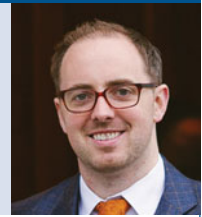


## Editorial

## The right to mental healthcare: India moves forward

Richard M. Duffy and Brendan D. Kelly



In 2018, India's Mental Healthcare Act 2017 granted a legally binding right to mental healthcare to 1.3 billion people, in compliance with the Convention on the Rights of Persons with Disabilities. Many countries, including the UK, ratified the Convention but only India has stepped up to the mark so dramatically.

**Declaration of interest**

None.

**Keywords**

Human rights; low- and middle-income countries; psychiatry and law; psychosocial interventions; service users.

**Copyright and usage**

© The Royal College of Psychiatrists 2018

**Richard M. Duffy** (pictured) is a consultant psychiatrist at the Mater Misericordiae University Hospital, Dublin and PhD student in Trinity College Dublin. **Brendan D. Kelly** is a professor of psychiatry at Trinity College Dublin and author of *Mental Illness, Human Rights and the Law* (RCPsych Publications, 2016).

There are gross inequities in the distribution of health and healthcare worldwide. This is the single greatest bioethical issue of our times. In January 2017, the World Health Organization pointed out that law plays a 'vital role' in realising the 'right to health'.<sup>1</sup>

Mental healthcare is a good example. Depression is the leading cause of disability worldwide and approximately 800 000 people die by suicide each year. Despite these figures, most people affected by mental illness – 75% in many low-income countries – cannot access treatment.<sup>2</sup> This reflects failures of medicine, politics and human rights.

In India, the *National Mental Health Survey of India, 2015–16*, the most ambitious epidemiological survey to date, showed a treatment gap of 85% across the country for common mental disorders and highlighted the profound existing challenges that new rights-based legislation in India is designed to address.<sup>3</sup>

There is an extensive literature on the concept of the 'right to healthcare' as a potential solution to this problem.<sup>4</sup> But despite some compelling arguments in favour of rights-based approaches, there is still a lack of data about the effectiveness of creating a legally enforceable right to healthcare. Does it really work? Or do the transaction costs exceed the benefits?

There is currently a unique opportunity to study the effects of a legally binding right to mental healthcare as India's Mental Healthcare Act 2017 came into effect on 29 May 2018, granting a legally binding 'right to access mental healthcare and treatment' to India's population of 1.3 billion people, one-sixth of the planet's population.<sup>5</sup> India's new legislation contains many ambitious and progressive measures but none is more ambitious than the granting of this fully justiciable right, which can be pursued in the courts. The challenge is great but the vision is greater still.

In 1948, the United Nations' Universal Declaration of Human Rights stated that 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control' (Article 25(1)).

But this Declaration is not strictly legally binding and controversy has always surrounded its inclusion of economic and social

rights, given their inevitable relationship with a country's political and economic situations. In 1966, two separate covenants were adopted: the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. Civil and political rights were to be implemented immediately, whereas economic, social and cultural rights were to be implemented progressively as countries developed at different rates.

This makes good, practical sense because granting legally binding rights is not always the most reasonable or efficient way of achieving social goals. Policy measures can be more pragmatic and effective. It is not sensible to describe all human needs as 'rights'. But what if certain basic human needs are clearly not being met through policy, as is patently the case with mental health need? When should law step in, and how?

India's Mental Healthcare Act 2017 was designed 'to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services' (Preamble).

There are many interesting aspects to India's legislation, including new admission procedures, reviews of admissions, advance directives and *de facto* decriminalisation of suicide.<sup>6–8</sup> Most dramatically, however, the new legislation states that 'every person shall have a right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government' (Section 18(1)).

This 'shall mean mental health services of affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and caregivers' (Section 18(2)).

The detailed provisions in this section reflect current best practice in psychiatric care by outlining a minimum package of services to be provided. More specifically, the Government 'shall make sufficient provision as may be necessary' (Section 18(3)), including 'acute mental healthcare services' (out-patient and in-patient); 'half-way homes, sheltered accommodation, supported accommodation'; 'services to support family of person with mental illness or home based rehabilitation'; 'hospital and community based rehabilitation establishments and services'; and 'child mental health services and old age mental health services' (Section 18(4)).

The Government shall 'integrate mental health services into general healthcare services'; 'provide treatment in a manner, which supports persons with mental illness to live in the community

and with their families'; ensure that 'long term care' is 'used only in exceptional circumstances, for as short a duration as possible, and only as a last resort when appropriate community based treatment' has failed; and ensure services are available locally insofar as possible (Section 18(5)).

'Persons with mental illness living below the poverty line ... [or] who are destitute or homeless shall be entitled to mental health treatment and services free of any charge' (Section 18(7)). All 'medicines on the Essential Drug List shall be made available free of cost to all persons with mental illness at all times at health establishments run or funded' by the Government, as shall 'essential medicines from any similar list relating to the appropriate ayurveda, yoga, unani, siddha, homoeopathy or naturopathy systems' (Section 18(10)). To achieve this, 'the appropriate Government shall take measures to ensure that necessary budgetary provisions in terms of adequacy, priority, progress and equity are made for effective implementation' (Section 18(11)).

The right to access mental healthcare also includes access to mental health promotion and prevention services and not just treatment and rehabilitation services. As a result, 'Government shall have a duty to plan, design and implement programmes for the promotion of mental health and prevention of mental illness in the country' (Section 29(1)) and 'shall, in particular, plan, design and implement public health programmes to reduce suicides and attempted suicides' (Section 29(2)).

The law recognises the difficulties in meeting these rights without a corresponding duty on Government to develop human resourcing. The legislation states that 'Government shall take measures to address the human resource requirements of mental health services in the country by planning, developing and implementing educational and training programmes in collaboration with institutions of higher education and training, to increase the human resources available to deliver mental health interventions and to improve the skills of the available human resources to better address the needs of persons with mental illness' (Section 31(1)).


This commitment is binding on Government, as are commitments to 'at the minimum, train all medical officers in public health-care establishments and all medical officers in the prisons or jails to provide basic and emergency mental healthcare' (Section 31(2)) and 'make efforts to meet internationally accepted guidelines for number of mental health professionals on the basis of population, within ten years' (Section 31(3)).

Granting a legally binding right to mental healthcare and committing to resource it adequately are very ambitious steps for any country, including India. There are great challenges. Mental health services in India are substantially under-resourced;<sup>3,9</sup> specific measures, such as new licensing requirements for general hospital psychiatry units, may well hinder care rather than enhance it;<sup>10</sup> and the Act applies 'during delivery of mental healthcare and services' and not, arguably, between episodes of care, when many violations of rights occur such as neglect, homelessness, imprisonment and social exclusion.

But the greatest human rights violation among the mentally ill in India and elsewhere is simply the lack of care. The drafters of India's new legislation have demonstrated wisdom and vision in articulating a legally binding right to such care despite the inevitable challenges and complexities of such a bold move.

If the urgent, practical challenges presented by the Act are addressed effectively through resourcing, policy change and legislative amendment, in partnership with key stakeholders such as the Indian Psychiatric Society, India will have done the world a profound service by stepping forward and making the right to mental healthcare a reality for so many people.

The rest of the world should watch, listen and learn.

**Richard M. Duffy**, MB, BCh, BAO, MSc, PhD Student, Department of Psychiatry, Trinity College Dublin and Consultant Psychiatrist, Master Misericordiae University Hospital, Ireland; **Brendan D. Kelly**, MB, BCh, BAO, MA, MSc, MA, MA, MD, PhD, DGov, PhD, MCPsych, FRCPsych, FRCPI, FTCD , Professor of Psychiatry, Department of Psychiatry, Trinity College Dublin, Ireland

**Correspondence:** Brendan D. Kelly, Department of Psychiatry, Trinity Centre for Health Sciences, Tallaght University Hospital, Dublin 24, Ireland. Email: [brendan.kelly@tcd.ie](mailto:brendan.kelly@tcd.ie)

First received 20 Jul 2018, final revision 6 Oct 2018, accepted 10 Oct 2018

## Acknowledgements

The authors thank the reviewers for their comments and suggestions.

## References

- 1 World Health Organization. *Advancing the right to health: the vital role of law*. World Health Organization, 2017.
- 2 World Health Organization. WHO Mental Health Gap Action Programme (mhGAP). Available at: [http://www.who.int/mental\\_health/mhgap/en/](http://www.who.int/mental_health/mhgap/en/) (accessed 3 October 2018).
- 3 Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, et al. *National mental health survey of India, 2015–16: prevalence, patterns and outcomes (NIMHANS publication no. 129)*. National Institute of Mental Health and Neuro Sciences, 2016.
- 4 Peer RF. Right to healthcare: the way forward. *J Family Med Prim Care* 2013; **2**: 4–8.
- 5 Duffy RM, Kelly BD. India's Mental Healthcare Act, 2017: content, context, controversy. *Int J Law Psychiatry* 2018 (<https://doi.org/10.1016/j.ijlp.2018.08.002>).
- 6 Sachan D. Mental health bill set to revolutionise care in India. *Lancet* 2013; **382**: 296.
- 7 Duffy RM, Kelly BD. Concordance of the Indian Mental Healthcare Act 2017 with the World Health Organization's Checklist on Mental Health Legislation. *Int J Ment Health Syst* 2017; **11**: 48.
- 8 Kelly BD. Mental health, mental illness, and human rights in India and elsewhere: what are we aiming for? *Indian J Psychiatry* 2016; **58**: S168–74.
- 9 Gupta N, Basu D. The Mental Healthcare Bill 2016: exotic in nature, quixotic in scope ... but let's take the plunge, shall we? *Natl Med J India* 2016; **29**: 317–20.
- 10 Narayan CL, Shekhar S. The Mental Health Care Bill 2013: a critical appraisal. *Indian J Psychol Med* 2015; **37**: 215–9.