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The Mental Healthcare Bill, 2016: A Cure or A Mere Palliative?

by
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The Mental Healthcare Bill, 2016 was recently passed by the Rajya Sabha in August, 2016. Introduced in 2013 in the Parliament, the bill finally saw the light of the day three years after being first tabled. Though passed by the upper house, it still awaits the sanction of the Lok Sabha. The passing of the bill was met with intense jubilation in several circles and, at the same time, was criticized as being inadequate on several accounts by others. While it was applauded for its progressive approach as reflected in its conceptualization of mental illness, recognition of the rights of persons with mental illness, the advance directive and decriminalization of attempt to suicide by a mentally ill person, certain other provisions such as exclusion of several forms of psychotherapy and ambiguity with regards to financial resources were frowned upon. The Mental Healthcare Bill, 2016 does mark a watershed moment in the history of mental health related laws in India but is not free from deficiencies. Several modifications over the existing archaic laws show that it is, indeed, a stride in the right direction and is certainly reformist in nature.

India's mental health legislation has witnessed a gradual ideological transformation over a period of time. This transformation is reflected in the very terminology used in defining the law. Right at the outset, from being called the Indian Lunacy Act in 1912, the title was changed to the Mental Health Act in 1987 — a much-appreciated change marking a transition in how mental health was conceptualized and defined. The term "lunatic" defined as "an idiot or a person of an unsound mind"[1] was replaced with "mentally ill person" defined as "a person who is in need of treatment by reason of any mental disorder other than mental retardation"[2]. Although a simplistic definition, it was more dignified in its approach towards the mentally ill. Along with de-emphasizing labeling and highlighting the

treatability of mental illness, it also effectively underscored that the ambit of mental health was no longer limited to insanity or psychosis but was much more inclusive. The 2016 bill has furthered this inclusiveness through not just the title but also the objective, the approach and the definition of mental health that it has adopted. The bill is now called the Mental "Healthcare" Bill, defining mental healthcare as including "analysis and diagnosis of a person's mental condition and treatment as well as care and rehabilitation of such person for his mental illness or suspected mental illness"[3]. While the 1987 Act nowhere explicitly defined what mental healthcare or treatment constitutes and gave mere lip service to rehabilitation by mentioning it along with recreational activities as part of support facilities to be provided by psychiatric hospitals[4], the 2016 bill has effectively emphasized that rehabilitation lies at the very core of mental healthcare and must be prioritized.

The objective of the bill has also undergone a massive transition. While the existing Act of 1987 restricted its objective to "the treatment and care of mentally ill persons, to make better provision with respect to their property and affairs"[5], the 2016 bill expands its purpose "to protect, promote and fulfill the rights of such persons during

delivery of mental healthcare and services"[6]. The recognition of the rights of people with mental illness and a pledge to protect them is in concordance with the Convention on Rights of Persons with Disabilities and its Optional Protocol that was adopted by the United Nations in 2006 and signed and ratified by India on October 1, 2007[7]. The rights based approach that the Mental Healthcare Bill, 2016 has adopted is the first step towards aligning and harmonizing the existing laws with the Convention. Whereas the Act of 1987 provided only general protections against indignant or cruel treatment, Chapter V of the 2016 bill operates as a charter of rights for persons with mental illness consolidating and safeguarding the basic human rights of these individuals[8]. The bill recognizes and guarantees several rights to persons with mental illness including the right to access mental healthcare, right to equality and non-discrimination, right to protection from cruel, inhuman and degrading treatment, right to confidentiality, restriction on release of information in respect of

mental illness, right to access medical records, right to information, right to personal contacts and communications, right to community living, right to make complaints about deficiencies in provision of services and right to legal aid[9]. Further, as part of the right to equality and non-discrimination, the bill directs every insurer to make provision for medical insurance for treatment of mental illness just as it is available for physical illness[10]. This is an extremely desirable move, the need for which has been long felt.

Another progressive development in the Mental Healthcare Bill, 2016 is the inclusive definition of mental illness that it has adopted. While mental illness has never been explicitly defined in the history of mental health legislation in India, the 2016 bill embraces a very nuanced understanding of mental illness as constituting "a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub-normality of intelligence"[11]. Certain critics have argued that this expansive definition is over-inclusive and poses the threat of including even minor mental discomforts within the ambit of mental illness thereby increasing the possibility of labeling[12]. They have stressed that a more restricted and concise definition of mental illness would save many from the stigma. On the contrary, the author is of the opinion that a wide open-ended definition is likely to go a long way in de-stigmatizing the very notion of mental illness by emphasizing that mental illness is more common than assumed. This would enable several to accept and open up about their mental discomforts. Further, not only does this position reflect the complexity of mental illness, it also dismisses the stereotypical notion that mental illness is synonymous with insanity or psychosis. It recognizes that no singular blanket term is sufficient to capture the diversity of mental disorders that vary in nature, modality and intensity. It has successfully managed to contextualize mental illness respecting the uniqueness of each individual suffering from a mental health concern.

In fact, the bill needs to be applauded for making a visible effort in the direction of de-stigmatizing mental illness. It has explicitly specified,

right at the outset, that mental illness shall be determined only in accordance with nationally or internationally accepted standards and that classification shall be used only for purposes directly related to the treatment of the person[13]. The bill also cautions that religion, ethnicity, social, economic or political status of the person and non-conformity with moral, cultural or religious beliefs do not form the basis of classifying the person as mentally ill[14]. Further, a person who has been diagnosed with mental illness should not be assumed as having an unsound mind unless declared so by a competent court[15]. The bill, thus, recognizes and upholds the agency of the person to take his or her own decisions. This is unquestionably a reassuring development. While the Act of 1987 does not recognize the decision making capacity and adequacy of a mentally ill person, the 2016 bill adopts a radically different approach of enabling the individual to make decisions regarding their mental healthcare and treatment, and their guardians.

The bill seeks to accomplish this goal of empowering the persons suffering from mental illness to make the decisions concerning their mental healthcare and treatment in two significant ways. First, the bill has entitled every person suffering from mental illness (legal guardians in case of minors) to the right to issue a written directive specifying the manner in which the person wants to and does not want to be treated and taken care of[16]. Second, the person has also been entitled to issue an advance directive nominating a representative who shall be an all-encompassing guardian to the person with mental illness - shall be responsible for not only the care and treatment of the person with mental illness but also assist him in his decision making related to all matters. From seeking diagnosis related information and treatment to discharge planning, from considering the wishes of the person with mental illness to mitigating them with the life history and cultural values, from determining what's in the best interest of the person to challenging violations of their rights - all fall within the ambit of the duties of the nominated representative. This, certainly, is a positive development over the current law.

The bill has, for the first time in the history of mental health laws in India, regulated the use of certain intrusive procedures on mentally ill patients. The administration of electro-convulsive therapy (ECT) has been allowed only along with the use of anesthesia and muscle relaxants. Additionally, for minors, the informed consent of the guardian and approval by the State Mental Health Review Board has been mandated for the

performance of ECT. Kala (2013) is quick to point out that this provision might hinder the quick delivery of ECT in certain cases such as catatonia in minors where it is a treatment of choice[17]. This limitation, however, can be addressed to a large extent by ensuring expeditious action by the Review Board in reviewing and responding to such applications. Although empirical evidence suggests that ECT does not have more side effects for minors than for adults[18], the prerequisite will certainly act as an added safeguard for minors. Further, the bill has stipulated that psychosurgery may be performed only after the informed consent of the person concerned and the approval of the State Mental Health Review Board. Sterilization intended to treat mental illnesses and chaining of mentally ill individuals have been completely outlawed[19]. These regulations will certainly go a long way in limiting the indiscriminate use of these invasive procedures on people with mental illnesses.

Yet another achievement of the bill is that it seeks to decriminalize the attempt to commit suicide. The bill explicitly states that a mentally ill person who has attempted to commit suicide shall not fall within the purview of Section 309 of the Indian Penal Code[20]. Section 309 of the IPC prescribes the punishment for attempt to suicide as a term of up to one year or a fine or both[21]. After several failed attempts to decriminalize suicide, Section 309 shall finally be limited in its effect by the bill once it comes into force. The bill asserts that, unless proven otherwise, it shall be assumed that the person who attempts to commit suicide was undergoing severe stress[22]. The bill has ensured enough space to try people who threaten to commit suicide and create public nuisance under Section 309 of the IPC, but, at the same time, it endeavors to protect the interests of those who are genuinely suffering from mental discomfort. A mentally disturbed person who has attempted suicide is in need for care rather than punishment. Consequently, it has also imposed upon the government the duty to ensure

care, treatment and rehabilitation of such a person to reduce the risk of recurrence of such an attempt. Further, the bill has acknowledged the socio-genic roots of suicide and the need for primary intervention. It has directed the government to plan, design and implement public health intervention programs aimed at reducing the rate of suicides as well as suicide attempts in the country[23].

I. THE DOWNSIDE

Although undoubtedly a progressive step in the right direction, the bill is still miles away from being an ideal one. One of the major shortcomings of the bill is that it has failed to recognize and validate the diverse areas of psychotherapy. It has been vastly criticized for having attempted to banalize psychology. It is highly exclusionary with respect to whom it recognizes as a mental health professional. It has recognized practitioners of allopathic, ayurvedic, homeopathic, yoga and even naturopathy, unani and siddha medicine in treating patients with mental illness[24]. It has also recognized Clinical Psychologists registered with the Rehabilitation Council of India[25]. However, it's rather alarming to note that a large section of psychotherapists and counselors have been obliterated. In fact, there is not even a mention of the terms "psychotherapy" and "counseling" in the bill. The bill appears to be relying heavily on the bio-medical model of the psychopathology viewing mental illness as treatable through medication. It has completely ignored the importance of the socio-genic approaches that base their therapy on empathetic listening and human contact rather than prescribing medicines. The World Health Report (2001) of the World Health Organization highlights the effectiveness of "listening therapy" that an Indian voluntary non-governmental organization, Sneha, utilizes as a technique for suicide prevention. With its focus on empathy, human contact and emotional support, the therapy has catered to over one lakh calls of distressed individuals that the organization has received so far, with about 40% of the callers falling within the range of medium to high risk of suicide[26]. The bill, however, does not recognize these forms of approaches to therapy. A huge arena of psychotherapies including psychoanalytic therapy, art therapy, music therapy, drama therapy and movement therapy, to name only a few, has thus been ostracized.

By ignoring counseling services, the bill has also overlooked the needs of the people who do not suffer from any major mental illnesses but only minor mental health concerns for which counseling services are likely to suffice. The World Health Organization has defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[27]. A comprehensive mental health law should address not only the treatment needs of individuals suffering from mental illness but should aim at enhancing the quality of life and sense of well being of all. Counseling services that cater to individuals experiencing minor chronic discomforts such as free floating anxiety, mood related concerns, difficulty in managing stress, situational pressures or relationship problems work towards enhancing the quality of life of individuals. These services have not been recognized in the bill. Due to lack of recognition, counseling services are also not likely to be covered even in the new insurance schemes.

A closer look at the bill discloses several other gaps that would make its provisions difficult to execute and prone to misuse. The provision for issuing an advance directive with respect to care and treatment, for instance, although a benevolent one, is far from being a comprehensive one. It works on the presumption that the person suffering from mental illness, and his nominated representative, will be educated enough to not only have a complete understanding of his mental condition but also is knowledgeable about the care and treatment alternatives available to him and their relative effectiveness and suitability for his condition. In a country like India, where the majority of the population fails to display even an elementary understanding of mental illness, where any form of mental illness is labeled as "insanity" and where a Mental Healthcare Bill largely ignorant of the diverse approaches to psychotherapy has been proposed, one really wonders how sound that presumption is! Additionally, the exceptions and modification clause attached with the right to issues an advance directive dilutes the very purpose of protecting the interest of the person concerned while he is in a state when he cannot make decisions. The bill states that the advance directive does not apply to an emergency treatment given to the person concerned[28]. Also, the advance directive may be altered or cancelled through an application made to the Mental Health Review Board in case the mental health professional, a relative or a care-giver wishes not to follow the

directive[29]. Although these clauses are meant to offer scope for alternate treatment modes if necessary, they are also likely to be used as escapes. They offer sufficient latitude to diminish the status of the advance directive to, at best, a weak tool in the hands of the mentally ill person that can be modified and manipulated at the will of external agents. The provision of the advance directive, thus, is largely rendered purposeless.

A similar exception applies to the right to appoint a nominated representative. The bill provides that the nominated representative may be revoked or modified through an application made to the Mental Health Review Board by the person suffering from mental illness, a relative of the person concerned, the medical officer in-charge of the mental health facility or the psychiatrist taking care of the person[30]. The scope of the term "relative" has nowhere been defined. As pointed earlier, although the provision might have been inserted with the purpose of protecting the best interest of the person with mental illness if the nominated care taker fails to fulfill his duties,

bestowing the right to modify the wish of the person concerned upon so many third parties is likely to dilute the effectiveness of the provision making it highly susceptible to misuse and rendering it principally ineffective.

As a progressive move, the bill has emphasized the creation of Mental Health Establishments that provide for care, treatment and rehabilitation for persons with mental illness[31]. These establishments are required to meet such minimum standards and employ persons with such qualifications as outlined by the Central or State Authority[32]. However, there is no recognition of the importance of integrating mental health facilities with the existing medical institutes. Separating physical healthcare from mental healthcare and establishing exclusive mental health institutes is likely to further the stigma that is associated with mental illness and prevent people from approaching the separate establishments for care and assistance. There is, unquestionably, a massive shortage of mental health facilities available in India. According to the World Health Organization's Mental Health Atlas (2011), there are as few as 0.004 mental hospitals available and only 1.469 beds available in these mental hospitals per lakh of population in the country. The figure is even more dismal for general hospitals with only 0.823 psychiatric beds available in them per lakh. There are only 0.329 mental health outpatient facilities available per lakh of population[33].

Though the country requires a humongous increase in the number of mental health facilities, the urgent need is to expand the existing medical institutes to include mental health facilities and to develop these facilities wherever they already exist. Not only will this limit the stigma, it will also ascertain the speedy availability of the basic resources that are required since they preexist in these already functioning institutes. Additionally, increasing the number of mental health establishments is likely to serve no purpose unless proper quality of care is ascertained. The World Health Report (2001) by WHO, which had mental health as its focal area, reported that the Human Rights Commission found "appalling and unacceptable" conditions in several psychiatric hospitals that they visited in India during 1995-2000[34]. Though the shortage of mental health facilities available to the large number of mentally ill people in India is certainly a concern, the immediate focus should be on ensuring better quality of care and treatment in the existing facilities rather than merely on expanding the number of such establishments.

Further, although the bill proposes the ambitious plan of guaranteeing the "right to access mental health care and treatment from mental health services run or funded by the appropriate Government" to everyone and "ensure that as a minimum, mental health services run or funded by Government shall be available in each district"[35], it hasn't outlined how such an endeavor would be funded. Around 200 districts in India are already covered under the District Mental Health Program as of now[36]. Restricted funding has been identified as one of the major roadblocks in the effective implementation of these programs, the others being shortage of human resources and low motivation levels among service providers[37]. The government has given no indication about how it is preparing to tackle this major financial hurdle. Estimates indicate that about 5.8% of Indians are currently suffering from serious mental disorders[38]. With the inclusive definition of

mental illness that the bill has proposed, this figure is likely to increase significantly, with a proportional increase in the need for mental health facilities and resources. Along with a dearth in the mental health facilities, there is also an enormous paucity of the human resources trained in treating mental illnesses. The Mental Health Atlas (2011) suggests that there are only 0.047 psychologists and 0.301 psychiatrists available per lakh of population in India[39]. The National Human Rights Commission's report on Mental Healthcare and Human Rights (2008) notes that "the gap between the resources — human, material and financial needed on account of the growing demand for mental health services and the available resources is our major concern"[40]. Additionally, the bill promises a reimbursement of the costs of treatment in any other mental health facility in case a government mental health establishment is not present in the district in which the concerned person resides[41]. The bill, however, is silent on the modalities for mobilizing such huge resources that will be required by the government to render quality care and support to the rising population of the mentally ill.

India's expenditure in the health sector was a meager 1.4% of the country's GDP in 2014, as per WHO global health expenditure estimates[42]. This places India among the countries spending the lowest on their healthcare; even lower than Nepal. Most other BRICS countries spent a higher amount ranging from 3.1% - 4.2% of their GDP on healthcare in 2014[43]. India had a conservative target of spending 2.5% of its GDP on health under the Twelfth Five Year Plan[44], which it clearly has failed to meet so far. The amount allocated to mental health by the Centre is a little over 1% of the health budget[45]. The States approximate that amount with slight variations. The implementation of the provisions, if the bill becomes an act, will be the primary responsibility of the Sates since health is a State Subject. However,

the responsibility of the Centre is not limited to enacting a law. The Centre must clearly outline the allotment of adequate funds to the states and the sharing of the financial burden if the provisions of the bill are to be meaningful. Unless the government comes up with a definite and unequivocal plan of resource allocation, this ambitious proposal is unlikely to meet with much success.

II. THE WAY FORWARD

The NHRC's report on Mental Healthcare and Human Rights (2008) has stressed on the importance of community care and deinstitutionalization involving treatment and care of people outside of an institution[46]. It notes that treatment within a hospital has severe limitations. Not only is institutionalized treatment expensive, but there is also a massive shortage of resources available for it and it is likely to be ineffective without community based support systems to reintegrate patients discharged from the hospitals back into the community. The Mental Healthcare Bill, 2016, however, has primarily stipulated the nuances of mental health establishments and related procedural details and has failed to pay sufficient attention to community based treatment and rehabilitation services. While the world is shifting its focus towards community care and treatment, a mere lip service given to it in the bill is far from adequate. It is imminent for the mental health legislation to outline the establishment, functioning and funding of community based treatment and rehabilitation programs for people with mental illness.

There is also a strong need to integrate social workers with the mental healthcare system in India. There is no dearth of cases where the mentally ill person has been

judged as fit for discharge by the doctor but has nowhere to go, with no relatives who visit and with an incorrect home address entered by the relatives on the admission form. In such cases where admitting a person with mental illness to a hospital is seen as a way to discard responsibility by the family, the social worker can act as an effective link between the two. It is strongly recommended that the importance of social workers should be emphasized with some of their key responsibilities being history taking, home visits, background checks, monitoring the progress of the patient and family involvement and effective integration of the patient with the family and the community.

In the future, the focus of mental health legislation needs to shift from the treatment of mental illness to the prevention of mental illness. Statistics

show that mental health related problems in India are on a rise. According to the World Health Report (2001) the suicide rates in India increased from 7.5 to 10.03 per lakh of population between 1987 and 1997[47]. An increase of 15.8% in the number of suicides committed in India has been recorded for the decade of 2004-2014 with an alarming 1.35 lakh deaths due to suicide in 2012, according to the report on Accidental Deaths and Suicides in India (2014) published by the National Crime Record Bureau[48]. The First WHO Report on Suicide Prevention (2014) reported that India accounted for the highest number of suicides in the world in 2012[49]. According to the WHO estimates of the burden of disease for 2012, India is also the most depressed and the most anxious country in the world[50] with 36% of Indians likely to suffer from major depression at some point in their lives[51]. The figures are equally dismal for other psychological disorders including schizophrenia. Yet, India has no national policy or program targeted at prevention of psychological illness. Merely allocating the duty of planning and designing programs for the prevention of mental illness and the promotion of mental health to the State government, as is stipulated in the bill, is certainly not enough. As the next step, there is a need to have specific national policies on preventive programs and the state governments may be entrusted with the responsibility of their execution and implementation.

Finally, for any mental health legislation to be comprehensive, it must address the huge gap that exists with respect to training and development of the human resources. According to the Mental Health Atlas (2011), the number of mental health professionals being trained in educational institutes is abysmally poor — the rate for psychologists being 0.010 per lakh and for psychiatrists being 0.0364 per lakh of population[52]. The bill has allocated the duty to collaborate with institutes of higher education to develop and implement training and educational programs and increasing the human

resources available to deliver mental health services to the State governments[53]. A mere provision of this nature is highly inadequate to cater to the current requirement. Considering the fact that the modalities for generating funds for this endeavor and the timelines within which the States are bound to meet such requirements have nowhere been outlined, it is highly likely that these obligations will largely remain unfulfilled by the States. A detailed legislation to strengthen the research and training activities in the country ascertaining a stronger mental healthcare workforce in the future is

urgently required. Addressing such a need in the United States of America, a bill on "Building a Health Care Workforce for the Future Act" was introduced in the United States House of Representatives in 2015. With the aim to amend the Public Health Service Act to help build a stronger health care workforce in the United States, the bill discusses the nuances of issuing grants to states for scholarship programs, increasing and improving mentorship in primary care, and developing and promoting new competencies[54]. Our country has much to learn from a legislation of this nature. Such lawmaking will be a progressive next step for India too.

Additionally, the bill doesn't grant any recognition to the importance of soft skill development and sensitivity training of mental health professionals. In *Chandan Kumar Banik* v. *State of W.B.*[55] the Supreme Court observed that the "management of an institution like the mental hospital requires flow of human love and affection, understanding and consideration for mentally ill persons; these aspects are far more important than a routinized, stereotyped and bureaucratic approach to mental health issues"[56]. The indifference and insensitivity towards mental illness that is rampant in the Indian mental health system needs to be urgently addressed. Effective and compassionate "care" to the mentally ill can be ensured only through a law that mandates and details the nuances of training programs - both technical and soft skill oriented - for the personnel whose services it seeks to utilize.

That said, there is no denying that a huge gap exists between the laws, as stated on paper, and the reality, as it exists. While the bill aims to ensure

the availability of mental health services at the level of every district, the ground reality is that even well-functioning state hospitals which are supposed to be equipped with mental health facilities do not even offer regular psychiatric outpatient services, leave alone in-patient care. In government hospitals, medication to treat even the more common psychiatric disorders is not always available. Addressing these and other deficiencies did not require a new law. All it did require was a strong will to ensure access to quality health services and a healthy life to all citizens, which still appears lacking. With the few legislators present while the Mental Healthcare Bill, 2016 was discussed in the parliament, their lax attitude and indifference towards mental health issues, lapses in implementation and poor services provided by mental health practitioners, the future of actualization of the new law appears grim.

Despite the gaps and limitations, the general expectation is that the bill will usher a new era of mental health care ensuring a life of dignity to people with mental illnesses. The success of this more progressive law, if it is brought in to replace the Mental Health Act, 1987, however, will depend ultimately on the community keeping up the pressure on the designated Central and State authorities to implement it in letter and spirit.

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[1] Indian Lunacy Act, 1912 (Act No. IV of 1912). Retrieved from http://www.rfhha.org/images/pdf/Hospital_Laws/Indian_lunacy_act_1912.pdf last accessed on October 17, 2016.

[2] The Mental Health Act, 1987 (Act No. 14 of 1987), Ministry of Law and Justice, Government of India. Retrieved from http://lawmin.nic.in/ld/P-ACT/1987/The%20Mental%20Health%20Act,%201987.pdf last accessed in October 16, 2016.

[3] The Mental Healthcare Bill, 2016 (Bill No. LIV-C of 2013) as passed by the Rajya Sabha on the 8th August, 2016. Retrieved from http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf last accessed on October 17, 2016.

[4] The Mental Health Act, 1987 (Act No. 14 of 1987), Ministry of Law and Justice, Government of India. Retrieved from http://lawmin.nic.in/ld/P-ACT/1987/The%20Mental%20Health%20Act,%201987.pdf last accessed in October 16, 2016.

[5] ibid.

[6] The Mental Healthcare Bill, 2016 (Bill No. LIV-C of 2013) as passed by the Rajya Sabha on the 8th August, 2016. Retrieved from http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf last accessed on October 17, 2016.

[7] *Ibid.*

[8] *Ibid.*

[9] The Mental Healthcare Bill, 2016 (Bill No. LIV-C of 2013) as passed by the Rajya Sabha on the 8th August, 2016. Retrieved from http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf last accessed on October 17, 2016.

[10] *Ibid.*

[11] *Ibid.*

[12] Antony, J.T. (2014). The mental health care bill 2013: A disaster in the offing?. *Indian Journal of Psychiatry*, 56(1), 3-7. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3927243/last accessed on October 11, 2016.

[13] The Mental Healthcare Bill, 2016 (Bill No. LIV-C of 2013) as passed by the Rajya Sabha on the 8th August, 2016. Retrieved from http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf last accessed on October 17, 2016.

[14] *Ibid.*

[15] *Ibid.*

[16] *Ibid.*

[17] Kala, A. (2013). Time to face new realities; mental health care bill-2013. *Indian Journal of Psychiatry*, 55(3), 216-219. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3777341/last accessed on October 11, 2016.

[18] ibid.

[19] The Mental Healthcare Bill, 2016 (Bill No. LIV-C of 2013) as passed by the Rajya Sabha on the 8th August, 2016. Retrieved from http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf last accessed on October 17, 2016.

[20] The Mental Healthcare Bill, 2016 (Bill No. LIV-C of 2013) as passed by the Rajya Sabha on the 8th August, 2016. Retrieved from http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf last accessed on October 17, 2016.

[21] Indian Penal Code, 1860 (Act No. 45 of 1860), Ministry of Law and Justice, Government of India. Retrieved from http://indiacode.nic.in last accessed on October 16, 2016.

[22] The Mental Healthcare Bill, 2016 (Bill No. LIV-C of 2013) as passed by the Rajya Sabha on the 8th August, 2016. Retrieved from http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf last accessed on October 17, 2016.

[23] *Ibid.*

[24] *Ibid.*

[25] The Mental Healthcare Bill, 2016 (Bill No. LIV-C of 2013) as passed by the Rajya Sabha on the 8th August, 2016. Retrieved from http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf last accessed on October 17, 2016.

[26] The World Health Report 2001, Mental Health: New Understanding, New Hope, World Health Organization.

Retrieved from http://www.who.int/whr/2001/en/whr01_en.pdf last accessed on October 16, 2016.

[27] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[28] The Mental Healthcare Bill, 2016 (Bill No. LIV-C of 2013) as passed by the Rajya Sabha on the 8th August, 2016. Retrieved from http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf last accessed on October 17, 2016.

[29] *Ibid.*

[30] The Mental Healthcare Bill, 2016 (Bill No. LIV-C of 2013) as passed by the Rajya Sabha on the 8th August, 2016. Retrieved from http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf last accessed on October 17, 2016.

[31] *Ibid.*

[32] *Ibid.*

[33] WHO Mental Health Atlas 2011, Department of Mental Health and Substance Abuse, World Health Organization. Retrieved from http://www.who.int/mental_health/evidence/atlas/profiles/ind_mh_profile.pdf?ua=1 last accessed on October 16, 2016.

[34] National Human Rights Commission (1999). Quality assurance in mental health. In World Health Report 2001, Mental Health: New Understanding, New Hope, World Health Organization. Retrieved from http://www.who.int/whr/2001/en/whr01_en.pdf last accessed on October 17, 2016.

[35] The Mental Healthcare Bill, 2016 (Bill No. LIV-C of 2013) as passed by the Rajya Sabha on the 8th August, 2016. Retrieved from http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf last accessed on October 17, 2016.

[36] Mascarenhas, A. (2016, May 19). Mental illness India's ticking bomb, only 1 in 10 treated: Lancet study. *The Indian Express.* Retrieved from http://indianexpress.com/article/india/india-news-india/mental-illness-indias-ticking-bomb-only-1-in-10-treated-lancet-study-2807987/last accessed on October 3, 2016.

[37] *Ibid.*

[38] Reddy, B.V., Gupta, A., Lohiya, A. & Kharya, P. (2013). Mental Health Issues and Challenges in India: A Review. *International Journal of Scientific and Research Publications*, 3(2). Retrieved from http://www.ijsrp.org/research-paper-0213/ijsrp-p14129.pdf last accessed on October 12, 2016.

[39] Mental Health Atlas 2011, Department of Mental Health and Substance Abuse, World Health Organization. Retrieved from http://www.who.int/mental_health/evidence/atlas/profiles/ind_mh_profile.pdf?ua=1 last accessed on October 16, 2016.

[40] Mishra, L. (2008). Human rights in mental health care: an introduction. In D. Nagaraja, & P. Murthy (Ed.), *Mental Healthcare and Human Rights* (pp. 15-35). New Delhi: National Human Rights Commission. Retrieved from http://www.bhrc.bih.nic.in/Docs/Mental-HealthCare-and-Human-Rights.pdf last accessed on October 3, 2016.

[41] The Mental Healthcare Bill, 2016 (Bill No. LIV-C of 2013) as passed by the Rajya Sabha on the 8th August, 2016. Retrieved from http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf last accessed on October 17, 2016.

[42] Global Health Expenditure database, World Health Organization. Retrieved from http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS last accessed on October 16, 2016.

[43] Global Health Expenditure database, World Health Organization. Retrieved from http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS last accessed on October 16, 2016.

[44] Twelfth Five Year Plan (2012-2017), Planning Commission, Government of India. Retrieved from http://planningcommission.gov.in/plans/planrel/12thplan/pdf/12fyp_vol3.pdf last accessed on October 16, 2016.

[45] Editorial. (2016, August 13). A new deal for mental health. *The Hindu*. Retrieved from http://www.thehindu.com/opinion/editorial/mental-health-care-bill-2016-and-rajya-sabha/article8981801.ece last accessed on October 03, 2016.

[46] Mishra, L. (2008). Human rights in mental health care: an introduction. In D. Nagaraja, & P. Murthy (Ed.), *Mental Healthcare and Human Rights* (pp. 15-35). New Delhi: National Human Rights Commission. Retrieved from http://www.bhrc.bih.nic.in/Docs/Mental-HealthCare-and-Human-Rights.pdf last accessed on October 3, 2016.

[47] The World Health Report 2001, Mental Health: New Understanding, New Hope, World Health Organization. Retrieved from http://www.who.int/whr/2001/en/whr01_en.pdf last accessed on October 16, 2016.

[48] Accidental deaths & suicides in India 2014, National Crime Records Bureau, Ministry of Home Affairs, Government of India. Retrieved from http://ncrb.nic.in/StatPublications/ADSI/ADSI2014/adsi-2014%20full%20report.pdf last accessed on October 16, 2016.

[49] First WHO report on suicide prevention (2014), World Health Organization. Retrieved from http://www.who.int/mediacentre/news/releases/2014/suicide-prevention-report/en/last accessed on October 16, 2016.

[50] Disease Burden Estimates for 2000-2012, World Health Organisation. Retrieved from http://www.who.int/healthinfo/global_burden_disease/estimates/en/index2.html last accessed on October 16, 2016.

[51] Hiranandani, N. (2016, February 15). With 36% of India depressed, we must end taboo around mental health. *The Indian Express*. Retrieved from http://indianexpress.com/article/blogs/with-36-of-india-depressed-we-must-end-taboo-around-mental-health/last accessed on October 3, 2016.

[52] Mental Health Atlas 2011, Department of Mental Health and Substance Abuse, World Health Organization. Retrieved from http://www.who.int/mental_health/evidence/atlas/profiles/ind_mh_profile.pdf?ua=1 last accessed on October 16, 2016.

[53] The Mental Healthcare Bill, 2016 (Bill No. LIV-C of 2013) as passed by the Rajya Sabha on the 8th August, 2016. Retrieved from http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf last accessed on October 17, 2016.

[54] Building a Health Care Workforce for the Future Act (H.R. 1006 — 114th Congress, 2015-2016) as introduced in the House of Representatives on February 13, 2015. Retrieved from https://www.congress.gov/bill/114th-congress/house-bill/1006/text?q=%7B%22search%22%3A%5B%22%5C%22hr1006%5C%22%22%5D%7D&resultIndex=1last accessed on October 17, 2016.

[55] 1995 Supp (4) SCC 505.

[56] Mishra, L. (2008). Human rights in mental health care: an introduction. In D. Nagaraja, & P. Murthy (Ed.), *Mental Healthcare and Human Rights* (pp. 15-35). New Delhi: National Human Rights Commission. Retrieved from http://www.bhrc.bih.nic.in/Docs/Mental-HealthCare-and-Human-Rights.pdf last accessed on October 3, 2016.