

REPORT NO.

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PARLIAMENT OF INDIA

RAJYA SABHA

DEPARTMENT-RELATED PARLIAMENTARY STANDING COMMITTEE
ON HEALTH AND FAMILY WELFARE

SEVENTY-FOURTH REPORT

On

THE MENTAL HEALTH CARE BILL, 2013

(Ministry of Health and Family Welfare)

(Presented to the Chairman, Rajya Sabha on the 20th November, 2013)

(Forwarded to the Speaker, Lok Sabha on the 20th November, 2013)



Rajya Sabha Secretariat, New Delhi
NOVEMBER, 2013/ KARTIKA, 1935 (SAKA)



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* **to be appended at printing stage**

COMPOSITION OF THE COMMITTEE (2013-14)

RAJYA SABHA

- | | | |
|-----------------------------|---|-----------------|
| 1. Shri Brajesh Pathak | - | Chairman |
| 2. Shri Rajkumar Dhoot | | |
| 3. Shrimati B. Jayashree | | |
| 4. Shri Mohd. Ali Khan | | |
| 5. Dr. Prabhakar Kore | | |
| 6. Dr. R. Lakshmanan | | |
| * 7. Shri Rasheed Masood | | |
| 8. Shri Jagat Prakash Nadda | | |
| 9. Dr. Vijaylaxmi Sadho | | |
| 10. Shri Arvind Kumar Singh | | |

LOK SABHA

11. Shri Kirti Azad
12. Shri Mohd. Azharuddin
13. Shrimati Sarika Devendra Singh Baghel
14. Shri Kuvarjibhai M. Bavalia
15. Shrimati Priya Dutt
16. Dr. Sucharu Ranjan Halder
17. Mohd. Asrarul Haque
18. Dr. Monazir Hassan
19. Dr. Sanjay Jaiswal
20. Shri Chowdhury Mohan Jatua
21. Dr. Tarun Mandal
22. Shri Mahabal Mishra
23. Shri Zafar Ali Naqvi
24. Shrimati Jayshreeben Patel
25. Shri Harin Pathak
26. Shri Ramkishun
27. Dr. Anup Kumar Saha
28. Dr. Arvind Kumar Sharma
29. Dr. Raghuvansh Prasad Singh
30. Shri P.T. Thomas
31. Vacant

SECRETARIAT

Shri P.P.K. Ramacharyulu	Joint Secretary
Shri R. B. Gupta	Director
Shrimati Arpana Mendiratta	Joint Director
Shri Dinesh Singh	Deputy Director
Shri Pratap Shenoy	Committee Officer

* vacant vide disqualification as a member of the Council of States (Rajya Sabha) w.e.f. 19th September, 2013.

PREFACE

I, the Chairman of the Department-related Parliamentary Standing Committee on Health and Family Welfare, having been authorized by the Committee to present the Report on its behalf, present this Seventy-fourth Report of the Committee on the Mental Health Care Bill, 2013*.

2. In pursuance of Rule 270 of the Rules of Procedure and Conduct of Business in the Council of States relating to the Department-related Parliamentary Standing Committees, the Chairman, Rajya Sabha, referred** the Mental Health Care Bill, 2013 (**Annexure I**) to the Committee on the 20th August, 2013, as introduced in the Rajya Sabha on the 19th August, 2013 for examination and report within three months.

3. The Committee issued a Press Release inviting memoranda/views from individuals and other stakeholders. (**Annexure-II**). In response thereto, 59 Memoranda from individuals and others relevant to the Bill were received till the specified date. List of individuals from whom memoranda were received is at **Annexure-III**.

4. The Committee held seven sittings during the course of examination of the Bill, i.e., on 29th August, 16th September, 04th October, 11th October, 21st October, 1st November and 11th November, 2013. The list of witnesses heard by the Committee is at **Annexure-IV**.

5. The Committee considered the draft Report and adopted the same on 11th November, 2013.

6. The Committee has relied on the following documents in finalizing the Report:-

- (i) Mental Health Care Bill, 2013;
- (ii) Background Notes on the Bill received from the Department of Health and Family Welfare;
- (iii) Presentation, clarifications and Oral evidences of Secretary, Department of Health & Family Welfare;
- (iv) Memoranda received on the Bill from various institutes/bodies/associations/organizations/experts and replies of the Ministry on the memoranda selected by the Committee for examination.
- (v) Oral evidences and written submissions by various stakeholders/experts on the Bill; and
- (vi) Replies to the questions/queries raised by Members in the meetings on the Bill, received from the Department of Health & Family Welfare

7. On behalf of the Committee, I would like to acknowledge with thanks the contributions made by those who deposed before the Committee and also those who gave their valuable suggestions to the Committee through written submissions.

8. For facility of reference and convenience, the observations and recommendations of the Committee have been printed in bold letters in the body of the Report.

NEW DELHI;
11th November, 2013
Kartika 20 , 1935 (Saka)

BRAJESH PATHAK
Chairman,
Department-related Parliamentary Standing
Committee on Health and Family Welfare

* *Published in Gazette of India Extraordinary Part II Section 2, dated 19th August, 2013.*
** *Rajya Sabha Parliamentary Bulletin Part II, No.51174, dated 20th August, 2013.*

ACRONYMS

1.	AD	-	Advance Directive
2.	AIIMS	-	All India Institute of Medical Sciences
3.	BOV	-	Board of Visitors
4.	CIP	-	Central Institute of Psychiatry
5.	CMHA	-	Central Mental Health Authority
6.	CMHC	-	Central Mental Health Commission
7.	CRPD	-	Convention on the Rights of Persons with Disabilities
8.	CrPC	-	Code of Criminal Procedure
9.	CRR	-	Central Rehabilitation Register
10.	DMHP	-	District Mental Health Programme
11.	ECT	-	Electro-convulsive Therapy
12.	GHPUs	-	General Health Psychiatric Units
13.	IHBAS	-	Institute of Human Behaviour & Allied Sciences
14.	IPC	-	Indian Penal Code
15.	IRDA	-	Insurance Regulatory and Development Authority
16.	IPS	-	Indian Psychiatry Society
17.	LGBRIMH	-	Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tejpur
18.	MHA	-	Mental Health Act
19.	MHCB	-	Mental Health Care Bill
20.	MHRC	-	Mental Health Review Commission
21.	NIMHANS	-	National Institute of Mental Health and Neuro-Sciences
22.	NMHP	-	National Mental Health Programme
23.	NR	-	Nominated Representative
24.	PHC	-	Primary Health Centre
25.	PG	-	Post-Graduate
26.	PwD Act, 1995-	-	Persons with Disabilities Act, 1995
27.	RCI	-	Rehabilitation Council of India
28.	SMHA	-	State Mental Health Authority
29.	SMHC	-	State Mental Health Commission
30.	SOR	-	Statement of Objects and Reasons
31.	UNCRPD	-	United Nations Conventions on the Rights of Persons with Disabilities
32.	UT	-	Union Territory

REPORT

The Mental Health Care Bill, 2013 (hereinafter referred to as the Bill) was introduced in the Rajya Sabha on the 19th August, 2013 and referred to the Department related Parliamentary Standing Committee on Health and Family Welfare on the 20th August, 2013 for examination and report thereon.

2. As per the information furnished by the Ministry of Health and Family Welfare the Mental Health Care Bill, 2013 seeks to consolidate the legislations related to mental illness and improve the conditions in mental health facilities existing in the country while ensuring the process of appeal by a person admitted to a psychiatry institution, rehabilitation, reintegration with families and community in non-medical settings. The Bill addresses the issues of mental illness and capacity to make mental health care and treatment decisions; advance directive; nominated representative; rights of persons with mental illness; duties of appropriate government; central and state mental health authorities; mental health establishments; mental health review commission; admission, treatment and discharge. The Bill also consolidates the law regarding the responsibilities of other agencies, restriction to discharge functions by professionals not covered by professional offences and penalties.

3. According to the Statement of Objects and Reasons (SOR) of the Bill, the United Nations Convention on the Rights of Persons with Disabilities, which was ratified by the Government of India in October, 2007, made it obligatory on the Government to align the policies and laws of the country with the Convention. The need for amendments to the Mental Health Act, 1987 was felt by the fact that the related law, i.e., the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 was also in the process of amendment. The Mental Health Act, 1987 could not protect the rights of persons with mental

illness and promote their access to mental health care in the country. In the light of above it was proposed to repeal the Mental Health Act (MHA), 1987 and bring in a new legislation.

4. The Statement of Objects and Reasons (SOR) of the Bill further states that the Bill proposes to repeal the Mental Health Act, 1987. Its objectives are to: (i) protect and promote rights of the persons with mental illness during the delivery of health care in institutions and in the community; (ii) ensure that health care, treatment and rehabilitation of the persons with mental illness, is provided in the least restrictive environment possible, and in a manner that does not intrude on their rights and dignity; (iii) fulfil the obligations under the Constitution and the obligations under various International Conventions ratified by India; (iv) regulate public and private mental health sectors within a rights framework to achieve the greatest public health good; (v) improve accessibility to mental health care by mandating sufficient provision of quality public mental health services and non-discrimination in health insurance; (vi) establish a mental health system integrated into all levels of general health care; and (vii) promote principles of equity, efficiency and active participation of all stakeholders in decision making.

5. Keeping in view the objectives behind the proposed legislation and its impact on the people who are mentally ill, the caregivers, the families and professionals associated with this health sector, the Committee decided to have opinion of different stakeholders on the Bill, and issued a Press Release, inviting views/suggestions from all the stakeholders. An overwhelming response to the Press Release was received by the Committee. A considerable number of organizations/stakeholders/ individuals/associations submitted memoranda containing their views. The Committee held extensive interactions with representatives of associations/organizations/Councils/institutes as well as

renowned experts and professionals from the discipline of Psychiatry and caregivers/family members and patients.

6. The Ministry of Health and Family Welfare in its background note made the following submissions.:-

“The Mental Health Act, 1987 (MHA,1987) was enacted to regulate the admission and treatment of persons with mental illness to psychiatric institutions and for the management of their property and affairs. Over the years, the MHA, 1987 has been criticized by many stakeholders including persons with mental illness, families and caregivers, rights and disability activists, user-survivors of psychiatric care and a segment of the professional psychiatric community. The growing concern that the MHA ,1987 needed to be amended gained urgency with the ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) by the Government of India in October, 2007 which requires India to amend or replace laws not compliant with the CRPD. The demand for amendments to Mental Health Act, 1987 was strengthened by the fact that the related Act, The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 was also in the process of amendment. The MHA, 1987 could not protect the rights of persons with mental illness and promote access to mental health care in the country. Therefore it was proposed to repeal the MHA, 1987 and bring in a new legislation.

Essential Features of the Mental Healthcare Bill 2013:

- *The Central and State Mental Health Authorities will continue as regulatory agencies.*
- *Any person, with or without mental illness, can make an Advance Directive (AD) stating how he/she wishes to be treated for a future mental illness and also how he does not wish to be treated. Such an AD can also be challenged by families, professionals etc. This provision is included to meet the CRPD’s requirement for protecting legal capacity of persons with mental illness.*
- *A person with mental illness can appoint a Nominated Representative to take decisions for him/her. This provision too is included to meet the CRPD’s requirement for protecting legal capacity of persons with mental illness.*

- *A person with mental illness has the right to live in, be part of, and not segregated from society. Government has an obligation to provide for half way homes, community caring centres etc.*
- *The MHC Bill, 2013 makes a clear assertion that all persons have a right to access mental healthcare and treatment from mental health services run or funded by the Government. Such services should be affordable, of good quality and available without discrimination.*
- *A person with mental illness has the right to be protected from cruel, inhuman and degrading treatment. Some treatments currently being used will be prohibited, most importantly, Electro-convulsive Therapy given without anaesthesia and the practice of chaining patients to their beds.*
- *The Bill recognizes that the overwhelming majority of the mentally ill are in their homes. Caring for a mentally ill person is financially and emotionally draining for any family. A significant portion of the wandering homeless have mental illness. The Bill therefore addresses the needs of families and caregivers and the needs of the homeless mentally ill.*
- *In some instances of advanced illness, when the person is not in a position to make decisions for himself/herself, it may be necessary in the best interest of the health and welfare of the person with mental illness to be admitted, to a treatment facility with the support of their nominated representative. The Bill sets out in some detail the measures established to ensure that all cases of supported admission are reviewed without loss of time. This is well within the provisions of Article 12 of the UNCRPD.*
- *All cases of such supported admissions will be reviewed by a Mental Health Review Commission which will function through District Boards. The essential task of the Commission/Boards is to ensure that admission of any person to a mental health facility is the least restrictive care option under the circumstances.*
- *The MHC Bill has provisions for Central and State Mental Health Authorities (CMHA & SMHA) and a Mental Health Review Commission*

(MHRC). This is the structure followed in all modern and progressive legislations. The CMHA and SMHA are largely administrative bodies concerned with regulating/setting standards for mental health facilities, maintaining registers of such facilities and of mental health professionals and carry out training functions. The composition of these bodies reflects these functions.

- *The MHRC is a quasi-judicial body to provide an independent oversight to the functioning of mental health facilities and protect the rights of persons with mental illness in these facilities. It thus meets the need for an independent review mechanism as required under the CRPD. The composition of the MHRC reflects in quasi-judicial function(headed by a retired High Court Judge and staffed with District Judges).*
- *The direction and thrust of the MHC Bill, 2013 is that the State assumes the responsibility for providing adequate health care, including support to caregiving facilities. At present the District Mental Health Programme (DMHP) operates in 123 districts in the country though it must be recognized that delivery of healthcare services is not optimal essentially for the reason that the DMHP requires every district to have a full complement of appropriately trained professionals. Though the National Mental Health Programme (NMHP) offers financial support to state governments to increase the number of seats in medical colleges and nursing colleges in the appropriate disciplines, progress has not been fast. The 11th Plan outlay for NMHP including DMHP was Rs.623 crores. In a parallel exercise to the drafting of the MHC Bill 2013, the DMHP has been substantially reworked with a focus on community and home based care as required by the MHC Bill, 2013.”*

7. During the course of his oral evidence before the Committee on the 29th August, 2013, **the Secretary, Department of Health and Family Welfare** apprised the Committee of the salient features of the Bill. He pointed out that unlike the existing Act, which mixes healthcare and social care issues, the present Bill seeks to isolate the purely healthcare-related aspects while not going into the

questions of guardianship and civic and political rights. He pointed out that the number of psychiatrists in our country is very small; it is not more than 4,000. Further, the number in public sector, amongst these 4,000, would be a small number. Many are in private practice. So, this is one of the reasons that this Bill insists on various levels of community-based care and half-way homes. It is because every person with illness is not going to have access to a qualified psychiatrist. There may be one level of consultation, but on-going care and treatment will need to be provided in the districts, sometimes at the PHC level, through care givers. Number of those people is not adequate, but clearly, the onus is on the Department to create much larger number of health professionals in this area who cannot all be psychiatrists.

8. Further elaborating on the present scenario on the mental health care facilities in the country, the Secretary, submitted that the most exhaustive studies have been done by the National Human Rights Commission, which after the Erwadi tragedy of 2001, undertook a very detailed study. At that time, 36 mental health facilities were there in the country which is 38 now. The study was very detailed and that report brought out many of the instances of cruel treatment and people being chained, people being beaten, people being denied any kind of dignity. If there was one question that has driven this whole process, it was on the voluntary versus involuntary admission. It was presumed that all the time, a person with mental illness has the capacity to make a decision unless the situation was so exceptionally otherwise that he could not take a decision. Even in those situations, the quasi judicial process would come into play.

9. Apprising the Committee of the scenario of Post Graduation Education **Dr. P. Satishchandra, Director, NIMHANS, Bengaluru** during the course of his deposition before the Committee on 11th October, 2013 delineated on the brief

history of the Acts enacted in the field of mental health and the need for introduction of the present Bill. He also made the following suggestions as regards the Bill: (i) need to exclude general hospitals from the licensing procedure under the definition of 'Mental Health Establishment' in the Bill; (ii) need to exclude people with alcohol and substance users (who do not have substance induced mental illness and mental retardation/intellectual disability) in the definition of "Mental Illness"; (iii) Electro Convulsive Therapy should be done under Anaesthesia always; (iv) Need to have State Mental Health Commission(SHMC) in each State and Union Territories and the said commission will be formed in consultation with Central Mental Health Commission and the State. He further stated that Mental Health Boards will be constituted by the SHMC after assessing the needs, etc. He also delineated that the following rights need to be enlisted in the Bill: (a) Mental illness should not be a ground for divorce;(b) disability due to mental illness is usually ignored or discriminated. Mental disability need to be considered on par with physical disability for all disability benefits; (c) all general hospitals(public and private) shall not refuse emergency psychiatry treatment.

10. He further submitted that Post Graduate Education in Psychiatry in the country is growing very well now as compared to few years back. In the last five years, the number of seats have been doubled. In all medical colleges now, the Psychiatry Department has been started. There are many psychiatric departments running these courses. The Central Institutes like the National Institute of Mental Health and Neurosciences, Bengaluru, the CIP (Ranchi) and Tejpur have doubled the intake of the seats. However, the number of psychiatrists in this country still does not exceed 4,000, and that is why, there is a great need to add on the number of psychiatrists. He felt that the only way of addition was to increase the Institutes as well as the courses at the level of post-graduation in the medical colleges.

According to him a serious attempt has been made by the Government and it was expected that within the next two to three years' time, there would be a significant increase in the number of the post-graduates coming out of these institutions. But, compared to the western world, the number of psychiatrists in this country was definitely very low. The way to progress was to use the other mental health professionals in the form of psychologists. The psychiatrist social workers as well as the psychiatrist nurses are also needed. Their number is also significantly less. Thus, there is a dire need to increase the number of seats in all these colleges. Apart from this, the post-graduates in medicine are being trained in psychiatry now, and, a short-term training course has been given to many of the District Medical Officers. They have all been provided with a short-term training in the institutions like Central Institutes of Bangalore, Tejpur and Ranchi. He also stated that the physicians, general practitioners and the doctors in the District Mental Hospitals are being trained under the National Mental Health Programme as well as District Mental Health Programme, and, this short-term training helps them to deal with the acute emergencies at the peripheral centers. Regarding the Electroconvulsive Therapy with a modified variety, Dr. Satishchandra stated that the number of anaesthetists in the country is 16,000 and the number of psychiatrists is 4,000. So, at every place, where the psychiatrists were available, there were anaesthetists and that the Government has been requested to provide these facilities of anaesthetists. Further this law will ensure that the facilities are provided at all these places where ECT has to be given.

Views of the State Governments

11. To acquaint itself with the views of the State Governments, the Committee sought the written comments of all the State/UT governments. However, only Delhi government responded. In a written submission, the Government of Delhi furnished the following comments based on the experience of Institute of Human

Behaviour & Allied Sciences (IHBAS), Delhi and technical office of State Mental Health Authority (SMHA), Delhi:

(i) Differentiation of “treatment order” versus “admission order” in the Bill as mandatory admission for involuntary treatment is difficult to apply in the community setting and is also not in the spirit of the government policy of promoting and providing community based mental health services including rehabilitation.

(ii) Confidentiality of Psychiatric Case Records Related to Right to Information Act must be ensured. Thus the clause related to right to access to medical records must be finetuned accordingly.

(iii) Provision of Mobile Mental Health Service needs to be introduced in the Bill and specially the provision of legal authorization for emergency medication in the field by Mobile Mental Health Unit team should be mentioned in the draft Bill.

(iv) There should be separate provision in the draft Bill regarding foreign nationals with clear clauses as problems in terms of admission/initiation of treatment/forced treatment/discharge are faced when foreign national is being brought by Police/Magistrate/Embassy.

(v) A provision for district wise Board of Visitors should be made in the Bill and Board of Visitors should be sectorised by making provision for district wise BOV.

(vi) Make it mandatory for all licensed psychiatric hospitals/ nursing homes to provide emergency psychiatric services.

(vii) The provision of retired judge to be the Chairman of the proposed Mental Health Review Commission may be reviewed as it would be better if some person from user/carer/advocacy group can be given the charge of the Chairman of Mental Health Review Commission.

(viii) Government Hospital Psychiatry Units should be brought under ambit of SMHA in the Bill.

Views of Other Stakeholders/Experts

Some important issues raised by some of the other experts/stakeholders are discussed briefly hereunder:-

12. During her presentation on 21st October, 2013 before the Committee, Ms. Amita Dhanda, Professor and Head, Centre for Disabilities Studies, NALSAR University of Law, Hyderabad submitted that she was of the view that the said Bill was not in harmony with the United Nations Convention on Rights of Persons with Disabilities (UNCRPD) in letter and spirit and was in infringement of Part III of the Constitution. The said Bill gives no power to the affected person to seek exit

from the institution if he was not satisfied with the treatment. The Bill is also silent on the right of the affected person to live independently and there was a need to bring an amendment to the proposed legislation in this regard. Further there was a need to relook at clause 124 which says that all persons who attempt to commit suicide are presumed to be suffering from mental illness unless proved otherwise. Further there was a need to relook at clause 114(2) of the Bill in which "proof of Mental Illness" obtained from a Board would suffice for obtaining 'divorce' which was not fair to convert a legal dispute into a medical dispute. Therefore, there was a need to delete this provision.

13. Dr. Vikram Patel from the Public Health Foundation of India (PHFI) during his deposition before the Committee on 11th October, 2013 supported the Bill and stated that the proposed Bill is a vast improvement over the last enactment in 1987. He made the following points in support of the Bill: (i) Constitution of Mental Health Review Board in the districts under Section 80 of Chapter XI is a key step to safeguard the rights of persons with mental health conditions;(ii) the Bill contains sufficient safeguards in regard to the provisions for 'Advance Directive' and 'Nominated Representative' (iii) unlike previous legislation where the entire onus to protect the rights of the individual with mental condition was on the magistrate, the new Bill places this responsibility on a five member district board on which it would be mandatory to have a psychiatrist on board to review the clinical status of patient and the psychiatrist has major decision making powers in the functioning of the Board.

14. He further stated that for the majority of Indians who suffer from a mental illness, and in particular those who live in poor and rural circumstances, the unavailability of appropriate, evidence based mental health care was a major

impediment to their recovery. The quality of life of such persons and their caregivers was abysmal, often initiating a downward spiral into further poverty, hopelessness and even homelessness. Social exclusion, violent victimization and human rights abuse were more prevalent in people with mental illness. The lack of access to evidence based treatment and care for mental illness has reached a critical point and a concerted national effort was needed to address this public health crisis.

15. He also stated that the MHC B enshrines access to health care as a right and holds the Government accountable for service delivery. The Bill proposes to foster a climate of reforms both within Mental Hospitals and in the community by setting up a Mental Health Review Commission that would regulate admission, discharge and deal with violation of rights.

16. The Committee heard the views of **Dr. S.K. Deuri, Director, Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tejpur, Assam** on the Bill on the 16th December, 2013. Dr. Deuri submitted that entry point for treatment was given in the Bill but the Bill was silent on the procedure for exit of patients after availing treatment. The Bill was also silent on rehabilitation of the treated and recovered patients. He also raised the issues like criminals being sent to Mental Institutions without availability or otherwise of beds in such institutions; no proper definition of psychiatric nurse/psychiatric social worker; regressive provision for transportation of patient from one State to another which would not be in the interest of the patient. In a written submission, the Department of Psychiatric Social Work, LGBRIMH, Tezpur Assam made the following submissions:

(i) The Mental Health Care Bill 2013 has changed its outlook from a medical model to a social model by incorporating the rights based provisions of UNCRPD. Unlike the earlier Mental Health Act 1987(Chapter VIII, Section 81), the current one has made provision for detailed rights of the person with mental illness in the Chapter 5.

(ii) Chapter I, Clause 2 defines Mental Health Professionals and but the definitions put forth are wrongly inserted. It has been put forth that due to absence of adequate number of professional social workers with M Phil degree, a lower PG degree has been proposed as the required qualification for Psychiatric Social Workers. This similar justification should have also been applied for all the mental health professionals (Psychiatrist, Clinical Psychologists and Psychiatric Nurse) as all are in the similar status in terms of quantity.

(iii) Rules could be specified that in places where there are shortages of manpower with M Phil degree, personnel with PG in Social Work could be trained under the NMHP to augment the services as Psychiatric Social Worker Assistant, just as Medical Officers with training and experience in Psychiatry were designated to take on the role of Psychiatrists by the State authority. (Chapter 1, Clause 2 , Section x)

(iv) In regard to Mental Health Review Commission (MHRC), the number of members should be increased. A representative from the allied professions like psychiatric social work, clinical psychology and psychiatric nursing should be considered to be a part of the Commission. Sections 80 and 81 which deals with the Review Board at district levels, should consider increasing the number of members. A representative from the allied professions like psychiatric social work, clinical psychology and psychiatric nursing should be considered to be a part of the commission.

(v) The proposed Bill still continues its link with the correctional system. The clause 101, chapter XII, on 'leave from the hospital' requires a police officer to accost the person with mental illness to return to treatment facility. This further serves to stigmatise the person with mental illness. The section dealing with 'leave' should be repealed. It also contradicts with person's right to get discharged without any consent from officer in charge/psychiatrist.

(vi) The Bill vests the right to transfer the person with mental illness from one mental health establishment to another, within and outside a state to the State Authority and this could go against the interest of the person and his right . This has the danger of abandonment and alienation of the person. Treating personnel in Mental Health need to move to Prisons as part of integration of services and community extension initiatives . A prison set-up coming to a hospital is not a very practical move.

(vii) In Clause 109 under Chapter XIII , section 7 requires an FIR to be lodged for any mentally ill homeless person. The matter of using the police measures like lodging FIR further increases the stigma and the person could get lost in the system.

(viii) Clause 128 of protection for acts done in good faith does not include the mental health professionals. Non- inclusion of mental health professional in this provision is discriminatory.

(ix) The Bill is silent on issues of rehabilitation aspects for chronic mental illness. There is no provision for protecting the rights of persons with mental illness who are abandoned/disowned by their family members/who refuse to accept the person back into the family. The Bill also could make a provision for addressing stigmatizing behaviors in family, community and workplace. A provision should be inserted as a penalty for indulgence in stigmatizing behavior and act as deterrence in the society.

17. Dr. Sudhir K. Khandelwal, Professor of Psychiatry, AIIMS, New Delhi during the course of his deposition before the Committee on the 4th, October, 2013 stated that though the Bill had addressed certain other concerns, there were certain concerns which needed to be addressed viz. high level of qualification needed to qualify as a clinical psychiatrist would act as a dampener as manpower needed to qualify for the post of clinical psychiatrists would be difficult to find in practice; definition of mental illness is ill-conceived and is over inclusive; features like 'causing distress or impairment' would make practically whole of Indian population mentally ill at some point of time; number of clauses in the 'advance directive' would make it a difficult and lengthy process to actually implement the said directive in practice; it is not clear if the person with the power of advance directive has power for making the treatment decisions of the patient only, or if he could also make civil and property related decisions also; it had not been specified or defined 'serious mental harm' or likelihood of harm, thus the provision regarding access to medical records might be misused; it is not clear whether the Mental Health Review Commission (MHRC) will function as an Authority or a Tribunal; functions of MHRC not clearly defined; the issues of purview of State Mental Health Authority (SMHA), co-ordination among various SMHAs had not been addressed; need for exemption in the provisions of the said Bill for the purpose of admission and discharge of mentally ill persons in General Psychiatric care unit of the General Hospital; the Bill is silent on provisions of care and services for mentally ill homeless people; civil rights and property rights have been ignored in the Bill; process of drafting MHRC is neither clear, nor transparent.. He further stated that the Bill should focus on governance and not the treatment aspect and unmodified ECT treatment should be exempted from ban under this Bill.

18. At the meeting held on 4th, October, 2013, Ms. Vandana Gopikumar, Founder Trustee, The Banyan Centre, Chennai submitted before the Committee that she was in favour of the Bill in the present form. However, she suggested for need to reframe clause 124 of the Bill; and need to include Primary Health Centres (PHCs) under the ambit of the said Bill.

19. During the course of the meeting held on 16th September, 2013, the Committee heard the views of **Dr. Indira Sharma, President, Indian Psychiatry Society (IPS)** along with fellows of Indian Psychiatry. Dr. Sharma submitted before the Committee that as the Head of Indian Psychiatry Society she was against the enactment of the said Bill in its present form. Delineating the reasons for the same, she stated that the said Bill had been drafted without taking into consideration the viewpoint of Indian Psychiatry Society (IPS). She stated that though the society was a conglomeration of 5000 Members, it had been ignored while drafting the Bill. She was of the view that the concepts incorporated in the Bill like use of terms Advance Directive, nominated representatives; making willingness of the patient mandatory for availing treatment were alien to Indian culture, which would be dangerous for the patient as well as his near and dear ones. She emphasized focusing on the family model treatment in which the family members would be in a position to give consent on the need for subjecting a patient to psychiatric treatment.

20. **Dr. B.S Chavan, Chairman, IPS** submitted that the concept of parents of child having to take permission of Mental Health Review Commission for treatment of mental illness was dehumanizing for the parents and the child in question. **Dr. T.V. Asokan, President-Elect, IPS** was of the view that the concept of nominated representative would lead to a tussle between the family of the

person suffering from mental illness and the nominated representative who may not be a blood relation of the person suffering from mental illness and such nominated representative could misuse the said provision for usurping the property or deriving other benefits which would devolve upon the person suffering from mental illness. **Dr. T.S.S. Rao, Editor in Chief, Indian Journal of Psychiatry**, IPS was of the view that the said Bill treats Psychiatric diseases as a stigma which was not good from the patients' as well as from doctor's point of view. **Dr. Dinesh Kataria, Convenor, IPS** was of the view that the provisions of the said Bill would lead to the exodus of doctors studying Psychiatry in India to foreign shores.

21. Dr. Nirmala Srinivasan, Director, Action for Mental Illness, Bengaluru during her deposition before the Committee on 4th October, 2013 stated that while supporting the Bill she opined that the Bill needed to be nuanced in certain terms viz. proper definition of family care giver needed to be included in the Bill; need to make family of the affected person inclusive in the said Bill. She insisted on the need for more broader role for nominated representative in the said Bill and need to include safeguards in the Right to manage property of the affected person.

22. Shri Amrit Kumar Bakshy, President, Schizophrenia Awareness Association, Maharashtra; during his deposition on 4th, October, 2013 submitted the following that there was a need for a complete ban on modified ECT. Further it was important to provide definitions of family care giver and paid care giver separately in the said Bill. He submitted that nominated representative appointed under section 14 should be deemed to be nominated representative to give effect to advance directive when the need arises to avoid confusion and

conflict; a hierarchy among relatives may be given in the Advance Directive clause; “shall” in place of “shall endeavour” in Section 21 (2) regarding medical insurance to make it more effective; “who has reason to believe...” In sub-sections (1) and (2) of Sections 110 may be substituted with “who has some evidence to the effect...” to protect the family caregivers from harassment.

23. Shri Akhileshwar Sahay, Whole Mind India Foundation, Pune; during his deposition on 4th, October, 2013 submitted that he was a bipolar patient and undergoing psychiatric treatment for the same in AIIMS and was completely in favour of the present Bill. He felt that the present Bill should be passed by the Parliament into an Act and whatever infirmities which are presently in the said Bill could always be taken care of in the future by way of an amendment to the present Bill after it was passed. He was also thankful that the provision which decriminalized 'suicide' had become a part of the said Bill.

24. The Committee heard the views of **Dr. Shekhar Saxena, Director, Department of Mental Health and Substance Abuse, World Health Organization, Geneva, Switzerland** on 11th October, 2013. Dr Saxena delineated the following points on the said Bill: (i) the present Bill laid emphasis on the quality aspect and encouraged transparency in the field of Mental Health unlike previous Acts, (ii) laid emphasis on ECT treatment not to be given to children; (iii) the terms 'Advance Directive' and 'Nominated Representative' are in line with the United Nations Convention on Rights of Persons with Disabilities(UNCRPD).

Clause-by-Clause Examination of the Bill

25. During the course of the examination of the Bill the Committee took note of concerns, suggestions and amendments as expressed by various

experts/stakeholders duly communicated them to the Ministry for its response. Committee's observations and recommendations contained in the Report reflect an extensive scrutiny of all the viewpoints put forth before it. Upon scrutiny of the replies received from the Ministry, various amendments to the said Bill have been suggested by the Committee which are discussed in the succeeding paragraphs.

26. Clause 1(3) and 1(4)

1. (1) This Act may be called the Mental Health Care Act, 2013.

(2) It shall extend to the whole of India.

(3) The provisions of this Act, except the provisions of sections 33, 45 and 73, shall come into force within a period of three months from the date on which it receives the assent of the President.

(4) The provisions of sections 33, 45 and 73 shall come into force within a period of nine months from the date on which it receives the assent of the President.

27. Suggestions

The provisions of this Act, except the provisions of sections 33, 45 and 73, shall come into force within a period of three months from the date on which it receives the assent of the President. The provisions of sections 33, 45 and 73 shall come into force within a period of nine months from the date on which it receives the assent of the President. In this respect, it is important that usage of the phrase "within three months" may be confusing as the exact date is not fixed and could be anytime within three months. Moreover, no procedure such as notification in the gazette by the Central Government has been prescribed in the Bill as a means of notifying to the general public that the Bill has become effective. Thus either there should be fixed/ determinable date on which the Bill comes into effect or the Bill should clearly provide that the date on which the Central Government notifies in the gazette would be the date from which the law would be implemented.

28. Ministry's Response

The Ministry has agreed and stated that this Bill shall come into force 9 months from the date on which it receives the assent of the President, or any earlier date if so notified by Government.

29. Recommendation of the Committee

The Committee acknowledges that the Ministry has accepted the suggestion regarding amendments to clause 1(3) and (4). The Committee is of the view that the new provisions would lend greater clarity and coherence to the operation of the proposed Act and serve the intended purpose. The Committee, therefore, recommends that the proposed amendment may be incorporated in the Bill.

30. CLAUSES 2 (1)(f)

(f) "clinical psychologist" means a person—

(i) having a recognised qualification in Clinical Psychology from an institution approved and recognised, by the Rehabilitation Council of India, constituted under section 3 of the Rehabilitation Council of India Act, 1992; or

(ii) having a Post Graduate degree in Psychology or Applied Psychology and a Master of Philosophy in Clinical Psychology or medical and social psychology or Masters of Philosophy in mental health and social psychology obtained after completion of a full time course of two years which includes supervised clinical training or doctorate in clinical psychology which includes supervised clinical training, from any university recognised by the University Grants Commission established under the University Grants Commission Act, 1956;

31. Suggestions

Since Clinical Psychology professionals work with persons with Mental Illness (acute and chronic), the "Clinical Psychologists" are brought under the purview of the RCI Act and their registration with RCI has been made mandatory (In Clinical Rehabilitation Register, maintained by the Council).

Currently, no university, department, hospital, association, partnership, NGO, or corporate body without a valid recognition by the Council, under the provision of RCI Act, 1992, conduct, offer or offer to conduct any of Clinical Psychology training courses, unless these entities are approved by the Council for the function stated.

The RCI defines “Clinical Psychologists” as follows

- i. A Professional Qualification in Clinical Psychology recognized by the RCI, from time to time, obtained from RCI approved institutions and granted by an University recognized by University Grants Commission as per Section 11 and 12 of RCI Act, 1992.
- ii. Registration in the Central Rehabilitation Register (CRR) as per Section 13 of RCI Act, 1992.

In defining “Clinical Psychologists” in the proposed Bill, the RCI Act, 1992 has been over ruled by including degrees like ‘Master of Philosophy in Mental Health and Social Psychology’ of ‘Ph.D. in Clinical Psychology’ as qualification for Clinical Psychologists, whereas RCI, the apex body does not recognize them. In view of this, it is suggested to remove this section 2(1)(f)(ii) from the Bill. The terms in sub-clause (ii) of clause (f) which reads as “doctorate in clinical psychology which includes supervised clinical training” in the current version of the Bill may be omitted since Ph.D. in any branch of Psychology including so called “Clinical Psychology” is NOT RECOGNISED by the Council as professional qualification on various counts. Thus, there is scope of serious legal ramifications and a flawed legislation thus defeating the very purpose for which the Bill is being prepared.

32. Response of the Ministry:

The Government accepts the suggestion of RCI and section 2 (1) (f) will be amended accordingly :

The amended section 2 (1) (f) shall read as follows :

Clinical psychologist means –

(i) having a recognized qualification in clinical psychology from an institution approved and recognized by the Rehabilitation Council of India, constituted under Section 3 of the Rehabilitation Council of India Act, 1992 ; or
(ii) having a Post Graduate degree in Psychology or Applied Psychology and a Master of Philosophy or medical and social Psychology or Master of Philosophy in mental health and social psychology obtained after completion of a full time course of two years which includes supervised clinical training from any University recognized by the UGC established under the University Grants Commission Act, 1956 and approved and recognized by the Rehabilitation Council of India Act, 1992.

33. Recommendation of the Committee

The Committee recommends that the Ministry may bring the suggested amendment in the clause.

34. Clause 4 (1)

4. (1) Every person, including a person with mental illness shall be deemed to have capacity to make decisions regarding his mental health care or treatment, if such person has ability to,—

(a) understand the information relevant to the mental health care or treatment decision;

(b) retain that information;

(c) use or weigh that information as part of the process of making the mental health care or treatment decision; and

(d) communicate his decision by any means (including talking, using sign language or any other means).

35. Suggestions

The clause seeks to place onerous requirements on persons with mental illness to show that they have the capacity to make decisions related to their mental health treatment and care. To be deemed to have capacity, a person with mental illness is required to show that she/he is able to understand information relevant to mental health or treatment decisions, retain that information, use or weigh such information in decision-making and communicate her/his decision. If any of the

four mentioned criteria is not fulfilled then the person will not be 'deemed' to have capacity to make mental health treatment and care related decisions. Despite the stated objective of the Bill to respect the autonomy and promote active participation of persons with mental illness in decision-making, section 4 creates a presumption in law against the capacity of person with mental illness. Section 4, especially section 4(b) and (c), in their application, will exclude, amongst others, persons with Alzheimer's and dementia.

It is suggested that there be a presumption in favour of persons with mental illness and that the section be altered as follows:

Every person, including a person with mental illness shall be deemed to have capacity to make decisions regarding his mental health care or treatment unless it is proved that

- (a) The person is unable to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, and
- (b) The person is unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

36. Ministry's Response

The Ministry accepts this suggestion and suggests that Section 4 be changed as follows :

Section 4 (1) shall read as follows

Every person, including a person with mental illness shall be deemed to have capacity to make decisions regarding his mental health care and/or treatment unless it is proved that

- a) The person is unable to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, and
- b) The person is unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision.
- c) Unable to communicate his decision by any means (including talking, using sign language or any other means)

Section 4 sub-sections (2), (3) and the Explanation remain the same.

37. Recommendation of the Committee

The Committee observes that there is merit in the reservations expressed with regard to Clause 4 and the Ministry, has agreed to incorporate the necessary

changes and thus, uphold the constitutional norm of equality. It also reflects the principle of self-determination which gives right to a person with mental illness to make mental health care and treatment decisions. The Committee, therefore, recommends that the new/alternate clause as proposed by the Ministry in respect of Clause 4(1), may be included in the Bill.

38. Clause 11(1) and 11(2)

11. (1) Where a mental health professional or a relative or a care-giver of a person desires not to follow an advance directive while treating a person with mental illness, such mental health professional or the relative or the care-giver of the person may make an application to the concerned Board to review, alter, modify or cancel the advance directive.

(2) Upon receipt of the application under sub-section (1), the Board may, after giving an opportunity of hearing to all concerned parties (including the person whose advance directive is in question), either uphold, modify, alter or cancel the advance directive after taking into consideration the following, namely:—

(a) whether the advance directive was made by the person out of his own free will and free from force, undue influence or coercion; or

(b) whether the person intended the advance directive to apply to the present circumstances, which may be different from those anticipated; or

(c) whether the person was sufficiently well informed to make the decision; or

(d) whether the person had capacity to make decisions relating to his mental health care or treatment when such advanced directive was made; or

(e) whether the content of the advance directive is contrary to other laws or constitutional provisions.

39. Suggestions

The proposed clause allows a mental health professional or relative or care-giver to override an advance directive where they 'desire' not to follow it. Such a person may make an application to the Board to review, or cancel the advance directive. It is suggested that it should be mandatory to make an application to the Board to review the decision to not follow the advance directive. The provision is too broad and vague, since nearly anybody can challenge an advance directive, merely on a subjective 'desire'. Though the decision to override the advance directive has to be

reviewed by a Board, the burden of proof regarding the validity of the advance directive as well as their capacity lies on the person with mental illness. The provision overrides the right to autonomy and consent of a person with mental illness. The right to autonomy stems from the right to dignity, which is an inherent part of the right to life guaranteed under Article 21 of the Constitution of India.

40. Ministry's Response

The Ministry accepts this suggestion and proposes the following changes:

11 (1) Where a mental health professional or a relative or a care-giver of a person desires not to follow an advance directive while treating a person with mental illness, such mental health professional or the relative or the care-giver of the person **shall** make an application to the concerned Board to review, alter, modify or cancel the advance directive.

11(2) Upon receipt of the application under sub-section (1), the Board shall, after giving an opportunity of hearing to all concerned parties (including the person whose advance directive is in question), either uphold, modify, alter or cancel or otherwise determine the applicability of the advance directive after taking into consideration the following, namely:—

- (a) whether the advance directive was made by the person out of his own free will and free from force, undue influence or coercion; or
- (b) whether the person intended the advance directive to apply to the present circumstances, which may be different from those anticipated; or
- (c) whether the person was sufficiently well informed to make the decision; or
- (d) whether the person had capacity to make decisions relating to his mental health care or treatment when such advanced directive was made; or
- (e) whether the content of the advance directive is contrary to other laws or constitutional provisions.

41. Recommendation of the Committee:

The Committee recognizes the fact that if Clause 11(1) and (2) is not amended, it may become tool of exploitation of person with mental illness and dilute their rights. Thus, the Committee endorses the proposed amendments to Clause 11(1) and (2) and recommends that the changes may be suitably made in the Bill so that the Board be required to examine the bonafides of the decision to override the advance directive in a holistic manner.

42. Clause 18(4)

18(4) Without prejudice to the generality of range of services under sub-section (3), such services shall include—

(a) provision of acute mental health care services such as outpatient and inpatient services;

(b) provision of half-way homes, sheltered accommodation, supported accommodation;

(c) provision for mental health services to support family of person with mental illness or home based rehabilitation;

(d) hospital and community based rehabilitation establishments and services;

(e) provision for child mental health services and old age mental health services.

43. Suggestions

In Clause 18(4)(b), the terms “half-way homes”, “sheltered accommodation” and “supported accommodation” have been not defined in the Bill. Further, in Clause 18 (4)(d) the term “community based rehabilitation establishments and services” too has not been defined. It will be in order to either define these concepts under the Bill or instead allow the Central Authority or State Authority to frame rules for establishment of these institutions. Therefore, sub-clause (4) of Clause 18 may be modified as follows:

“(4) Without prejudice to the generality of range of services under sub-section (3), such services shall include-

(a)

(b) Provision of half-way homes, sheltered accommodation, supported accommodation, as may be prescribed:

(c).....

(d) Hospital and community based rehabilitation establishments and services, as may be prescribed:

(e).....

44. Response of the Ministry

The Ministry has suggested that the words “as may be prescribed” may be inserted at the end of Clause 18(4) (b) and (d).

45. Recommendation of the Committee

While endorsing the inclusion of the words “as may be prescribed” to Clause 18(4) (b) and (d), as proposed by the Ministry, at the Committee’s behest, the

Committee recommends that the Government should carry out the proposed modifications in the Bill.

46. Clause 21(2)

21 (2) The Insurance Regulatory Development Authority established under the Insurance Regulatory Development Authority Act, 1999 shall endeavour to ensure that all insurers make provisions for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness.

47. Suggestions

Clause 21 of the MHCB aims to obtain equality for persons with mental illness by treating them at par with persons with physical illness. However this equality is only limited to equality in emergency facilities; ambulance services; living conditions and health services. When it comes to medical insurance which is one of the areas of discrimination, Clause 21(2) only mandates “IDRA to endeavour to ensure that all insurers make provisions for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness.”

48. Ministry’s Response

The term “shall endeavour” was inserted on the insistence of the Dept of Financial Affairs. However, change has been made as below:

The Insurance Regulatory Development Authority established under the Insurance Regulatory Development Authority Act, 1999 shall (~~delete “endeavour to”~~) ensure that all insurers make provisions for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness.

49. Recommendation of the Committee

The Committee notes that Clause 21(2) which seeks to provide for acceptance of medical insurance policies for persons with mental illness by the

insurance companies the same way as for physical illness is intended to eliminate the existing discriminatory provisions and would provide a great relief to persons with mental illness and their families. The effect is however, diluted by the word “shall endeavour”. The Committee, therefore, endorses deletion of the word “endeavour” and recommends that as agreed to by the Ministry, at the Committee’s behest, the word “shall” may be retained in the Bill.

50. Clause 23(2)

23 (2) All health professionals providing care or treatment to a person with mental illness shall have a duty to keep all such information confidential which has been obtained during care or treatment with the following exceptions, namely:—

(a) release of information to the nominated representative to enable him to fulfil his duties under this Act;

(b) release of information to other mental health professionals and other health professionals to enable them to provide care and treatment to the person with mental illness;

(c) release of information if it is necessary to protect any other person from harm or violence;

(d) only such information that is necessary to protect against the harm identified shall be released;

(e) release of information in the case of life threatening emergencies where such information is urgently needed to save lives;

(f) release of information upon an order by concerned Board or the Commission or High Court or Supreme Court or any other statutory authority competent to do so; and

(g) release of information in the interests of public safety and security.

51. Suggestions

Clause 23(2)(e) is very vague and leaves scope for ambiguity and confusion in implementation stage. It does not specify why, when and how much information is to be released. It simply says that release of information in the case of life threatening emergencies where such information is urgently needed to save lives.

52. Ministry's Response

The Ministry has proposed the following changes in 23(2)(e)

“(e) release of information if it is necessary to protect any other person from harm or violence provided that only such information that is necessary to protect against the harm identified shall be released;”

53. Recommendation of the Committee

The Committee observes that the clause 23(2) in the Bill deals with the right to confidentiality in respect of a person with mental illness. Therefore, any scope of ambiguity will defeat the purpose of this clause to keep all such information confidential which has been obtained during care or treatment by health professionals providing care or treatment to a person with mental illness. Any exception to such important clause should be carefully framed with clear intentions so as to avoid conflict and confusion at the implementation stage. The Committee therefore recommends that the proposed changes may be incorporated in the Bill.

54. Clause 25

1) All persons with mental illness shall have right to access their medical records.

(2) The psychiatrist in charge of such records may withhold specific information in the medical records if disclosure would result in,—

(a) serious mental harm to the person with mental illness; or

(b) likelihood of harm to other persons.

(3) When any information in the medical records is withheld from the person, the psychiatrist shall inform the person with mental illness of his or her right to apply to the concerned Board for an order to release such information

55. Suggestions

The Clause does not specify or define ‘serious mental harm’ or ‘likelihood of harm’ and in what form this access is to be provided . This provision is to be seriously reconsidered in view of potential of it being misused.

56. Ministry's Response

Serious mental harm or likelihood of harm is a judgement to be made by the psychiatrist and will have to be justified by the psychiatrist if this decision is challenged by the person with mental illness. The way this provision may be misused has not been specified.

57. Recommendation of the Committee

The Committee recommends that the scope of misuse of medical records may be relooked and suitably addressed before finalising the Bill.

58. Clause 27(2)

27(2) It shall be the duty of medical officer or psychiatrist in charge of a mental health establishment to inform the person with mental illness that he is entitled to free legal services under the Legal Services Authorities Act, 1987 or other relevant laws or under any order of the court if so ordered and provide the contact details of the availability of services.

59. Suggestions

Clause 27 (2) is insufficient when read in relevance to Clauses 109 and 111 which brings within its ambit persons who 'may have a mental illness'. It imposes duty only on the medical officer or psychiatrist in charge of a mental health establishment to inform the person with mental illness that he is entitled to free legal services. The purpose of clause 111 is to divert people from the criminal justice system into the health care system. Section 111 sub-section (1) clause (a) mentions that the person shall be dealt with in accordance with the provisions of this Act and therefore all the rights protections in this Bill will become applicable. However, Clause 27 (2) does not impose any responsibility on the magistrate or

police officer to inform the person about his right to legal aid with respect to Section 111. Thus, there is scope of arbitrariness application.

60. Ministry's Response

Taking into account the concerns expressed here, the Ministry proposes the following:

It shall be the duty of **the magistrate, the police officer, person in charge of a custodial institution**, medical officer or psychiatrist in charge of a mental health establishment to inform the person with mental illness that he is entitled to free legal services under the Legal Services Authorities Act, 1987 or other relevant laws or under any order of the court if so ordered and provide the contact details of the availability of services.

61. Recommendation of the Committee

The Committee observes that it is important to amend clause 27 (2) so that for want of information or due to their ignorance people with mental illness are not deprived of legal remedies and rights guaranteed to them through various provisions of the Bill. The Committee is of the view that the suggested changes will address the concerns regarding arbitrariness. The Committee, therefore, recommends that the amendments to Clause 27(2) as agreed to by the Ministry, at the Committee's behest, may be duly incorporated in the Bill.

62. Clause 65(4)

(4) Every mental health establishment shall, for the purpose of registration and continuation of registration, fulfil—

(a) the minimum standards of facilities and services as may be specified by regulations made by the Central Authority;

- (b) the minimum qualifications for the personnel engaged in such establishments may be specified by regulations made by the Central Authority;
- (c) provisions for maintenance of records and reporting as may be specified by regulations made by the Central Authority; and
- (d) any other conditions as may be specified by regulations made by the Central Authority.

63. Suggestions

As per Clause 65 (4) of the Bill, Central Authority appears empowered to make regulations in relation to, *inter alia*, minimum standards of facility and services, minimum qualification of personnel engaged in such establishment, provisions regarding maintenance of records and reporting etc.

However, delegation of this power solely to Central Authority to the exclusion of the State Authority militates against the concept of multi-layered regulation. This is also required as the local exigencies play a major role in any public health planning and regulation. The State Authorities will be in best position to understand the requirements and practical difficulties in their own state, and the regulations made by them will be more suited to administration. This is even more important as the implementation of the regulation will, in fact, be undertaken by the State Authorities. In view of the same, it is only proper that any regulation made for regulating the mental health establishment also involves the State Authorities. This may be achieved in various ways, such as:

- a) The regulations made by Central Authority must be made in consultation with State Authorities. This may pose practical challenges as there will be numerous State Authorities to be consulted, and consequently the regulation making process may get unduly delayed.
- b) The regulations made by Central Authority may be modified by the State Authority with its own local jurisdiction.
- c) The State Authority may be empowered to make regulations for mental health establishment within the jurisdiction of its own state. This may pose difficulties of implementation as many State Authorities may lag behind in framing their own regulations.

The power to the State Authority to modify the regulations for registration made by Central Authority may be the most suitable *via-media*. While such amending

regulations of the State Authority will need to be placed before the State Legislature, a further level of scrutiny may be built by requiring the Governor to ratify the regulations made by the State Authority for them to be effective.

In view of the above, we suggest addition to the following proviso to Clause 65(4) of the Bill:

“Provided that the State Authority may modify, alter or amend any regulation made by the Central Authority in so far as such regulation applies to any mental health establishment within the jurisdiction of the State Authority (not being a mental health establishment under the Central Government).

Provided further that no regulation made by the State Authority modifying, altering or amending the regulations made by the Central Authority shall be effective unless ratified and approved by the Governor.”

64. Ministry’s Response

Every mental health establishment shall, for the purpose of registration and continuation of registration, fulfil—

- (a) the minimum standards of facilities and services as may be specified by regulations made by the **(word Central deleted)** Authority;
- (b) the minimum qualifications for the personnel engaged in such establishment as may be specified by regulations made by the **(word Central deleted)** Authority;
- (c) provisions for maintenance of records and reporting as may be specified by regulations made by the **(word Central deleted)** Authority; and
- (d) any other conditions as may be specified by regulations made by the **(word Central deleted)** Authority.

65. Recommendation of the Committee

The Committee notes that the amendment suggested by the Ministry is not clearly framed. There is scope of ambiguity in interpretation. The Committee, therefore, recommends that while retaining the amendments proposed by the Ministry, the term Authority may be explicitly defined.

66. Clause 81

Each Board shall consist of—

- (a) a District Judge, or an officer of the State judicial services who is 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 who shall be mental health professionals of whom at least one shall be a psychiatrist;
- (d) two members who shall be persons with mental illness or care-givers or persons representing organisations of persons with mental illness or care-givers or non-governmental organisations working in the field of mental health.

67. Suggestion

Both the members of the Mental Health Review Board proposed under the above clause should be psychiatrists as a psychiatrist, being a specialist is better-equipped to protect the interests of the patient.

68. Recommendation of the Committee

The Committee notes that out of the two members proposed under Clause 81(c), at least one shall be a psychiatrist. The Clause, however, does not clearly spell out who the other “mental health professional” shall be. Keeping in view the fact that the Mental Health Review Boards have been envisaged to play a critical role in protecting the interests of persons with mental illness, the Committee feels that the second “mental health Professional” proposed under Clause 81(c) needs to be a qualified medical practitioner so that the two qualified medical professionals appointed under this Clause are able to share their expertise with the rest of the Board and

enable it to take appropriate decisions. The Committee, therefore, recommends that the Ministry may make necessary amendments in Clause 81(c).

69. Clause 99(11)

99(11) If a person with mental illness has made an advance directive, it shall be taken into account before the commencement of treatment.

70. Suggestions

Mental illness is a chronic illness, the patient has to undergo treatment for a long time, and insisting admission in a Government hospital for more than 90 days or more than 120 days and waiting for a decision from the District Review Commission is definitely cumbersome procedure. There are conditions where the patient does not want to get treated and has to be forced to get treated. Secondly, there are certain legal situations. When the patient claims to be unaware of what he had done, a different set of rules will govern him. Medical treatment without the informed consent of the person amounts to cruel, inhuman and degrading treatment and is a violation of the rights to dignity, consent, autonomy and bodily integrity under Article 21 of the Constitution.

71. Ministry's Response

For purposes of clarity in Section 99, the Ministry proposes the following amendment to Section 99 sub-section 11 to read as follows

*Every person with mental illness admitted under this section shall be provided treatment after taking into account, -
(a) An Advance Directive if any; or*

(b) informed consent of the patient with the support of his nominated representative subject to the provisions of sub-section 12.

72. Recommendation of the Committee

The Committee feels that for purposes of clarity in Section 99 it is important to bring the amendment to Clause 99 (11) and remove the fallacies. The Committee, therefore, endorses the changes suggested by the Ministry and recommends that the same may be carried out in the Bill to remove the lacunae and make it in consonance with Article 21 of the Constitution.

73. Clause 100(2) to (9)

(2) The leave referred to in sub-section (1) shall not be extended beyond the period of the duration of admission permissible under section 96 or section 98 or section 99, as the case may be.

(3) The medical officer or psychiatrist in charge of the mental health establishment shall obtain the consent of the nominated representative before taking a decision of granting leave.

(4) The medical officer or psychiatrist in charge of the mental health establishment may in writing cancel the leave of absence of the person with mental illness admitted in such establishment if he considers it appropriate to do so in the interest of such person.

(5) If the person with mental illness, on expiry of the period of his leave or on cancellation of his leave of absence under sub-section (4) does not return to the establishment, the medical officer or psychiatrist in charge of the mental health establishment shall first contact the person on leave and his nominated representative.

(6) If the person with mental illness and his nominated representative feel that continued admission in the mental health establishment is not necessary, then, such person and his nominated representative shall communicate the same to the medical officer or psychiatrist in charge of the mental health establishment, who shall formally discharge such person from the mental health establishment.

(7) If the medical officer or psychiatrist in charge of the mental health establishment has reason to believe that the person requires ongoing admission to a mental health establishment and the nominated representative agrees with the assessment of such medical officer or psychiatrist, and such person with mental

illness refuses to return to the hospital on expiry of leave or cancellation of his leave of absence, the medical officer or the psychiatrist in charge of the mental health establishment shall report to the Police Officer in charge of the police station within the limits of whose jurisdiction the mental health establishment is situated, to convey the person to the mental health establishment.

(8) If the person with mental illness referred to in sub-section (7), is not conveyed by the Police Officer for any reasons, to the mental health establishment within one month of the expiry of his leave or cancellation of his leave of absence, as the case may be, such

person shall be deemed to have been discharged from such mental health establishment.

(9) The provisions of sub-section (8) shall not preclude readmission of the person with mental illness in accordance with the provisions of this Act.

74. Suggestions

The section perpetuates the perception of people in mental health establishments as dangerous to society and continues to stigmatize them. Requiring a police officer to forcibly convey the person back to the mental health establishment against his will take away all the fundamental rights of a person guaranteed under the Constitution.

75. Ministry's Response

The Ministry agrees with this suggestion and therefore, recommends the following changes :

Section 100 (1) is retained. All sub-sequent subsections from (2) to (9) are deleted.

76. Recommendation of the Committee

The Committee appreciates the changes proposed by the Ministry at the Committee's behest and recommends that necessary changes may be carried out in the Bill.

77. Clause 101

If a person with mental illness admitted to a mental health establishment under this Act absents himself without leave or without discharge from the mental health establishment, he shall be taken into protection by any Police Officer at the request of the medical officer or psychiatrist in charge of the mental health establishment and taken back to the mental health establishment immediately:

Provided that in the case of a person with mental illness not admitted under section 112, the provisions of this section shall not apply after the expiry of a period of one month from the date of such absence of such person from the mental health establishment.

78. Suggestions

The proposed Bill still continues its link with the correctional system. The clause 101, chapter XII, on 'leave from the hospital' requires a police officer to accost the person with mental illness to return to treatment facility. This further serves to stigmatise the person with mental illness. The section dealing with 'leave' should be repealed. It also contradicts with person's right to get discharged without any consent from officer in charge/psychiatrist.

79. Ministry's Response

The Ministry has proposed following changes:

If a person with mental illness whom section 112 applies absents himself without leave or without discharge from the mental health establishment, he shall be taken into protection by any Police Officer at the request of the medical officer or psychiatrist in charge of the mental health establishment and taken back to the Mental health establishment immediately. Delete the proviso to Section 101.

80. Recommendation of the Committee

The Committee agrees to the changes proposed by the Ministry and recommends that required modifications may be made in the Bill.

81. Clause 104 (2)

104(2) Notwithstanding anything contained in sub-section (1), if, in the opinion of psychiatrist in charge of a minor's treatment, electro-convulsive therapy is required, then, such treatment shall be done with the consent of the guardian and prior permission of the concerned Board.

82. Suggestions

Although the Bill prohibits ECT for minors, it may be used if in the opinion of the psychiatrist in charge of treatment ECT is required. Currently, consent of the guardian and prior permission of the Board are pre-requisites for ECT for minors. There is no requirement for informed consent of the guardian before administering ECT. It is suggested that in granting permission for ECT, the Board should make an enquiry into the maturity of the minor to understand the nature and consequence of the treatment. Especially in cases where the minor disagrees with the decision of the guardian. International best practice suggests that ECT should be done only after the opinion of a non-treating psychiatrist is sought which is also absent from the section. It is submitted that, if at all allowed, there should be an accompanying provision prohibiting the use of ECT on minors below a certain age, as is done in many countries. However, due to its extreme side effects and its controversial practice in the treatment of mental illness in minors, a blanket ban on ECT for minors is suggested as is recommended by the World Health Organisation.

83. Ministry's Response

This provision has been made in consultation with the medical professionals as there may be rare emergencies when a minor may require this for life saving purposes. Hence the Bill provides for this in exceptional circumstances with

adequate protection of the Board. Indian legal system does not recognize the concept of maturity of minors. The opinion of a non-treating psychiatrist before administering ECT will happen automatically as a non-treating psychiatrist will be a member of the District Board which has to give its approval before administering the procedure. However, it is agreed that the word “informed” is missing in Section 104 sub-section 2. Thus, clause 104 (2) will read as: Notwithstanding anything contained in sub-section (1), if, in the opinion of psychiatrist in charge of a minor’s treatment, electro-convulsive therapy is required, then, such treatment shall be done with the **informed** consent of the guardian and prior permission of the concerned Board.

84. Recommendation of the Committee

The Committee is of the opinion that Clause 104 prohibiting certain treatments, such as unmodified ECT and sterilisation and restrain on chaining are highly desirable pro human right provisions. The Committee however has reservations on ECT for minors and recommends that the Ministry must ensure that all treatments are to be done with informed consent by bringing in proposed necessary changes in the Bill. Appropriate changes may be made in the Bill accordingly.

85. Clause 106

(1) The physical restraint or seclusion may only be used when,—

(a) it is the only means available to prevent imminent and immediate harm to person concerned or to others;

(b) it is authorised by the psychiatrist in charge of the person’s treatment at the mental health establishment.

(2) Physical restraint or seclusion shall not be used for a period longer than it is absolutely necessary to prevent the immediate risk of significant harm.

- (3) *The medical officer or psychiatrist in charge of the mental health establishment shall be responsible for ensuring that the method, nature of restraint or seclusion, justification for its imposition and the duration of the restraint or seclusion are immediately recorded in the person's medical notes.*
- (4) *The restraint or seclusion shall not be used as a form of punishment or deterrent in any circumstance and the mental health establishment shall not use restraint or seclusion merely on the ground of shortage of staff in such establishment.*
- (5) *The nominated representative of the person with mental illness shall be informed about every instance of seclusion or restraint within a period of twenty-four hours.*
- (6) *A person who is placed under restraint or seclusion shall be kept in a place where he can cause no harm to himself or others and under regular ongoing supervision of the medical personnel at the mental health establishment.*
- (7) *The mental health establishment shall include all instances of restraint and seclusion, in the report to be sent to the concerned Board on a monthly basis.*
- (8) *The Commission may make regulations for the purpose of carrying out the provisions of this section.*
- (9) *The Board may order a mental health establishment to desist from applying restraint and seclusion if the Board is of the opinion that the mental health establishment is persistently and wilfully ignoring the provisions of this section.*

86. Suggestions

Seclusion might be used widely on the grounds of shortage of staff. There is no evidence for efficacy of seclusion. Thus, seclusion should be banned.

87. Ministry's Response

Seclusion or solitary confinement of a person with mental illness is banned. Physical restraint may only be used when, -

- (a) it is the only means available to prevent imminent and immediate harm to person concerned or to others;
- (b) it is authorised by the psychiatrist in charge of the person's treatment at the mental health establishment.
- (2) Physical restraint (**word 'or seclusion' deleted**) shall not be used for a period longer than it is absolutely necessary to prevent the immediate risk of significant harm.

(3) The medical officer or psychiatrist in charge of the mental health establishment shall be responsible for ensuring that the method, nature of restraint (**word ‘or seclusion’ deleted**), justification for its imposition and the duration of the restraint or seclusion are immediately recorded in the person’s medical notes.

(4) restraint (**word ‘or seclusion’ deleted**) shall not be used as a form of punishment or deterrent in any circumstance and the mental health establishment shall not use restraint (*word ‘or seclusion’ deleted*) merely on the ground of shortage of staff in such establishment.

(5) The nominated representative of the person with mental illness shall be informed about every instance of (**word ‘seclusion’ deleted**) or restraint within a period of twenty-four hours.

(6) A person who is placed under restraint (**word ‘or seclusion’ deleted**) shall be kept in a place where he can cause no harm to himself or others and under regular ongoing supervision of the medical personnel at the mental health establishment.

(7) The mental health establishment shall include all instances of restraint (**word ‘and seclusion’ deleted**), in the report to be sent to the concerned Board on a monthly basis.

(8) The Commission may make regulations for the purpose of carrying out the provisions of this section.

(9) The Board may order a mental health establishment to desist from applying restraint (**word ‘and seclusion’ deleted**) if the Board is of the opinion that the mental health establishment is persistently and wilfully ignoring the provisions of this section.

88. Recommendation of the Committee

The Committee accepts the deletion of the word “seclusion” from Clause 106

(2) (3) (4) (5) (6) (7) and (9) and hopes that it would bring more clarity in the said Clause with regard to the rights of persons with mental illness to dignity and liberty. The Committee, therefore, recommends that the deletions as proposed by the Ministry may be carried out in the Bill.

89. Clause 108

(1) The professionals conducting research shall obtain free and informed consent from all persons with mental illness for participation in any research involving interviewing the person or psychological, physical, chemical or medicinal interventions.

(2) In case of research involving any psychological, physical, chemical or medicinal interventions to be conducted on 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.

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

(a) the proposed research cannot be performed on persons who are capable of giving free and informed consent;

(b) the proposed research is necessary to promote the health of the population represented by the person;

(c) the purpose of the proposed research is to obtain knowledge relevant to the particular health needs of persons with mental illness;

(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.

(4) The provisions of this section shall not restrict research based study of the case notes of a person who is unable to give informed consent, so long as the anonymity of the persons is secured.

90. Suggestions

Persons participating in such research must also be given the right to withdraw their consent during any stage of the research to give meaning to their rights to dignity, autonomy, consent and bodily integrity. Similarly, the nominated representative should also have the right to withdraw their consent during any stage of the research.

It is submitted that the current guidelines for the State Authority to permit research and medical intervention are not sufficient. The State Authority should make an inquiry into the potential harm and benefits that may be caused to the concerned person.

91. Ministry's Response

The Ministry has proposed amendments as under:

(b) the proposed research is necessary to promote the **mental** health of the population represented by the person;

(c) the purpose of the proposed research is to obtain knowledge relevant to the particular **mental** health needs of persons with mental illness;

(5) Persons participating in research shall have the right to withdraw their consent at any stage of the research. In circumstances mentioned under sub-section (3), if a nominated representative has given informed consent for the person with mental illness to participate in research, the nominated representative shall have the right to withdraw this consent at any stage of the research.

92. Recommendation of the Committee

The Committee appreciates that the Ministry has accepted the suggestions and proposed amendments in the Bill. The proposed amendments may be incorporated in the Bill

93. Clause 112

(1) An order under section 30 of the Prisoners Act, 1900 or under section 144 of the Air Force Act, 1950, or under section 145 of the Army Act, 1950, or under section 143 or section 144 of the Navy Act, 1957, or under section 330 or section 335 of the Code of Criminal Procedure, 1973, directing the admission of a prisoner with mental illness into any suitable mental health establishment, shall be sufficient authority for the admission of such person in such establishment to which such person may be lawfully transferred for care and treatment therein.

(2) The medical officer of a prison or jail shall send a quarterly report to the concerned Board certifying therein that there are no prisoners with mental illness in the prison or jail.

(3) The Board may visit the prison or jail and ask the medical officer as to why the prisoner with mental illness, if any, has been kept in the prison or jail and not transferred for treatment to a mental health establishment.

(4) The medical officer in charge of a mental health establishment wherein any person referred to in sub-section (1) is detained, shall once in every six months, make a special report regarding the mental and physical condition of such person to the authority under whose

order such person is detained.

94. Suggestions

Under clause 112, Chapter XIII, Prisoners with mental illness needs to be guarded by the State authorities. Since prisons have all facilities, all prisoners with mental illness could be treated in the hospital section of jails. Treating personnel in Mental Health need to move to Prisons as part of integration of services and community extension initiatives. A prison set-up coming to a hospital is not a very practical move.

95. Ministry's Response

Section 112 does not require that persons should be moved out of the prison compound to access mental health care. There can be mental health establishments in the medical wing of prisons and persons with mental illness are cared for in these areas.

96. Recommendation of the Committee

The Committee feels that the reply of the Ministry does not address the concern in an explicit manner and there is need to ensure that there is no ambiguity whatsoever in the clause. The Clause should spell out details in a more explicit manner so as to avoid confusion and conflict in the implementation. The Committee, therefore, recommends that the Ministry may re-examine the concern raised with regard to Clause 112 and address the same appropriately.

97. Clause 113

If it appears to the person in charge of a State run custodial institution (including beggars homes, orphanages, women's protection homes and children homes) that any resident of the institution has, or is likely to have, a mental illness, then, he shall take such resident of the institution to the nearest mental health establishment run or funded by the appropriate Government for assessment and treatment, as necessary.

98. Suggestions

Apart from those sections relating to transfer, the Mental Health Care Bill does not apply in custodial care institutions including prisons. Individuals with mental illness in prisons and other State run custodial institution (e.g. beggars homes, orphanages, women's protection homes and children homes), should be monitored under the Act.

99. Ministry's Response

The Ministry has suggested following changes:

If it appears to the person in charge of a State run custodial institution (including beggars homes, orphanages, women's protection homes and children homes) that any resident of the institution has, or is likely to have, a mental illness, then, he shall take such resident of the institution to the nearest mental health establishment run or funded by the appropriate Government for assessment and treatment, as necessary. The medical officer in charge of the mental health establishment shall be responsible for assessment of the person and the treatment needs of the person with mental illness shall be addressed in accordance with the provisions of this Act as applicable in the particular circumstances.

100. Recommendation of the Committee

The Committee is of the opinion that people in custodial institutions are very vulnerable to abuse of their rights. Thus, keeping in view their special circumstances, proposed amendments are very much warranted. The Ministry has accepted the suggestions and come out with the amendment and the Committee accepts it. The Committee, recommends that the addition in Clause 113 as agreed to by the Ministry, at the Committee's behest, may be suitably incorporated in the Bill.

101. Clause 114(1)

114. (1) Notwithstanding anything contained in any other law for the time being in force, a person's current or past admission to a mental health establishment or a person's current or past treatment for mental illness shall not by itself, without prejudice to the provisions of any law for the time being in force or custom or usage governing personnel laws of such person, be a ground for divorce.

102. Suggestions

Sub-clause (1) of Clause 114 starts as a 'notwithstanding' clause, however, towards the end it turns into a clause which does not prejudice other laws for the time being in force. This creates confusion as to the status of this provision. If this provision is to operate notwithstanding other laws for the time being in force, there is no need for a without prejudice clause, and if this law is not intended to prejudice any other law for the time being in force, this provision is not required.

The right to divorce flows from other laws and these laws have their own intricacies. At a time when divorce laws are being liberalized to ensure that unhappy and unworkable marital relations are allowed to end, if this provision is intended to close a right to divorce available under divorce laws, it may have other unintended consequences. It is best that any change to marital laws be undertaken as separate exercise and only after its consequences have been sufficiently

analysed. Further, certain forms of mental illness are grounds for divorce under the respective personal laws. Therefore, an amendment to such legislations may be required to give full effect to this provision, if it is decided to retain the same.

103. Ministry's Response

The Ministry proposes an amendment to Clause 114 by deleting sub-clause(1).

104. Recommendation of the Committee

The Committee accepts the suggestion of the Ministry to delete sub- clause 1 of Clause 114 from the Bill. The Committee recommends that this amendment may be carried out in the Bill.

105. Clause 123

(1) Notwithstanding anything contained in this Act, the provisions of this Act shall, taking into consideration the communication, travel and transportation difficulties, apply to the States of Assam, Meghalaya, Tripura, Mizoram, Manipur, Nagaland, Arunachal Pradesh and Sikkim, with following modifications, namely:—

(a) under sub-section (3) of section 80, the president of the Commission may constitute a single Board for all the States;

(b) in sub-section (2) of section 88, reference to the period of “seven days”, and in sub-section (3) of that section, reference to the period of “twenty-one days” shall be construed as “ten days” and “thirty days”, respectively;

(c) in sub-section (9) of section 96, reference to the period of “seventy-two hours” shall be construed as “one hundred twenty hours”, and in sub-sections (3) and (12) of that section, reference to a period of “seven days” shall be construed as “ten days”;

(d) in sub-section (3) of section 97, reference to the period of “twenty-four hours” shall be construed as “seventy-two hours”;

(e) in clauses (a) and (b) of sub-section (9) of section 98, reference to the period of “three days” and “seven days” shall be construed as “seven days” and “ten days” respectively;

(f) in sub-section (3) of section 99, reference to the period of “seven days” and in sub-section (4) of that section, reference to the period of “twenty-one days” shall be construed as “ten days” and “thirty days” respectively;

(g) in sub-section (4) of section 103, reference to the period of “seventy-two hours” shall be construed as “one hundred twenty hours”.

(2) The provisions of clauses (b) to (g) of sub-section (1) shall also apply to the States of Uttarakhand, Himachal Pradesh and Jammu and Kashmir and the Union territories of Lakshadweep and Andaman and Nicobar Islands.

106. Suggestions

Chapter XVI section 123 makes provision for a single Board for 8 North Eastern states. Keeping in view the difficulties of connectivity and terrain a single board would never be able to take on this onerous responsibility. It is not understandable for whose convenience one Review Board (NE region) has been proposed for an area spreading across 262,230 sq kms. It is proposed that this provision for a single board for NER be discontinued. In States like Assam every district should have a board like in other parts of the country. As an alternative, all districts having District Mental Health Program should have a Mental Health Review Board in the rest of the states of North East Region if district level board are not possible.

107. Ministry's Response

This is only an enabling provision which was made on the basis of suggestions from stakeholders at the regional meeting held in the North-East. It is not compulsory that there is only one Board for the North Eastern states and it is possible to have separate District Boards for the North Eastern States as well as all districts in Assam.

108. Recommendation of the Committee

The Committee feels that ambiguity in this regard should be removed. The Committee recommends that necessary drafting modifications may be made in the clause so that the intent behind the clause that this is only enabling provision and it is possible to have separate district boards for the North-Eastern States including Assam, is reflected in the Bill.

109. Clause 124

Presumption of mental illness in case of attempt to commit suicide by person.

124. (1) Notwithstanding anything contained in section 309 of the Indian Penal Code, any person who attempts to commit suicide shall be presumed, unless proved otherwise, to be suffering from mental illness at the time of attempting suicide and shall not be liable to punishment under the said section.

(2) The appropriate Government shall have a duty to provide care, treatment and rehabilitation to a person, having mental illness and who attempted to commit suicide, to reduce the risk of recurrence of attempt to commit suicide.

110. Suggestions

The decriminalization of persons attempting to commit suicide is a welcome step. However, the lack of criteria for what may constitute 'an attempt to commit suicide' is vague and ambiguous. As opined by the Supreme Court of India in *P. Rathinam v. Union of India* [1994 AIR1844] people may attempt suicide for a number of reasons, which may not necessarily be related to their mental health. The section therefore becomes open to arbitrariness and is in violation of article 14 of the Constitution.

Three issues which we feel will arise with the enactment of Section 124:

- A. The unintended consequence of the law creating this presumption of mental illness is that a person who has attempted suicide will now be subject to 'mental health treatment'.
- B. There are serious concerns with regard to the issue of abetment of suicide, which is punishable under Section 306 IPC.
- C. There are concerns with regard to the role played by institutionalization in silencing victims of domestic violence.

111. Ministry's Response

The Ministry has proposed following amendments

Title of the Section : Presumption of severe stress in case of attempt to commit suicide

(1) Notwithstanding anything contained in Section 309 of the Indian Penal Code and the Code of Criminal Procedure , any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress at the time of attempting suicide and shall no be liable to prosecution and punishment.

*(2) The appropriate Government shall have a duty to provide care, treatment and rehabilitation to a person having severe stress and **who** attempted to commit suicide, to reduce the risk of recurrence of attempt to commit suicide.*

112. Recommendation of the Committee

Though section 124 of the Bill seeks to make a presumption vis-à-vis mental illness, the stage at which such a presumption operates is unclear. It is necessary to avoid any scope of ambiguity in both enforcement as well as interpretation of the clause. The Committee, therefore, accepts the modifications proposed by the Ministry and recommends that they may be duly incorporated in the Bill.

113. Clause 126

The Central Government may, if it considers so necessary in the interest of persons with mental illness being governed by the Mental Health Act, 1987, take appropriate interim measures by making scheme for the smooth implementation of the provisions of this Act.

114. Suggestions

Clause 126 of the MHCB only allows for the Central Government if it considers it necessary in the interest of persons with mental illness being governed by the MHA to take appropriate interim measures by making a scheme for the smooth implementation of the provisions of MHCB. Insofar as MHCB does not address the issues undertaken by Chapter VI of MHA, this clause is of little assistance.

It is therefore submitted that the MHA cannot be repealed until the question of property management by persons with mental illness is settled. There is an

inextricable relationship between the economic status of persons with mental illness and their care and treatment. It is important to ensure that these connections are duly appreciated before a statute on mental health care is enacted. Such an examination is especially required because the present Bill, as this memorandum has attempted to show is neither in harmony with the CRPD nor with the Indian Constitution.

115. Ministry's Response

The Central Government may, if it considers so necessary in the interest of persons with mental illness being governed by the Mental Health Act, 1987, take appropriate interim measures by making necessary transitory schemes (*words "for the smooth implementation of the provisions of this Act" deleted*).

116. Recommendation of the Committee

The Committee feels that precautionary measures are to be taken before totally repealing the Mental Health Act, 1987 and accepts the suggestion of the Ministry.

117. The Committee adopts the remaining clauses of the Bill without any changes. The Bill may be passed incorporating the suggestions made by the Committee.

Miscellaneous

118. The Committee notes that there are as many as 18 clauses of the Bill which will become sections after enactment which involve expenditure from

the Consolidated Fund of India and Financial Memorandum appended to the Bill states that it is not possible to estimate the financial burden at this stage but at the same time the Financial Memorandum does not assure that necessary allocation shall be made when the provision of the Bill will be implemented. States will have to implement its provisions, health being a State subject. The Committee, therefore, recommends that as most of the States are facing resource crunch it is the duty of the Centre to ensure funds for implementing the provisions of the Bill and it should be reflected in the Demands for Grants.
