilities of other agencies, and putting restrictions on discharge of functions by professionals not covered by their profession.
- Any person, with or without mental illness, gets right to make an AD stating how he wishes to be treated for a future mental illness and also how he does not wish to be treated.
- Provision to challenge an AD by families, professionals etc.
- A PwMI gets right to appoint an NR to take decisions for him.
- A PwMI gets right to live in, be part of, and not segregated from society.
- Government to provide for half way homes, sheltered accommodation, Community Centres etc.

- Right to access mental healthcare and treatment from mental health services run or funded by the Government, which shall be affordable, of good quality and available without discrimination.
- Protection from cruel, inhuman and degrading treatment in an MHE.
- Prohibition of some treatments and practices, such as, ECT without anesthesia and the practice of chaining patients to their beds. Provisions that all cases of supported admission shall be reviewed in accordance with safeguards for protecting the rights of PwMI provided in Article 12 of the UNCRPD.
- CMHA and SMHA to continue as regulatory and administrative agencies with wider and well defined role and responsibilities which include regulating/setting standards for MHEs, maintaining registers of such establishments and of MHPs and carrying out training functions.
- MHRBs to function as quasi-judicial bodies to provide an independent oversight to the functioning of MHF and address violation of rights of PwMI in these establishments, ensuring that admission of a person to an MHF is the least restrictive care option under the circumstances, thereby meeting the need for an independent review mechanism as required under the CRPD.
- Determination of mental illness in accordance with international standards
- Presumption of capacity for making decisions on mental healthcare and treatment unless proven otherwise
- Right to Access Medical Records
- Right to Complain against deficiencies in services
- Duties of the Government - awareness, sensitization, human resources, etc.
- Minimum standards for mental health services/facilities
- Decriminalisation of suicide

8. Can we get a brief easy to understand summary of the Act?

SUMMARY-MHCA 2017Capacity to make mental healthcare and treatment decisions

The Act recognises the right of PwMI to make decisions regarding their mental healthcare and treatment, with the presumption, that they have the capacity to do so unless proven otherwise.(4)Every person shall

have a right to make an AD stating how he wishes, his mental illness to be treated and cared and how not to be. (5)

Every person shall have a right to appoint an NR to support him, in case of need, in taking treatment related decisions. (5.c, 14.1 & 17)

Treatment Related Rights

- Right to access to mental health care, treatment and services run or funded by the Government which shall be affordable, of good quality, in sufficient quantity, available nearby and without any discrimination (18.1 &2)
- Free mental health services and treatment at state run or funded health establishments to BPL persons (with or without BPL cards), destitute or homeless (18.7)
- Mental health services of equal quality as other general health services without any discrimination (18.8)
- Medicines on the essential drug list, free of cost to all the PwMI, at all times, at all the MHEs run or funded by the Government (18.10)

Rights in an MHE

- Protection from cruel, inhuman and degrading treatment (20.2)
- Safe and hygienic living environment, proper sanitation and facilities for leisure, recreation, education, religious practices and privacy (20.2.b, c & d)
- Proper and dignified clothing to prevent exposure (20.2.e)
- Wholesome food, sanitation, space and access to articles of personal hygiene (20.2.h)
- Right to refuse work and receive appropriate remuneration for the work done. (20.2.f)
- Protection from all forms of physical, verbal, emotional and sexual abuse (20 k)
- Right to move to a less restrictive community based establishment, when it is no longer required to stay in a more restrictive mental health establishment (19.3)

Human Rights in an MHE

- No forced tonsuring (20.2.i)
- No compulsion to wear uniforms (20.2.j)
- No discrimination on any basis - gender, sex, sexual orientation,

religion, culture, caste, political beliefs, class or disability (21.1.a)

- Right to information (22)
- Right to confidentiality (23)
- Right to access medical records (25) Right to personal contacts and communication (26)
- Right to legal aid (27)
- Right to complain about deficiencies in services (28)

Services by the State

- Adequate acute mental health care services, both for outpatients and inpatients (18.4.a)
- Services such as Half way Homes, Sheltered Accommodation, Supported Accommodation (18.4.b)
- Services to facilitate Home Based Rehabilitation (18.4.c)
- Setting up of Community Based Rehabilitation Establishments (18.4.d)

Integrated Mental Health Services as a part of general health care services (18.5a)

- Treatment to PwMI in a manner which inter alia helps their living in the community and with their families (18.5.b)
- Setting up of MHEs across the country to ensure that no PwMI has to travel far for treatment (18.5.d)
- Reimbursement of the cost of treatment in a non-government health establishment if the state run mental health services are not available within a district (18.5.f)
- Quality mental health services to beprovided by the state on par with general health services (18.8)
- Medicines on the essential drug list to be made available free of cost at all times at all the MHEs run or funded by the Government (18.10)

Central Mental Health Authority (CMHA)

Central Authority shall register and supervise all mental health establishments under the control of the Central Government and maintain a register of all MHEs in the country and a national register of all mental health professionals registered to work as such. (43)

State Mental Health Authority (SMHA)

The State Authority shall register, supervise and fix category wise norms

of all MHEs in the state, (except those under the control of the Central Government) and maintain and publish a register of such establishments. The State Authority shall also register all those MHPs who work as such in the state and publish their list. (53)

Mental Health Review Boards (MHRB)

The State Authority shall constitute MHRBs one or more for a district or a group of districts in a state. Powers and functions of the Board shall be mainly to register an AD and to appoint an NR, to adjudicate complaints against MHEs and conduct their inspection and audit. (73 & 82)

Prohibitions and Restrictions

- No Electroconvulsive Therapy (ECT) without anesthesia and muscle relaxant (95.1.a)
- Restriction on Electroconvulsive Therapy (ECT) for minors (95.1.b)
- No sterilization as a part of treatment (951.c)
- No chaining (95.1.d)
- Restriction on Psychosurgery (96)
- No solitary confinement (97)
- Restriction on Physical Restrain (97)

Miscellaneous Provisions

- A less than three year old child not to be separated from inpatient mother unless the severity of her illness poses a threat to the child's life or health (21.2)
- Insurance Companies to make provisions for medical insurance for the treatment of mental illness on the same basis as for the treatment of physical ailments (21.4)
- Free legal services to exercise rights available under the Act (27.1)
  Measures to reduce stigma associated with mental illness (30)
- Registration in place of licence for MHEs (65)
- Provision for Emergency Treatment (94)
- Police to take under protection any person found wandering who, appears to have mental illness and is incapable of taking care of himself or is a risk to himself or others by reason of mental illness (100).
- Decriminalisation of attempt to commit suicide; those with attempted suicide to be rehabilitated by the Government as opposed to prosecution. (115)

Chapter I (Sections 1 & 2): Preliminary

9. What are the concerns of caregivers in regard to the definition of "caregiver" in the Act?

In India, 'caregivers' are 'family caregivers'. The institution of 'paid caregivers' hardly exists. Some of the caregivers feel that it is not appropriate to club the two under one definition. Family Caregivers provide services out of love and bonding, whereas Paid Caregivers are professionals or trained persons who work for money. Family Caregivers and Paid Caregivers should have been defined separately in the Act. (2.e)

10 Why does the Act insist on qualification in clinical psychology from an RCI approved and recognized institution? In some states not a single college is approved by RCI. Why can't it be RCI approved or UGC approved? (2.g.ii)

The RCI is a Statutory Body and its specific role is to develop, standardize and regulate training programmes / courses in the field of Rehabilitation and Special Education. It maintains the Central Rehabilitation Register for qualified Professionals/ Personnel in the area of Rehabilitation and Special Education. The RCI insists that the qualifications prescribed by the Government should be as recognized by them from the institutes recognized and approved by them.

11. What exactly is meant by a Mental Health Establishment? The definition given in the Act is too general!

Irrespective of the size and the number of beds, all such establishments where PwMI are admitted as inpatients for treatment, care, convalescence, recovery or recuperation are MHEs for the purpose of the MHCA. Such facilities may still carry the obsolete name 'Lunatic Asylums' or Mental Hospitals or Psychiatric Hospitals or Half Way Homes or any other name, these would be covered by the definition of MHE. The only exception is a residential place, where the PwMI resides alone or with his family members or friends. (2.1.p)

12. What is the difference between a psychiatrist and a Mental Health Professional?

A psychiatrist is also a mental health professional, which is a wider term and includes professionals having equivalent postgraduate qualifications in mental health in one of the AYUSHpathies and other professionals registered with an SMHA as MHPs (2.1.r)

13. Why has the Act lowered the Psychiatrists' status by bracketing them with other mental health professionals registered with the State Mental Health Authority?

There is no lowering of psychiatrists' position. Mental Health Professional is a broad term and includes all mental health professionals from different streams and with different professional roles and responsibilities and includes a professional registered with a SMHA. (2.1.r)

14. How can a family know for definite that a family member has mental illness?

The Act defines "mental illness" as 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. It is, however, best to leave it to the judgement of a psychiatrist or any other MHP who has training in the diagnosis and treatment of mental illness to determine whether a person has mental illness. (2.1.s)

15. Which are the Mental Illnesses covered under the Act?

The Act does not provide a list of mental illnesses. It, however, states by way of clarifications, some specific inclusions and exclusions. (2.1.s)

16. Is addiction to alcohol/drugs is considered mental illness under the Act?

Yes, mental conditions associated with the abuse of alcohol and drugs are covered by the definition of mental illness given in the Act. (2.1.s)

Chapter II (Sections 3 & 4): Capacity for Mental Healthcare and Treatment Decisions

17 What are the norms given in the Act for determination of various mental illnesses?

The Act provides for determination of mental illness as per nationally or internationally accepted medical standards (including ICD 10) as notified by the Government. (3.1)

18. What about illnesses related to mind/brain such as Intellectual Disability, Down Syndromes, Autism, Alzheimer, Parkinson etc.? Are any of these mental illnesses included or excluded in the Act?

The Act excludes mental retardation (intellectual disability) describing it as a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence. Whether the other illnesses related to brain, named in the question, can be included or excluded as mental illnesses under the Act, will depend on whether these are included or excluded as mental illnesses in ICD 10 of WHO or other internationally accepted medical standards such as DSM 5, as may be notified by the Central Government. Till such time Central Government issues a notification, it would be appropriate to be guided by ICD 10 (chapter v) as it is specifically mentioned in the Act. (3.1)

19. What about LGBTQ? Are they considered as persons with mental illness requiring treatment?

Homosexuality is no longer considered a mental illness. The Act provides that mental illness of a person shall not be determined on the basis of non-conformity with moral, social, cultural, work or political values or religious beliefs prevailing in a person's community. (3.3.b)

20. What are the implications for a person classified under the Act as a person with mental illness?

A person can be classified under the Act as a person with mental illness only for the purposes directly relating to the treatment of mental illness or any other matter covered under the Act or any other law such as

RPwDA 2016 or other operating laws.

The Act states that no person or authority shall classify a person as a PwMI except for purposes (benefits, rights, protections etc.) directly relating to the treatment of the mental illness or in other matters covered under the Act or any other law. (3.2)

21. Is it correct to say that a person classified as a person with mental illness is a person with unsound mind?

No, a person with mental illness is not suo moto a person with unsound mind. Mental illness, being an illness is a medical term and is to be determined by a psychiatrist or another competent MHP, whereas unsound mind is a legal term and is to be determined by a competent court.

The determination of a person's mental illness by itself shall not imply or be taken to mean that the person is of unsound mind. (3.5)

22. Why the term 'unsound mind' has not been defined in the Act, leaving it to the subjective assessment of the judiciary?

The term 'unsound mind' has not been defined as such in any law though it has been used since 19th century by our legal system. Only in section 12 of the Indian Contract Act, it is explained for the purpose of signing a contract. MHCA 2017 being a mental healthcare act, it defines mental illness mainly for treatment purposes. As the term 'unsound mind' appears in the context of legal capacity, it is not relevant in MHCA 2017. Further, as the term 'unsound mind' appears in the Constitution also, instead of a piecemeal approach, a separate legislation including constitutional amendment would be required to get rid of this term from our legal system. Till then it is for the courts to interpret and take a view, as per the facts of the case whenever the matter is placed before them.

The Act gives parameters to determine capacity to take mental healthcare and treatment related decisions. (4.1)

23. What about legal capacity of a PwMI?

The earlier drafts of MHCB contained a statement about Legal Capacity which was subsequently dropped, it being not relevant to mental healthcare and treatment. Since it is a Mental Healthcare Act, only mental health treatment related capacity is described. Legal capacity is described in section 13 of RPwDA.

24. How far is it correct to leave decision making with a PwMI regarding his mental healthcare and treatment?

While protecting the decision making right of a PwMI, the Act contains a proviso. It states that a PwMI is deemed to have capacity to make decisions regarding his mental healthcare or treatment provided he understands the information relevant to take a decision on the treatment, consequence of a decision or lack of decision on the treatment or admission and can communicate his decision. (4.1)

25. How is it to be judged that a PwMI understands the information given to him about his illness, the consequences of his decision on treatment and his ability to communicate it properly? Will it not lead to subjectivity?

The element of subjectivity will be minimal as an Expert Committee appointed by the CMHA shall prepare a guidance document for MHPs, containing procedures for assessing, when necessary, the capacity of PwMI to make mental health care or treatment decisions. Every MHP, while assessing capacity of a person to make mental healthcare or treatment decisions, shall comply with such guidance document and follow the procedure specified therein. (81.1 & 81.2)

26. What can be done by a family caregiver to stop a PwMI, from taking treatment related decisions, which are inappropriate for recovery?

Where a PwMI takes a decision regarding his mental healthcare or treatment, perceived by others as inappropriate or wrong, that by itself, does not mean that the PwMI does not have the capacity to make mental healthcare or treatment decision. (4.1)

A caregiver can definitely give his viewpoint and advice to the PwMI but his opinion cannot override the decision taken by the PwMI. Only if a PwMI lacks capacity and his caregiver is his NR, then alone the caregiver can take decisions on behalf of the PwMI keeping in view what decision, the PwMI would have taken if he were to have the capacity. (Section 4.3)

27. When a treatment related decision is to be taken, a PwMI may have one opinion, his NR another. A caregiver may have a still different opinion and an MHP may have his professional opinion. Will it not cause utter confusion and delay the treatment?

It's not that bad. When a decision is to be taken in regard to treatment, a caregiver may give his opinion/advice but he has no structured role in

decision making. An NR steps in to decision making role, when the PwMI is in need of high support. It cannot be both of them with different views. Further, an NR has to go by the known wishes of the PwMI. So finally, it is between the MHP and the PwMI. An MHP may give his professional opinion and advice and with informed consent of the PwMI start the treatment. A PwMI has a right to refuse the treatment and/or seek modified or different treatment. The MHP has a right to modify the treatment plan as desired by the PwMI or refuse to treat him. (4 and 17.a) .

Chapter III (Sections 5 to 13): Advance Directive

28. What is an Advance Directive?

Definition in the Act - Advance Directive (AD) means an AD made by a person under section 5. (2.1.a).

Universal Definition - An AD means an advance expression by the person of his will and preferences concerning treatment that may need to be taken in respect of him if he subsequently lacks capacity.

Who can write an AD?

Every person, who is not a minor, irrespective of his past mental illness or treatment, has a right to make an AD. (5.1&2)

29. What is the purpose of making an AD?

The purpose is to state how to be cared for and treated and how not to be cared for and treated for a mental illness, and to appoint individual or individuals in order of precedence as NR(s). (5.1)

30. Is it right to leave it to the patients to decide how they want to be treated or not treated? How can we pre suppose that patients will have a sufficient knowledge about the various treatment options or the pros and cons of non-treatment? Even those who have no mental illness comply with what doctors prescribe!

For taking a decision about one's treatment one need not be an expert or a professional. We do so for our physical ailments; treatment is not forced on us. An adult PwMI, who has the capacity to make mental

healthcare and treatment decisions, shall have a right to make an AD. It is up to him to decide on exercising that right. (5.1 & 5.4)

A PwMI is deemed to have capacity to make decisions regarding his mental healthcare or treatment provided he understands the information relevant to take a decision on the treatment, consequence of a decision or lack of decision on the treatment or admission and can communicate his decision. (4.1)

31. What are the requirements for a valid AD?

- It should be in writing on the prescribed form. (5.1)
- It should not be contrary to any law of the land. (11.2.e)
- The person who writes should not be a minor. (5.1)
- It should be registered with the MHRB. (7)
- The person has the capacity to take mental health and treatment related decisions. (11.2.d)
- The person should have written the AD out of free will (11.2.a)
- He is sufficiently well informed to make the decision (11.2.c)

32. Where an AD states that the PwMI wants no treatment but his condition deteriorates to an extent that without treatment, there is risk to his life, will it not amount to euthanasia which is not legal?

If the situation becomes such that there is a danger to the life of the PwMI, emergency treatment can be given, with informed consent of the NR if available, to prevent death or irreversible harm to the health of the PwMI. (94.a)

33. When can an AD be invoked?

An AD becomes operative when the person ceases to have capacity to make mental healthcare or treatment decisions and it remains operative till the person regains capacity to make mental healthcare or treatment decisions. (5.3)

34. What is the procedure for modifying or cancelling an AD?

The procedure for revoking, amending or cancelling an AD is the same as for making an AD. (8.2)

35. What are the implications of an AD for a caregiver/ family?

A caregiver unless he is an NR, will have no say in the treatment which will be as per AD.

If a family caregiver is also an NR, then as an NR, he has a duty to provide

access to the AD to the attending MHP.

There is no compulsion for the family to bear the expenses for the treatment sought in an AD.

36. How will the treating MHP learn about an AD?

Every MHRB shall maintain an online register of all ADs registered with it and make them available to the concerned MHPs as and when required. (7)

It is also the duty of a person writing his AD and his NR to inform, when required, about the AD to the treating MHP. (11.3)

37. What happens to an AD during an emergency?

An AD shall not apply to an emergency treatment given to a person who made the AD. (9)

38. If a treating MHP or a relative or a caregiver does not approve of the AD what are the options available to him?

Where a mental health professional or a relative or a caregiver desires not to follow an AD, while treating or providing care to a PwMI, such person may make an application to the concerned Board to review, alter, modify or cancel the AD. (11.1)

The Board shall, after giving an opportunity of hearing to all concerned parties (including the person whose AD is in question), either uphold, modify, alter or cancel the AD. (11.2)

39. What is the procedure for registering an AD by a minor?

Aminor has no right to make an AD. His guardian as his NR by default can take all treatment related decisions on his behalf. (5.1)

40. The decision making ability of a PwMI suffers due to their illness and they have to depend on a family member to decide on their behalf. How far is it right to leave it to them to decide in advance about their treatment?

No doubt a treating psychiatrist is the best person to take treatment related decisions and an AD might not only delay the treatment but it might also not be the best medical option. An AD is an enabling provision to protect human rights of PwMI. It is not a requirement for a PwMI to make an AD. He may choose not to do so.

41. What are the responsibilities and obligations of an MHP in regard

to an AD of a patient?

- Every MO I/C of an MHE and the psychiatrist I/C of a person's treatment shall give treatment to a PwMI, in accordance with his valid AD. (Section 10)
- Before taking cognizance of an AD produced by an NR, an MHP may ensure that the AD is currently operative and its registration is displayed on MHRB's website.
- If the AD is not registered with the MHRB, it is not a valid AD and not binding on an MHP.
- If it is a valid AD, but its copy has not been given to the attending MHP, he shall not be held liable for not following it. (13.2)
- If a professional decides to treat a PwMI after getting a copy of his AD, he will be required to follow the AD.
- If, an MHP has reservations about the treatment desired in an AD, for ethical or professional reasons, or finds it against his conscience, he may challenge it before the MHRB.
- It would be understandable if he is disinclined to treat such a patient. A professional cannot be coaxed to give a treatment he conscience inappropriate for the patient.
- An MHP has no risk or liability for any adverse consequence resulting from following a valid AD. (13.1)

42. PwMI have been given the right under the Act to get their ADs registered with MHRB but those with physical illnesses have no such right. Is it not discriminatory especially as MHCA 2017 insists on equality in treatment care with persons with physical illness?

MHCA 2017 is an Act for PwMI, therefore making provisions for persons with physical illnesses is beyond its scope. Moreover, persons with physical illness, even they are seriously ill, are generally capable of taking their treatment related decisions without any impairment.

Chapter IV (Sections 14 to 17): Nominated Representative

43. Who is a Nominated Representative?

A Nominated Representative (NR) is not defined in the Act. NR, however, is a person legally nominated by another person to act and take decisions on his behalf.

44. Who can appoint an NR?

A person with mental illness has the right to appoint an NR to take on his behalf all health related decisions. (14.1)

Nomination should be in writing, on plain paper with the person's signature or thumb impression. (14.2)

45. Who can be appointed as an NR?

An NR shall not be a minor, shall be competent to discharge the duties or perform the functions assigned to him and shall give his consent in writing. (14.3)

46. What if no NR is appointed by a PwMI?

Where no NR is appointed, the following persons in order of precedence shall be deemed to be the NR: –

(a)NR in the AD (b) a relative (c) a caregiver (d) Person appointed by the MHRB (e) Director, Department of Social Welfare, or his representative

A person representing an NGO working for PWMI may temporarily be engaged by an MHP to discharge the duties of an NR pending appointment of an NR by the MHRB. (14.4)

47. What is the procedure for changing an NR?

PwMI who has appointed a person as his NR may revoke or alter the appointment at any time following the same procedure laid down for making an appointment of NR.

48. A PwMI can appoint one or more NR to implement AD during treatment and one more to provide support in treatment decisions when the AD is not invoked. Is it not a duplication which might cause confusion and conflict?

Yes, it is a bit confusing. In terms of section 5.1.c, a PwMI has a right to

appoint individual or 'individuals in order of precedence' as NRs. "In order of precedence'' would mean that at one time only one NR would represent the PwMI. Read this with section 14.1, it would be correct to assume that if 2nd or 3rd NRs are nominated, they would function as NRs only in the absence of the NR(s) above them in order of precedence.

49. In our country, where 99% of patients are provided care by families, what is the logic of giving priority to an NR over the family?

In compliance with the UNCRPD, a patient should get the right to decide as to whose support he wants and decide on his NR accordingly.

50. As per section 14.4 of the Act, if no NR is appointed under 14.1 and under 5.1.c, then a relative shall be deemed as an NR. Which relative?

The definition of a relative as given in section 2(y) of the Act is 'any person related by blood, marriage or adoption'. There is no clarity as to which relative, if more than one relatives are willing to be the NR. A hierarchy among relatives should have been included to avoid confusion and conflict. It was there in the second draft but was dropped in the 3rd draft.

51. Will a relative require approval from the Board to perform his duties as a deemed NR?

The Act and the Rules are silent in this regard. Some clarification may come in Regulations. It would be prudent for a relative to inform the MHRB before assuming the role and responsibilities of an NR.

52. Whether a person has the authority to appoint an NR for a minor of whom he is a guardian?

In case of a minor, the legal guardian is the suo moto NR. But if the MHRB, is convinced that the legal guardian is not acting in the best interests of the minor or is otherwise not fit to be the NR of the minor, it may appoint, an individual to act the NR of the minor with mental illness. If no individual is available, the MHRB can appoint the Director Department of Social Welfare or his nominee, as the NR of the minor with mental illness. (15)

53. Why should a psychiatrist be expected to ascertain before starting the treatment, whether an NR is appointed, causing additional paper work and legal complexities for him?

The Act does not make it obligatory for an MHP to find out whether an

NR has been appointed by a PwMI whom he is treating. It is for the NR to show his written appointment and satisfy the MHP, if required, that the appointment is valid and in force besides giving his consent in writing that he will discharge the duties and perform the functions assigned to him under the Act. (14.3)

Any patient, present for appointment, in normal course, should be deemed to have capacity to make his mental health care and treatment decisions and give his informed consent for it as defined in the Act. (2.1.i)

However, if the attending MHP has a doubt about the capacity or if the accompanying NR so indicates, the MHP may take a view as provided in the Act. (4.1.a, b and c)

54. What are the varying levels of support, a PwMI may require from an NR?

Varying levels of support is not elaborated in the Act, though reference to PwMI with high support needs has appeared at several places. The context in which it has been used requires no elaboration. All it means is that level of support needed may vary in the range of nominal/ minimum to maximum/ nearly total. But this does not amount to permanent impairment of capacity to make healthcare or treatment decisions. (14.9)

55. What are the duties and responsibilities of an NR?

An NR has the duty to follow the current and past wishes of the person whose NR he is (17.a), and anything else related to treatment of the PwMI, specifically the following:

- Give particular credence to the views of the PwMI to the extent the PwMI understands the nature of the decisions under consideration
- Providing support to PwMI in making treatment related decisions (17.c)
- Seeking information on diagnosis and treatment (17.d)
- Seeking access to the home based rehabilitation services (17.e)
- Involvement in discharge planning (17.f)
- Applying to MHE for admission (17.g)
- Applying to Review Board for discharge (17.h)
- Appointing an attendant (17.j)
- Apply for supported admission (89.1)

- Provide support to the patient in latter's giving consent for providing treatment (89.6.b)
- Give temporary consent for treatment plan on behalf of the patient requiring nearly 100% support (89.7)
- Participation in consultations in regard to discharge planning (98.1)
- Give, withdraw or withhold consent for research (99.3 and 5)

56. What is outside the domain of an NR?

An NR shall not take any decision which is unrelated to treatment or which is contrary to the AD or the known wish of the PwMI.

57. Do the NRs have the right to ask an MHE for a copy of recorded information pertaining to the PwMI?

Yes. NRs step in to the shoes of a PwMI as far as mental health care and treatment is concerned and can seek information on diagnosis and treatment needed to provide support to the PWMI and fulfill his duties. (17.d & 23.2.a)

58. What is the safeguard against NRs misusing their position, to misappropriate the assets of the PwMI?

An NR is appointed to provide support in only mental health and treatment related matters. (17.c)

59. How far is it correct to give access to an NR about an intimate personal information shared by a PwMI with his psychiatrist?

The Act allows disclosure of information to NR so that he can fulfil his duties under the MHCA. (23.2.a)

An NR, however, can apply for only basic medical records on prescribed form and shall get only specific minimum medical records in prescribed format. No intimate information, unrelated to treatment, will be shared. [MHC (Rights of PwMI) Rules, 6.2 & 6.3, Forms A and B]

60. Can an NR give consent for research involving a person of whom he is an NR?

Yes. An NR has the right to give or withhold consent for research (17.k)

61. Can an NR request an MHE to admit a PWMI against his will?

If a PwMI does not have the capacity to make mental healthcare and treatment decisions (4.1) and conditions required for supported admission under section 89(1) are met, then the NR can request for

admission of PwMI despite his being unwilling for such admission.

62. What is the procedure to be followed by a family member to become an NR for another family member with mental illness?

It is for the family member with mental illness to appoint an NR. If a family member has not appointed any NR, then the order of precedence as given in section 14(4) will be followed to decide on a deemed NR.

63. How will the families and the MHPs come to know that the PwMI has appointed an NR?

Families and Professionals are not expected to keep a track as to whether the PwMI has appointed an NR. It is for an NR to show his nomination from the PwMI to an MHP or to the family and his own acceptance of the same. An NR may also need to satisfy/confirm that he is not a minor and the nomination document produced is, indeed, the last one and has not been revoked or replaced. (14.3)

64. If an NR decides to admit a PwMI in an exclusive MHE as per the wishes of the latter, beyond the means of the family, what should the family do?

An NR may decide on the place and type of treatment but there is no legal obligation on a family to finance such treatment.

65. If an NR and a guardian differ, whose decision will prevail?

This is a hypothetical question and such a situation normally should not arise. Once a limited guardian is appointed, the role of an NR becomes redundant. Also the roles and responsibilities of the two are different. An NR, appointed by the PwMI or by the Board under the Act can take only treatment related decisions, whereas a limited guardian under the RPwDA is appointed, by the Court, to take legally binding decisions on behalf of and in consultation with the PwMI. In the unlikely event, if both, the limited legal guardian and the NR are functioning and have unresolved different views on a gray area issue, the views of the court appointed limited guardian should prevail.

Chapter V (Sections 18 to 28): Rights of Persons with Mental Illness

66 What are the important rights available to a PwMI under "Right to access mental healthcare"?

The Act provides the following key rights to a PwMI related to mental health care -

- Right to treatment and services in establishments run or funded by the Government which shall be affordable, of good quality, in sufficient quantity, available nearby and without any discrimination (18.1 &2)
- Reimbursement of the cost of treatment in a non-government MHE if the state run mental health services are not available within the district. (Section 18.5.f)
- Right to treatment and services, free, at no financial cost at state run or funded and other designated MHEs to BPL PwMI, destitute or homeless. (18.7)
- Right to mental health services, of equal quality as of general health services. (18.8)
- Right to get medicines on the essential drug list, to all PwMI, free of cost and at all times, at the establishments run or funded by the Government. (18.10)

67. What are the main services that the Government is required to provide under the Act?

- Acute MHC services, outpatient and inpatient (18.4.a)
- Half-Way Homes, Sheltered Accommodation, Supported Accommodation (18.4.b)
- Services which facilitate Home Based Rehabilitation (18.4.c)
- Hospital and Community Based Rehabilitation Establishments and Services (18.4.d)
- Mental Health Services as part of General Health Care Services at primary, secondary and tertiary level of the public health system (18.5.a)
- Treatment which enables PwMI living in the community and with their families (18.5.b)
- Provide minimum mental health services in each district (18.5.e)

- Provisions for child mental health services and old age mental health services (14.4.e)
- Basic and emergency mental healthcare services at all CHC and upwards in the public health system.

68. What can be expected from the Government sponsored/supported services such as Half-Way Homes, Sheltered Accommodation and Supported Accommodation (18.4.b)?

The above services have been briefly explained in the Mental Healthcare (Rights of Persons with Mental Illness) Rules, 2018 as under:

"Half way homes" will be a transitional living facility for persons with mental illness who are discharged as inpatient from a mental health establishment, but are not fully ready to live independently on their own or with the family. (2.c)

"Sheltered accommodation" will be a safe and secure accommodation option for persons with mental illness, who want to live and manage their affairs independently, but need occasional help and support. (2.h)

"Supported accommodation" will be a living arrangement whereby a person, in need of support, who has a rented or ownership accommodation, but has no live-in caregiver, gets domiciliary care and a range of support services from a caregiver of an agency to help him live independently and safely in the privacy of his home. (2.I)

69. What treatment options are available to the family of a PwMI, if there are no OPD/IPD facilities available in the nearby district hospital?

The Act requires the Government to provide a range of minimum mental health services in each district (18.5.e)

If minimum specified mental health services are not available in a district where a PwMI resides, then the PwMI is entitled to access any other mental health service in the district and the costs of treatment at such establishments in that district will be borne by the Government limited to the rates specified by the Central Government. (18.5.f and Rights Rule 5.2)

70. What is the procedure for claiming reimbursement of expenses incurred on treatment from a private MHE?

Reimbursement of the cost of treatment in a non-government MHE can be claimed provided the state run mental health services are not

available within a district. Till such time the services are made available in an MHE, run or funded by the State Government, in the district where a PwMI resides, he may apply to the CMO of the district for reimbursement of costs of treatment. The CMO shall examine the application and issue an order to reimburse such costs by the Directorate of Health Services of that State Government. The cost of reimbursement shall be limited to the rates specified by the Central Government from time to time. (MHC-RPwMI Rules-Rule 5)

71. What relief the Act provides to a family who finds it difficult to afford treatment of its family member with mental illness?

The following provisions in the Act will help the financially week families in providing treatment to the family member with mental illness:

- Right to access to mental health care, treatment and services run or funded by the Government which are affordable, of good quality, in sufficient quantity, available nearby and without any discrimination (18.1 &2)
- Free treatment to PwMI living below poverty line, a destitute or a homeless at state run or funded health establishments. (18.7)
- Quality mental health services provided by the state of the same quality as of general health services. (Section 18.8)
- Medicines on the essential drug list free of cost at all times at all the mental health establishments run or funded by the Government. (18.10)
- Reimbursement for treatment at private mental healthcare services in the absence of government mental healthcare services in the district. (18.5.f)

72. What should be done if no free drugs are available in local MHEs?

The Act provides that the Government shall notify Essential Drug List and all medicines on the Essential Drug List shall be made available free of cost to all persons with mental illness at all times at health establishments run or funded by the Government starting from Community Health Centres and upwards in the public health system (18.10)

If there is a non-compliance of the above provision, the matter should be taken up with the State Directorate of Health Services and also SMHA.

73. Is there any relief in the Act for lakhs of homeless PwMI and

thousands of recovered patients languishing in custodial establishments whose families do not accept them?

The Act provides right to community living to all PwMI as follows –

a) Right to live in, be part of and not to be segregated from the society.
b) No one to be kept in an MHE because he does not have a family or is not accepted by family or is homeless or due to absence of community based facilities. (19.1)
c) Where a PwMI is unable to return to his family or relatives, or where a PwMI has been abandoned by his family or relatives, the Government to provide support including legal aid to facilitate his living in the family home. (19.2)
d) The Government to provide or support less restrictive community based establishments including half-way homes, group homes and the like for persons who no longer require treatment in more restrictive MHEs. (19.3)
e) State run custodial institutions (beggars' homes etc.) to take any resident who has or is likely to have a mental illness to the nearest public mental health institution for assessment and treatment. (104)

74. Whether Shelter Homes, Supported Living Facility and Day Care Centres come under the preview of the SMHA?

The Half-Way Homes, Sheltered Accommodations and Supported Accommodations established by the Government or any other entity or person shall follow the minimum standards specified by the Authority under sub-section (9) of section 18 and sub-section (6) of section 65. (3.2 MHC 'Rights of Persons with Mental Illness' Rules, 2018)

Under supported accommodation, however, a person in need of support gets domiciliary care and other support services from a paid caregiver in the privacy of his home. It may not be possible to enforce minimum standards decided by SMHA in a private home. This appears to be an oversight which would need to be corrected.

75. What rights and protections are available to a PwMI admitted in an MHE?

- Right to protection from cruel, inhuman and degrading treatment. (20.2)
- Right to live in an environment which is safe and hygienic and has

other basic amenities. (20.2.a)

- Right to safe and hygienic living environment, proper sanitation and facilities for leisure, recreation, education, religious practices and privacy (20.2.b, c & d)
- Right to proper and dignified clothing to prevent exposure (20.2.e)
- Right to refuse work and get paid appropriate remuneration for the work done (20.2.f)
- Right to wholesome food, sanitation, space and access to articles of personal hygiene (20.2.h)
- Right to refuse tonsuring (20.2.i)
- Right to wear own personal clothes (20.2.j)
- Right to protection from physical, verbal, emotional and sexual abuse (20 k)
- No discrimination on any basis including gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class or disability. (21.1.a)
- Right of equal treatment with persons who have physical illness and right against discrimination
- Right to confidentiality
- Right to information
- Right to personal contacts and communication
- Right to access medical records
- Right to complain against deficiency in services

76. Is it permissible under the Act to keep a PwMI, admitted in an MHE under supported admission, in a closed ward?

MHEs may have to do away with closed wards. Keeping PwMI in closed wards, except convicts, would be construed denial of their rights of free movement/access amounting to cruelty and inhuman, degrading and discriminatory treatment in contravention of provisions contained in section 20 of the Act.

Also PwMI have to be treated at par with persons with physical illness. Hence, if the latter are not placed in closed wards, the same shall apply to PwMI.

77. What is implied by right to equality and non-discrimination provided to PwMI under the Act?

The Act provides that PwMI shall be treated equal to persons with physical illness in all healthcare services, no discrimination on any basis. Emergency facilities and services for mental illness shall be of same

quality and availability as for physical illness including the use of ambulance services in the same manner, extent and quality as for physical illness. Further living conditions in health establishments shall be of same manner, extent and quality as for physical illness; and any other health services provided for physical illness shall also be provided in same manner, extent and quality for mental illness. (21.1)

78. Can an inpatient female in an MHE be permitted to keep her child with her in the ward?

A woman receiving institutional care, treatment or rehabilitation shall ordinarily not be separated from her child if the child is below the age of three. Only, where the treating Psychiatrist, on his examination of the woman or on information provided by others, is of the opinion that there is risk of harm to the child from the woman due to her mental illness or it is in the interest and safety of the child, the child may be temporarily separated from the woman during her stay at the MHE. The woman, however, shall have access to the child under supervision of the staff of the MHE or her family. (21.2)

79. What is the provision in the Act regarding insurance cover for a PwMI and what recourse is available if an insurance company refuses to provide insurance cover for mental illness?

Every insurer is required under the Act to make provision for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness." It eliminates the existing discriminatory provisions and provides a great relief to PwMI and their families. (21.4)

If an insurance company refuses to provide an insurance cover for mental illness, it will be a contravention of the Act and will attract punishments. (108 & 109)

It will also be a non-compliance of the directions given to Insurance Companies in this regard by IRDAI. (Ref IRDA/HLT/MISC/CIR/128/08 /2018 dated 16th Aug. 2018) Aggrieved persons can also approach the Insurance Ombudsman or the IRDAI for relief.

80. PwMI mostly get OPD treatment. Will there be a safeguard for them to get insurance cover for OPD treatment and also against pre-existing mental illness?

Denial of insurance coverage for mental illness or to a PwMI for any other physical ailments/injuries was discriminatory and the MHCA has ended this discriminatory practice. Exclusion of pre-existing mental

illnesses, and OPD costs are conditions common to all policy holders and therefore cannot be addressed in MHCA 2018.

81. What type of information can be sought by a PwMI regarding his forced admission in an MHE?

Under the Right to Information section of the Act, a PwMI or his NR has right to get the following information in a language and form he can understand:

a) provision of the MHCA 2017 or any other law under which he has been admitted, and the criteria for admission under that provision;

b) his right to make an application to the MHRB for a review of the admission;

c) nature of the mental illness of the PwMI and the treatment planned and its known side effects.

In case complete information cannot be given to the PwMI at the time of admission or start of treatment, it shall be provided to the NR promptly and to the PwMI when he is in a position to receive it. (22)

82. If a PwMI is admitted by a caregiver in an MHE, then to what extent should the treating MHP discuss with him about treatment and would the caregiver's consent stand valid in the legal context?

If a caregiver is not an NR, he may accompany a PwMI for Independent Admission but has no formal authority under the Act to admit a PwMI in an MHE. In an MHE, an MHP should discuss the treatment plan with the patient if it is an independent admission and with an NR if it is a supported admission. Any consent required should be from the PwMI or the NR as the case may be. (22.1.c, 85, 89)

83. What provisions are made in the Act to maintain confidentiality in regard to the treatment provided to a PwMI?

The Act provides that a PwMI has the right to confidentiality in respect of his mental health, mental healthcare, treatment and physical healthcare. Health professionals providing care or treatment to a PwMI must keep such information with them confidential with some exceptions as provided in the Act. (23)

84. How much of information can be shared with an NR, keeping in view the need to maintain confidentiality?

An NR can be given the information in regard to treatment which is

required to enable him to fulfil his duties. Personal confidential information unrelated to treatment should not be shared. (23.2.a)

85. Is it permissible under the Act to use group photographs of PwMI in an MHE for an article in a journal?

If the faces in the group photographs are identifiable, or if there is any visual or text which identifies a person, prior consent should be obtained from the concerned PwMI or his NR before sharing it with the media including electronic media. (24.1)

86. Is it permissible for a PwMI or his NR to seek access to his internal medical records, reports, notings etc with the MHE in regard to admission and treatment?

A PwMI has the right to access medical records pertaining to his diagnosis, investigation, assessment and treatment. On his applying in prescribed form for a copy of his basic inpatient medical record to the in charge of the MHE, he shall be provided the same within 15 days from the date of receipt of submission, basic inpatient medical records to him in prescribed form. (25.1, Rule 6)

87. How should a professional proceed if he has reservations about sharing information from medical records with a PwMI or his NR?

The MHP in charge of such records may withhold specific information in the medical records if disclosure would result in serious mental harm to the person with mental illness; or if there is likelihood of harm to other persons.

If an MHP or an MHE is unable to decide, whether to disclose information or provide basic inpatient medical records or any other records to the applicant for ethical, legal or other sensitive issues, he or it may apply to the MHRB stating the issues involved and his or its views seeking directions. The Board shall, after hearing the concerned PwMI, by an order, give directions, to the MHP or MHE. (25.2, Rule 6)

88. If an MHP/MHE refuses to share the information required by a PwMI or an NR or provides inadequate information, what remedies are available with a PwMI?

When any information in the medical records is withheld from a PwMI or his NR, the MHP shall inform him of his right to apply to the Board for an order to release such information. An application may then be made by a PwMI/ NR to the MHRB. (25.3 & 77)

89. Are there any provisions in the Act which enable a PwMI to have

free communication with friends and relatives on mobile or in person and use of social media?

PwMI in an MHE has the right to refuse or receive visitors and to refuse or receive and make telephone or mobile phone calls at reasonable times. He may also send and receive e-mails. If he informs the in charge of the MHE that he does not want to receive mail or e-mails from any named person, the in charge may restrict any such communication by the named person. There are, however, some exceptions to this provision in the Act. (26)

90. In some MHEs, families are not allowed to meet or contact the admitted PwMI for the first few weeks. Is it sustainable under the Act?

No, such restrictions by an MHE are not sustainable. A PwMI in an MHE has a right to receive visitors and receive or make telephone/mobile calls at reasonable time and on payment where cost is involved. (26.1)

91. Is there any provision for legal support to a PwMI?

PwMI is entitled to receive free legal services, under the Legal Services Authorities Act, 1987, to exercise his rights available under the Act. (27.1)

92. How can we create awareness among stakeholders about the availability of free legal services to PwMI?

Magistrates, police officers, persons in charge of custodial institutions and in charges of MHEs are required to inform PwMI that they are entitled to free legal services under the Legal Services Authorities Act, 1987 and other relevant laws and provide the contact details of the availability of services. (27.2)

93. What is the way for a PwMI or his NR to seek redressal of the poor services provided by an MHE?

"A PwMI or his NR can complain regarding deficiencies in services in an MHE to (a) the in charge of the MHE and if not satisfied (b) to the MHRB and if still not satisfied (c) to the SMHA.

"A PwMI may also seek any judicial remedy for violation of his rights in an MHE or by an MHP under the Act or any other law. (28)

Chapter VI (Sections 29 To 32): Obligations of the State

94. The Act provides delivery of quality mental health services at affordable cost and also free quality treatment for homeless persons and for those below poverty line (BPL), even if they do not possess a BPL card. (18.3 &18.7).

Is there a provision in the Act for availability of funds to meet large expenses in delivery of such universal services?

No doubt the financial implications for the Government will be huge. The Government will have to make much more budgetary allocations for health to meet its obligations under the Act and the current allocation of meagre less than 1% of health budget on mental health will have to be increased many fold. The Act provides that the Government shall take measures to ensure that necessary budgetary provisions are made in terms of adequacy, priority, progress and equity for effective implementation of the provisions concerning rights of the PwMI. (18.11)

95. Are there any provisions in the Act to promote mental health and to remove stigma?

The Act casts upon the Government responsibility to plan, design and implement programmes for the promotion of mental health and prevention of mental illness and to reduce suicides and attempted suicides in the country. (29.1 & 29.2)

The Government shall take measures to ensure that, -

(a) provisions of the Act are given wide publicity through public media, including television, radio, print and online media at regular intervals;

(b) programmes to reduce stigma associated with mental illness are planned, designed, funded and implemented in an effective manner;

(c) Government officials including police officers get periodic sensitisation and awareness training on the issues covered in the Act. (30)

96. How will the Government meet the huge human resource requirements which will increase many fold to provide services committed in the Act?

The Act provides that the Government shall take measures to address

the human resource requirements of mental health services in the country by planning, developing and implementing educational and training programmes in collaboration with institutions of higher education and training, to increase the human resources available to deliver mental health interventions and to improve the skills of the available human resource to better address the needs of PwMI. (31.1)

The Government has initiated several measures in this regard. The medical colleges now have Psychiatry Departments and the number of postgraduate seats has been doubled. In near future, there would be a significant increase in the number of the postgraduates in psychiatry passing out from the medical colleges.

The Act casts obligation on the Government to train all medical officers in public healthcare establishments and all medical officers in the prisons or jails to provide basic and emergency mental healthcare. (31.2)

Accordingly graduates and postgraduates in medicine are being trained in psychiatry and short term training programmes are being arranged for the District Medical Officers to deal with emergencies.

Further to augment the human resource needed to provide wider mental health care services listed in the Act, it is provided that the Government shall make efforts to meet internationally accepted guidelines for number of MHPs on the basis of population, within ten years from the commencement of this Act. (31.3)

Chapter VII (Sections 33 To 44): Central Mental Health Authority (CMHA)

97. Is there any provision in the Act for representation of stakeholders on CMHA?

The Central Government shall nominate, MHPs as members of the Central Authority, one AYUSH MHP, one PSW, one clinical psychologist and one mental health nurse, having a minimum of fifteen years' experience in their respective fields and registered as MHP with a State Authority, as members of the Central Authority. (34.1. i, j, k, l & CR 5.1)

The Central Government shall also nominate non-professional stakeholders as members of the Central Authority, who should of the age not exceeding 67 years, among them two persons each representing (a) persons who have experienced mental illness; (b)

persons representing care-givers of PwMI or organisations representing care-givers; (c) persons representing non-governmental organisations which provide services to PwMI; and (d) persons representing areas relevant to mental health. (34.1.m, n, o, p & MHCCMHA & MHRB Rules 5.2)

98. What is the process followed for nominating non-professionals on CMHA?

A vacancy for the post of nonofficial member of the CMHA shall be given wide publicity through open advertisement in at least two national daily newspapers (one English and one Hindi) having wide circulation and the advertisement shall also be made available on the website of the Ministry. The Selection Committee constituted shall consider all applications received and decide about the suitability of the applicants for being selected as members of Central Authority. The persons selected by the Selection Committee shall be nominated by the Central Government on the CMHA.

99. Why is there no provision for a psychiatrist member on the CMHA?

It is wrong to say that there is no psychiatrist on the CMHA. There is adequate representation of psychiatrists on the CMHA and further safeguards have been built in Rules to ensure that psychiatrists never remain unrepresented on the CMHA.

CMHA will have Directors of the Central Institutions for Mental Health as ex-officio members (34.1.g). All these directors are usually psychiatrists. One MHP to be nominated could also be a psychiatrist (34.1.i). If in the most unlikely situation, where none of the members nominated under clause (34.1.g) and clause (34.1.i) are psychiatrists, then two psychiatrists shall be nominated as members under the clause "two persons representing areas relevant to mental health". (34.1p & MHC-CMHA & MHRB Rules 2.d).

100. What are the functions of CMHA?

The CMHA is a central regulatory agency. It shall advise the Central Government on matters relating to mental health care and services. Its functions, inter alia, will include registering and supervising all MHEs under the control of the Central Government, maintaining a register of all MHEs in the country and maintaining a national register of clinical psychologists, mental health nurses and psychiatric social workers and discharge such other related functions as the Central Government may decide. (43.1)

Chapter VIII (Sections 45 To 56): State Mental Health Authority (SMHA)

101. What is stakeholders' representation on SMHA?

The State Government shall nominate members on SMHA as following:
One eminent psychiatrist and one MHP (AYUSH, Psychiatry), one PSW and one mental health nurse having a minimum of fifteen years' experience in their respective fields and registered as MHPs with the State Authority, as members of the State Authority. (46.1.g, h, i, j, & k) (Rule 5.1&2)

Two persons each from the following categories namely: —

(a) persons representing persons who have or have had mental illness;

(b) persons representing care-givers of PwMI or organisations representing care-givers; and

(c) persons representing non-governmental organisations which provide services to PwMI. (46.1.l, m & n), (Rule 5.3, SMHR)

102. What are the functions of SMHA?

An SMHA is a state level regulatory authority. It shall register all MHEs in the State (except those under the control of the Central Government) and shall maintain and publish a register of such establishments. Its other important functions include developing quality and service provision norms for MHEs in the state, supervise all MHEs in the state and register clinical psychologists, mental health nurses, and psychiatric social workers in the State and publish their lists and discharge such other related functions as the State Government may decide. (55.1)

Chapter IX (Sections 57 to 64): Finance, Accounts and Audit

103. Will funds for implementing the Act come out of funds created for CMHA and SMHA?

The Act provides for creation of CMHA Fund and SMHA Fund but the funds are meant only to meet the expenses incurred by the respective CMHA and SMHAs. (58 & 62)

Chapter X (Section 65 To 72): Mental Health Establishments (MHEs)

104. Which type of hospitals or nursing homes qualify as MHEs?

Any health establishment where PwMI are admitted and reside at or kept in for care, convalescence and rehabilitation is an MHE under the Act. (2.p)

105. Are there/any legal requirements under the Act for starting an MHE?

No person or organization shall establish or run an MHE unless it has been registered (MHA 1987 required a licence) with the concerned authority. (65.1)

106. What are the requirements to be met by an MHE for registration with an MHCA/CMHA?

Every MHE shall, for the purpose of registration and continuation of registration, fulfill—

(a) minimum standards of facilities and services as may be specified;
(b) minimum qualifications for the personnel engaged as may be specified;
(c) maintenance of records and reporting as may be specified; and
(d) any other conditions as may be specified. (65.4)

107. MHEs are required to engage personnel with specified qualifications. Clinical psychologists and psychiatric social workers with requisite qualifications as defined in the Act are very few. How can MHEs comply with this requirement?

Both the above qualifications as defined in the Act have a proviso, "or such recognized qualifications as may be prescribed". It is expected that the SMHA, while making regulations in regard to "minimum qualifications for the personnel engaged in such establishments" shall take into account the availability factor. (65.4.b read with 2.g & 2.x)

108. Why conditions for registering and running of MHEs are made cumbersome, which would become disincentives to continue existing MHEs and to start new MHEs?

Provisions in regard to registration of MHE and checks and balances provided are necessary. The obligations cast on MHEs are desirable and easily implementable. The annoying provisions found in earlier drafts in regard to periodic renewals and nontransferability which would have discouraged the opening of new MHEs were also removed.

109.In MHA 1987, general hospitals/nursing homes with psychiatric wards were excluded from licensing requirement. Further psychiatric hospitals established or maintained by the Central/State Government were also exempted. The MHCA 2017 includes such establishments as MHEs. What caused the withdrawal of exemptions?

There is no justifiable reason for excluding certain establishments providing residential mental health care from the ambit of the Act. An all-inclusive definition covering all the MHEs will ensure that the minimum standards are uniformly followed by all MHEs without any exception. If, however, a general hospital is registered under any other act, it may send a copy of such registration along with an application on the prescribed form and an undertaking that the minimum standards are being fulfilled as specified by the Authority. (Explanation to 65.2)

The Act provides for exemption from registration of any MHE by notification by a Central Government. (Proviso to 65.2)

110. What is the position in regard to registration of the Day Rehab Centres and establishments providing ambulatory services?

PwMI attending Day Rehab Centres or getting ambulatory services are not required to reside in or kept at establishments providing such services. Hence such establishments are not MHEs for the purpose of the Act. In earlier drafts, the plain reading of the definition of an MHE conveyed the meaning that all establishments including day centres and where treatment was provided on ambulatory basis would get covered. The stake holders sought changes in the definition which was done subsequently by adding the words “reside at”.

111. Under 1987 Act, for establishing or maintaining a psychiatric hospital or nursing home, a valid license was required from a competent authority. The MHCA 2017 provides for registration of an MHE with CMHA or SMHA. What is the reason for this change?

License under MHA 1987, with a local health licensing authority required renewal once in 5 years. Registration with CMHA or SMHA, once the classification of MHEs is done and the minimum standards are laid down, shall be a onetime affair and no renewal shall be required. Registration is also a simpler process based on self-certification regarding compliance with minimum standards, requiring no prior inquiry. The procedure ensures standardization. Further the Authority is required to grant or reject permanent registration within 45 days. If there is no communication from the Authority within 45 days, the registration is deemed to have been granted. (66)

112. If an old age home has a few inmates on neuroleptics for their mental illness as prescribed by their psychiatrists, whether the old age home is required to get registered with SMHA as PwMI reside there?

If the old age home only provides boarding and lodging to senior citizens and is not a health establishment where PwMI are admitted for their mental health care, treatment, convalescence and rehabilitation, the home is not covered by the definition of an MHE. Therefore, no registration is required by the old age home under the Act. (2.p & 65.1)

113. Why is there no inspection of an MHE, prior to granting registration? Will it not lead to non-compliance?

There is no mandatory inspection before issuing a registration certification. Instead selfcertification in regard to compliance with the minimum standards is required. This ensures that the registration is not delayed due to procedural reasons. This together with once in 3 year Audit together with inspection and inquiry suo moto or on receipt of a complaint are considered adequate checks. (66)

114. At the time of applying for provisional registration, whether provisional category under which registration is sought is to be stated?

For grant of provisional registration, there is no mention of a category in the Application Form. However, after the standards are fixed category-wise, the MHEs will need to apply afresh for category-wise permanent registration within a period of six months from the date of notification of such standards. (66.8) (Form B, State Rules)

115. If the registration granted to an MHE is permanent, how will the Authority ensure that the minimum standards continue to be observed by them?

While registration once granted is not required to be renewed periodically, there is a provision for audit of MHEs once in 3 years conducted by the MHA to ensure that MHEs comply with the requirements of minimum standards. Failure to do so can lead to cancellation of the registration. (66)

116. What is the difference between an audit and an inspection of an MHE?

Once in 3 year, SMHA Audit of an MHE is a statutory requirement to ensure that minimum standards and other requirements for continuation of registration are being complied with. Inspection and Inquiry of an MHE by SMHA is done in response to a complaint or when there is a need for it otherwise. An audit is ordinarily a more

comprehensive exercise whereas an inspection or inquiry may be more specific to look into specific issues. (Sections 67 & 68)

117. Will it be in order for a general nursing home, which is not registered as an MHE, to admit persons with mental illness for treatment not related to mental illness?

The Act defines MHE as a health establishment, meant wholly or partly for the care of persons with mental illness and where such persons are admitted and reside at or kept in for care, treatment, convalescence and rehabilitation. (2.p).

If the nursing home does not provide treatment or care related to mental illness, no registration is required with the Mental Health Authority for admitting a person for treatment and care for other illnesses even if he happens to have mental illness.

118. If a person needs to be admitted to a de-addiction and rehabilitation centre recognized under the Act, where one can get this information?

De-addiction and Rehabilitation Centre is an MHE under the MHCA. There is no provision for recognition of an MHE. There is, however, a requirement for registration by an MHE. The State Authority shall register all MHEs in the state except those referred to in section 43 and maintain and publish (including online on the internet) a register of such establishments (55.1.a)

Further every MHE shall display the certificate of registration in a conspicuous place in such manner so as to be visible to everyone visiting the MHE. (70.1)

119. Where can one find the names and other particulars of MHEs in the State?

SMHA is required to maintain in digital format a register of registered MHEs in the State which shall be in public domain, accessible to all. (71)

120. What options are available with an NR, if he has a grievance regarding the deficiencies in services in an MHE? Where can he get the information?

If there is no redressal or not satisfied with the responses at the MHE level, an NR may write to the Review Board, followed by SMHA If not satisfied with MHRBs answer. Every MHE is required to display within the establishment at conspicuous place (including on its website), the contact details including address and telephone numbers of the concerned Review Board. (72) Any judicial remedy should be the ultimate recourse. (28)

Chapter XI (Sections 73 To 84): Mental Health Review Boards

121. Which is the authority responsible to constitute MHRBs? What are their functions?

The SMHA is required to constitute MHRBs for a district or a group of districts in the State. The Act provides for the constitution of MHRBs by SMHA as an independent review mechanism to oversee the functioning of MHEs and to protect the rights of PwMI in such facilities, as required under the CRPD. (73)

122. What is the rationale of setting up MHRBs without any office, staff and regular work?

MHRBs have been setup to protect and safeguard the human rights of PwMI as provided under the Act and in compliance with the UNCRPD. To keep the costs low, the provision of setting up of Mental Health Review Commission in earlier drafts was dropped and provision made for low cost setup of MHRBs. The Act provides for meetings of MHRBs at MHEs which would save costs and ensure visits to the MHEs. If any need is felt for secretariat, the same can be provided in regulations.

123. Who all constitute an MHRB?

Each Board shall consist of— (a) a District Judge, or an officer of the State Judicial Services qualified to be appointed as District Judge or a retired District Judge who shall be chairperson of the Board; (b) representative of the District Collector or District Magistrate or Deputy Commissioner of the districts in which 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 PwMI or care-givers or persons representing organisations of PwMI or care-givers or NGOs working in the field of mental health. (74.1)

124. Will it not be a logistic problem, and a wasteful burden on the exchequer, to constitute over 700 MHRBs? How do we expect busy district civil officers and officers from Judiciary to find time to undertake additional work of MHRBs? Also from where can we get psychiatrists in the districts to work on MHRBs? (73, SMHA Rule 17)

That all the districts in the country will have Review Boards causing logistic problem is a misapprehension. The SMHA shall constitute Review Boards, the number of which will be decided in consultation

with the State Government as per norms prescribed by the CMHA and keeping in view the workload. There could be one MHRB even for 3 districts. Further, the chairperson of the Review Board need not be a busy District Judge. He could also be an officer of the state judicial service or a retired district judge. Furthermore, it is not the busy district magistrate but a representative appointed by him who will be on the Board. Districts having MHEs, will also have psychiatrists.

125.What are the functions of MHRBs?

The functions of the Board include registering advance directive, appointing nominated representatives, receiving and disposing of complaints received against MHEs, enquiring and taking action against MHEs where violations of human rights of PwMI are reported, to adjudicate complaints regarding deficiencies in care and services specified under section 28; to visit and inspect prisons or jails and seek clarifications from the medical officer in-charge of health services there. (82.1)

126.MHRBs are to be chaired by district judges. What competence do they have in regard to admissions, discharge, and adequacy of treatment?

Such bodies with multiple responsibilities and duties should have representatives of different stakeholders besides ex officio members. Judicial officers hear and decide all type of cases. It is somewhat juvenile to doubt their capability and to expect that only professionals should be nominated.

127.For a complaint made by an NR to an MHRB, will he be required to present himself and the patient before the Board?

In respect of any application concerning a PwMI, the Board shall hold the hearings and conduct the proceedings at the MHE where such a person is admitted. Thus a PwMI need not go to the Board. The Board will come to the person to hear him. (80.8)

128.What protection can be provided by an MHRB to PWMI admitted in an MHE against ill treatment?

The Board, in consultation with the Authority, may take measures, to protect the rights of PwMI, it considers appropriate.

Where it is brought to the notice of a MHRB or CMHA/SMHA that a mental health establishment violates the rights of PwMI, the Board or the Authority may conduct an inspection and inquiry and take action to protect their rights. (82.2 & 82.3)

Chapter XII (Sections 85 to 99): Admission, Treatment and Discharge

129. Can a PwMI seek self-admission and self- discharge in an MHE?

Any person who considers himself to have a mental illness and desires to be admitted to any MHE for treatment may request the concerned authority in the MHE for admission as an independent patient. (86.1)

Any person admitted as independent patient shall be discharged immediately on a request made by him. (Rule 8, Form G)

A mental health professional, however, may delay discharge for a maximum period of 24 hrs. to make an assessment necessary for readmission and continuation of treatment under the category Supported Admission with High Support Needs. (89) Depending upon the assessment, the patient would either be discharged or readmitted as a supported patient before the expiry of 24 hour period. (88)

130. If a father requires admission for his minor daughter in an MHE, can he stay with her as her guardian cum attendant?

In the case of minors, legal guardians shall be their NR unless the MHRB orders otherwise.

Where the NR is male, a female attendant shall be appointed by the NR under all circumstances, who shall stay with the minor girl in the MHE for the entire duration of her admission. Some MHEs may be able to provide a female attendant on payment. (87.6)

131. How far is it correct to bracket a psychiatrist with a medical practitioner as co-signatory for supported admission in an MHE? Is the latter competent to assess a PwMI for supported admission?

A second MHP's endorsement is required for supported admission, for first admission as it is difficult for an NR to find a 2nd psychiatrist apart from the attending psychiatrist. The second certifying signatory, however, if he is a clinical psychologist or a medical practitioner, cannot provide treatment to a PwMI. Further, if the supported admission needs to be continued beyond 30 days, then both the certifying MHPs shall be psychiatrists only. (89.1.a and 90.2.a)

132.Why should the discharge of a person admitted as an independent patient be delayed to assess the need for his retention under supported admission? Why not follow the same procedure laid down for supported

admission given in S.89?

The law makers have made this provision to save on procedural delays that would be caused in the process of discharge under one category and then readmission under another category. If the assessment is for re-admission under supported category, then the due procedure for supported admission, under section 89 will be followed. This will obviate the likelihood of imminent harm to self or others.

133. If a PwMI soon after admitting himself in an MHE for treatment, asks for a discharge against medical advice, whether a caregiver can insist on his staying for more time in the hospital till he recovers fully?

It being an independent admission under section 86, if medical advice is against his discharge in terms of section 88 (3), he will need to be readmitted under section 89 as a supported admission. As a caregiver you have no formal say in the matter. But if you are also his appointed or deemed NR, your role will be there for his supported admission.

134. If a family member is a caregiver but not a documented NR is convinced that his family member has severe mental illness and requires in patient care but the family member refuses to go to hospital, what should be done in such a case?

As the caregiver is not a nominated NR, he cannot take any medical decisions on behalf of his family member with mental illness. But assuming that the caregiver is also a deemed NR (14.4.b.), he will have to establish that the family member with mental illness does not have the capacity to make mental healthcare and treatment decisions (4) and seek admission under section 89 following the laid down procedure.

135. What is the requirement for supported admission? Where can one get help to facilitate supported admission?

The MO or MHP I/C of an MHE shall admit a PwMI, upon application by the NR, if—

(a) the person has been independently examined on the day of admission or in the preceding seven days, by one psychiatrist and one MHP or a medical practitioner, and both independently conclude based on the examination and on information

provided, that the person has a mental illness of such severity that he—

(i). has recently threatened or is threatening or attempting to cause bodily harm to himself; 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 inability to care for himself to a degree that places him at risk of harm to himself;

(b) the psychiatrist or the MHP or the medical practitioner certify, after taking into account an AD, if any, that admission to the MHE is the least restrictive care option possible in the circumstances; and

(c) the person is ineligible to receive care and treatment as an independent patient because the person is unable to make mental healthcare and treatment decisions independently and needs very high support from his NR in making decisions. (89.1)

136. Supported admission in a psychiatry hospital is given only if a patient is likely to cause harm to self or others or is unable to take care of self. Is it not stigmatising, as it equates severe mental illness with dangerousness?

Further majority of patients do no harm but need admissions for treatment and prevention of deterioration. Why should we wait until condition worsens and a patient starts hurting himself or others and then admit him?

Supported admissions being forced admissions, these can be only under compelling circumstances which need to be stated. For independent admission, there is no waiting. The Act states that all admissions in the MHEs shall, as far as possible, be independent admissions. (85.2)

137. In the context of supported admission, what is meant by "the least restrictive care option possible in the circumstances"? (Section 89.1.b)

Similar terms are defined in the Act as under:

"least restrictive alternative" or "least restrictive environment" or "less restrictive option" means offering an option for treatment or a setting for treatment which— (i) meets the person's treatment needs; and (ii) imposes the least restriction on the person's rights." (2.1.j)

138. If a PwMI takes admission in an MHE as an independent patient, and asks for discharge a few days later, but instead is detained for a day and then readmitted under supported category, what should he do for his discharge?

The PwMI can apply to the Review Board challenging his detention and seeking review of the decision of the MO or MHP I/C of the MHE in this regard. The Board shall review and give its findings within seven days

which will be binding on all. (88.3) and (89.10)

139. What are the requirements for Supported Admission in an MHE?

A PwMI, with high support needs can be admitted in an MHE, for a maximum period of 30 days, on an application made by the NR of the person provided a psychiatrist and a MHP/medical practitioner have independently examined the person during the last 7 days and both have observed/concluded that the person has a mental illness of such severity that the person has caused or can cause harm to himself or to others or is unable to take care of himself which places him under risk/harm. (89, Rule 8, Form E) On the expiry of 30 days, the patient may continue to stay in the MHE after a fresh independent assessment by two psychiatrists and approval by the Board for a period of 90 days. The 90 day period may be extended by a period of 120 days and thereafter by a period of 180 days each time following the procedure as above.

If the assessment is negative, the patient may still continue to stay at the MHE as an independent patient after meeting the required conditions for independent admissions. (90)

140. What is the procedure for challenging continuation of a supported admission in an MHE against the wishes of a PwMI?

A PwMI admitted under section 89 or his NR or an NGO with the consent of the PwMI, can apply to the MHRB for review of the decision of the in charge of the MHE to admit or continue admission of the PwMI to the MHE under this section. The MHRB shall review the decision of the in charge of the MHE and give its findings thereon within seven days of receipt of request for such review which shall be binding on all the concerned parties.

141. If a person suffers from chronic schizophrenia and due to old age his parents are unable to look after him, what is the procedure given in the Act for keeping him in an MHE on a long term basis?

There is no provision in the Act to keep a patient in an MHE for a long term amounting to keeping him permanently. The maximum period for which a supported admission can be granted at one time is one hundred and eighty days which can be extended by the Board from time to time subject to the laid down conditions. (90.9&10)

142. If a PwMI requires 100% support from his NR, then NR can give consent on behalf of patient. What would amount to 100% support and

what would be less than that?

Hundred percent would, of course, mean total and nearly hundred percent would mean nearly total.

The phrase used in the Act is “nearly hundred percent” and it is in the context of “consent to the treatment plan”. If a PwMI with high support needs, admitted in an MHE beyond thirty days, requires nearly hundred per cent support from his NR, in making decision in respect of his treatment, the NR may temporarily consent to the treatment plan on behalf of such person. (90.12)

143.If the family members of a PwMI, admitted in an MHE, are going out of station and want him to come with them, will it be necessary for them to seek discharge and readmission?

No, discharge and re-admission are not required for a few days' absence from an MHE. The MO or the MHP I/C of the MHE may grant leave to any PwMI admitted under section 87, 89 or 90, to be absent from the MHE subject to conditions, if any, and for such duration as may be decided. (91, Rule,9, Form I)

144.If an admitted PwMI who is granted leave of absence by the MO I/C does not report after the expiry of leave, what action should be taken by the MHE?

In clause 101 of the Mental Healthcare Bill 2013, the provision of police taking into protection a PwMI absent without leave or discharge applied to all the persons granted leave by an MHE. Parliamentary Standing Committee on Health and Family Welfare, however, objected to its saying that it perpetuated the perception that PwMI admitted in MHEs were dangerous to society and that police forcibly conveying the person back to MHE would take away the fundamental right of the person guaranteed under the constitution. Accordingly, the clause was modified. Thus, now no legal recourse is available in respect of a PwMI not returning to an MHE on expiry of leave granted, except in the case of prisoners. It would, however, be okay for an MHE to remind the NR of the PwMI about the expiry of leave and also keep the police informed. MHEs will also do well to grant leave to PwMI sparingly in exigencies only. (92 & 103 of MHCA 2017)

145. If a patient escapes from the hospital, can his NR or caregiver ask the hospital to get police help in searching for him in terms of Section 92 of the Act?

Section 92 is to be read with section 103. If any prisoner with mental

illness, who is detained in an MHE under section 103 of the Act, absconds or absents himself without leave or without discharge from the MHE, he shall be taken into protection by any Police Officer at the request of the MO or MHP in-charge of the MHE and shall be sent back to the MHE immediately. Even if an escaped patient is not covered by section 92, it would be prudent for an MHE to inform the police about a missing patient. (92)

146. Is it possible to transfer a wandering PwMI from one MHE to another in his home state without going through the process of discharge and readmission?

An PwMI admitted to an MHE, may by an order of the MHRB can be removed from one MHE and admitted to another MHE within the State or with the consent of the CMHA to an MHE in any other state provided that no PwMI admitted to an MHE shall be transferred unless intimation and reasons for the transfer are conveyed to concerned PwMI or his NR. (93)

147. If a PwMI, charged with an offence, is detained in a jail. Is there any way to get him moved to a hospital from the jail? What should be done for this?

The State Government may make such general or special order as it thinks fit directing the removal of any prisoner with mental illness from the place where he is for the time being detained, to any MHE or other place of safe custody. The concerned authority can be approached for such an order and if necessary a court can be approached for issuing such an order to the concerned authority. (93.2)

148. If a person with severe mental illness gets violent and refuses to visit hospital, can the family take the help of a medical practitioner to sedate him against his will, to enable the family to take him to the nearest MHE? Can a caregiver, not a registered NR give consent for such procedure in the interest of the patient and the family?

The Act permits any RMP to initiate emergency treatment to any PwMI at a health establishment or in the community where it is immediately necessary to prevent -

(a) Death or irreversible harm to the health of the person; or
(b) Person inflicting serious harm to himself or to others; or
(c) Person causing serious damage to property belonging to himself or to others

In such a situation, NR consent is not compulsory. The Emergency Treatment can be given with the consent of the NR if available. If not available, then without his consent also (seems incomplete statement). If you are not an NR, then your consent has no meaning. (94.1)

149. For emergency treatment, families may need to take a patient to an MHE without his cooperation. Whether an ambulance service provided by the Government can be used on such occasions?

Emergency treatment includes transportation of the PwMI to a nearest MHE for assessment. Further a PwMI is entitled to the use of ambulance services in the same manner, extent and quality as provided to persons with physical illness (94.1 Explanation & 21.c)

150. Why compliance with AD is excluded from Emergency Treatment? Is it not an infringement of the rights of the PwMI to decide about their treatment?

It being an emergency, the Act provides that the lifesaving treatment can be given by any available RMP, even in the absence of the NR. It is an enabling provision in an emergent situation. The RMP available at that time may not know anything about AD. This is justifiable, in the circumstances, medically and ethically.

151. What are the restrictions/checks/prohibitions in regard to treatment given to a PwMI?

- No ECT without the use of muscle relaxants and anesthesia. (95.1.a)
- No ECT on minors. In exceptional cases, however, with an informed consent of the guardian and permission of the Review Board. (95.1.b and 95.2.)
- No sterilization as a treatment for mental illness (95.1.c)
- No chaining in any manner or form. (95.1.d)
- No psychosurgery without informed consent of the PwMI and Board's approval.(96.1)
- Physical restrains if absolutely needed, and are the least restrictive method available. (97.1)
- Total ban on seclusion and solitary confinement (97.1)

152. Whether the Act allows private psychiatrists to perform ECT in their private clinics?

Section 95 of the Act only prohibits ECT without the use of muscle relaxants and anesthesia. There is no restriction as such on performing ECT in an outpatient setting in a dedicated ECT Treatment space, which is not a part of an MHE.

153. Why Psychosurgery, which is archaic and barbaric and does irreversible damage to the brain, finds a place in the Act?

When the Act was in drafting stage, it was demanded that psychosurgery (lobotomy) should be totally banned. It was, however, stated that in some rare cases, lobotomy might be required to save life. The section in its present form has adequate safeguards and regulations are expected to make it an extremely rare procedure to be permitted. (96.2)

154. What is post discharge planning?

Whenever a PwMI is discharged from an MHE, back to the community or to a different MHE or where a new psychiatrist in the same MHE has to takes over, the attending psychiatrist in consultation with all concerned including the PwMI, NR, caregiver, other family members and MHPs, shall draw a treatment and care plan showing how treatment and mental health services should continue to be provided to the PwMI (98)

155. Will it be okay for an MHE to agree to a research project by an agency engaged by a pharmaceutical company involving IPD patients?

Agency conducting research will need to obtain through MHE free informed consent from all those inmates whose participation is required for research. If an inmate is unable to give free and informed consent but does not resist participation in it, permission to conduct research should be obtained from SMHA after seeking informed consent of the NR. The SMHA may allow if satisfied that the proposed research is necessary to promote the mental health. (99)

156. If a family member has mental retardation and does not have the decision making capacity, can a family caregiver give consent on his behalf for psychological research? (99)

A person with mental retardation being not a person with mental illness, provisions of MHCA are not applicable in his case. (2.1.s)

But if it is a case of comorbidity, the family member has mental illness also and needs high support, a family member as deemed NR may give informed consent on his behalf to a researcher. Final permission, however, will be given by SMHA. (99.3)

Chapter XIII (Sections 100 To 105): Responsibilities of Other Agencies

157. What care is available in the new Act to a wandering PwMI?

- Officer I/C of a police station shall take under protection any person found wandering at large within the limits of the police station, if he appears to be with mental illness and is incapable of taking care of himself/herself. (100.1.a)
- The person taken under protection shall not be detained in a lockup and shall be taken within 24 hrs.to the nearest public health establishment for assessment of the person's health care needs. (100.3)
- On assessment, if it is found that the person has mental illness of a degree which requires admission in an MHE, the same will be arranged in a government run or supported MHE. If not, the person will be taken to his residence or if homeless, to a government establishment for homeless person. (100.6)
- For homeless persons an FIR for missing person shall be lodged by the police and efforts shall be made to trace the family. (100.7)

158. Can a family seek police help if the family member with mental illness refuses treatment or talks about suicide?

Refusing to take medicine or casual talking about suicide may not be enough ground for the police to take the person under its protection. Police, however, is required to take cognisance if -

- The person is a risk to himself or a risk to others
- The risk is by reason of mental illness.
- The person resides within the jurisdiction of the police station. (100.1.b)

PwMI, due to the nature of their illness tend to accuse their family members of ill treatment. Sometime neighbours, friends or relatives may believe in such accusations and may report it to the police or even to the magistrate. What can be done to protect families against such false accusations? (101)

There is need to provide sensitization and awareness training to the police and the judiciary; the Act casts this responsibility on the Government. (30.c)

159.Is there any change in the Act in regard to admission through a

Reception Order?

In the new Act, there is no provision for a "Reception Order". If a magistrate still passes a Reception Order for admission and treatment in an MHE, the magistrate's attention should be drawn to the repealing of the MHA 1987 and the new provisions under the MHCA 2017.

There is, however a provision in MHCA 2017 for admission under a Magisterial Order. When a person, who may have a mental illness, and is neglected or ill-treated in his private residence, is brought before a magistrate, the magistrate may convey the person to a public MHE for assessment and treatment. Alternatively, the magistrate may authorize the admission of the person in a MHE for a period not exceeding 10 days to enable the MHE to carry out an assessment of the person and plan for necessary treatment.

On completion of the assessment, the MHE shall submit a report to the concerned magistrate and the person shall be dealt with as per the provisions of the Act. (102)

160. Who can seek a Magisterial Order for admission of a PwMI in an MHE, an NR or a family member or a friend or a neighbor?

An NR can take a PwMI directly to the MHE for admission under section 89 of the Act. A magisterial order is not required for that. A magistrate can be approached for conveyance of a PwMI to an MHE by any person or an officer I/C of a local police station, who has reason to believe that the PwMI is being ill-treated or neglected by a person having responsibility for care of such person.

If the Magistrate has reason to believe, based on the report of a police officer or otherwise, that any PwMI within the area of his jurisdiction is being ill-treated or neglected, the Magistrate may cause the PwMI to be produced before him and pass an appropriate order conveying him to a public MHE for assessment or treatment if required or the magistrate may authorize his admission to an MHE for maximum 10 days for an assessment report and treatment if required. (101 & 102)

161. In a court case where the disputed issue is the mental illness, the Act provides that the Court shall refer the evidence of mental illness produced for further scrutiny to the MHRB. Is the MHRB, competent to give a decisive opinion considering that out of 6 members, only one is a psychiatrist?

The Act provides that MHRB may submit its opinion after examining the

person alleged to have mental illness either by itself or if required through a committee of experts. Such committee of experts will consist of MHPs and other experts competent to give expert opinion. (105)

162. What should the families do for approaching a magistrate for guardianship?

In the MHCA, there is no provision for a guardianship. Also a magistrate has no power to grant guardianship of a PwMI. There is a provision for limited guardianship in the RPwDA for which a family member may approach a district court or a designated authority notified by the State Government. (14, RPwDA)

Chapter XIV (Section 106): Restriction on Functions by Professionals

If a person with mental illness, refuses allopathic treatment but is willing to go to an ayurvedic doctor, will it be okay to request the ayurvedic doctor to prescribe antipsychotic medicines (may be along with other ayurvedic medicines) which worked for him in the past?

No, it will not be okay; the Act does not allow crosspathy. No MHP or a medical practitioner shall specify or recommend (or prescribe) any medicine or treatment not authorised by his professional field. (106)

163. Whether under the Act, clinical psychologists and General Medical Officers are authorised to prescribe neuroleptic drugs to PwMI?

Clinical psychologists, though MHPs are not authorized by their field of profession to prescribe medicines.

General Practioners, though not MHPs under the Act should be deemed as qualified to give first line of treatment and section 106 should not come in the way of their prescribing medicines for mental illness. Government's policy is to provide short online training in psychiatry to the MBBS doctors at PHCs. NIMHANS and some other institutes of mental health have devised such programmes. New MBBS curriculum now has a full paper on mental illness. To bring clarity, this should be notified /confirmed by the CMHA/SMHAs. In an emergency, of course, any RMP is authorized to provide treatment subject to certain stipulations. (2.1.r, 2.1.y, 94, 106)

Chapter XV (Sections 107 TO 109): Offences and Penalties

164. What are the penalties for contraventions of the provisions of the Act?

For running an MHE without registration, penalty shall be between five thousand rupees and fifty thousand rupees for first contravention and between fifty thousand rupees and two lakh rupees for a second contravention and a penalty between two lakh rupees and five lakh rupees for every subsequent contravention.

Whoever knowingly serves as an MHP in an MHE which is not registered shall be liable to a penalty up to twenty-five thousand rupees. (107)

The punishment for violation of provisions under this Act by an individual or a company (in-charge responsible to the company for conduct of business) is imprisonment up to 6 months or Rs. 10,000 or both. Repeat offenders can face up to 2 years in jail or a fine between Rs. 50,000 and 5 lakhs or both. (108)

165. If an insurance company does not make a provision for medical insurance for treatment of mental illness on the same lines as for physical illness, can the insurance company be punished for violation of law under the MHCA 2017?

If an offence, under the Act is committed by an insurance company, a person who is incharge and responsible to that insurance company for conduct of business and if the offence is committed with the consent or connivance of or neglect by a director or any other officer, he too shall be deemed to be guilty of the offence and liable to be proceeded against and punished. (109)

166. Why are the penalties imposed for violations so moderate? These don't seem enough deterrents?

Penalties proposedin MHCB 2013 were even milder. Based on suggestions received, these were upwardly revised. What is the right quantum of punishment is a matter of opinion. The law framers consider these provisions adequate.

167. If a family member with mental illness gets violent and refuses treatment, the officer I/C of the police station is expected to take him to the nearest MHE, in accordance with Sec 108 of the Act. In case of his

refusal to help, what should be done to make him comply with the law?

An officer I/C of a police station has a duty to take under protection any person within the limits of the police station who, the officer has reason to believe, is at risk to himself or others by reason of mental illness. Every such person taken into protection is required to be taken to the nearest public health establishment as soon as possible but not later than twenty-four hours from the time taken into protection, for assessment of the person's healthcare needs. (100.1 & 3)

Section 108 is about punishment for contravention of provisions of the Act. There appears to be no such contravention here, The Police Officer has to be reasonably convinced that the PwMI is, indeed, a risk to himself or others.

Chapter XVI (Sections 110 To 126): Miscellaneous

168. If a person under treatment for depression attempts suicide, can this be condoned under the new Act?

Yes, in normal circumstances, it is no more a punishable offence. The Act provides that notwithstanding anything contained in section 309 of the IPC, any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the said Code. (115.1)

169. My daughter with mental illness, who was deserted by her husband, attempted suicide and nearly killed herself. Can her husband be prosecuted for abetting attempt to suicide under this Act?

MHCA 2017 provides relief only for the person who has attempted to commit suicide.

Abetment of suicide committed is a punishable offence under section 306 of IPC. Abetment to cause unsuccessful attempt to commit suicide, however, may be outside the purview of section 306.

170. Though the Act was notified on 29th May 2018, still there are no MHRBs and new SMHAs though formed in some states, are not functional. What should be done by those MHEs whose licences have expired and those which are new and need a licence or registration for their functioning?

The Central Government, in the interest of the PwMI, could have drawn

a transitory scheme to overcome such transitory issues and to end confusion during the transitory phase. In the existing circumstances, MHEs whose licences under MHA 1987 have expired and those which are new would do well to apply for temporary registration in the prescribed format to the SMHA which was formed under the MHA 1987 and which continue to function till the new SMHA is formed. (117)

171. Who will frame the Regulations and when? Why is it delayed so much? Delay is causing confusion and uncertainty!

Central Regulations will be framed by CMHA and State Regulations by SMHA. Draft Regulations were framed by the Committee of Experts constituted by the MOHFA. Hopefully, both the regulations, Central and State will be finalized and notified soon to ensure smooth implementation of the Act. (122 & 123)

172. There seem to be a number of contextual errors in the Act, which cause confusion. How will that be corrected?

It appears that when the MHCB 2013 was modified and certain clauses were added or deleted, a few consequential contextual changes in the text of relevant clauses were left out. Some minor typing errors were also there. This was brought to the notice of the Ministry of Health and Family Welfare. Ministry of Law has notified most of these corrections. The readers may make the following notified corrections in their copy of the Act: (Vide Ministry of Law Gazette Notification dated 8th January 2018)

173. Chapter V of the Act is all about the treatment related rights of the PwMI. With rights come responsibilities. What responsibilities are assigned to PwMI in the Act especially to take sensible decisions regarding their treatment?

The preamble of the Act states that it is an Act to protect, promote and fulfil the rights of PwMI during delivery of mental healthcare and services. Further the Statement ofObjects and Reasons of the Act state that as PwMI constitute a vulnerable section of the society and are subject to discrimination, the Act is made to protect and promote their rights during the delivery of health care in institutions and in the community. (SoOR2.a.i& 2.b.i)

Hence the entire chapter V is devoted on the treatment related rights of the PwMI. (18 to 28)

As regards their responsibilities to take apt decisions regarding

Stakeholders' Concerns - PwMI

Page No.	Line(s)	For	Read
2	20	“sub-section (1) of section 80"	"sub-section (1) of section 73"
4	6	"clause (x)"	"clause (y)"
6	16	"clause (a) of sub-section (1) of section 91"	“clause (a) of sub-section (1) of section 82"
6	25	"section 103"	"section 94"
10	15 and 16	"clause (e) of sub-section (4)"	“clause (e) of this sub-section"
20	10	": clause (q)"	"clause (r)"
30	31	"section 85"	"section 77"
43	4	"sub-section (5)"	“sub-section (6)"
47	29 and 30	"sub-clause (ii) of clause (f) of sub-section (1) of section 2"	"sub-clause (ii) of clause (g) of sub-section (1) of section 2"
47	31 and 32	"clause (w) of sub-section (1) of section 2"	"clause (x) of sub- section (1) of section 2"
48	14	"manner"	"the manner"
48	15	"a State"	“a State under sub-ection (3) of section 73”
48	16 and 17	"clause (e) of sub-section (2) of section 82"	"clause (e) of sub-section (2) of section 74"
49	16	"confirm under-sub-section (6) of section 103”	"conform under-sub-section (7) of section 103"
49	25	"manner"	"the manner"
49	39	"provisions"	"the provisions"
50	1	“manner	“the manner”
50	3 to 5	Omitted	
50	6	“clause (n)	“clause (m)”
50	8	"clause (o)"	"clause (n)"
51	5	"14 of 1897."	"14 of 1987."

treatment, the Act states that a PwMI is deemed to have capacity (and ability) to make decisions regarding his mental healthcare or treatment. (4.1)

If a PwMI requires support to make mental health care or treatment related decisions, it can be provided by the NR or by a deemed NR as provided in the Act. (14.4 & 14.9)

A PwMI has a deemed responsibility under the Act to nominate an NR in writing and to make an AD, get it registered with the Review Board and inform the attending psychiatrist about it himself or through his NR.

174.How far is it right to leave the treatment related decision entirely to a

PwMI, knowing well that the person could be in a denial mood? Are we not aping the West blindly and in the process doing harm to the PwMI?

The Act has been enacted to align and harmonise it with CRPD and its Optional Protocol. The Act recognizes that normally a PwMI has the capacity to take decisions regarding his mental health care and treatment and if such a decision is perceived by others as inappropriate or wrong that by itself does not mean that the person has no capacity to take decisions about his own mental health care or treatment. (Preamble and 4)

Further, the Act provides for the situations, when a PwMI may not be able to take decisions. During such a phase the treatment related decisions shall be taken by the NR in accordance with the registered AD if any

Stakeholders' Concerns - Families

175. Why is there nothing for family caregivers in the Act?

The Act is enacted "to provide mental healthcare and services to PwMI and to protect, promote and fulfill their rights during delivery of mental healthcare and services and for matters connected therewith and incidental thereto". It is not an Act for other stakeholders. Any reference to other stakeholders including families is in context of delivery of mental healthcare and services to PwMI.

The Act, however, states that the Government shall provide for mental health services to support family of PwMI or home based rehabilitation (18.4.c)

176. Families play a major role in providing care and arranging treatment for PwMI. Why is there no recognition of their role in the Act?

In its Preamble, the Act, does recognize that "families bear financial hardship, emotional and social burden of providing treatment and care for their relatives with mental illness". Two family caregivers each can be nominated on CMHA and SMHA and may also get nominated on MHRB. (34.1.n & CR 5.1), (46.1.m & n, SR 5.3), (74.1.d)

177. By adding provisions in regard to NR and AD in the Act, which are alien and in conflict with the traditional role of families in India, are we

not destroying the valuable institution of families?

With changing times, the number of nuclear families is increasing and joint family system is slowly crumbling. Stakeholders expect the state to play a larger role in mental health care and treatment of PwMI so that families get some respite. The Act takes into account modern day realities, and aspirations.

NR and AD are enabling provisions for PwMI to exercise their basic human rights and were required to be included to comply with UNCRPD. A PwMI may choose not to write an AD and may choose one of his family members as his NR. Many believe that these clauses may remain ornamental clauses and may seldom be used unless specific campaigns are launched to educate PwMI to use such clauses in the Act.

178. If the treatment is based on AD and the decisions about treatment taken by NRs, will it not make the family caregivers redundant?

The fear is exaggerated. In all likelihood, family caregivers will be the NRs, nominated or deemed. But yes, there could be some erosion in the role of family caregivers especially if the NR is not a family member. If human rights of PwMI are to be protected, they should have the freedom to take their own decisions related to their medical care and treatment. Family caregivers need to understand, accept and adjust.

179. A good number of PwMI are non-cooperative about their treatment. Caregivers get medicines prescribed for them by describing symptoms to a known psychiatrist and mix the medicines in food. Will there be any problem to this arrangement under the new Act?

The Act does not specifically cover the practice of Proxy/Surreptious Prescriptions and covertly administering medicines. There are legal, practical, ethical and professional issues involved. Seeking prescriptions without a doctor seeing a patient will become more difficult in days to come.

The Act emphasizes on informed consent. If, however, it is established that a PwMI does not have the capacity to make mental healthcare and treatment decisions in terms of section 4 of the Act, it might be possible for the NR to take treatment related decisions on behalf of PwMI and administer medicines. If there is deterioration and conditions are met for supported admission, then NR can choose that option also.

180. Is there any provision in the Act which requires the Government to provide treatment to PwMI in a manner that enables families to keep

PwMI at home?

There is no such provision and there is no need for such a provision. Normally PwMI live with their families and receive treatment as OPD patients at Government run or funded MHEs as well as in private clinics and General Hospitals with psychiatric wards. Admission as inpatient is done only when there is aggravation.

181. What should caregivers do to make the Government allocate necessary budget and launch schemes for mental health care as provided in the Act?

The Act requires the Government to ensure that necessary budgetary provisions in terms of adequacy, priority, progress and equity are made for effective implementation of the provisions related to "Right to access mental healthcare". The expressions, "adequacy", "priority", "equity" and "progress" have been elaborated. (18.11)

Health being a state subject, the financial burden of implementing the provisions of the Act will be on the states. Where the states have a resource crunch, the Central Government will need to make necessary allocations to meet the expenditure from the Consolidated Fund of India.

The caregivers and other stakeholders may need to lobby through joint representations and petitions, seek help of the public representatives and through courts etc. if there are deficiencies in the implementation of the provisions of the Act.

182. Under which provision in the MHCA a guardian can be appointed for a family member with mental illness, who requires support in day to day life and in decision making? How should this be done?

The provision of guardianship existed in the MHA 1987. MHCA 2017 being a healthcare act only, provision in regard to guardianship does not find a place in this Act. This provision, now, is included in the RPwDA 2016.

As per section 14(1) of the RPwDA 2016, where a district court is satisfied that a person with disability (including a PwMI) is unable to take legally binding decisions, it may provide the support of a limited guardian to take legally binding decisions on his/her behalf in consultation with the concerned person with disability. The district court may also grant total support (plenary guardianship) in special circumstances or where the limited guardianship is granted repeatedly.

Stakeholders' Concerns - MHEs

183. What are the added responsibilities for existing Mental Hospitals/Nursing Homes under the new Act?

- Seeking provisional and permanent registrations on the prescribed form. (65.1 & 66, State Rule 11, Form-B)
- Compliance with minimum standards as laid down by Central or State Mental Health Authority. (65.6)
- Following procedures for admission, treatment and discharge as laid down in Chapter XII of the Act. (85 to 98)
- Ensuring that no PwMI admitted in their establishments is subjected to any cruel, inhuman or degrading treatment, protection against which is provided in the Act (20)
- Compliance with a registered AD if it is brought to their knowledge by an NR. (10)
- Taking cognizance of an NR for admission and any other treatment related decisions Complying with requirements for audits/inspections conducted by the CMHA/SMHA.
- Compliance with any other obligation under the Act.

184. What are the major compliance related concerns for MHEs?

Compliance with the minimum standards will be challenging for MHEs. The existing MHEs may need to make major alterations and up-gradations and provide amenities etc. to meet the requirements. The staff at MHEs will have to make attitudinal changes to protect the human rights of the PwMI admitted in the establishment. They will also need to make procedural changes in the style of their working.

185. Will digitization be compulsory for an MHE?

The Act is silent about it but it may be provided in the regulations as Authorities will have all the records online.

186. How will the Act affect the General Hospitals and the PG Institute?

General Hospitals and PG Institutes with psychiatric beds are covered by the definition of MHE in the Act. As such, these establishments will have to apply for registration and comply with the minimum standards laid down in the Regulations and with all such provisions applicable to MHEs.

A farfetched fear is expressed that some general hospitals may choose to close their psychiatric wards to avoid the hassles of compliances and

those which were contemplating starting psychiatric wards might feel discouraged.

Stakeholders' Concerns - MHPs

187. Statutory bodies consist of professionals to oversee and regulate the working of professionals. Why do the surveillance bodies in the Act, MHRBs and CMHA/SMHAs consist of non-professionals who do not understand the profession?

The bodies have been constituted under the Act to supervise the MHEs (not the MHPs) and mental health care and treatment of PWMI. These bodies are not for surveillance over MHPs.

188. How will the Act affect the Private Psychiatrists running only consulting clinics?

- The psychiatrists doing private practice which does not involve admission and overnight stay, need not get their clinics registered under the Act.
- There is no requirement to comply with the minimum standards.
- They will, however, be required to comply with the provisions regarding AD, NR, Prohibited Procedures, confidentiality and other general provisions not specific to MHEs.
- They will follow valid ADs, which are registered with MHRBs and copies of which are given to them.
- They will take cognizance of NRs who produce appointment letters to that effect and there is no doubt about their authenticity.
- If they administers ECT, the procedure will be modified ECT and they will seek informed consent from the PwMI or their NRs.
- If the patients to be given ECT are minors, informed consent from the Guardians and prior approvals from the Review Board will have to be obtained by the psychiatrists doing the procedure.

189. The Act comprehensively provides about the rights of PwMI in regard to their treatment; what about the rights of the treating MHPs?

It is an Act to provide for mental healthcare and services for PwMI and to protect, promote and fulfill the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto (Preamble)

Rights of other stakeholders are not covered under this Act. There are,

however, other laws, which should take care of the interests of the MHPs and other stakeholders.

Stakeholders' Concerns - Miscellaneous

190. Will those doing their PG in psychiatry require approval from the CMHA/SMHA for their research and clinical trial involving a PwMI with high support needs?

In case of research involving any psychological, physical, chemical or medicinal interventions to be conducted on a person who is unable to give free and informed consent but does not resist participation in such research, permission to conduct such research shall be obtained from concerned State Authority. (99.2)

The State Authority may allow the research to proceed based on informed consent being obtained from the NR of persons with mental illness, if the State Authority is satisfied that—

(a)the research cannot be performed on persons capable of giving free and informed consent; (b) the research is necessary to promote mental health of the population represented by the person; (c) the purpose of the research is to obtain knowledge relevant to the particular mental health needs of PwMI; (d) a full disclosure of the interests of persons and organisations conducting the proposed research is made and there is no conflict of interest involved; and (e) the proposed research follows all the national and international guidelines and regulations concerning the conduct of such research and ethical approval has been obtained from the institutional ethics committee where such research is to be conducted. (99.3)

191. The Act provides that all information about MHPs and ADs of PwMI shall be available in an online register. Will it not be a breach of confidentiality?

The Act provides that SMHA shall register clinical psychologists, mental health nurses and psychiatric social workers in the State to work as MHPs, and publish list of such registered MHPs in a manner specified by regulations by the State Authority. There is no confidentiality involved in publishing such a list. (55.1.d)

Further MHRB shall maintain an online register of all ADs registered with it and make them available to the concerned MHP when required. As the AD will be available only to the concerned MHP, there is no breach of confidentiality. (7)

192. Will a roaster of Board Members be available on line?

Hopefully it will be clarified in the Regulations.

193. If a PwMI or his NR refuse treatment, what will be the SOP?

If a PwMI or his NR decides not to take the treatment, there is not much that can be done. If, however, an emergency treatment is required and the NR is not available for his consent, an RMP may administer the appropriate treatment up to 3 days provided any of the 3 conditions laid down for emergency treatment are met. (94)

Further if there is an AD stating that no treatment should be given, a caregiver or a relative or a MHP may seek a review, alteration or modification or cancellation of the AD with the concerned MHRB.

194. Are there any special provisions mandating MHEs to make special arrangements for women to meet their gender specific requirements?

A few safeguards provided in the Act are as under:

- A female staying in an MHE shall ordinarily be permitted to keep her child below 3 years with her or if separated briefly for safety reasons, shall have supervised access to the child. (21.2)
- Access to mental healthcare and treatment without discrimination on the basis of gender and sex. (18.2)
- Women's personal hygiene shall be adequately addressed by providing access to items that may be required during menstruation.
- There shall be no discrimination on any basis including inter alia gender and sex. (21.1.a)
- A minor girl in an MHE, during entire duration of her stay shall, have a female NR or female attend ant staying with her.

Other safeguards for women such as separate wards with female staff, adequate number of separate toilets, adequate privacy etc. are likely to be included in regulations/minimum standards.

195. In Mental Healthcare Bill 2013, there was a salutary provision that current or past treatment for a mental illness of a person shall not be a ground for seeking or granting divorce. Why was it dropped subsequently?

There were legal issues involved. On a recommendation from the Parliamentary Standing Committee, the Government agreed that any change in marital laws should be undertaken as a separate exercise.

196. Is there any special provision in the Act for veterans?

No, there is no special provision for veterans in the Act. Armed forces, however, take adequate medical care of their retired personnel.

197. Is there a mechanism available to address the implementation of the Act and its continuous monitoring?

There is no such mechanism exclusively to monitor the implementation of the Act except that CMHA and SMHCA are required to submit annual reports to the Central and the respective State Governments giving full account of their activities during the previous year, which are laid by the Governments before both the houses of Parliament and before the State legislature. (60 & 64)

198. While some stakeholders consider the Act as the best thing that happened to the Mental Health Sector, some others find it too ambitious, provisions impractical to implement and bound to create difficulties for psychiatrists and families. What would be an objective assessment?

- It is too early to make an assessment.
- No law of the land is perfect.
- No law can fully satisfy all the stake holders.
- No law is forever; it can be amended when required and even replaced by a new law.
- MHCA 2017 extends substantial benefits to PwMI, and protects their human and health related rights.
- The Act is progressive and in tune with the changing times.
- Some of the provisions may pose challenges for the families.
- The state may not find resources for some of the cost intensive benefits.
- Intense advocacy will be required to find resources to implement the provisions of the Act and the Rules made under it.
- While, being optimistic about the Act, there is a need to wait and watch for its implementation.
- PwMI have remained deprived of their basic rights for centuries. All the stakeholders need to work in unison to implement the Act for their betterment.

Schizophrenia Awareness Association

Kamalini Kruti Bhavan,
Lane No. B 30-31, off Dhayari Road, Pune - 411041
Tel. : 020- 24391202 / 9881190000 9834899383
schizpune@gmail.com,
www.schizophrenia.org.in,
www.facebook.com/SAA.Help

Registrations :

- **Societies' Act: Maharashtra/1155-97/Pune**
- **Public Trust Act :** F/14439/Pune, **PWD Act**: 09-10/2971
- **IT Exemption :** Pn/CIT-III-Tech/80G/435/2012-13/622,
- **FCRA Registration :** 083930633
- **ISO** 9001 : 2015