A Critical Review Of India's Mental Healthcare Law

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Abstract
The concept of mental health has secured mammoth credibility in the past few years, with the focus being shifted towards enhanced mental health care professionals and facilities and attention paid towards a sounder mental and emotional health development of the youth and adults. However, the palpitating question persists: how far along has India traveled on this tumultuous journey to achieve the definitive aspiration of securing stable mental health across the country for persons of every age group? Through the means of this paper, the author will endeavor to find an answer to this question by delving into the mental healthcare laws in India [The Mental Health Act, 1987 and The Mental Healthcare Act, 2017] coupled with the understanding of international [The Mental Health (Compulsory Assessment and Treatment) Act, 1992] as well as constitutional aspects concerning mental health care laws. This paper would not be inclusive enough without mentioning some important case laws, which further the central theme of this paper. Towards the end, the author presented a few proposals, which may prove assistive for bettering the mental health care law drafting and their implementation in India. The cornerstone of this paper is to view the concept of mental health from a legalistic and social microscope at the national and international echelon.

Keywords
Mental health; Mental health care; Mental healthcare professionals; The Mental Health Act, 1987; The Mental Healthcare Act, 2017.

1. INTRODUCTION

In contemporaneous times, the definition of "health" is not confined to the mere physical health of a person but also includes his/her mental, spiritual, and emotional well-being. Possessing stable mental health entails that a person can cope with the demanding adversities of life and remains calm, composed, and collected in the face of a crisis. Further, emotional, mental health also translates to the fact that a person can effectively use his/her resources to contribute to their community and achieve their highest potential. Mental health is not a concept of illness, rather a concept of wellness. Even though India is home to the second-largest population globally, it is still overflowing with social stigmas concerning the concept of mental health. A cavernous investigation in the Indian mental health care laws will thus be undertaken by the author post interpreting the mental health care concept in a generic, global sense.

The World Health Organisation (Who) And Mental Health
The largest and the most authoritative international institution which deals with the “health of the world,” is the WHO. The WHO provides a set of 10 basic principles[1] for developing

mental health care laws in different countries and the protection of mentally ill patients around the globe. These principles have been derived from the Principles for Protection of Persons with Mental Illness, 1991, and the Improvement of Mental Health Care adopted by the UN General Assembly Resolutions, 1991[2]. These principles, in brief, are as follows:

1. The Prevention of Mental Disorders and the Promotion of Mental Health is the first principle, focusing upon implementing such measures that assist in preventing mental disorders with simultaneous measures being undertaken to promote the concept of mental health and eradicate the associated stigma. A sincere implementation of this principle becomes enormously necessary for a country like India, where mental disorders are still viewed more as a "reckless attitude" and less as a medical illness.
2. Any and everyone who requires basic mental health care should have rightful access to the same. This access means affordability in financial as well as geographical terms across countries. This principle is most certainly depend upon the existing resources in a country; however, immaculate efforts are required on the part of the governments to ensure the individual's dignity and allow him/her to access mental healthcare facilities that can help him/her to combat their illnesses. The focus should be on developing a system that provides adequate care facilities (clinical and non-clinical) and improves the patient's quality of life. The WHO has also suggested that mental health care should be included in the Primary Health Care centers, keeping the treatment culturally appropriate.
1. Assessment of mental health should align with internationally accepted standards. An example of the same can be the International Classification of Diseases- 10 (ICD-10) of the WHO, which provides a Classification of the Mental and Behavioral Disorders. The WHO suggests that clinical training for such diagnosis should also be carried out in a standard of internationally accepted formats and principles. Mental healthcare professionals should be careful not to base their diagnosis merely upon the economic, social or political standing of a person or simply based on his/her past medical history. The effort should be to conduct novel assessments and appropriate diagnoses to help detect and cure the patient.
2. Patients with mental health disorders should be provided treatment opportunities that are the least restrictive or constrictive. The slightest restrictive alternatives should be decided upon by considering the patient's mental disorder, the available treatments for the disorder, and the autonomy level required to undergo that treatment (including the patient's acceptance to undergo a particular treatment). Furthermore, necessary care should be provided to such patients who can potentially harm themselves and others due to their diagnosed conditions. Community and institution-based mental healthcare treatment should be made available, no doubt; however, in cases where only the physical restriction of the patient is the immediate solution, the WHO enlists the following guidelines under this fourth principle:

* All other alternatives of treatment should have been exhausted.
* Regular observations and periodical assessment by approved healthcare workers should be carried out in these 'restrictive surroundings.'
* It is indispensable to document the patient's mental health history in the restrictive surrounding and ensure that this treatment lasts, preferably only for a limited period. This principle of the WHO seems to be deeply rooted in having a socially sanctioned, rights-based approach towards mental illness, which obliterates stereotypes and looks into the treatment aspect.

3. Self-determination and consent are one of the most critical principles provided by the WHO. The patient's consent for receiving any mental disorder treatment should be free, informed, and without any coercion or undue influence. The WHO mentions the concept of "surrogate decision makers" who can provide consent for patients incapable of doing so, albeit with a properly granted authority. The patient should be provided with all the relevant information in a verbal, written, or sign-language format as is necessary for him/her to

furnish an informed consent. In a country like ours, where individuals are mostly expected to conform to their family units, this principle becomes quite noteworthy.

4. A knowledgeable third party can assist the patient in exercising his/her right to self-determination in matters of ambiguity or confusion. These confusions can emanate due to language barriers or mere lack of general knowledge. An effort should be made to provide this third-party assistance free of cost. In India, where the languages are diverse and the traditional education rates are low, such free third-party assistance can make a key difference in the ways people can access and view mental healthcare.

5. A Reviewing Procedure should be reachable to any interested and/or concerned parties regarding any decision implemented by the official or surrogate decision-makers. If possible, a Review Board should be set up by the national government to provide these reviews in a timely, transparent manner; this review process should be guided by authorities possessing official and sufficient capacity.

6. An Automatic Reviewing System should be established for catering to all the interested parties. These reviews should happen automatically, at consistent intervals, by authorized officials. Furthermore, defaulting officials should be duly sanctioned.

7. The decision-makers for the patient, for example, the official or the decision-maker on behalf of the patient, such as a friend, family member, etc., should be qualified and authorized to take decisions; they should be competent, knowledgeable, independent, and impartial. A sufficient remuneration amount should be awarded to the official decision-makers for rendering their services; however, in case they default or display any personal interest in the case, they should be disqualified from their positions,

8. The last yet the most imperative principle highlighted by the WHO remains that all the decisions regarding the mental health care facilities and the implementation of mental health care legislation should be enacted and implemented while respecting and keeping in tandem with the law of the land, i.e., there should be respect for the rule of law in a particular jurisdiction and the specific mental healthcare legislation should align with the general laws of the country, ensuring facile understanding of the law. This principle also includes informing patients about their legal rights and the judicial or administrative institutions under law, who will independently monitor the mental health care status in the country. To understand the last principle better, the mental healthcare legislation in our country has been analyzed in different sections.

It is imperative to note that these ten basic principles, as provided by the WHO, work nearly as a fundamental norm for mental health care administration and legislations worldwide. These inclusive principles must be revered while drafting mental healthcare legislation to ensure the mentally ill's rights.

Mental Healthcare In India- The Constitutional Viewpoint

The Constitution of India is the Grundnorm based on which other laws are formulated and enacted. While the Indian Constitution cannot boast much about possessing natural mental healthcare-based provisions, a few articles have a positive connotation regarding the right of health and indirect relation to rights of mental health.

The Preamble of the Indian Constitution[3] seeks to ensure that Indian being a welfare state with a socialist ideology, would, under Article 21[4], guarantee the right to life and personal liberty. The principle of democratic socialism is embedded deeply in our country, where the State assumes a paternalistic role. This democratic socialism levies the responsibility upon the state, as ensured by the Preamble, to provide for and advance the healthcare conditions in the country.[5]

As enshrined in Part IV[6] of the Constitution, the Directive Principles of State Policy further promote the scheme of public health and welfare.

Article 38[7] levies the responsibility upon the State to ensure social order for promoting public welfare.
Article 39(e)[8] provides for protecting the workers' health, may it be women, men, or children. It further states that no person should have to engage in occupations unsuited for their strength or age or which could potentially be critically hazardous to their health. However, this provision of the Constitution is openly flouted when many underage children are employed in firecrackers industries or men have to stay underground for an unregulated and illegal number of hours at mining sites.
Article 41[9] of the Constitution charges the State with the duty to secure assistance, occupational, and education rights for the sick and disabled. However, this Article additionally mentions that this assistance needs to be provided while being mindful of the State's economic and developmental constraints.
Article 42[10] states the State's duty to ensure that a mother's and her infant's health are shielded from the predators such as unjust and inhumane working conditions. It is upon keeping this Article as the base point that the Maternity Benefit Act, 1961[11] and the Maternity Benefit (Amendment) Act, 2017[12] have been drafted and implemented, guarding healthcare of the new mother, the expectant mother, and the infant.
It is Article 47[13] which obligates the State to boost the standards of living as well as the nutrition level of the citizens- this obligation of the State should be treated as their primary responsibility.[14]
The village Panchayats and the Municipalities should take it upon themselves to improve and safeguard public health- this is enshrined in Article 243 (G)[15] of the Constitution. The Panchayats and Municipalities would further be delegated with the requisite authority and powers to manage public health affairs. This Article assumes substantial relevance to the current Coronavirus pandemic that has viciously affected countries worldwide, including India. Assistance can be drawn from this Directive Principle, whereby the State can mandate the municipality officers, and the Panchayat heads to work at the root levels to make sure that due sanitation measures are being pursued and social distancing is being maintained.
Fundamental Right and Health
The Directive Principles are non-justiciable rights and thus act as mere directives for the state, bereft of enforceability. Hence, a diverse set of Articles have to be considered to maintain public health.
Article 21[16] quite famously states that a person shall not be deprived of his life or personal liberty, except according to the procedure established by law. Herein, the "right to life" does not merely equate to an animal-like existence but to a life of dignity and decency- such a life should comprise decent standards of physical and mental health. Matters of mental health can be emboldened through the means of Article 21.
Furthermore, Article 23 is circuitously related to the concept of health. Article 23(1)[17] prohibits human trafficking, which prohibits the spread of AIDS; thus, a pattern of public health guardianship can be observed. Article 24[18] also becomes essential since it deals with child labor and prohibits the employment of children in conditions that are hazardous and detrimental to their health. On the foundation of these constitutional provisions, several enabling and caregiving legislation have been drafted to ensure the health and welfare of the citizens.
It is quite inopportune that none of the Articles in the Constitution neither directly deal with mental health care nor advocate mental health care promotion by the State. However, with the available Articles of the Constitution, the judiciary has provided a broader interpretation to the concept of health, thereby securing the citizen's right to a life of dignity, which shall incorporate stable physical as well as mental health.

In Dr. Upendra Baxi v. State of Uttar Pradesh,[19], the Apex court ordered a medical panel to be set up, duly examining the Agra Home inmates and submitting a timely report. This report revealed that thirty-three out of the fifty mentally ill patients had differing levels of mental illness that had not been examined during their admission into the facility. Therefore, the treatment that these inmates were recipients of was not tailored to their particular illness, thus leading to a flood of flawed treatments. Further, fourteen patients had been let out of the facility without assessing their mental state/status. Lamentably, many of these patients did not even possess sufficient financial resources to traverse back to their homes. The Supreme Court considered this to be a grave violation of the constitutional provisions that ensured the right to life and public health. The facility members' actions were deemed inappropriate, and the Supreme Court adopted a rights-based approach.

At this juncture, it is imperative to delve into a detailed analysis with regards to specific mental health care legislation in India for understanding the preparedness level of our country in dealing with and handling mental health issues, which are only bound to multiply due to the lockdown imposition, owing to the Coronavirus pandemic.

The Mental Health Act, 1987[20] (Mha, 1987)

The MHA, 1987 came into force in India in 1993 and replaced the Indian Lunacy Act, 1912. This Act aimed to institute central authorities[21] and state authorities[22] who would establish, license, and supervise the administration of psychiatric hospitals. It intended to create composite and compact legislation whereby the rights of the mentally ill could be protected, and special provisions could be enacted for their treatment and care. These Central and State government Authorities were responsible for providing advice to the central and state governments.

Section 5[23] of MHA, 1987 mandated the institution and maintenance of psychiatric nursing homes and psychiatric hospitals. Further, section 17[24] and section 18[25] dealt with voluntary and dignified admission and discharged from the hospitals or the nursing homes, as the case may be. Emphasis was applied upon the consent of the patient for his admission and discharge.

Section 23[26] of MHA, 1987 was incorporated to shift the responsibility upon the police officers, since this section states that the police officers were bound to take into "protection" such individuals in the locality who seem to be mentally ill and are unable to take care of themselves. The Officer could also consider "protection" such people he believed to be potentially detrimental to society, owing to their mental health condition. However, arbitrary power was not attributed to the police officials since the person was taken into "protection" had to be produced before the Magistrate within twenty-four hours.

Section 38[27] was included in the legislation by our experienced legislature, which enabled three visitors to check the conditions of the psychiatric wards and nursing homes each month. The inspection included the examination of the patients' histories as well as the relevant medical certificates. The remarks of these visitors were duly recorded for further review and facility improvement.

Section 39[28] also constitutes a part of this legislation. Incorporated in welfare-driven judicial wisdom, this section mandates the inspection of even those mentally ill patients who have been imprisoned and constrained. In an era where mentally ill patients were looked down upon in society and faced the wrath of the lawmakers well as the prison authorities alike, MHA, 1987 stood as a beacon of hope for them, viewing them through a compassionate lens.

Section 81[29] is possibly one of the most legislatively luminous sections of MHA, 1987 since it explicitly mentioned the fundamental human rights of a mentally ill patient in India. According to this section, mentally ill patients should be treated with dignity and should not face discrimination in any form. Further, such patients cannot be exploited for research

purposes on anyone's whims and fancies; rather, the consent for the same should be furnished by the patient (however, the guardians could provide the necessary consent on behalf of minors). Further, no communication made by and to a mentally ill patient in any psychiatric health facility can be interpreted openly by an outsider. This section is probably one of the most elevating, empowering, and protective sections of MHA, 1987, as it explicitly tends to the rights of the mentally ill. Chapter IX[30] of MHA, 1987 deals with the legal penalties and sanctions in case of violations of any provisions of the Act.

In totality, this Act was quite beneficial for the mentally ill patients of the past years as it endeavored to protect them in every possible form.

However, MHA, 1987 shortly ceased to be relevant and assistive since the field of mental health and psychiatry developed and expanded by leaps and bounds. The plethora of transformations that had and were occurring in the field of mental health care and psychiatry could hardly be acknowledged within the ambit of MHA, 1987. The public demand for a new and refined mental health (care and regulation) legislation surged.

Mental Health To Mental Health Care: Why Was A Novel Legislation Necessary?

As mentioned above, the demand for new mental health care laws was rising. Below mentioned are a few points of criticism of MHA, 1987, which ultimately led to the enactment of substantially streamlined and effective legislation:

* MHA, 1987 seemed to be missing out on the ten cardinal Principles advocated by the WHO. Further, it also did not advocate much of the principles of the United Nations Convention on the Rights of Persons with Disabilities.[31] These considerations weakened MHA, 1987 in an international comparative aspect.
* Increased emphasis was laid upon the legal aspects of handling the mentally ill compared to the medical aspects. This was a major fallacy in the Act because, without the considerations of psychiatrists, psychologists, counselors, etc., the legislation remained deficient and hollow.
* Barely any weight was provided to the family and the social unit of the mentally ill patient. Further, no community-based psychiatric treatment was enabled. This discouraged several individuals from accepting their mental health woes- they feared penetrating a system that was devoid of warmth and their family's care, lacking community representation.
* A major criticism also remains that Chapter IX of MHA 1987 was devoid of penal sanctions for those relatives and/or officers who made requests for unnecessary detentions of the patients admitted to the mental health facilities.
* Undue importance was laid upon establishing new mental health care facilities, without realizing that a superior alternative would instead be the improvement of the existing mental health care facilities.
* Not a single provision of MHA, 1987 gave any rehabilitation guidelines, mandates, or objectives for the mentally ill who had been discharged after proper treatment. A single section prohibiting discrimination barely served any purpose.
* MHA, 1987 provided that research could be conducted upon minors by taking due consent from their guardian. The author believes this to be severely problematic from a human rights perspective.

The Mental Healthcare Act, 2017[32] (Mha, 2017) - Some Improvements, Some Lost Out Opportunities

The data presented as per Figure 2 is substantial evidence to depict that the expenditure made for the mental healthcare administration in India is dismal. A mere 0.6% of the entire budget is spent on the mental healthcare development in the country is quite a grim figure as one

would expect it to rise after the implementation of MHA, 2017. Therefore, it is essential that the author deliberates upon MHA, 2017 and draws a comparison to its predecessor, MHA, 1987.

The Welcome Changes- MHA, 2017

1. The most commendable provision in MHA, 2017 is the decriminalization of suicide[33]. The Act assumes that the person who attempted to commit suicide was under mental stress and/or illness and therefore is not liable for punishment under the Indian Penal Code (IPC). Duties have been levied upon the appropriate governments to ensure that they provide the necessary care and protection to the person who attempted to commit suicide to reduce such instances in the future.

The Indian Psychiatric Society (IPS) was invited and consulted at different junctures for deliberating upon diverse aspects of the Act. However, they were not permitted to partake in the drafting of the Act. Thought the IPS has its fair share of reservations about NHA, 2017, it has explicitly stated that the decriminalization of suicide (based on their advice) has been the single most monumental change.[34] The IPS believes that reading down section 209[35] of the IPC will assist with enhanced reporting of suicide cases (which would be beneficial from a legal and social standpoint).[36]

2. Section 21(4)[37] of the Act provides that medical insurances should be provided for by insurers (for treating mentally ill patients), just at par with other insurances which are provided for illnesses. The Insurance Regulatory and Development Authority of India (IRDAI), in a very optimistic step, has issued directives to health insurers across the nation to embrace the segment of mental illnesses in the medical insurance policies.[38]

3. The IPS and the MHA, 2017 have been a successful duo in the decriminalization of homosexuality in India in the year 2018. The IPS' position statement, while closely keeping in tandem with the MHA, 2017 has perennially been that "homosexuality is not a mental disorder." This statement of the IPS and relevant MHA, 2017 provisions carved their paths to be constituted as a part of the judgment in this landmark decision. The non-discrimination clauses[39] from the MHA, 2017, was incorporated into the judgment. It was also noted that section 377[40] was unconstitutional in correspondence to the contradictions it possessed to MHA, 2017.

4. Section 29[41] of MHA, 2017 obligates the government to plan and implement such programs which seek to promote the concept of mental health and reduce the stigma surrounding it.

Section 30[42] ensures that the government disseminates important information about mental health as far and wide as possible. This dissemination also includes the widespread promotion of the provisions of MHA, 2017. It has also been mandated that relevant public authorities undergo timely sensitization and training programs to connect to mental health care issues.

Section 31[43] strengthens the responsibility of the government while stating that it is upon the government to ensure that medical, mental healthcare professionals in public hospitals or the prison cells should be adequately trained, matching up to internationally accepted standards- a link between this provision and Principle 3 of the UN Principles can be observed. Therefore, an enhanced international dimension has been affixed to MHA, 2017, compared to MHA, 1987.

5. As per MHA, 2017, a person who is diagnosed with a mental disorder and is embroiled in a legal dispute (owing to the exercise of his rights accruing from MHA, 2017) would be provided the required legal aid to pursue their case.[44]

6. Section 2(s)[45] of MHA, 2017 provides an inclusive definition of mental illness founded upon medical considerations and societal considerations. It roughly defines any disorder of a substantial nature related to the mood, thinking, perception, memory, or orientation of a person, which severely affects and diminishes his/her sense of judgment and

behaviors. Such a person may have difficulty understanding and identifying reality and may also have difficulty carrying out simple tasks of life. This definition of mental illness also includes the mental conditions which originate due to alcohol and drug abuse. However, the definition excludes “mental retardation” from its ambit. With a balanced, medically sound definition in MHA, 2017, a solid ground has been set for any potential cases which may arise from this legislation.

7. Section 5[46] of MHA, 2017 provides for the issuing of "advanced directives," which essentially bestows the power upon a patient to exercise his right and furnish directives well in advance, with regards to the treatment they desire for their illness or the remainder of their illness. They may also choose their nominated representative for this cause. These directives have to be appropriately vetted and approved by the relevant medical authorities.

8. Chapter V[47] of MHA, 2017 delves into the rights of the mentally ill patients, just like its predecessor, the MHA, 1987. However, the rights included in MHA, 2017 are more elaborate, empowering, and liberal to ensure the patients' social, financial, physical, and emotional safeguarding. Sections 18-28 of Chapter V[48] are the golden provisions of this Act. Right to confidentiality, right to emergency services, right to refuse visitors, right to medical insurance, right to be included in the society without prejudice, and several other welfare-oriented rights have been incorporated under MHA, 2017.

9. The Central Mental Health Authority has to be established under section 33[49] of MHA, 2017. Section 45[50] mandates the setting up of the State Mental Health Authority. These Authorities would be responsible for the planning and designing Mental Healthcare Programs and the effectual implementation of MHA, 2017.

Criticisms Of Mha, 2017 And The Associated Proposals

Even with the tremendously laudable provisions of MHA, 2017, the Act lags in several aspects:

1. MHA, 2017, undoubtedly took into consideration the viewpoints of mental healthcare professionals and the IPA; however, the IPA was excluded from the drafting process. This has been one of the most debated and criticized aspects of MHA, 2017.

1. No standard procedure has been mentioned in Section 5 of the Act to furnish advanced directives. Since the procedure is absent in the Act itself, ambiguity regarding the exercise of the very right generates. Such hazy provisions deter the very legislative intent of providing the option of issuing advanced directives

2. Surprisingly, MHA, 2017 is devoid of even a single provision that deals with removing a Nominated Representatives. Furthermore, not even the medical officials possess the capacity to remove such a representative (even when their advice is not in the patient's best interest). This seems to be a hurriedly drafted provision, and even though it poses a difficult hurdle to overcome, personal contracts can be entered into between the parties, which will regulate the potential removal of a Nominated Representative (when the need maybe).

3. Via section 94[51] of MHA, 2017, electroconvulsive therapy has been banned as an emergency treatment to prevent the patient's death or any irreversible harm that they may suffer. It is to be noted that this form of therapy is a classical lifesaving emergency treatment for the mentally ill (especially for those with higher suicidal tendencies).[52] This section of MHA, 2017 has been harshly criticized by several mental health professionals as electroconvulsive therapy could significantly assist in controlling and managing patients in emergencies.[53] A collective appeal by mental health professionals can be made regarding the Central and State Mental Health Authority, who could expeditiously look into the matter.

4. No standard set of qualifications has been provided by MHA, 2017 for medical and mental health professionals. This reduces the standard of mental health care and makes one

question the workforce's competency in whose hands, the minds, and brains of this country will be placed with trust and hope of recovery. Immediate action is required to look into this critical loophole. However, in the long run, proper amendments should be effectuated about standards qualifications.

An important judicial decision that needs to be mentioned at this juncture is that of Meenu Seth v. Binu Seth.[54] The issue herein was that a case was already ongoing under the MHA, 1987. After MHA 2017 came into effect, the appellants appealed that their case should proceed in tandem with the provisions of MHA, 2017. However, the Delhi High Court dismissed the appeal and stated that even though MHA, 1987 has been repealed by MHA, 2017, section 126 2(f)[55] of MHA, 2017 clearly states that any cases which were ongoing and pending in any courts of India under MHA, 1987 will continue under the ambit of MHA,1987.

Comparative Analysis With New Zealand: An International Outlook

- The Mental Health (Compulsory Assessment and Treatment) Act, 1992 (MCATA) is the primary act which deals with the mental healthcare framework in New Zealand. As mentioned in this Act, a guaranteed compulsory treatment provides a mentally ill patient with an opportunity to recover, rehabilitate in society, and take control of their mental health. MCATA promotes this compulsory treatment by focusing on timely and regular consultation sessions between the "compulsory patients" and the mental health professionals.[56]
- Under the provisions of this Act, any person can request a mental health assessment, which should be accompanied by a recommendation provided by a registered medical practitioner.[57] Mental health professionals would have to invigilate the entire process, and the support of family members throughout the entire process is permitted.

When this is contrasted with the Indian legislation, such liberty in approaching the doctors and undergoing an assessment seems absent.

- A major guideline enlisted by the New Zealand Ministry of Health[58] mentions that even though there is a compulsory assessment permitted, the healthcare professionals still have to obtain the patient's consent wherever it is possible to do so. This consent should be "informed" and be obtained without undue influence or coercion.
- Part 6[59] of the MCATA mentions the eleven essential rights of the mentally ill patient:

Right 1-The patients have the right to obtain information with regards to their rights as well as their legal status. They also possess a right to be made aware of the treatment they are receiving under the Act; this information includes details about side effects.

Right 2- This right ensures that the cultural and religious ideologies of the individual are respected during the assessment and treatment of mental disorders.

Right-3- This right ensures that the State provides competent interpreters for interpreting and communicating on behalf of those who cannot voice their concerns.

Right 4- Herein, the treatment provided to the patients should conform to internationally accepted standards and match the treatment provided for any physical illness.

Right 5- This provides that the patients be informed and notified about their treatments.

Right 6- Ensures that the patients have the right to refuse or deny any video recording.

Right 7- Asking for a second opinion from an independent psychiatrist is one of the major rights attributed to the citizens of New Zealand.

Right 8- This grants the patients the power to consult an independent lawyer. Right 9- Assures the patient that his contact with his family and community will not be broken. This consideration seems to have been missed out on by the Indian legislature during the drafting of MHA, 2017.

Right 10- This right relates to right 9 as it ensures that visitors and phone calls are allowed.

Right 11-The patients also have the right to not only receive but also send mails.

Though some of the rights mentioned above can be found in our legislative framework, it is noteworthy that most of them are either absent or not implemented efficiently.
In addition to the abovementioned Acts, the Bill of Rights Act, 1990 (which states the life and liberty of New Zealanders), the Human Rights Act, 1993 (makes discrimination illegal even based on mental disability), and the Health and Disability Commissioners Act, 1994 (which provides an elaborate yet compact set of rights and states the importance of consent) work in full force to detect and prevent mental health disorders.
The provision of a critical assessment in New Zealand has led to breaking major stereotypes surrounding mental health disorders. If the Indian legislature could devise a model of a similar nature, it would ensure an enhanced reporting and treatment of mental disorders. However, it is to be noted that the populations of New Zealand and India are starkly different and that a diverse and innovative set of measures need to be implemented in our country to bring our mental health legislation at par with international standards to work in consonance with the WHO principles.

2. CONCLUSION

The author understands that even though India's current mental health care legislation is not of golden quality, it has showcased significant improvement compared to its predecessor, MHA, 1987.
The data presented above explicitly depicts that a chunk of the issues is rooted in the society itself. A metamorphosis in the mindset at an individual level is the need of the hour, and blatantly shifting the entire burden on the legislature would be redundant. Suppose consistent, sincere efforts are not directed towards an empathetic acceptance of mental disorders in our country. In that case, the benefits of the available legislation cannot be availed. The stigmas attached to mental disorders can never be discarded; a conscious effort on the part of the citizens, the legislature, and the executive agencies would be massively beneficial for improvement in the perception of the concept of mental health care in India.

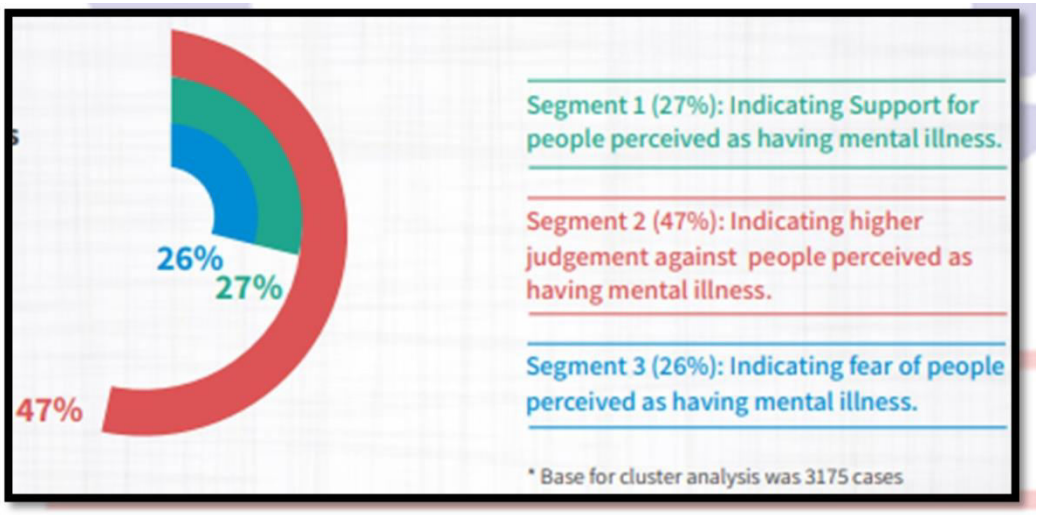
3. REFERENCES

[1]. Mental Healthcare Law: Ten Basic Principles, Division of Mental Health and Prevention of Substance Abuse, World Health Organization (1996), accessible at: https://www.who.int/mental_health/media/en/75.pdf.
[2]. Resolution 46/119, Mental Health Care, UN General Assembly (1991).
[3]. Preamble, The Constitution of India, 1949.
[4]. Indian Const. art 21.
[5]. P.M. Bakshi, Constitution of India (Universal Law Publishing Pvt. Ltd. 2003).
[6]. Indian Const. part IV.
[7]. Indian Const. art 38.
[8]. Indian Const. art 39(e).
[9]. Indian Const. art 41
[10]. Indian Const. art 42.
[11]. The Maternity Benefit Act, 1961.
[12]. The Maternity Benefit (Amendment) Act, 2017.
[13]. Indian Const. art 47.
[14]. Javed v. the State of Haryana, AIR 2003 SC 3057.
[15]. Indian Const. art 243 G.
[16]. Supra note 4.
[17]. Indian Const. art 23(1).
[18]. Indian Const. art 24.
[19]. Dr. Upendra Baxi v. State of Uttar Pradesh, (1983) 2 SCC 308.

[20]. The Mental Health Act, 1987.
[21]. The Mental Health Act, 1987 § 3.
[22]. The Mental Health Act, 1987 § 4.
[23]. The Mental Health Act, 1987 § 5.
[24]. The Mental Health Act, 1987 § 17.
[25]. The Mental Health Act, 1987 § 18.
[26]. The Mental Health Act, 1987 § 23.
[27]. The Mental Health Act, 1987 § 38.
[28]. The Mental Health Act, 1987 § 39.
[29]. The Mental Health Act, 1987 § 81.
[30]. The Mental Health Act, 1987, Chapter IX.
[31]. Article 4-32, United Nations Convention on the Rights of Persons with Disabilities, (2006), accessible at: http://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pd.
[32]. The Mental Healthcare Act, 2017.
[33]. The Mental Healthcare Act, 2017 § 115.
[34]. Jagadish, Furkhan Ali, Mahesh Gowda, Mental Healthcare Act 2017—The Way Ahead: The Opportunities and Challenges, 41, Indian Journal of Medical Psychology 113-118 (2019).
[35]. The Indian Penal Code, 1860 § 209.
[36]. Supra note 35.
[37]. The Mental Healthcare Act, 2017 § 21(4).
[38]. Health Insurance To Now Cover Treatment Of Mental Illnesses, QUINT (2018), accessible at::https://www.thequint.com/news/insurance-to-cover-mental-healt.
[39]. The Mental Healthcare Act, 2017 § 18, 21.
[40]. The Indian Penal Code, 1860 § 377.
[41]. The Mental Healthcare Act, 2017 § 29.
[42]. The Mental Healthcare Act, 2017 § 30.
[43]. The Mental Healthcare Act, 2017 § 30.
[44]. The Mental Healthcare Act, 2017 § 27.
[45]. The Mental Healthcare Act, 2017 § 2(s).
[46]. The Mental Healthcare Act, 2017 § 5.
[47]. The Mental Healthcare Act, 2017, Chapter V.
[48]. Id.
[49]. The Mental Healthcare Act, 2017 § 33.
[50]. The Mental Healthcare Act, 2017 § 45.
[51]. The Mental Healthcare Act, 2017 § 94.
[52]. Lancet, Efficacy and Safety of Electroconvulsive Therapy in Depressive Disorders: A Systematic Review and Meta-Analysis, UK ECT Review Groups, 799-808 (200).
[53]. Manoj Kumar, Mental Healthcare Act 2017: Liberal in Principles, Let Down in Provisions, 30, Indian Journal of Medical Psychology 101-107 (2018).
[54]. Minu Seth v. Binu Seth, FAO No. 411/2017.
[55]. The Mental Healthcare Act, 2017 §126 2(f).
[56]. Soosay and Rob Kydd, Mental Health Law in New Zealand, BJ Psychology Journal (2016).
[57]. Mental Health (Compulsory Assessment and Treatment) Act, 1992 § 8.
[58]. Ministry of Health (2012a), Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act,1992, accessible at: http://www.health.govt.nz/publication/guidelines-mental-health-compulsory-assessment-and-treatment-act-1992.

[59]. Mental Health (Compulsory Assessment and Treatment) Act, 1992, Part 6.

Figure 1



Source for Figure 1: The Three Segments of General Public based on their Attitude Towards Mental Health, TLLLF NATIONAL SURVEY REPORT (2018) (https://www.thelivelovelaughfoundation.org/downloads/TLLLF_2018_Report_How_India_Perceives_Mental_Health.pdf.)

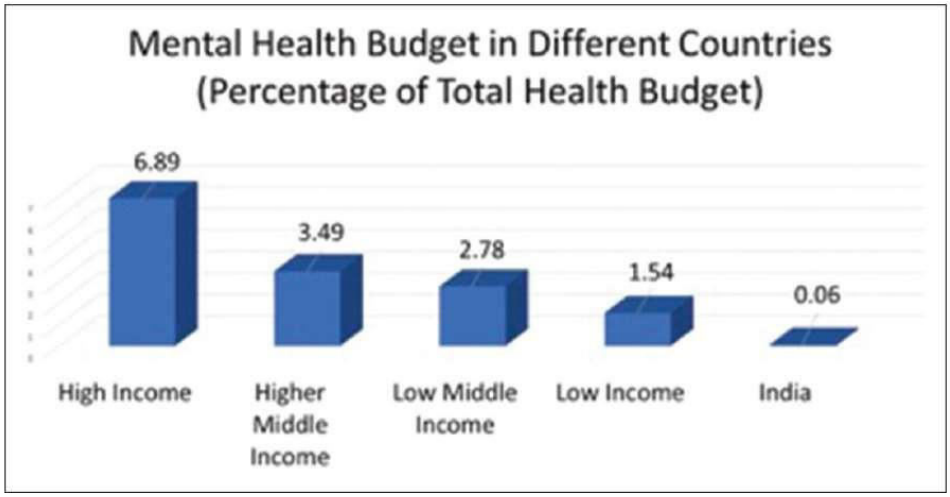


Figure 2

Source of Figure 2: Indian Journal of Psychiatry, Indian Psychiatric Society (2019) (http://www.indianjpsychiatry.org/viewimage.asp?img=IndianJPsychiatry_2019_61_4_415_262796_f2.jpg)