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A Study on Perspective of Mental Health Professionals on Mental Healthcare Act, 2017

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Abstract

The Indian Mental Healthcare Act 2017 received presidential assent on April 7th, 2017 and replaced the 1987 Act (MHA,2017). The bill has several positive aspects such as : Introducing proxy decision-making options and including opportunities to make advance directives (AD), regulatory monitoring of restraints and seclusions; banning practices that are widely considered as inhumane, defining the role of police in ensuring patient safety; bringing informed consent to the core of practice, minimizing the role of magistrates in mental health care, instructing insurance providers not to discriminate against mental illness, decriminalizing suicide, the language of the new act is also an indicator of this shift.

The present study focused on the perspective of Mental Health Professionals' on MHA,2017. India has taken a bold step in passing the most theoretically progressive piece of mental health legislation in the world. Despite having its many advantages, practical implication of the Act in Indian context is a unanswered question. This study analyses the provisions of the Act from the perspective of mental health professionals regarding their attitude towards the Act and its applicability. The study also explores the social work perspective of the selected provisions made in the MHA. It will be relevant to understand their attitude and their perspective about the applicability of the Act in India as they need to work within the boundaries of the Act. It was found that all the professionals have shown a tendency to be positive towards the Act. The

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attitude towards the provisions AD, NR, health insurance and CBR was found to be positive among MHP irrespective of the profession and this finding is supported by many studies. Psychologists found to be positive towards the applicability of MHA 2017 while other MHPs was less positive towards its applicability.

Key words: Mental Healthcare Act, Advance directive, Nominated representative, Community based rehabilitation

Introduction

The World Health Organization (WHO) 2004, defines health as: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Mental health is clearly an integral part of this definition. Mental health is described by WHO (2014) as: "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". In this positive sense mental health is the foundation for well-being and effective functioning for an individual and for a community. Mental health of people can vary according to their age.

Mental health in India

India has moved forward to addressing the needs of the mentally ill with the development of a National Mental Health Programme (NMHP) in 1982 (NMHP, 2016). According to the NMHP, 2016 the overall weighted prevalence for any mental morbidity was 13.7% lifetime. The age group between 40 to 49 years were predominantly affected (Psychotic disorders, Bipolar Affective Disorders, Depressive disorders and Neurotic and stress related disorders). The prevalence of Substance Use Disorders was highest in the 50-59 age group (29.4%). Residents from urban metro had a greater prevalence across the different disorders. Persons from lower income quintiles were observed to have a greater prevalence of one or more mental disorders. An individual's risk of suicide was observed to be 0.9% (high risk) and 0.7% (moderate risk); it was highest in the 40-49 year age group, greater amongst females and those

from urban metros.

The major factors that affects mental health in India is scarcity of resources, socio-economic burden, beliefs, explanations, and help-seeking behaviors, violation of human rights and treatment gap.

Mental healthcare resources

Mental healthcare depends primarily on trained personnel and infrastructure to ensure early diagnosis, treatment, and prevention of mental illness (World Health Organization 2014). Inadequate infrastructure and the scarcity of healthcare professionals in India contribute to wide treatment gaps in mental healthcare (Thirunavukarasu 2011). Statistics suggest that there are fewer psychiatrists than the requirement for the Indian population. The findings suggest that the unpopularity of psychiatry stems from a limited curriculum in medical colleges (Lingeswaran 2010), and a view among medical students that psychiatry is a difficult and non-scientific discipline (Manohari et al 2013). In India, healthcare providers involved in mental healthcare are not well informed of the objectives of various state programmes and believe that these programmes serve only to spread awareness. They also report dissatisfaction with training because of the extensive use of complex vocabulary and a lack of vernacular language use (Desai et al 2004). Training of trainers is also essential for ensuring that mental health programmes are a success. The health teams of various healthcare providers must be trained together to distribute responsibilities and to understand all the roles involved.

Mental health in Kerala

Current overall prevalence of any mental disorders in Kerala is 11.36%. This includes schizophrenia and other psychotic disorders, depressive disorders, bipolar affective disorder, neurotic and stress related disorders and alcohol and other substance use. There were a total of 626 mental health professionals within the state (psychiatrists: 400, clinical psychologists:211, and psychiatric social workers: 15). Thus, for every 1,00,000 population, there would be 1.2 psychiatrists, 0.63 clinical psychologists and 0.04 psychiatric social workers.

There are 3 mental hospitals, 7 medical college psychiatry departments and 18 general hospital psychiatry units in government sector. Beds available for inpatients admission in government sector is 1962 (5.87 beds for 1,00,000 population). In addition there are several psychiatry hospitals, clinics and psychiatry units in private hospitals.(NMHP, 2016).

Mental Healthcare Act, 2017

The Indian Mental Healthcare Act 2017 received presidential assent on April 7th, 2017 and replaced the 1987 Act (MHA,2017). Convention on the rights of persons with disabilities(CRPD) was passed by the United Nations(UN) General Assembly in 2006 and was signed and ratified by India in 2007 and made India eventually responsible for the revision of disability laws in India and introduction of MHC Act 2017. MHC act is published in the spirit of UNCRPD with human rights of person with mental illness (PMI) and review board acting as the backbone on the fulcrum of mental capacity. The act is hailed both as a revolutionary legislation as well as a hindrance to appropriate patient care. It is true that the bill is a big leap in principles, and it has the rights of the mentally ill at its heart (Chadda, 2015). The bill has several positive aspects such as : Introducing proxy decision-making options and including opportunities to make advance directives (AD), aspiring to establish parity with physical disorders; regulating all facilities that provide psychiatric care irrespective of systems of medicine practiced or nature of service provider, setting up systems to ensure due process when personal liberties are restricted, regulatory monitoring of restraints and seclusions; banning practices that are widely considered as inhumane, defining the role of police in ensuring patient safety; bringing informed consent to the core of practice, minimizing the role of magistrates in mental health care, instructing insurance providers not to discriminate against mental illness, decriminalizing suicide, the language of the new act is also an indicator of this shift. The word "detention" appeared 32 times in the old act; this word is not mentioned in the new act even though more patients are brought under the purview of the new act. The word "consent" appears 40 times in the new act whereas only three of

the 11 appearances in the old act relate to patient consent.

Perspective Mental Health Professionals' on MHA,2017

India has taken a bold step in passing the most theoretically progressive piece of mental health legislation in the world. In addition to adhering to the UNCRPD, it provides 1.3 billion people with a justifiable right to mental healthcare. This initiative might well prove too ambitious in certain respects and potentially impossible to realize in full. Whatever its outcomes, however, the new legislation has commanded international attention and may well become the mold for the next generation of rights-based mental health legislation(Duffy., et.al, 2018).

Despite having its many advantages, practical implication in Indian context is a unanswered question. It can be best answered by mental health professionals because they are the people who stood between the person with mental illness and the Act. This study analyses the provisions of the Act from the perspective of mental health professionals regarding their attitude towards the Act and its applicability. The study also explores the social work perspective of the selected provisions made in the MHA. It will be relevant to understand their attitude and their perspective about the applicability of the Act in India as they need to work within the boundaries of the Act.

Objectives of the study

1. To understand the awareness level of mental health professionals regarding the selected provisions in Mental Healthcare Act 2017 (MHA): Advance Directive, Nominated Representative, Community Based Rehabilitation and Health insurance

2. To understand about the attitude of mental health professionals regarding the selected provisions in Mental Healthcare Act 2017 (MHA) :Advance Directive, Nominated Representative, Community Based Rehabilitation and Health insurance

3. To understand about the applicability of selected provisions in MHA 2017.

Methodology

The primary objective of the study is to understand the perspective of mental health professionals' about Mental Healthcare Act, 2017. The samples were collected from various private and public institutions and include mental health professionals such as psychiatrist, psychologists, psychiatric social workers and psychiatric nurses of age above 25 years and experience more than one years. 30 samples were collected. The data is collected through a self prepared questionnaire and a online version of the questionnaire. First five items was intended to check the awareness of participants. The rest 25 items was rated on a 5 point scale. Ten items was meant for exploring the attitude of professionals towards the Act, 10 items were related to the applicability of the Act and 5 were intended to understand the social work perspective of the Act.

Demographic details

Table 1. Distribution of respondents on Frequency and percentage for the demographic variables

Major findings

Variable	Frequency	Percentage
1. AGE		
25-35	23	76.7
36-45	3	10.0
46 above	4	13.3
2. GENDER		
Male	16	53.3
Female	14	46.7
3.PROFESSION		
Psychiatrist	10	33.3
Psychologist	10	33.3
Social worker	5	16.7
Nurse	5	16.7

4. INSTITUTION		
Private	18	60.0
Public	12	40.0
5. YEARS OF EXPERIENCE		
1-4 years	11	36.7
5-8 years	13	43.3
Above 12	6	20.0

Findings through the statistical analysis

It was found that there is no significant difference in the awareness level about the Act between the professionals. This might be because of various reasons. Mental Healthcare Bill, 2016 was a long anticipated piece of discussion among the mental health professionals. Also, during the interview with mental health professionals, many reported that they had been discussing about the MHA, 2017 long back itself and in addition, many had undergone classes regarding the new Act. It is also the ethical responsibility of every professional to update their knowledge. In addition, it was found during the data collection that most of the participants went through the Act before responding to the items in the questionnaire. So all these factors might be the probable reasons for not having a significant difference in the level of awareness.

It was found that there is no significant difference in their attitude and irrespective of their profession, all have shown a tendency to be positive towards the Act. The attitude towards the provisions AD, NR, health insurance and CBR was found to be positive among MHP irrespective of the profession and this finding is supported by many studies. All these provisions empowers a person with mental illness and have the capacity to guard patient autonomy and self determination.

The difference in perception of MHPs towards the MHA 2017 was found using ANOVA. There is significant difference in the perception of MHPs. Psychologists found to be positive towards the applicability of MHA 2017 while other MHPs was less positive towards its applicability. Psychiatrists might be

concerned about the fact that, the provisions in MHA 2017 interfere with the treatment process and limits the autonomy of doctors in deciding the treatment. In case of nurses, they are the people who works with doctors. They are providing treatments with the directions of psychiatric doctors and they do face the situations like doctors while providing services. Psychiatric social workers help the multi disciplinary treating team in identifying the underlying socioeconomic cultural realities to arrive at the accurate diagnosis. As a result they might view the applicability of Act in terms of the social, cultural and economic realities existing in India. They know that with the existing condition in India it will be difficult to implement the Act . So these above factors might be the reasons psychiatrists, nurses and psychiatric social workers respond less positively to the applicability of Act. Psychologists were more positive towards the applicability of MHA, 2017. This might be due to the fact that they are dealing with more or less stable clients unlike psychiatrists and they might feel more scope for change with the applicability of MHA 2017.

Findings from the consultation organized by Center for Constitutional Rights Research & Advocacy (CCRRA).

A consultation was held on 15 th June 2019 among stakeholders working on mental health, relating to treatment and rehabilitation. The consultation aims at engaging in a concrete discussion to ensure the systems in consonance with The Mental Healthcare Act, 2017. Through the consultation it was found that many cases of person with mental illness is already came in court, but the court is still vague about the provisions in the Act. Even though the Act came into effect two years back, many mental health professionals are not clear and unaware about the Act.

As per the Act, there is a need to set up a review board in order to regulate and monitor the matters concerned with the person with mental illness such as the admission process, discharge, protection of rights etc. But no review board was set up so far.

One of the psychologist said that they can do a lot of things for people

suffering from mental health issues but they couldn't because it was not something that comes within their duties as per the legislations.

Suggestions

All the provisions in MHA, 2017 will create a need to increase staffing numbers and provide additional training to existing staff to facilitate satisfied service delivery.

Efforts must be made to make the act easily accessible to individuals, families and community, at a time when they need it and in a way that they can make use of it meaningfully.

The higher rate of usage of the Act might be ensured if the powers to determine what is needed to treat a patient (including the power to detain at emergency) to psychiatrists such that the act becomes more relevant to the daily clinical activities of a psychiatrist.

Individuals without clinical training will have disproportionate impact on clinical decisions under the Act which may happen in case of advance directive and nominated representative. So it is suggested to build knowledge and awareness of families and care takers regarding the provisions in the Act.

Conclusion

India has a long history of mental health understanding and practices. What today is broadly understood by mental health as a state can have its origin tracked back to developments in public health, in clinical psychiatry and in other branches of knowledge. The evolution of Mental Health Act (MHA) in India can be considered as a direct descent of the colonial rule. Hence, the history of mental health legislation in India was originated from the British Raj in India, especially in the colonial and post-colonial era. The new Mental Healthcare Act 2017 received presidential assent on April 7th, 2017 and replaced the 1987 Act. Its aim is to bring the legal framework in India in consonance with the provision of UNCRPD. The new Act have many salient features but with the existing infrastructure, scarcity of healthcare profession-

als and socioeconomic burden may make the provision of MHA 2017 like 'advance directive' practically difficult to implement. The study explored the mental health professionals' attitude and awareness towards the Act and their perspective on the applicability of the Act. Through this study it was found that the professionals have a positive attitude towards the Act but they have less positive opinion about the applicability of the Act except for psychologists.

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