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UNSHACKLING

Mental Illness and The Mental Health Care Act 2017



Editor
Savita Malhotra

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CHAPTER 10

Implementation Gap in Mental Health Care Act 2017: A Survey Report

Savita Malhotra, Shruti Srivastava, Mahesh Gowda, Nidhi Sharma, Jayaprakashan KP, Mohan Roy Gopalan, Imon Paul, Vidyadhar Govind Watve

[The IPS constituted a Task Force named "Mental Health Care Act (MHCA 17) Task Force" for the year 2023–24, with following as its members: Dr Savita Malhotra: Chairperson, Dr Jayaprakashan KP: Co-Chairperson, Dr Mohan Gopal Roy: Convenor, Dr Shruti Shrivastava: Member, Dr Nidhi Sharma: Co-opted Member, Dr Mahesh R Gowda: EC Co-Ordinator, and Dr VG Watve: Advisor.)

INTRODUCTION

"Mental health is an integral and essential component of the right to health," said Dr Tedros Adhanom Ghebreyesus, World Health Organization (WHO) Director-General. Mental health has been acknowledged and accepted as a universal human right and is essential to realize the right to health. This right would include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of mental health. It also entails the right to services that are available, accessible, acceptable, and of appropriate or good quality. Persons with mental illnesses are more vulnerable to economic and social marginalization. National mental health legislations should provide a legal framework for addressing all these rights and protections for persons with mental disorders. The United Nations (UN) Convention on the Rights of Persons with Disabilities (UNCRPD), 2006,[1] reinforces the protection of international standards of human rights in mental health care and recognizes that the rights of persons with mental health conditions and psychosocial disabilities are equal to those of any person. According to WHO (2023),[2] legislation on mental health must take a new direction away from the narrow traditional "biomedical paradigm" and fully embrace human rights. There is a clear mandate for mental health systems to adopt rights-based approaches, enabling person-centered and community-based services, raising awareness and challenging stigma, eradicating discrimination and coercion, promoting community inclusion and participation, and developing accountability measures. Mental health and human rights and legislation are inextricably interlinked.

Mental health laws in India are largely a legacy of the British and were mostly concerned with custodial care and protection of the society, with limited concern for the care and treatment of the mentally ill. It is only with mental healthcare reform movement that the focus shifted toward eliminating custodial approach and stigma, de-institutionalization, and community care. This change also required support of suitable legislation. In the past 30 years, many countries have launched mental health reforms. Historically, care for the persons with mental illness (PMI) has been fraught with stigma, discrimination, indignity, and human rights violation.

Mental health law in India, like most other countries in the world, is a standalone legislation. While several countries have begun to integrate CRPD-inspired measures into their laws, it is too early to understand the true impact of the CRPD

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on national mental health legislative frameworks. In most legal systems, the legal capacity of a person can be restricted in many areas of life based on a mental health diagnosis or the lack of "mental capacity". "Where a stand-alone law already exists, it should be reviewed by countries to prevent separate or distinct regulation. Countries should also avoid the separate regulation of the rights of persons with psychosocial disabilities through stand-alone mental health laws, which are amenable to being mainstreamed into disability or anti-discrimination legislation" (WHO 2023).[2] Rather, it has been proposed that there should be efforts at mainstreaming of mental health and well-being as a strategic objective in general health and legislative framework.

Mental health legislation in India was significantly shaped by the British. In 1858, three pieces of legislation were introduced: the Lunacy (Supreme Courts) Act, the Lunacy (District Courts) Act, and the Indian Lunatic Asylum Act. To these, the Military Lunatic Act was added in 1877. These pieces of legislation were consolidated in 1912 under the Indian Lunacy Act, which drew heavily on the English Lunatics Act, 1845. Shortly after Indian independence in 1947, a modern mental health act (MHA) was drafted, but this legislation took over 35 years to be adopted, finally becoming the Mental Health Act, 1987.[3]

Under the Indian Lunacy Act 1912, admission and certification procedures were defined. It offered only detention and custody but no care and treatment. It was highly stigmatizing in terminology: Patients were called lunatics and institutes were named as lunatic asylums. There were only 19 asylums throughout the country with a total bed strength of 10,000.[4] The Alma-Ata declaration of "health for all" and the need for treatment rather than seclusion led to the enactment of a new law for mental health care which was named as Mental Health Act (MHA) 1987.[5] This Act aimed to establish central and state authorities for licensing of psychiatric hospitals, provide custody for those mentally ill persons who were unable to look after themselves, were dangerous to self/others, and were unable to safeguard their rights. These authorities did not include any doctor. It made provisions to regulate admission and discharge procedures, and the major stress was on institutionalization and no provision was made for after-discharge community care. The Erwadi tragedy exposed the reality about major gaps in the care of mentally ill individuals in the community. In 2001, 28 inmates of a faith-based mental asylum in Erwadi village in Tamil Nadu, who were bound by chains awaiting the divine command in their dreams to go back home, died in fire. The lack of implementation of the MHA was the main reason for Erwadi tragedy. The patients were not getting treatment and were detained in the asylum in the name of the Act.[6]

Laws are required for addressing critical issues such as care, rights, regulations, and protection of vulnerable sections of society, ensuring equal opportunity and participation of all. It makes provision for funding and fixes accountability for the quality of services. Legislation provides vital support for implementing effective mental health services because the mentally ill as a group are mostly stigmatized, discriminated, and may be incapable of accessing treatment due to impaired decision-making abilities.

India ratified the UNCRPD 2006[1] in 2007. The UNCRPD 2006 set out the legal obligations on states to promote and protect the rights of persons with disabilities. It aimed to promote, protect, and ensure the human rights and fundamental freedoms of all persons with disabilities and to promote respect for their inherent dignity. After India ratified the UNCRPD, the government revised all legislations relating to persons with disabilities (PWD), including the MHA 1987, to bring them in consonance with the UNCRPD.

The Mental Health Care Act (MHCA) received the assent of the President of India on April 7, 2017, and was notified on May 29, 2018. MHCA

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2017 is "an Act to provide for mental healthcare and services for PMI and to protect, promote, and fulfil the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto." This is an Act fully aligned with the provisions of the UNCRPD with focus on provision of mental healthcare services for all, promotion of the rights of PMI, community inclusion, dignity, autonomy, empowerment and recovery, and making access to mental health care a statutory right. This is progressive and an ambitious legislation with the hope of improving the mental health care in the country.

The MHCA 2017 mainly focuses on the rights of PMI, only during hospital admission, but does not guide about the continuity of treatment in the community. The Act does not acknowledge and facilitate the role of family members in providing care to PMI which is an essential resource in care of PMI in India. The paucity of mental health professionals (MHPs) in India makes the role of family in caregiving all the more important in India. Moreover, traditional values system of concern and care of family members is a unique strength of India that has to be respected and utilized for the best benefit of PMI.

There are many shortcomings and challenges in the Act such as "advance directives" (AD) and "nominated representatives" (NR) that are discussed and published earlier as well.[7] Similarly, several difficulties and impediments were experienced in treating PMI due to very restrictive clauses in the MHCA 2017 leading to denial and delay in the treatment of severe mental illness, putting the families and patients under tremendous distress. Most psychiatrists were discussing the deficiencies in MHCA 2017 in their day-to-day clinical practice in various fora such as conferences, seminars, social media groups, and so on. It has been amply clear that there is a great deal of dissatisfaction about the Act among psychiatrists. There is no data available so far documenting the real-time difficulties faced by psychiatrists in treating patients with mental illness on account of MHCA. The Act has not been implemented fully in India which also caused problems in managing patients. For example, due to absence of Mental Health Review Boards (MHRBs) or State Mental Health Authorities (SMHAs), seriously ill patients could not be admitted for treatment, putting tremendous burden on their families.

The feasibility of the implementation of the Act has been much discussed earlier without any supporting database. There was a dire need to undertake a critical analysis of MHCA 2017, studying its practical utility and the feasibility of its implementation. Considering this need, MHCA 2017 Task Force of the Indian Psychiatric Society (IPS) planned to conduct a nationwide online survey of psychiatrists in India about the status of MHCA implementation and the problems faced in clinical practice.

A survey was carried out to understand the following:

- What was the current level of implementation of the MHCA in the country and what was the level of knowledge and awareness of various provisions of the MHCA among psychiatrists in India?
- What has been the experience of the practicing psychiatrists in using and complying with the provisions of the MHCA 2017?
- What is the overall level of satisfaction with the Act?

A set of 65 questions in 16 domains were framed, to ask about the awareness, knowledge, experience, opinion, and suggestions about the various provisions of the Act for an online survey. The questions were simple, short, easy, and quick to answer. There was an option for free text responses on major aspects of MHCA that are relevant in everyday practice. A survey

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was conducted between April and May 2023, for 4 weeks. An online survey form was sent individually to all members (3,500 Life Fellows + 4,000 Life Members) of the IPS by email and also circulated widely in WhatsApp groups of psychiatrists. Weekly reminders were sent for filling the survey form. Online informed consent was taken from all participants. Data was analyzed for both quantitative analysis and qualitative analysis. Based on the results, recommendations for amendments were framed.

Pooled data was analyzed using frequency count and percentages to structured responses (Section 1). Qualitative content analysis was done for free text open-ended responses using manual method as well as QDA Minerlite v3.0 software and has been described in detail under the respective heading in Section 2.

There was a total of 600 responses. The post observed sample size was calculated. 92% of population proportion expressed dissatisfaction with the Act. Keeping the relative margin of error at 0.05 for 95% confidence interval and z score 1.96 (assuming normal distribution), the sample size calculation indicated 540 as the required number {using the formula $n = [z^2 \times (1 - p)]/e^2 \times p$, where $p = 0.92$; $e = 0.05$}. We got a sample size of 600 from 29 states and union territories of India, which makes the survey as representative and an authoritative voice of psychiatrists in India. The highest number of responses was obtained from Karnataka (18%), followed by Maharashtra (15.8%) and Kerala (9%), so results could be skewed to represent the situation in these states more than in others.

Results are given in two sections. Section 1 pertains to structured response of the survey questionnaire and Section 2 pertains to qualitative analysis of the descriptive comments on respective matters. The results of the survey have been published briefly in the Indian Journal of Psychiatry,[8,9] and a full report is published here.

SECTION 1

Most of the psychiatrists who participated belonged to 31–45 years of age (49%) and 46–60 years of age (30.7%) **(Table 1)**. Majority (70.3%) had completed more than 10 years after psychiatry degree **(Table 2)**. 69% of the participants were Life Fellows of IPS and 28.5% were Life Ordinary Members **(Table 3)**.

About their current work setting, over 75% worked in outpatient as well as inpatient facility and telepsychiatry was used by about 27% respondents **(Table 4)**.

For the question about the service sector, 58% of them answered as working under private sector and 37.5% under government sector **(Table 5)**. 56.9% were working at psychiatric hospitals/centers/nursing homes and 39.1% in medical colleges, corporate hospitals, district hospitals, and general hospital psychiatry units (GHPUs) **(Table 6)**.

TABLE 1: Age in years.

Age (in years)	*Up to 30 years (%)*	*31–45 years (%)*	*46–60 years (%)*	*Above 60 years (%)*
	25 (4.2%)	294 (49.0%)	184 (30.7%)	97 (16.2%)

TABLE 2: Number of years after psychiatry degree.

Number of years after psychiatry degree	*1–5 years (%)*	*5–10 years (%)*	*>10 years (%)*
	86 (14.3%)	92 (15.3%)	422 (70.3%)

TABLE 3: IPS membership status.

IPS membership status	*Percentage (%)*
Life fellow	414 (69.0%)
Life ordinary member	171 (28.5%)
Nonmember	15 (2.5%)

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Current Status of SMHA, MHRB, and Mental Health Establishment and Minimum Standards

Regarding SMHA, 75.2% of the psychiatrists were aware of it in their areas but only 45.4% of them knew whether it was working there and only 7.5% were a part of it. Only 45.5% were aware of the rules been framed in their area and 51.5% said it is not operational as well. When only 50.7% knew about the presence of MHRB in their area, only 27.3% knew whether it was working and only 4.7% were a part of it.

Although 72.5% were aware of mental health establishment (MHE) minimum standards described by Central Mental Health Authority (CMHA), only 48.5% had registered their clinic/nursing home as a MHE **(Table 7)**. About 19–31% were unaware if the SMHA or MHRB was working in their area of practice.

Respondents were asked to share their major concerns and difficulties encountered in their practice on account of SMHA or MHRB.

About 18% expressed concern that SHMA and MHRB are not working in their area, 41% expressed other concerns about SMHA, and 43% expressed other concerns about MHRB **(Table 8)**.

TABLE 4: Current working structure: Setting.

Current working structure	*Percentage (%)*
Outpatient and indoor only	345 (57.5%)
Outpatient and indoor with telepsychiatry	108 (18.0%)
Outpatient only	83 (13.8%)
Outpatient with telepsychiatry	49 (8.2%)
Telepsychiatry only	4 (0.7%)
Others	11 (1.8%)

TABLE 5: Current working structure: Service sector.

Current working structure	*Percentage (%)*
Private	348 (58.0%)
Government	225 (37.5%)
Others (NGO, semigovernment)	27 (4.5%)

(NGO: nongovernmental organization)

Registration, Admission/Discharge Procedures, Capacity Assessment, Physical Restraints

When asked regarding registration under SMHA, only 39.8% had registered themselves and 42.8% had registered their establishment under SMHA, and 6.5% did not even know about it. Only 51.1% of them were adhering to the minimum standards described by CMHA and 7.1% did not even know about it. For the questions regarding MHCA and related documentation, almost 55% of them were practicing admission and discharge procedures and capacity assessment as prescribed by MHCA. More than 35% knew about it but were not practicing it. Only 60% were documenting about physical restraints and monitoring, whereas 7.4% did not even know about it. More than 55% were found to make postdischarge plan as continuity of care plan (57.5%) and made judicial over-reach in matters that were clinical (56.7%) **(Table 9)**.

TABLE 6: Current working structure: Type of facility.

Current working structure	*Percentage (%)*
GHPU/district hospital/corporate hospital/medical college	235 (39.1%)
Psychiatry hospital/center/nursing home	341 (56.9%)
Others (rehabilitation center, home for destitute)	24 (4.0%)

(GHPU: general hospital psychiatry unit)

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TABLE 7: Current status of State Mental Health Authority (SMHA), Mental Health Review Board (MHRB), and minimum standards.

Variables (*n* = 600)	*Yes (%)*	*No (%)*	*Don't know (%)*
State Mental Health Authority: Are you aware of it in your area?	451 (75.2%)	123 (20.3%)	27 (4.5%)
State Mental Health Authority: Is it working in your area?	272 (45.4%)	214 (35.8%)	114 (18.8%)
State Mental Health Authority: Are you a part of it?	45 (7.5%)	555 (92.5%)	–
Have the Rules been framed and notified: Are you aware of it in your area?	193 (32.2%)	273 (45.5%)	134 (22.3%)
Have the Rules been framed and notified: Are these operational?	101 (16.8%)	309 (51.5%)	190 (31.7%)
Mental Health Review Board: Are you aware of it in your area?	304 (50.7%)	222 (37.0%)	74 (12.3%)
Mental Health Review Board: Is it working in your area?	164 (27.3%)	283 (47.2%)	153 (25.5%)
Mental Health Review Board: Are you a part of it?	28 (4.7%)	572 (95.3%)	–
Is your clinic/nursing home registered as mental health establishment?	291 (48.5%)	309 (51.5%)	–
Are you aware of mental health establishment (MHE) minimum standards described by CMHA?	435 (72.5%)	165 (27.5%)	–

TABLE 8: Concerns about SMHA and MHRB.

Concerns	*State mental health authority (n, %)*	*Mental health review board (n, %)*
Not yet started	43 (7.2%)	95 (15.8%)
Nonfunctional	63 (10.5%)	17 (2.8%)
Lack of awareness	127 (21.2%)	93 (15.5%)
Other concerns	246 (41.0%)	260 (43.3%)
No concern	121 (20.2%)	135 (22.5%)

Advanced Directives and Nominated Representative

When asked whether patients had come to them with AD or if they facilitated for AD, 95% said "NO". When the same thing was asked regarding NR, 90.5% said "NO". While 53% said they have used capacity assessment as per MHCA in any of their patients, 47% said no. For the question whether penalties outlined in the Act had deterred them from taking any medically necessary decisions, 55.7% said yes as a response, whereas 66.5% said that the procedural issues deter them from taking necessary decisions medically helpful for the patients **(Table 10)**.

When 78.2% of the psychiatrists think that the majority of the patients with common mental disorders need not come under the purview of the Act, 72.3% think that patients do not need NR when they are brought and taken care of by family. 70.2% did not think that persons with moderate-to-severe mental illness, who may not have sound judgment or sufficient knowledge about the potential or methods of psychiatric treatments, can exercise valid AD, but 22.7% did think so. 71.5% of the psychiatrists think that the Act in its current form defies the spirit of its own stated objectives and available medical knowledge. 75.2% of them were of the opinion that the Act in its present form is unimplementable **(Table 11)**.

60.8% opined that there should be a Common Healthcare Act and not a separate MHCA.

77.7% were of the opinion that mental health care provided in GHPUs, medical college hospitals, outpatient clinics, community clinics,

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TABLE 9: Registration, admission/discharge procedures, capacity assessment, physical restraints.

Variables (n = 600)	*Yes (%)*	*No (%)*	*Don't know (%)*
Have you registered yourself in SMHA	239 (39.8%)	315 (52.5%)	46 (7.7%)
Has your establishment been registered in SMHA	257 (42.8%)	304 (50.7%)	39 (6.5%)
Adhering to minimum standards described by CMHA	306 (51.1%)	251 (41.8%)	43 (7.1%)
Practicing admission and discharge procedure as prescribed MHCA	334 (55.7%)	218 (36.3%)	48 (8.0%)
Assessing capacity as prescribed in MHCA	327 (54.5%)	238 (39.7%)	35 (5.8%)
Documenting physical restraints and monitoring	360 (60.0%)	196 (32.7%)	44 (7.4%)
Making a postdischarge plan as continuity of care plan	345 (57.5%)	210 (35.0%)	45 (7.5%)
Judicial overreach in matters that are clinical	340 (56.7%)	226 (37.7%)	34 (5.6%)

TABLE 10: Advanced directives, nominated representative, and other miscellaneous questions.

Variables (n = 600)	*Yes (%)*	*No (%)*	*Don't know (%)*
Have any of the patients come with or you have facilitated for advance directive as prescribed in MHCA	30 (5.0%)	570 (95.0%)	–
Have any patients come with or you have facilitated for Nominated Representative as prescribed in MHCA	57 (9.5%)	543 (90.5%)	–
Did you use capacity assessment in any of your patients	318 (53%)	282 (47%)	–

TABLE 11: Miscellaneous questions relating to practice using MHCA.

Do penalties outlined in the Act deter you from taking any medically necessary decisions?	334 (55.7%)	159 (26.5%)	107 (17.8%)
Do procedural issues deter you from taking necessary decisions medically helpful for patients?	399 (66.5%)	128 (21.3%)	73 (12.2%)
Do you think that majority of patients with common mental disorders need not come under the purview of the Act?	469 (78.2%)	83 (13.8%)	48 (8.0%)
Do you think patients do not need NR when they are brought and taken care of by family?	434 (72.3%)	105 (17.5%)	61 (10.2%)
Do you think that persons with moderate-to-severe mental illness, who may not have sound judgment or sufficient knowledge about methods of psychiatric treatments, can exercise valid AD?	136 (22.7%)	421 (70.2%)	43 (7.2%)
Do you think the Act in its current form defies the spirit of its own stated objectives and available medical knowledge?	429 (71.5%)	99 (16.5%)	72 (12%)
Act in its present form is unimplementable	451 (75.2%)	73 (12.2%)	76 (12.7%)

(AD: advance directive; MHCA: Mental Health Care Act; NR: nominated representative)

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or any other medical setting should be treated at par with treatment of physical illnesses and thus not regulated by legal procedures.

64.7% said that the definition of MHE should exclude the entire range of medical settings in the general healthcare system in which mental health care is also provided. 85.5% were of the opinion that MHRB should be headed by a psychiatrist.

When 93.3% agreed that all treatment of mental illness (both inpatient and outpatient) should be covered by insurance, 3.3% disagreed to it. When 50.5% said AD should be abolished, 20.3% did not know what to say about it.

79% of the psychiatrists said that NR should be applicable only if the family is unavailable or uninvolved.

Capacity assessments should be done for patients suffering from mental illness under specific conditions such as medicolegal purposes or any other specific situations according to 85.5% of them.

76.2% were of the opinion that private psychiatric care facilities should be covered under the Ayushman Bharat scheme.

93.2% agreed that the psychiatrists should be excluded from penalties for actions taken in good faith for the treatment and welfare of patients during mental health care.

84.3% said that SMHAs should be constituted on a priority basis.

84.5% were of the opinion that the admission and discharge procedures should be restricted to patients who are severely sick such as those with a substantial disorder of mental functions, loss of insight or capacity, and those who are wandering, homeless, abandoned, etc., and need the protection of the law.

When asked about the concerns regarding SMHA, lack of awareness contributed to 21.2%, SMHA not being functional contributed to 10.5%, and 7.2% was that SMHA had not started yet.

When asked about the concerns regarding the MHRB, lack of awareness constituted 15.5% and MHRB not being started yet and being functional contributed to 15.8% and 2.8%, respectively **(Table 12)**.

Community Treatment Order

When 72.3% thinks that a new provision like "Community Treatment Order" (CTO) to treat chronic psychotic or frequently relapsing patients with no insight to take treatment in the community would help, 12.3% disagreed to it. 81% of the psychiatrists said that the Treatment Order by MHRB to Police to bring the patient to Hospital will be helpful for families to mobilize patients in the community to take them to MHE **(Table 13)**.

Around three-fourth (73.3%) said that the Act should be amended, 19.2% said it has to be repealed, and 2.2% said to keep it as it is **(Table 14)**.

Respondents were asked to share their major concerns and difficulties encountered in their practice on account of SMHA or MHRB.

About 18% expressed concern that SHMA and MHRB are not working in their area; 41% expressed other concerns about SMHA and 43% expressed other concerns about MHRB **(Table 14)**.

State-wise Distribution of Responses

Responses were obtained from 29 states and UTs in India. The highest number of responses was from Karnataka (18%), followed by Maharashtra (15.8%) and Kerala (9%) **(Table 15)**.

SECTION 2

Qualitative content analysis of data was carried out by a senior psychiatrist (SM) with over four decades of experience of working in GHPU and about one decade in private practice and another psychiatrist Shruti Shrivastava (SS) with two decades of experience of working in a psychiatric hospital setting and a GHPU attached to a medical college. Methods used for analysis included manual method and using QDA Minerlite v3.0

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TABLE 12: Suggestions for improvements in MHCA.

Variables (n = 600)	*Yes (%)*	*No (%)*	*Don't know (%)*
There should be a Common Health Care Act and not a separate MHCA	365 (60.8%)	182 (30.4%)	53 (8.8%)
Mental health care provided in GHPUs, medical college hospitals, outpatient clinics, community clinics, or any other medical setting should be treated at par with treatment of physical illnesses and thus not regulated by legal procedures	466 (77.7%)	108 (18.0%)	26 (4.3%)
Definition of MHE should exclude the entire range of medical settings in general healthcare system in which mental health care is also provided	388 (64.7%)	161 (26.8%)	51 (8.5%)
MHRB should be headed by a psychiatrist	515 (85.8%)	50 (8.3%)	35 (5.8%)
All treatment of mental illness (both inpatient and outpatient) should be covered by insurance	560 (93.3%)	20 (3.3%)	20 (3.3%)
AD should be abolished	303 (50.5%)	175 (29.2%)	122 (20.3%)
NR should be applicable only if the family is unavailable or uninvolved	474 (79.0%)	74 (12.3%)	52 (8.7%)
Capacity assessments should be done for patients suffering from mental illness under specific conditions such as medicolegal purposes or any other specific situations	513 (85.5%)	57 (9.5%)	30 (5.0%)
Private psychiatric care facilities should be covered under Ayushman Bharat scheme	457 (76.2%)	58 (9.7%)	85 (14.2%)
Psychiatrists should be excluded from penalties for actions taken in good faith for the treatment and welfare of patients during mental health care	559 (93.2%)	24 (4.0%)	17 (2.8%)
SMHAs should be constituted on priority basis	506 (84.3%)	26 (4.3%)	68 (11.3%)
Admission and discharge procedures should be restricted to patients who are severely sick such as those with a substantial disorder of mental functions, loss of insight or capacity, wandering, homeless, abandoned, etc., and need the protection of the law	507 (84.5%)	75 (12.5%)	18 (3.0%)

(AD: advance directive; GHPUs: general hospital psychiatry units; MHCA: Mental Health Care Act; MHE: mental health establishment; MHRB: Mental Health Review Board; NR: nominated representative; SMHAs: state mental health authorities)

TABLE 13: Community treatment order.

Variables (n = 600)	*Yes (%)*	*No (%)*	*Don't know (%)*
Will a new provision like "Community Treatment Order" to treat chronic psychotic or frequently relapsing patients with no insight to take treatment in the community help?	434 (72.3%)	74 (12.3%)	92 (15.3%)
Will Treatment Order by MHRB to Police to bring the patient to Hospital will be helpful for families to mobilize patients in the community to take them to mental health establishment?	486 (81.0%)	55 (9.2%)	59 (9.8%)

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TABLE 14: Recommendation.

The Act should be	*Percentage (%)*
Amended	440 (73.3%)
Repealed	115 (19.2%)
Status quo	13 (2.2%)
Do not know	32 (5.3%)

TABLE 15: State-wise distribution of responses.

State	*Number of responses (%)*
Uttarakhand	4 (0.7%)
Uttar Pradesh	23 (3.8%)
Tripura	1 (0.2%)
Telangana	36 (6%)
Tamil Nadu	51 (8.5%)
Rajasthan	12 (2%)
Punjab	21 (3.5%)
Puducherry	4 (0.7%)
Odisha	6 (1%)
Mizoram	1 (0.2%)
Meghalaya	2 (0.3%)
Maharashtra	95 (15.8%)
Madhya Pradesh	14 (2.3%)
Karnataka	108 (18%)
Kerala	54 (9%)
Jammu and Kashmir	3 (0.5%)
Haryana	14 (2.3%)
Gujrat	33 (5.5%)
Goa	7 (1.2%)
Delhi	15 (2.5%)
Chhattisgarh	7 (1.2%)
Chandigarh	15 (2.5%)
Bihar	5 (0.8%)
Assam	10 (1.7%)
Andhra Pradesh	21 (3.5%)
Himachal Pradesh	7 (1.2%)
Jharkhand	3 (0.5%)
Ladakh	1 (0.2%)
West Bengal	27 (4.5%)

software for qualitative analysis and Microsoft Excel.

Both SM and SS read the anonymized data thoroughly that was given in response to nine open-ended statements. Based on the purpose of the survey, two research questions were framed by SM and SS, with focus on the experience of Indian psychiatrists in using the MHCA and suggestions for improvement arising from their experience.

Research Question (RQ) 1: What is the experience of the practicing psychiatrists in using and complying with the MHCA 2017?

Research Question (RQ) 2: What reforms, if any, are recommended in the current MHCA 2017 provisions?

Descriptive suggestions obtained in response to the last open-ended question on nine domains respectively in the survey questionnaire—16A (definitions of MHEs), 16B (definition of mental illness), 16C (SMHA), 16D (MHRB), 16E (admission and discharge procedures), 16F (AD), 16G (NR), 16H (capacity assessment), 16I (any other suggestions)—were noted individually. Data was analyzed separately for each of the first eight open-ended statements in two steps and for the ninth open-ended statement in three steps.

Analysis

Analysis was carried out in three steps.

The total number of responses received was 1,239. The number of responses to each question was as follows:

- 16A (Definitions of MHEs): 154
- 16B (Definition of mental illness): 138
- 16C (SMHA): 116
- 16D (MHRB): 129
- 16E (Admission and discharge procedures): 145
- 16F (AD): 138
- 16G (NR): 140
- 16H (Capacity assessment): 135
- 16I (Any other suggestions): 144

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Step 1 of Qualitative Analysis

Six content category codes, as described below, were prepared and assigned to each response for all the nine open-ended statements separately.

1. *Responses highlighting their understanding and compliance to existing provisions* of MHCA 2017
2. *Amendments/repeal MHCA 2017*, which were analyzed from the responses using keywords like "revise, change, scrap, exclude, exclusive, abolish, exempt"
3. Suggestions for existing MHCA 2017
4. *General Comments*, i.e., comments on some aspects related to mental health, the questionnaire itself. For example, the response such as the way the analyzed data should be discussed in the closed group first and then sent to higher authorities was included in this category.
5. *Status quo* responses indicating "no change" were identified by keywords like "fine, okay, status quo, complete" in the existing provisions of MHCA 2017.
6. *Others*: For responses that lacked any content required for RQ1 or RQ2 or were unclear/unrelated responses

The total number of responses in each of the six category codes was computed and is presented in the form of percentages for all nine open-ended statements. Separately showed frequency for each category code for all the nine open-ended statements, the data being analyzed qualitatively.

Table 16 shows the frequency of content category codes of nine open-ended statements given by practicing psychiatrists.

Step 2 of Qualitative Analysis

Amendments (Category Code 2) and suggestions for MHCA under Category Code 3 in Step 1 were further analyzed by picking up themes for each of the nine domains separately. Themes were discussed between the SM and SS and manually

TABLE 16: Frequency of content category codes of nine open-ended statements given by practicing psychiatrists.

Domain	*Number of responses*	*Code 1 General understanding*	*Code 2 Amend/repeal*	*Code 3 Specific suggestions*	*Code 4 General comments*	*Code 5 Status quo*	*Code 6 Others*
Definitions of mental health establishment	*154*	37.01%	*18.83%*	*29.22%*	6.49%	7.79%	0.65%
Definition of mental illness	*138*	11.59%	*29.71%*	*35.50%*	5.07%	17.39%	0.72%
State mental health authority	*116*	12.93%	*12.06%*	*64.65%*	3.44%	4.31%	2.58%
Mental health review board	*129*	13.95%	*27.13%*	*55.04%*	2.32%	0.77%	0.77%
Admission and discharge procedures	*145*	6.89%	*15.17%*	*66.20%*	1.38%	6.89%	3.45%
Advance directive	*138*	11.59%	*47.82%*	*36.95%*	0.72%	0.72%	2.90%
Nominated representative	*140*	6.43%	*37.14%*	*47.85%*	1.43%	3.57%	3.57%
Capacity assessment	*135*	14.07%	*16.30%*	*59.26%*	5.92%	3.70%	1.43%
Any other suggestions	*144*	2.77%	*22.92%*	*56.25%*	14.58%	1.38%	2.08%

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coded for frequency analysis and pie charts. Themes that were considered important even with low frequency were included finally in pie chart.

Step 3 of Qualitative Analysis Using Software

Confirmatory analysis (step 3) was carried out for open-ended responses for the last response option "any other suggestions", using the software (QDA Miner lite v3.0). This exercise was carried out as it had lengthy statements, and the purpose was not to miss out on any useful information. Six category codes as described above were assigned to the statements. Document of "any other suggestion" was pasted in the software. Relevant text was highlighted, coded in one of six categories. All the responses were assigned minimum one code, though some had more than one code. A chart was generated showing the word count with category codes for any other suggestions and descriptive comments. Code frequencies were analyzed. Retrieval data on suggestions was tallied with manually generated themes for suggestions.

Results

A total of 1,239 descriptive responses were received on Q16 and for the nine subparts (Q16A to Q 16I) to Q16, the number of responses varied between 116 and 154 **(Table 16)**. The analysis of each subpart was done separately and is presented below. Effort has been made to retain original comments as much as possible.

Question 16A: Definition of MHE, Chapter 1, MHCA 2017

A total of 154 responses were obtained for the open-ended statement pertaining to definition of MHE, Chapter 1, MHCA 2017. 37.01% responses highlighted the understanding and compliance to existing provisions on the definition of MHE as given in MHCA, 2017 (Category Code 1). 18.83% responses mentioned amendments/repeal of MHCA 2017 (Category Code 2). 29.22% gave suggestions for the changes in MHE (Category Code 3). 6.49% responses on general comments were assigned Category Code 4. 7.79% responses asked for status quo to be maintained for MHE as per the existing Act (Category Code 5). 0.65% response did not provide any content that could be analyzed (Category Code 6).

Suggestions for changes in definition of MHE were further analyzed qualitatively and the following themes emerged:

a. There should be exemption of GHPUs from definition of MHE.
b. MHE should be applicable only for indoor facility/involuntary admission/severe mental illness.
c. MHE should be applicable only for psychiatric hospitals; deaddiction and rehabilitation centers should also be included.
d. Outpatient services should be excluded from MHCA.
e. Qualified MHPs should run MHEs.
f. There are difficulties encountered in implementing MHCA 2017 because it is complicated and overinclusive. Hence, it should be reframed highlighting the purpose/function of MHE.
g. There should be separate provisions for armed forces hospital in the MHCA 2017.
h. There should be a distinction between MHEs run by qualified psychiatrists and those run by unqualified people where most human rights violations occur.
i. Psychiatrists should be essential for what is designated as MHE. MHE should be an establishment owned and run by psychiatrists.

Question 16B: Definition of mental illness (MI), Chapter 1, MHCA 2017

A total of 138 responses were obtained pertaining to the definition of mental illness. 11.59% responses highlighted the understanding and compliance to existing provisions on the

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definition of mental illness as given in MHCA, 2017 (Category Code 1). 29.71% responses asked for amendments to be proposed for MHCA 2017/repeal of Act (Category Code 2). 35.50% responses gave suggestions to be incorporated in the definition of mental illness, MHCA, 2017 (Category Code 3). 5.07% responses were based on general comments (Category Code 4). 17.39% responses asked for status quo to be maintained for definition of mental illness, Chapter 1, MHCA 2017 (Category Code 5). 0.72% data had no conclusive response (Category Code 6).

Themes that emerged pertaining to the changes suggested in the definition of mental illness are as follows:

a. Definition of mental illness should be changed in MHCA 2017.
b. Definition should be based on the international classifications such as ICD-10 (10th revision of the International Classification of Diseases), ICD-XI, and DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition).
c. Mental illnesses should also include other categories such as common mental disorders and intellectual disability for purposes of services.
d. Suggestion was made to give clearcut diagnostic criteria for alcohol and substance-use disorders.
e. Personality disorders should be excluded from the definition of mental illness for the purpose of MHCA.
f. Definition of mental illness should be broadened to include behavioral changes or disturbed mental states, disturbances in emotions, thinking, behaviors, and significant impairment in activities of daily living.
g. There should be separate definitions for mental illness for clinical and legal purpose.
h. People with common mental disorders and neurotic disorders who can take care of themselves should be excluded from legal definition of mental illness. Only severely psychotic, wandering, those with impaired judgement, and homeless who are likely to have human rights violations should come under the legal protection of law.
i. Difficulty faced in implementing MHCA 2017 is that it is too complicated.
j. Mental illness should not be covered under law; it should be freely treated by psychiatrists like that for physical illness.

Question 16C: State mental health authority, Chapter VIII, MHCA 2017

A total of 116 responses were obtained. 12.93% responses were assigned Category Code 1 that highlighted the understanding and compliance to existing provisions about SMHA as per MHCA 2017. 12.06% responses asked for amendments/repeal, MHCA 2017 (Category Code 2). 64.65% responses gave suggestions that should be incorporated in SMHA, MHCA 2017 (Category Code 3). 3.44% responses were based on general comments (Category Code 4). 4.31% responses did not ask for any change in the existing provisions of SMHA, MHCA 2017 (Category Code 5). 2.58% responses did not give any relevant information that could be included in qualitative analysis (Category Code 6). Frequency of code categories for SMHA data analyzed qualitatively is shown below.

The *themes* that emerged from the responses on open-ended statements on SMHA, MHCA 2017 were as follows:

a. Change in composition of SMHA should be carried out. SMHA should be headed by a psychiatrist. It should have greater representation of psychiatrists. It is difficult to incorporate PMI/caregivers in SMHA.
b. Clearcut guidelines for SMHA should be laid down. A functional website for online registration should be created and SMHA should proactively monitor its services.

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c. SMHA should be constituted on a priority basis and should be made operational at earliest.
d. SMHA should exclude GHPUs from its purview.
e. More fund allocation should be done and proper infrastructure should be provided for SMHA office space.
f. More public awareness should be created for the role of SMHA. SMHA should conduct workshops for board members and psychiatrists.
g. Patient's or family's consent should suffice for outpatient or inpatient treatment respectively. Institutional Medical Board can handle discharge or admission beyond 30–60 days.
h. There should be relaxation in the requirements of SMHA due to shortage of MHPs.
i. SMHA should take suo moto action against unauthorized centers.
j. They should hold regular meetings.
k. SMHA should register only destitute/homeless mentally ill, medicolegal cases, and children in conflict with law.
l. SMHA should sensitize judiciary/law-enforcing agencies.
m. SMHA should be a medical body responsible for fair medical practices, and faster and easier treatment rather than a legal body.
n. Too much monitoring and control is causing difficulties in seeking and delivering treatment.
o. SMHA should focus on provision of mental health services rather than controlling patient management.

Question 16D: Mental Health Review Board, Chapter XI, MHCA 2017

A total of 129 responses were obtained for MHRB. Category Code 1 included 13.95% responses that had highlighted the understanding and compliance to existing provisions of MHRB, Chapter XI, MHCA 2017. Category Code 2 had 27.13% responses that asked for amendments/repeal, MHCA 2017. 55.04% responses that suggested changes in MHRB were assigned Category Code 3. Category Code 4 had 2.32% responses that were based on general comments. Category Code 5 had 0.77% responses that did not ask for any change in existing MHRB, MHCA 2017. 0.77% responses were assigned Category Code 6 that did not provide any content that could be analyzed.

The following themes emerged regarding MHRBs:

a. MHRB composition should be changed—should be headed by a psychiatrist, minimum two psychiatrists, and 50% members should be psychiatrists.
b. MHRB should not be controlled by judiciary and should have full-time staff.
c. MHRB should be formed at the earliest and should be made operational, easily accessible, and be able to provide online services.
d. MHRB should be more for medical rather than legal purpose.
e. Location of MHRB should be unbiased, for example, outside the premises of a government medical college or an institution setup to avoid conflict of interest.
f. MHRB should be given power for fund allocation, and honorarium should be given to MHRB officials and working staff.
g. There should be only one option for grievance redressal of medical negligence for an aggrieved person rather than many, such as state medical council, consumer forum, MHRB, and SMHA. Appeal in higher forum should be possible.
h. MHRB should be considered only for specific situations and should be constituted by the District Magistrate in contentious cases where patients or families seek review of decisions taken by the medical board.
i. MHRB should comprise individuals with genuine interest in mental health, not necessarily government officials.

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j. There is no need for MHRB at all, as there are no review boards for other branches of medicine.

Question 16E: Admission, Treatment, and Discharge, Chapter XII, MHCA 2017

A total of 145 responses were obtained pertaining to admission, treatment, and discharge, Chapter XII, MHCA 2017. Category Code 1 was assigned to 6.89% responses that highlighted the understanding and compliance to existing provisions on admission, treatment, and discharge, Chapter XII, MHCA 2017. Category Code 2 had 15.17% responses that mentioned amendments/repeal of Act. 66.20% responses gave suggestions for the admission, treatment, and discharge, Chapter XII, MHCA 2017 (Category Code 3). Category Code 4 had 1.38% responses that were based on general comments. Category Code 5 had 6.89% responses that did not ask for any change required in admission, treatment, and discharge, Chapter XII, MHCA 2017. 3.45% responses that lacked any useful content for the purpose of analysis was assigned Category Code 6.

The following themes emerged that should be incorporated as changes in admission, treatment, and discharge, Chapter XII, MHCA 2017:

a. Should simplify the provisions for admission/discharge/treatment in MHCA 2017, should be made easy, and should have less paperwork
b. Admission, discharge, and treatment of PMI should have relaxed criteria, and these should be similar to those in other medical specialties.
c. Decision-making should be with a psychiatrist.
d. Family members should be involved in all admissions. Family's consent should be sufficient for admission.
e. Criteria for admission/discharge laid down in the Act for this chapter should be restricted to specific conditions and severe mental illness.
f. Procedures are not in keeping with the sociocultural situation in India. To ease the suffering of patients and their families, the family should be allowed to take decisions for the patient's treatment. There is no need to routinely update the SMHA or MHRB in all cases.
g. Legal provisions should be invoked only in care of chronic long-stay patients (>2–3 months) who exhibit risk of harm to self or others. The main motto of community mental health services is to integrate PMI in the community and in primary health care which will be defied if the treatment of all mental illnesses is brought under the ambit of law.
h. Admission and discharge procedures should be similar to what exists for medical illnesses. Only if involuntary admission exceeds 60 days, legal provisions should be invoked.
i. Emergency electroconvulsive therapy (ECT) should be allowed immediately after admission.
j. Admission/discharge procedures, as laid down in the Act, are difficult to implement in GHPUs.
k. There should be no need to update MHRB for every client admitted.
l. Patient's right to privacy should be considered during Board visits and while checking inpatient records.
m. Procedure for bringing hostile and wandering mentally ill patients to MHE should be laid down.

Question 16F: Advanced directives, Chapter III, MHCA 2017

A total of 138 responses were obtained on AD pertaining to MHCA 2017. Qualitative data on AD was analyzed using the different category codes such as: 11.59% responses were assigned Category Code 1 that highlighted the understanding and compliance to existing provisions on AD, MHCA 2017. Category Code 2 was assigned for 47.82% responses that asked for amendments/repeal of the Act. Changes suggested in provisions of AD,

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Chapter III, MHCA 2017, were assigned Category Code 3 that consisted of 36.95% responses. Category Code 4 had 0.72% responses that were based on comments. 0.72% responses did not mention any change in the existing provisions laid down in Chapter III, Advance Directive, MHCA 2017 (Category Code 5). 2.90% responses that lacked any content was assigned Category Code 6.

The following themes that emerged from the analysis of the suggestions on AD, Chapter III, MHCA 2017, are as follows:

a. AD is not needed for every case. It should be optional.
b. AD should be applicable for remitted cases/PMIs having adequate capacity/good insight, the same as that for medical illness.
c. Public awareness is needed for AD.
d. AD should be restricted for medicolegal or under specific situations and not for all patients.
e. AD should be made operational, practical, and include a renewal period.
f. Majority opined that AD is a hindrance to service, especially due to ignorance, stigma, and misconceptions about mental illness and treatments among larger population.
   There is widespread prevalence of superstitious practices. So, patients are unable to exercise informed decisions for AD.
g. There can be no umbrella dissent in AD for treatments recommended as standard practice. Any AD that may run the risk of relapse or worsening of condition should automatically stand cancelled.
h. Current AD provisions as laid down in MHCA 2017 are a good initiative but asking MHRB to register AD is unrealistic. AD is currently not feasible and not useful if family members are taking care, and hence it is not sure if AD is helpful. AD is a controversial entity.

Question 16G: Nominated Representative, Chapter IV, MHCA 2017

A total of 140 responses were obtained on NR, MHCA 2017. Data was analyzed initially using category codes given such as: 6.43% responses highlighted the understanding and compliance to existing provisions on NR, MHCA 2017 (Category Code 1); 37.14% responses asked for amendments/repeal (Category Code 2); 47.85% responses suggested changes in NR provisions, MHCA 2017 (Category Code 3); 1.43% responses were based on general comments (Category Code 4); 3.57% responses said no change/status quo in provisions for NR (Category Code 5); and 3.57% responses lacked content (Category Code 6). Frequency of category codes obtained on analyzing qualitative data for NR, MHCA 2017, open-ended statement is given below.

The themes that emerged from the suggestions to be incorporated in NR, MHCA 2017, Chapter IV, are as follows:

a. NR should be optional, when the family is not available, state should be NR of homeless mentally ill. NR for mental illness should be the same as for medical illnesses.
b. Where there is family involvement, there is no need for NR.
c. NR should be restricted to specific cases. NR provisions should be operational, renewable, and not mandatory.
d. NR is needed when the patient/family exhibit discordant views; NR should be taken as a legal document.
e. There is a need for public awareness for NR provisions.
f. NR should be a close relative unless proved otherwise. We need not follow the west due to cultural, religious, and geographical differences.
g. Difficulties in implementing NR provisions for homeless PMI need to be worked out.

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h. Legal guardian as in previous Act was a more useful concept than NR. NR would cause unnecessary obfuscation of the real needs of mentally ill and their caregivers; NR are difficult to appoint.
i. NR forms should be made available by each state; NR needs detailed explanation,

Question 16H: Capacity Assessment, Chapter II, MHCA 2017

A total of 135 responses were obtained for open-ended statement of capacity assessment, MHCA 2017. The responses were then coded as follows: 14.07% responses highlighted the understanding and compliance of the participants to existing provisions on capacity assessment, Chapter II, MHCA 2017 (Category Code1). 16.30% responses asked for amendments/repeal (Category Code 2). 59.26% responses suggested changes in capacity assessment, Chapter II, MHCA 2017 (Category code 3). 5.92% were based on general comments (Category code 4). 3.70% said "no change" required in the provisions laid down on capacity assessment, MHCA 2017(Category code 5). 0.74% responses lacked content (Category Code 6).

Themes that were suggested to be included in capacity assessment of MHCA 2017 are as follows in order of their frequency:

a. Capacity assessment (CA) should not be needed for all cases.
b. It should be restricted to specific conditions—medicolegal cases, severely ill, court order.
c. CA should include insight assessment. CA depends on clinical judgement and requires a psychiatrist's opinion. Many a times, capacity is intact but there is a serious risk of harm.
d. CA needs to be simplified and periodically assessed and requires operational criteria, valid tools, and uniformity in practice.
e. CA should not be carried out in routine practice.
f. Training of psychiatrists and MHPs should be required for CA.
g. CA should be done by review board; its use should only be for supported admission, that too if required.
h. The concept is vague and dynamic, and assessment of capacity is not foolproof. Current recommendations are highly inadequate.
i. CA in substance-use disorders and personality disorders should be clarified as there is no insight in them. They make poor decisions about their treatment.

Question 16I: Any other suggestions, pertaining to MHCA 2017

A total of 144 responses were obtained for open-ended statement on any other suggestion. Category codes were analyzed as follows: 2.77% responses highlighted the understanding and compliance to the existing provisions of MHCA 2017 (Category Code 1), 22.92% responses mentioned amendment/repeal of the Act (Category Code 2), 56.25% responses had any other suggestions pertaining to MHCA 2017 (Category Code 3), 14.58% responses were based on general comments (Category Code 4), 1.38% responses asked for status quo/no change in MHCA 2017 (Category Code 5), and 2.08% responses had no content that could be entered in qualitative analysis (Category Code 6).

The themes that were obtained for any other suggestions after tallying the manual coding and the software generated retrieval for coding on suggestions are as follows:

a. Amendments/repeal of MHCA 2017 was suggested by overwhelming majority to make it user friendly, doctor friendly, simple, and with less paperwork. Remove biases against psychiatrists, give liberty to psychiatrists to treat patients in their best interest, and remove penalty/punitive action against psychiatrists for decisions taken in good faith.
b. In the upcoming amendments, psychiatrists should be more involved.

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c. Many questioned the need for a separate Act for mental health care. There are no similar Acts for other medical specialties. Mental illness is no different from physical illness. Laws for PMI should be at par with those for physical illness.
d. Family role should be emphasized.
e. A separate Mental Health Care Act stigmatizes patients and mental illness. MHCA is cumbersome, dehumanizing, stigmatizing, and very expensive to implement. Registration of MHE as a separate category is stigmatizing. There are other laws such as Clinical Establishment Act, or Karnataka Private Medical Establishment Act, which may suffice.
f. Budget provisions for mental health should increase in order to implement MHCA 2017. Logistics need to be assessed before implementing it.
g. Mental health insurance coverage for admissions just on pattern similar to physical illness should be implemented. Insurance coverage should be available for deaddiction and long-term rehabilitation.
h. Community psychiatry services including mobile units should be set up by government to provide care to homeless, poor, and many others who cannot go to psychiatric centers.
i. AYUSH, homeopathy, unani, etc., should be removed from the definition of mental health provider in MHCA. There can be a separate Act for AYUSH and other pathies.
j. Composition of Centre Mental Health Authority should be changed.
k. Role of courts/magistrate should be specified more clearly.
l. Consider caregiver rights for treatment and care.
m. There should be more mental healthcare centers and services to cope with the numbers in need of such care. Law should make access and delivery of mental health care easy. The present Act is detrimental to immediate care to psychotic patients.
n. There should be separate provision for capacity assessment for dementia, delirium, mental illness.
o. Public awareness should be made for existing provisions of MHCA 2017.
p. Online registration for SMHA should be provided. There should be a functional website for mental health services.
q. Mental illness is mostly treated by medical physicians, neurologists, and pediatricians in India. They should be barred in keeping with the law to practice only within the field of one's expertise.
r. Human rights violations occur more in places that are not run by qualified psychiatrists. The Act should curb this in nonpsychiatric centers or places. All such places should be regulated by law.
s. There should be specific amendments or provisions for armed forces or paramilitary services or they should be excluded from provisions of this Act.
t. MHCA must not hinder right to mental health care.
u. Lay volunteers with some training should be recognized and accepted as mental healthcare workers.

DISCUSSION

The MHCA 2017 is a progressive legislation based on rights with many good aspects such as commitment of the state to provide the entire range of mental healthcare services to all PMI, making mental health care a right of all citizens (Chapter V),[10] and protecting the rights of PMI during treatment. Another important statute is the decriminalization of suicide (Section 115). However, even after 5 years of its promulgation, the Act has not been implemented in most parts of India. Moreover, there have been many

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difficulties faced by psychiatrists in complying with its provisions that has been hindering the delivery of mental health care to PMI. There have been large-scale discussions and debates among members of IPS highlighting problems with MHCA provisions. This prompted us to do a nationwide survey to assess the situation and to know what psychiatrists who are in the forefront of treating mental illnesses are experiencing. The authors also asked what changes would be desirable in the Act.

To the best of the knowledge of authors, this is the largest survey to study the problems faced in day-to-day clinical practice by psychiatrists from IPS on account of MHCA 2017. 70% of respondents had more than 10 years of experience after specialization **(Table 2)**. The respondents had an option to answer the questions as an open-ended statement, if the questions framed by us did not capture what they wanted to say. Suggestions were asked on most aspects of MHCA 2017 that were analyzed qualitatively. Most of the participating psychiatrists were involved in both inpatient and outpatient services **(Table 4)** and were distributed across 29 states and UTs **(Table 15)** serving private sector, government sector, nursing homes, psychiatric hospitals, rehabilitation centers, and homes for destitute **(Tables 5 and 6)**. So, this is pretty much a representative sample survey representing the opinions of SMs from all types of services and settings.

Level of Implementation of MHCA 2017, Awareness, and Experiences of Using MHCA 2017

The findings indicate that the level of implementation of MHCA across country is very patchy and piecemeal. About 45% mentioned that SMHA and 27% said that MHRB is working in their area **(Table 7)**, most of whom were from states of Karnataka, Maharashtra, Kerala, and Tamil Nadu. 51% said that rules have not been either framed or notified in their area **(Table 7)**. A higher number of responses in the survey were obtained from the states of Karnataka, Maharashtra, Tamil Nadu, and Kerala, which may be a reflection of the implementation of MHCA 2017 in their respective states, as can be appreciated by the active and functioning website in the state of Kerala. In most other states, the level of implementation is negligible. It has been reported earlier that implementation of MHCA 2017 is not uniform throughout the country;[11] some states are still in the incipient phase and have not yet started SMHA or MHRBs, whereas others are showing some functioning/some implementation, reflected by the varying responses of the participating psychiatrists from different states.

Prashanth et al.[6] shared the experience of Karnataka SMHA and suggested the need for liaison with government in framing mental health rules that are more realistic and helpful for stakeholders.

72.5% of the respondents are aware of the CMHA notification dated 18 December, 2020,[12] that has laid down the minimum standards for facilities and registration of MHEs. The CMHA website as per the provisions of the Act, Section 43, should maintain a register of all MHEs in the country, compiled as well as made online on the internet. The information of MHEs needs to be provided by SMHA. As per the survey reports, 35.8% of experienced psychiatrists reported that SMHA in their respective areas are not working. The CMHA website has not updated the list of MHE till the time of finalization of the survey results. Training programs as per Section 43 should be conducted for all stakeholders as 20.3% of psychiatrists are not aware of SMHA in their area and 37% are not aware of MHRB in their area. 51.5% have not registered a clinic/nursing home as MHE.

Most respondents suggested that the composition of CMHA, SMHA, and MHRB should

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be changed with increased representation of psychiatrists. Section 78, Chapter XI, MHRB has been given judicial powers. The survey findings suggest that MHRB should be utilized for medical rather than legal purpose. 85.5% reported that MHRB should be headed by a psychiatrist. Moreover, MHRBs require to be formed at the earliest, should function from an unbiased location, and funds should be allocated in order for it to function smoothly.

Regulatory bodies exist in many countries such as Australia (Mental Health Act Australia 2015)[13] and United Kingdom (Reforming the Mental Health Act UK Gov),[14] where the mental health legislation of the United Kingdom has incorporated several amendments which are mentioned on their official website. It has been proposed that the MHCA 2017 must be taken up for amendments as 5 years have passed since its notification.[15] 73.7% of psychiatrists in the present survey asked for amendment and 19.2% proposed repeal of the Act. Subsequent to MHCA 2017, being passed by both houses of the parliament and gazette, CMHA and MHRB rules were notified under subsections (1) and (3) of Section 121 of MHCA, 2017. Attempts have been made to explain MHCA 2017 in simple terms, at the same time suggesting its importance and outlining procedures on how to work on different provisions laid down in the Act and utilize them in daily practice.[16]

Definition of Mental Illness

Psychiatrists participating in the survey of IPS have given suggestion to change the definition of mental illness (35.50%). The definition of mental illness in the Act is contradictory and confusing. Chapter 1 2(s) of MHCA 2017 states that mental illness means "a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence", whereas Chapter 2, 3 (1) of MHCA 2017 mentions that "mental illness shall be determined in accordance with such nationally or internationally accepted medical standards (including the latest edition of the International Classification of Disease of the WHO) as may be notified by the Central Government", wherein the definition of mental illness is much broader. It is clear that the definition of mental illness in the MHCA is meant for legal purposes, whereas that in the international classifications is meant for clinical diagnostic and management purposes. This causes confusion.

35.5% survey respondents proposed suggestions in the definition of mental illness. Many felt that mental illness in the Act should be broadened to include all categories and clinical conditions, whereas few others felt that it should be restricted to more severe forms of illness. For the first part of the preamble of the Act, i.e., "An Act to provide for mental healthcare and services for persons with mental illness…", the definition of mental illness needs to be broad to include all types of mental disorders, whereas for the second part of the preamble "and to protect, promote and fulfil the rights of such persons during delivery of mental health care and services and for matters connected therewith or incidental thereto", the definition of mental illness needs to be restrictive. These are two separate objectives of the Act: One is about provision of services and the other is about protection of rights. There has to be a separate definition for either of the objectives. So, there could be separate definitions for legal and clinical purposes, and mental illness should be defined as per the international classifications such as ICD-11 and DSM-5. The other question

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is as to how these international classificatory systems would apply to other alternative systems of medicine which have been included as MHEs.

Definition of Mental Health Professional

Under the Act, MHP status has been given to psychologists, nurses, and social workers as well as to those working in other systems of medicine like ayurveda, homeopathy, unani, siddha, etc. Assessment of capacity, insight, judgment, and risk of harm are highly complex tasks which even psychiatrists who are not sufficiently trained would find it hard to do. The decision for involuntary treatment is a major decision and cannot be left at the hands of unskilled professionals. This short-sighted decision is a major loophole and deficiency in the Act. Further, the Act does not refer to any separate set of guidelines, definitions of mental illness, or treatment protocols applicable to other alternative systems of medicine, even though they have been recognized as MHPs. Psychiatrists are the main healthcare professionals responsible for diagnosis and treatment of mental illnesses and should be recognized as such. All others have supportive and adjunctive roles which is also important but does not replace the role of a psychiatrist.

Definition of Mental Health Establishment

About 57% of psychiatric care is provided by psychiatric centers, nursing homes, and psychiatric hospitals, whereas 39% is provided by GHPUs, medical colleges, district hospitals, etc. **(Table 6)**. As per the survey results, MHE should be run by a psychiatrist. 29.22% respondents suggested that the definition of MHE should be changed. Survey findings reveal that psychiatric hospitals should be called as Mental Health Care Establishments whereas GHPUs and others can be called as General Health Care Establishments (including mental health care). A major theme that emerged from the survey was that SMHA should exclude GHPUs from its purview. GHPUs are primarily set up to treat mental illness at par with the physical illness, without any stigma, and are conveniently located in the same setup as other disciplines of medicine, and thus are easily accessible. GHPUs assist in early assessment and intervention. Mental illnesses in an acute state are dynamic in nature and may shift from a condition of severe, uncooperative, lacking insight to a better, cooperative with insight condition in a short span of days to weeks. It is difficult for families to pursue sections of supported admission which may soon shift to requirements of independent admission. It would be therefore advisable that admissions in GHPU for a period of 6–8 weeks be permitted outside the purview of MHRB and only if the patient requires to be admitted for longer than 8 weeks, the MHRB should come in picture. GHPUs should primarily be engaged in the treatment of all mental disorders and should be freely accessible for 6–8 weeks at par with that for physical illness without invoking the law. This would reduce stigma and make mental health care easily accessible in the community. 72.3% of the psychiatrists reported that GHPU should be exempted from MHCA, 2017. Family members often stay with the patients in a GHPU setting just like other physical illnesses, thus reducing the risks of human rights violations.[17]

According to Therayil,[18] "The new Act has brought all mental health establishments (MHE), private and public, under its purview. The previous Act required the MO (defined as gazetted medical officer in the service of Government) to be a party to compulsory admissions; this made compulsory admissions possible only in public facilities. The new Act has allowed the MO in charge of MHE's to make decisions on compulsory admission in consultation with others as the case may be. It appears that the state clearly wants private sector providers to step in to care for patients

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under supported admissions." However, the Act does not mention how the government will bear the cost of such treatment and aftercare provided by the private sector. We all know that the public sector inpatient facilities are insufficient in the country and hence the government should partner with the private sector for sharing the burden and bolstering services.

Nominated Representative and Advance Directive

95% of practicing psychiatrists reported that none of the patients came with/needed facilitation of AD. 90.5% of the participants did not encounter any patient mentioning NR. As per the survey finding, AD and NR are not needed in every case, except in certain specific conditions which should be framed. In India, the family plays a pivotal role in taking care of PMI. Requirement of establishing the presence of AD and NR at the first instance of patient treatment is an unnecessary and cumbersome step causing delay and prolonging distress to the patient and family as well as the MHP.

The Act provides for the patients to appoint NR who act as proxy decision makers. Whether this nomination is made with free will or whether the patient had the capacity to make such a nomination is not required to be verified. A patient cannot be admitted to the hospital against his or her wish without an application from NR. Thus, the responsibility of decision to admit patients against their wish is left on family members or NR. This makes the patient hostile to family, thus losing trust and faith which may be already precarious due to effects of the mental illness itself. It can totally break down the family system. Ideally, the decision for involuntary treatment should lie with professionals and not with family or NR. Further, there is no way to ensure that the NR is acting in the best interest of the patient and the patient will have no way to remove the NR, particularly so if the patient has lost capacity. "Unfortunately, the patient can do so only if they have the capacity, and if they had the capacity, they would not have needed an NR in the first place".[18] This is the internal contradiction and fallacy in the Act.

Separate provisions of AD (Chapter III) and NR (Chapter IV) in line with western models should be repealed/amended and shall be reframed as per the requirements of a country like India. Even in western nations, the concept of AD still has not gathered sufficient evidence as a useful concept.[6] AD, if detrimental to a patient's recovery from mental illness or posing threat of harm or deterioration in the patient's mental condition, should not be accepted, ideally speaking. Patients with mental illness may lose judgment and insight or may be ill informed about mental illness and its treatment and therefore may make decisions that may be detrimental to their health. There should be a way to overrule the AD in favor of medical recommendations.

Capacity Assessment

Patient autonomy is considered important in MHCA, 2017 in line with the UNCRPD, 2006. Introducing a new concept in India, a term, capacity assessment (CA), which was primarily being practiced in developed nations, a western concept, raises an ethical dilemma even in those countries where it is enforced.[19] Capacity assessment is currently being used by 54.5% of Indian psychiatrists who participated in the survey. An expert panel constituted by the central government of India laid down the guidelines for capacity assessment (Guidance Document for Capacity Assessment, MHCA, 2019).[20] It requires a valid tool as capacity assessment is a fluid concept that rapidly changes with passage of time. Existing tools give different readings with different psychiatrists on assessment of the same client. Capacity assessments lack clarity for substance-use disorders and personality disorders. The findings of this survey on CA are in line with those

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by Namoodiri.[21] 85.5% practicing psychiatrists suggest that CA should be made optional for specific or medicolegal conditions only. The survey finding also highlighted that CA should be simplified and periodically assessed, not necessarily as a routine clinical practice measure. Along with capacity assessment, assessment of insight and risk assessment should be done and included as criteria for supported admission. There are many situations where a patient with full capacity would require compulsory treatment. The present Act has no provision for such situations leading to denial of treatment to most severely sick psychotic patients. Further, there is a possibility that a patient after involuntary admission fails to give consent for treatment, the MO will be helpless, and the patient will remain admitted in the hospital without treatment for any length of time.

It is presumed in the Act that everyone has capacity till proved otherwise, whereas, as per the definition of mental illness in the Act, most such patients are unlikely to have sound judgment or insight or capacity. Capacity as the sole criterion for supported admission is insufficient.

Admission and Discharge Procedures

66.20% survey responses on admission, treatment, and discharge provisions of MHCA 2017, Chapter XII, suggested changes in the form of simplification of the procedure, need of less paperwork, and ease of procedures, similar to that for physical illnesses. 84.5% psychiatrists stated that admission and discharge procedures should be restricted only for severely mental illness, with decision-making to lie with the psychiatrist or family members. Legal provisions should be invoked only for chronic long-stay patients, or if involuntary admission exceeds 60 days. There are many patients in the early stages of severe mental illness who have preserved capacity but lack insight and judgment and are in need of urgent treatment, which if not provided can lead to deterioration, harm to self or others, and refractoriness. This is neither in the best interest of the patient nor in line with the sound principle of ethical medical practice. Admission procedures certainly need changes in the Act.

In an emergency situation, under Section 94, a MO can administer all treatments that are immediately necessary for 72 hours, to prevent death or irreversible harm to the health of the patient or stop the patient from inflicting serious harm to self or others. The psychiatrist in such a situation should be allowed to use ECT as a life-saving measure. This practice is allowed in many countries including England and Australia.[18] Majority of psychiatrists opined that emergency ECT should be allowed immediately after the admission in case of need.

In the case of a minor, the patient and parents should be able to access care directly from a mental healthcare facility like that for physical illness, without having to go through the procedure of application to MO. MO is required to assess the patient for the presence of a serious mental disorder, which the MO may not be sufficiently trained or skilled in. In India, general doctors serving as medical officers in MHEs are not trained in diagnosing mental illness in children or adolescents. This is a major deficiency. Further, in cases of acute anxiety or dissociation or somatization, the label of a serious mental illness is not tenable and thus, such a patient will be denied inpatient treatment which may be the most appropriate requirement for full assessment of diagnosis and treatment at that time. Also, for a female minor, a male relative such as father is not acceptable as per law. This is discriminatory and prejudicial to the interests of the family. Therefore, there are several lacunae in the Act concerning treatment of minors.

32.7% psychiatrists in the survey do not know that a form needs to be filled for physical restraints and monitoring as given in the rules notified by the central government. 57.5% of the

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experienced psychiatrists of the country are not aware of the postdischarge plan as a requirement for continuity of care.

93.2% of the survey respondents opined that a psychiatrist is a doctor who is treating patients in good faith and therefore should also be excluded from the penalty clause at par with other officials who are taking treatment decisions about the patient (as per Section 107, 108, Chapter XV of MHCA, 2017). Penalty clause is discriminatory against the psychiatrists. However, a review by Hongally et al.[22] suggested that measures such as proper documentation and maintenance of medical records of outpatient/inpatient and records of psychological assessments should be meticulously carried out in order to prevent the above-mentioned punishments and penalties.

Stand-alone Legislation Versus General Healthcare Laws

Several members in the survey raised the objection on the need for separate laws for mental health care when there are already sufficient laws and safeguards in general healthcare laws, disability laws, and civil and criminal laws in the country. There are many physical health conditions where patients temporarily lose capacity and where they have to be admitted in the hospital for varying lengths of time, e.g., neurosurgical operations, patients in coma, patients with severe trauma, or patients who are unconscious due to any reason and cannot give consent. In all such conditions, the family's consent is sufficient to undertake treatment without any legality to be involved. In many circumstances, patients have to undergo mutilating surgeries in order to save their lives; again, no questions are raised on the intent of the surgeon. Mental illness, on the other hand, is seen with suspicion and motives are attributed to the family or the treating psychiatrist. This is discriminatory and stigmatizing. In fact, separate mental health laws are a legacy of the colonial past and is archaic in current times. It stigmatizes mental illness as well as PMI. Such laws were needed when there was no treatment for mental illness and patients had to be kept in custodial care away from the society. Now, with tremendous advancement in understanding and treatment of mental illnesses, and with the advent of effective and powerful psychotropic medications, most mental illnesses are treatable at the outpatient level, in the general healthcare facilities. A small fraction of patients who are severely ill, and have lost insight, or capacity, or are at risk of harm to self and others, are required to be admitted in a specified mental healthcare facility needing the protection of law. Bringing all mental illnesses and all healthcare facilities where mental illnesses are treated under the law as in MHCA 2017 is a disservice as well as a retrogressive step.

According to WHO (2023),[2] "legislation often treats mental health as a separate regime, either through stand-alone laws or separate 'mental health' sections in general health laws. This has been shown to emphasize the segregation of mental health, potentially reinforcing stigma and a siloed approach". Instead of adopting stand-alone legislation, countries should consider addressing mental health comprehensively in relevant pieces of legislation such as those related to health, patients' rights, antidiscrimination, employment, or social protection. This approach would contribute to reducing stigma and underscore community inclusion. There are several countries where there are no separate mental healthcare laws. **Table 17** shows how general health care and other laws can fill in and suffice for mental health care, without requiring any separate laws.

Budget Allocation, Policies, and Other Matters

One of the most common suggestions was that insurance coverage should be provided for mental

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TABLE 17: Comparative table showing the main streaming of mental health as a strategic objective in general legislation (WHO 2023).[2]

Typical provisions in stand-alone mental health laws	*Laws where provisions could be integrated*
Access to mental health services	General health law
Mental health prevention and promotion	General health law, education law
Development of community-based mental health services and programs	General health law; social care law
Prohibition of discrimination in mental health care	Antidiscrimination law; law on equal opportunities; patient's rights law
Rights of service users	Patient's rights law; social service law
Informed consent to treatment	General health law; patient's rights law
Supported decision-making	Civil code; capacity law; patient's rights law
Advance directive	General health law
Remedies	Patient's rights law; general health law; Access to justice law; criminal law
Mental health in workplaces	Employment law
Rights of persons with psychosocial disabilities	Disability laws; antidiscrimination laws

illnesses just like that for physical illnesses. Insurance coverage is currently being provided only for inpatients (Health Insurance Article 2023)[23] till the time of the survey. The Ayushman Bharat scheme should cover the treatment of mental illnesses as well.

72.3% of psychiatrists from India in the survey agreed that a new provision of CTO may help chronic psychotic patients who are relapsing or those who do not have insight. However, a CTO already in practice in other developed countries like the United Kingdom, Australia, Canada, and United States, etc., has not emerged as a useful concept that helps to prevent relapse or reduce hospitalization, according to a recent research report.[24,25] A CTO wherever permitted by mental health laws raises conflicting views between a patient's autonomy, on one hand, and the use of coercion/legal mandate of administering treatment in the community, on the other hand. CTO, therefore, remains a controversial issue.

Several contradictions and limitations in the MHCA 2017 have been brought out in a paper by Manoj Kumar Therayil from Kerala published in the Indian Journal of Psychological Medicine.[18] He has highlighted that Section 21(1) states that "every person with mental illness shall be treated as equal to persons with physical illness in the provision of all healthcare." Contrary to these declared principles of parity with physical illness, the Act has brought all voluntary admissions of adult PMI under its purview which is an internal contradiction in the provisions of the Act. Further, he states that the government has abdicated its statutory responsibility toward "individuals admitted for the safety of others (under section 89 or 90), where the state should provide all required care". So, all voluntary admissions for the treatment of mental illness should be outside the purview of MHCA.

Since MHA 1987 came into existence, the government had established the system of psychiatric hospitals throughout the country and allocated huge budgets to develop centers of excellence in mental health under the National Mental Health Program (NMHP, Government

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of India) and District Mental Health Program.[26] Now, in the current financial year 2023–2024, significant budget has been allotted for National Tele Mental Health Program (National Tele Mental Health Program 2023),[27] development of new medical colleges, increase in seats of postgraduate institutes, and so on. As per the prevailing system under the earlier MHA 1987, the practice of treating wandering, homeless, or destitute persons with mental illness via a magistrate order should be continued in the present Act, mandating psychiatric hospitals run under state/central/autonomous Institutes of National Importance to provide care to all such PMI.

Chapter V, MHCA, 2017, Rights of persons with mental illness, provides for right to access mental health care; right to community living; right to protection from cruel, inhuman, and degrading treatment; right to information; right to confidentiality and restriction of release of information in respect of mental illness; right to access medical records; right to make personal communication; right to legal aid; and right to make complaints about deficiencies in provision of services. It is the duty of the state to fulfil the rights of persons suffering from mental illness. In ground reality, there is no evidence of any action at mass level by the government to fulfil the above-mentioned rights of persons suffering from mental illness. It is estimated that implementation of MHCA, 2017 requires an estimated budget of ₹94,073 crores.[28] It is unlikely that the government will ever have so much resource allocated for mental health care in India. No wonder that 75.2% psychiatrists in the survey reported that the present form of the Act is unimplementable.

The uniqueness of this survey is rich quantitative and qualitative data that could be gathered from experienced, practicing psychiatrists raising their concerns about the current working lacunae in the existing MHCA 2017, problems faced, and possible solutions that could improve mental health services of PMI. The above-mentioned figures mentioned for the functioning of the regulatory bodies require some caution, as it has not been corroborated directly by the data obtained from the state governments. Adding a patient's or caregiver's perspective would have further enhanced the value of findings, but this would require a separate study.

The present survey has the limitation of being answered by 600 psychiatrists, out of a total of 7,500 who were mailed the questionnaire. The reasons could be many such as lack of awareness or understanding of the MHCA, lack of clarity, finding it a futile exercise, time constraints, and the like. Moreover, the findings are skewed as majority of respondents represented three to four states, namely Karnataka, Maharashtra, Tamil Nadu, and Kerala. The present survey brings out a strong opinion favoring amendments requiring major reforms or a total repeal of the Act. Implementation of MHCA 2017 in its current form is not practically feasible.

CONCLUSION

92% respondents are dissatisfied with the present Act, 73% respondents recommended amendments to the Act, and 19% wanted repeal. There is a strong opinion favoring greater representation and authority to be given to psychiatrists in SMHA and MHRB for taking clinical decisions. Families should be recognized as natural guardians of patients in all matters concerning treatment and care of patients with mental illness. Many concepts borrowed from western laws such as AD and NR have a negative impact on mental health care in India. At present due to improper admission rules, MHCA is hindering appropriate treatment decisions by psychiatrists and also hindering early treatment for patients who are most severely sick and in need of immediate care. There are inherent contradictions in the Act: For example, (1) Patient with mental illness as

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defined in MHCA in all probability is incapable of acknowledging that he/she has mental illness and incapable to consent for treatment which is against the basic presumption that every patient has capacity till proved otherwise. (ii) Also, on one hand, the Act states that "every person with mental illness shall be treated as equal to persons with physical illness in the provision of all healthcare," whereas contrary to this declared principle, the Act has brought all voluntary admissions of adult PMI under its purview. MHCA does not support the tenets of integration of mental health care with general health care; rather, it isolates mental health care from general health which is stigmatizing and does not provide any roadmap for increasing access to and delivery of mental health care to all patients in need of such care. There is only minimal implementation of the MHCA, even after 5 years of its existence. MHCA is more of a regulatory tool rather than a facilitatory tool. Implementing MHCA in its true letter and spirit is a huge expensive exercise which the government would find it impossible to fulfil. 71.5% of the psychiatrists think that the Act in its current form defies the spirit of its own stated objectives and is unimplementable.

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