[Downloaded free from http://www.indjsp.org on Friday, August 10, 2018, IP: 137.97.82.183]

Viewpoint/Perspectives (Theme Section: Mental Health Care Bill, 2013)

Recent Developments in Community Mental Health: Relevance and Relationship with the Mental Health Care Bill

Rakesh Kumar Chadda, Bichitra Nanda Patra, Nitin Gupta[1]

Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, [1]Department of Psychiatry, Government Medical College and Hospital, Chandigarh, India

Abstract

Community mental health refers to the treatment of persons with mental disorders in the community. In the earlier periods, treatment of patients with mental illness was limited to the mental hospitals or asylums. This paper traces the beginnings of community psychiatry in India from the time Dr. Vidya Sagar initiated his famous experiment of treating patients with mental illnesses along with family members in tents outside the mental hospital, Amritsar. It then discusses the role of the National Mental Health Program and the District Mental Health Program. The role of the United Nations Convention on the Rights of Persons with Disability in leading onto the development of the current Mental Health Care Bill, 2013 is discussed. Authors critically evaluate some of the merits and drawbacks of the Bill as related to recent developments in community mental health in India.

Key Words: *Community, law, mental health*

Introduction

Community mental health refers to the treatment of persons with mental health problems in community setups. Such setups include community mental health clinics and other health services located in the community, primarily any service away from a custodial care mental health setting. Community psychiatry movement started more than 100 years ago, with the purpose of rehabilitation of the persons with mental illnesses in the community after a prolonged hospitalization in the mental hospitals. There were also concerns about violation of basic human rights of the persons with mental illness and the ill effects of institutionalization. Further revolutions in psychopharmacology have contributed a lot to the growth of community mental health.

Whether the community mental health services should be regulated by the common law of the land or the mental health legislation is debatable? In this background, it would be worthwhile to review the types of mental health services available in the community, and then consider whether these require any legal help or supervision. If yes, what could be the legal framework needed to regulate their functioning. In India, the recently introduced Mental Health Care Bill (MHCB), latest revision being the MHCB, 2013, has a number of sections which have the potential of influencing the community mental health services in India. These sections are critically evaluated in this paper.

Address for correspondence: Dr. Rakesh Kumar Chadda, Department of Psychiatry, All India Institute of Medical Sciences, New Delhi - 110 029, India. E-mail: drrakeshchadda@gmail.com

Access this article online

Quick Response Code:

Website: www.indjsp.org

DOI: 10.4103/0971-9962.173296

Community Mental Health in India

Beginnings

In India, traditionally the persons with mental illnesses have been taken care of in the community by the family members. During the colonial rule by the British, a number of asylums or mental hospitals were opened in India, mostly for the British soldiers and the British who suffered from mental illnesses. Most of these hospitals continued after India got independence in 1947, and many more were built in the next few decades though the number was much less than what existed in the West.

In the last three decades, many reforms have been initiated in the mental hospitals in India by involving the family members of the persons admitted and those attending the outpatient services. The strength of joint family, marriage, the close-knit community, greater tolerance of deviant behavior in the larger community, religion and faith-based coping and healing have all contributed to a large number of persons with various mental disorders being taken care of in the community in India.[1] Globally, the gradual closure of the mental hospitals has occurred due to the issues of

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as the author is credited and the new creations are licensed under the identical terms.

For reprints contact: reprints@medknow.com

How to cite this article: Chadda RK, Patra BN, Gupta N. Recent developments in community mental health: Relevance and relationship with the mental health care bill. Indian J Soc Psychiatry 2015;31:153-60.

[Downloaded free from http://www.indjsp.org on Friday, August 10, 2018, IP: 137.97.82.183]

repeated cases of ill-treatment of patients, geographical and professional isolation of the institutions and the staff, failure of management and leadership, poorly targeted financial resources, poor staff training, and inadequate inspection and quality assurance procedures.[2] On the other hand, the mental hospitals in India have modified by developing training facilities, expanding outpatient and community services, and also downsizing the inpatient units.[3] In India, no mental hospital was closed unlike in the West, where it was a common phenomenon in the second half of the last century.

Involving families in taking care of the patients under care of mental health services have been a unique contribution from India. It was initiated by Dr. Vidya Sagar in 1950s at Amritsar Mental Hospital followed by the Mental Health Centre at Christian Medical College, Vellore, and All India Institute of Mental Health, Bengaluru, in 1960s. Family members would actually be admitted along with the persons with mental illness to be a part of the care for the patient. This practice has been continued in most of the general hospital psychiatric units (GHPUs), which developed from 1960s onward in India. During the 1970s and 1980s, efforts were also made to understand the functioning of families with an ill person in the family and their needs.

National Mental Health Programme

In the next phase, emphasis was on utilization of the existing general health care infrastructure through integration of mental health services with general health services. This occurred along with the development and expansion of the GHPUs. During this period, many community mental health outreach services were also started all over the country. The most important development was of the launching of the National Mental Health Programme (NMHP) of India in 1982, and later the District Mental Health Programme (DMHP) in a stepwise fashion from 1996 onward.[4,5]

NMHP was launched with the objectives to ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population; to encourage the application of mental health knowledge in general healthcare and in social development; and to promote community participation in the mental health service development, and to stimulate efforts toward self-help in the community. The thrust was on decentralization of the mental health services. The main strength of the NMHP was the mutually synergistic integration of mental health care with general primary health care.

DMHP was launched in 1996 with four districts, based on earlier experiences at Bellary District, Karnataka State. DMHP envisaged a community-based approach to the problem, which included training of mental health team at identified nodal institutions; increasing awareness about the mental health problems, and reducing the associated stigma provision of services for early detection and treatment of mental disorders in the community, and collecting information and getting experience at the level of community for future planning. It followed a more realistic and practical approach compared to the ambitious aims of the NMHP. Presently, the DMHP has been implemented in 241 districts of the country, and it is proposed to expand it to more districts. Currently, the emphasis is on a judicious balance between various components of the mental health care delivery system with clearly specified budgetary allocations. A plan for integration of NMHP with National Rural Health Mission (later renamed as the National Health Mission) was also developed.[6-8] Under the restrategized program, a number of centers of excellence in mental health have been established all over the country to enhance the manpower with facilities of providing training for psychiatrists, clinical psychologists, psychiatric nurses, and psychiatric social workers. Many GHPUs of the medical colleges have also been given funds to enhance their capacity for training of psychiatrists as well as to start courses in the paramedical fields.[9] Following the implementation of NMHP and DMHP, there has been a significant improvement in human resource development. The public awareness has also increased enormously due to community-based mental health care, and the trained mental health professionals working in remote areas in the private sector as well as due to a massive effort by professionals to address the general public with modern mental health information. The Indian Council of Medical Research severe mental morbidity demonstration project showed that about 20% of people with mental disorders could be brought into care with this approach. However, the population covered was very small in comparison to the national need.[10]

Role of voluntary sector

Another important development in community psychiatry in India is the increasing role of voluntary organizations in developing small-size locally relevant community-based psychiatric care facilities such as day care centers, vocational training centers, sheltered workshops, half-way homes, and long stay homes.[11] Community-based mental health services are currently offered by multiple settings in primary care as extension clinics under the DMHP, district hospitals, the GHPUs, community psychiatry programs by certain tertiary care centers; and in the private sector by many private general hospitals, psychiatric nursing homes, and office-based practice. Most of the community-based mental health services are not currently covered under the Mental Health Act (MHA).

During the last 20 years, a more active role for families has emerged in the form of formation of self-help groups and professionals accepting to work with families in

[Downloaded free from http://www.indjsp.org on Friday, August 10, 2018, IP: 137.97.82.183]

partnership. However, many of the leads provided by pilot studies and successes of family care programs have not received the support of professionals and planners to the extent it could become a routine part of psychiatric care in the 21st century.[10] There has been an increasing recognition of the value of family involvement in mental health care even in the developed countries.[12]

Recently, for the first time in India, a mobile telepsychiatry unit commissioned by Schizophrenia Research Foundation (SCARF) and supported by the Tata Educational Trust was initiated in 2011. The program includes a bus with teleconferencing facilities, a computer for data storage, and a large television (TV) fixed at its rear. The TV is used for awareness programs in the villages. The bus moves from village to village accessing persons with mental illness. After the psychiatric consultation through linking with Chennai SCARF office, the medicines are given from the pharmacy located on the bus. There have also been developments in telepsychiatry-based services at other places in the country including the All India Institute of Medical Sciences, New Delhi, and the Postgraduate Institute of Medical Education and Research, Chandigarh. Feasibility of linking mental health services in distant locations to the central place has also been studied at Chandigarh.[12]

Research in community psychiatry

In addition to community mental health services, there has been a considerable progress in the community mental health research in India. Many epidemiological studies of psychiatric disorders have been conducted in India on the general population in the community. There is a great variation in the reported prevalence rate which varies from 9.5 to 370/1000 of the population. However, this discrepancy is not limited to the Indian epidemiological studies but has also been observed in international studies such as the Epidemiological Catchment Area Program and the National Comorbidity Survey.[13] However, the number of psychiatric epidemiological studies (community-based and school-based) exclusively on a child and adolescent population is limited compared to those conducted on the adult population.

As India is a culturally diverse country, explanations for mental disorders have been influenced by systems of traditional medicine and supernatural beliefs. Psychiatric disorders in India are often attributed to the influence of supernatural phenomena.[14,15] The beliefs and/or explanatory models held by patients or caregivers of various psychiatric disorders have been studied in India.[14,16-18] This belief system also influences the help-seeking behavior or pathways to care.[19] Beliefs about supernatural causation of illness and greater superstitious beliefs about mental illness are associated with the appearance of religious healers in the pathway of psychiatric care.[20] The pathways to care in various psychiatric disorders have been evaluated by many Indian researchers.[19,21-24]

Apart from these areas, the effectiveness of various community-based interventions by nonspecialists has also been examined. The Community Care for People with Schizophrenia in India (COPSI) study examined the clinical effectiveness of a collaborative community-based care for people with schizophrenia and their caregivers.[25] The intervention was delivered by community health workers who had at least 10 years of schooling and good interpersonal skills. These workers were systematically trained over 6 weeks and assessed for competence. The intervention was delivered in three phases: An intensive engagement phase in the initial 3 months which included 6–8 home visits made by community health workers; a stabilization phase spread over another 3–4 months which included fortnightly sessions, and a maintenance phase in the last 4 months with monthly sessions. The components of this collaborative community-based care intervention were structured need assessments and clinical reviews, psychoeducation, adherence management strategies, rehabilitation strategies, dealing with stigma and discrimination, and linkage to self-help groups. The COPSI trial found that the collaborative community-based care plus facility-based care intervention is modestly more effective than a facility-based care, especially in reducing disability and symptoms of psychosis. The authors proposed that the intervention can be implemented in settings where services are scarce, for example, in rural areas by the nonspecialists.[25] The study had used a 3-tier model for the delivery of mental health services consisting of an outpatient program, deployment of mental health workers for community care, and involvement of the family members and key people in the community in form of local health groups. The "compliance with treatment" rate was much higher in the active arm (63%) compared with another group, which used only the outpatient service (46%). The compliant participants had significantly better outcomes compared with partially compliant or noncompliant participants. Mental health workers, who had been taken from the local community, communicated effectively with patients and their families and used shared cultural idioms, thus promoting greater adherence to treatment. Though Gupta and Srinivasamurthy[26] have critiqued the COPSI trial regarding its implementation in areas where services are scarce as per the authors,[25] it is one of the landmark studies with significant potential for impact. Community-based rehabilitation by trained rehabilitation workers has also been found to be a feasible and acceptable intervention with a beneficial impact on disability for the majority of people with psychotic disorders (schizophrenia, bipolar affective disorder, and other psychosis) in low-resource settings.[27]

Similar results have also been found in the case of common mental (depression and anxiety) disorders. A collaborative stepped-care intervention with case management and psychosocial interventions provided by a trained lay health

[Downloaded free from http://www.indjsp.org on Friday, August 10, 2018, IP: 137.97.82.183]

counselor and supplemented by antidepressant drugs by the primary care physician with supervision by a mental health specialist has been found to improve recovery from depression and anxiety disorders, suicidal behavior, and psychological morbidity, and reduction in disability days among those attending public primary care facilities.[28,29]

Mental Health Legislation and Community Mental Health Services

There are different approaches toward mental health legislation in various countries. In some, there is no separate mental health law, and provisions related to mental health care are inserted into relevant laws concerning general health, employment, and criminal justice. This is often called the "dispersed law" approach. On the other hand, some countries have a consolidated mental health law where all issues of relevance to mental health care have been brought together under a single law. Most countries, including India, have a combined approach and have an MHA, mainly concerned with issues of treatment, particularly involuntary admission and the protection of human rights of the mentally ill.[30]

Admission to the mental hospitals is generally regulated by the mental health legislation of the country. In India, earlier it was regulated by the Indian Lunacy Act, 1912, and since 1993 by the MHA, 1987. MHA, 1987, includes psychiatric inpatient units of the private general hospitals under the broad category of psychiatric hospitals/nursing homes, making it mandatory for them to admit/discharge the patients as per the act. With the downsizing of the mental hospitals across the world and also in India, the relevance of community mental health services becomes more relevant. With a huge gap between the mental health needs and the available resources, strict legal regulations sometimes become counterproductive with lesser and lesser mental health professionals becoming interested in developing community mental health services, especially those with facilities for emergency and inpatient treatment.

For the acute psychiatric crises, which constitute a vast majority of psychiatric admissions in the country, involuntary admissions should be accommodated in the GHPUs (besides the mental hospitals) as well as the nursing homes. Facility of brief hospitalization of such nature should also be available in primary care and community settings. The procedure for such admissions should be less cumbersome to facilitate a convenient access to treatment even in remote parts of the country. Typically, such admissions would usually last from a few days to few weeks. The requirement for licensing and monitoring of institutions under MHA has negatively impacted the growth of acute care services in general hospital settings, especially in private sector.[30] NMHP and DMHP have envisioned a decentralized community-based approach to the problem of the mental health gap, which aim at the adequate provision of services in the periphery to promote early detection and treatment of mental illness in the community itself with facilities of outpatient as well as indoor treatment and appropriate follow-up measures. However, the MHA with its stringent licensing protocol and focus on legal issues is not in keeping with the goals of the NMHP.

Some of the foreign countries have laws which allow for the involuntary treatment of the patients in the community. In the USA, it is known as assisted outpatient treatment or Kendra's Law and was named after Kendra Webdale, a young woman who died in 1999 after being pushed in front of a New York City subway train by a person who failed to take the medication prescribed for his mental illness. In the UK and Australia, it is known as community treatment order. However, this type of law is lacking in our country. It is high time that such a provision is introduced in the mental health law in our country.

United Nations Conventions on the Rights of Persons with Disabilities

The United Nations Conventions on the Rights of Persons with Disabilities (UNCRPD) was adopted by the UN General Assembly in December 2006. The purpose was to promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedom by all persons with disabilities and to promote respect for their inherent dignity. Persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The principles of the UNCRPD include respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons; nondiscrimination; full and effective participation and inclusion in society; respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; equality of opportunity; accessibility; equality between men and women; and, respect for the evolving capacities of children with disabilities and respect for the rights of children with disabilities to preserve their identities.

The UNCRPD requires signatory states to make appropriate changes in law and policy to give effect to rights of disabled persons, and hence the amendments in MHA, 1987, are in process, and the MHCB has been drafted. This aspect of the relation of UNCRPD and the MHCB (2013) has already been discussed in detail in an earlier article in this issue by Chaturvedi *et al*.[31] and briefly referred to in the next section.

Mental Health Care Bill and Community Mental Health

After India signed and ratified the UNCRPD, 2006, Ministry of Health and Family Welfare (MOHFW),

[Downloaded free from http://www.indjsp.org on Friday, August 10, 2018, IP: 137.97.82.183]

Government of India initiated the exercise of revising the MHA1987 in 2010 to bring it in harmony with the UNCRPD. The Centre for Mental Health Law and Legislation, Indian Law Society, Pune, was given the responsibility of developing the proposed legislation. The first draft was circulated in February 2010 and a revised draft in April 2010. After nationwide consultations with various stakeholders, in which the Indian Psychiatric Society and the Indian Association for Social Psychiatry also took an active part, a modified draft was submitted to the MOHFW in March, 2011. This modified draft has gone through further consultation process by the government and is the new proposed MHCB. The new MHCB is longer than the existing MHA, and has 16 chapters and 136 clauses. The new Bill has many provisions for community care for patients with psychiatric illnesses.

There has been a lot of criticism of the MHCB. The inclusion of conditions associated with alcohol and drug abuse as mental illness in the definition is a welcome process as the prevalence of drug and alcohol use disorders is quite high in the community. However, the over-inclusive definition of mental illness may also bring the nonsevere mental illness under this law, which may increase the stigma toward the mental illness. Another unwelcome process is including GHPUs under the purview of this law. Most of the psychiatric admissions in India (some of which are also involuntary, but with consent of the family members) in the acute stage take place in the GHPUs. Once the GHPUs are brought under the MHCB, they will not be able to do involuntary admission, except for emergency situations. Large numbers of patients, who are suffering from nonpsychotic minor psychiatric ailments, also take benefit of these GHPU without any adverse stigma. If the services are not available in their vicinity but at a remote and secluded place, the stigma attached even to minor psychiatric illnesses would get accentuated. Psychiatry is essentially a branch of medicine, and it must function as such. If GHPUs are not encouraged, psychiatry will not be able to function properly as a branch of medicine and will be cut off from the mainstream medical system. The Medical Council of India norms stipulate that all medical colleges, which are providing undergraduate or postgraduate education, must have specified number of beds in psychiatry. After the MHCB comes into force, it will be a statutory requirement for all the medical colleges to get themselves registered as mental health establishment under MHCB. This will prove to be cumbersome for the medical colleges to get another registration with the MHCB and also would accentuate the stigma of mental illness in the community.[32] However, not including the GHPUs under any law has been criticized by the human rights activists and nongovernmental organizations, who are projecting the hospitals as the "trade unionists," not wanting regulation and monitoring.[33]

As per this Bill, unmodified electroconvulsive therapy (ECT) is going to be banned. In many parts of our country, still direct ECT is practiced, as the anesthetists are not available at many places even in the district hospitals. Research has also shown that the risk of muscular and skeletal injuries with direct ECT may be overstated. The risk of injury can potentially be modified by administering a sedative drug (diazepam) before the procedure as diazepam acts as a muscle relaxant.[34,35] In addition, the data available to ban direct ECT are not sufficient.[36,37]

This Bill has also a provision to prohibit ECT to the minors. However, ECT has been found to be effective in the acute management of severe psychiatric disorders in children and adolescents.[38,39] Therefore, the prohibition of ECT to the children and adolescents as per this Bill has been criticized.[40] A detailed discussion of ECT in relation to the MHCB (2013) has already been discussed in detail in an earlier article in this issue by Gangadhar *et al*.[41]

According to Clause 18 of the MHCB, "every person shall have a right to access mental health care and treatment from mental health services run or funded by the appropriate Government." If a particular district has no public mental health services, the individual has a right to access private mental health services and get a refund for the expenses incurred. The state governments are mandated by the Bill to provide essential psychotropic medications free of cost. The insurance companies will have to consider mental illness at par with physical illnesses and will not be allowed to include mental illness as one of the exclusion criteria. These measures have been considered as progressive and "pro-poor." Combining this binding legislative measure with the policy measure of a revamped and upgraded DMHP, which plans to cover all the districts in a graded fashion, one has an ambitious blueprint of a network of mental health services free of cost to those who cannot afford it.[42] The Bill also states that there should be half-way homes, sheltered accommodation, supported accommodation, home-based or community-based rehabilitation services available for the patients. As per the Bill, the government should integrate mental health services into general health care services at all levels of health care including primary, secondary, and tertiary health care, and in all health programs run by the appropriate agency. The government should provide treatment in a manner, which supports persons with mental illness to live in the community and with their families. The government should plan, design, and implement programs for the promotion of mental health and prevention of mental illness and implement public health programs to reduce suicides and attempted suicides in the country. There should be awareness about mental health and illness and measures to reduce stigma associated with mental illness.

Though these are good provisions, considering India is a resource constraint country how much of this would be

[Downloaded free from http://www.indjsp.org on Friday, August 10, 2018, IP: 137.97.82.183]

feasible, is questionable. Going into the logistic issues, how the required mental health resources including the manpower and the services would be created, is difficult to answer. Health being a state subject, how this Act will come into force, especially in respect of creating the service structure with meager funds available with state, especially for mental health remains a big question to answer. There is scarcity of primary care centers, limited availability of basic psychotropic medications, lack of trained manpower and many social and physical health needs.[43] There has been a gap between needs and services for mental health, especially in low- and middle-income countries. Presently, most of the mental health care is institution-based with poor attention to community mental health.[44] The total number of psychiatrists in India was projected to be 15,400 in 2020 from 1500 in 1990.[45] It is difficult for a country like India to meet such a huge target with meager mental health resources coupled with very slow development in the area of psychiatry. Hence, the MHCB 2013 appears to be like a vision or policy document rather than the draft of an act.

In the new Bill, there is also a provision to introduce the use of advance directive in psychiatry. The advance directive is a statement of an individual's preference for future treatment. The concept initially evolved in the context of end-of-life treatment decision making. Subsequently, in some countries, advance directives have been promoted in the care and treatment of people with serious mental disorders. This has recently also been endorsed by the UNCPRD. An advance directive is a mandate that specifies a person's preferences for treatment, should she/he lose the capacity to make treatment decisions in the future.[46] The Bill states that, every person, who is not a minor, shall have a right to make an advance directive in writing, specifying any or all of the following: (a) The way the person wishes to be cared for and treated for a mental illness; (b) the way the person wishes not to be cared for and treated for a mental illness; and (c) the individual or individuals, in order of precedence, he/she wants to appoint as his/her nominated representative. This protects the basic rights of the patients and engages them in making treatment decisions which can help decrease coercion, increase treatment collaboration, motivation, and adherence, and help avoid conflict over treatment and medical issues.[47] As per the advance directive, if a patient wants to be treated in the community and not in a hospital setting, he/she can be treated in the community.

However, the competency of the person declaring advance directive will be decided by a medical practitioner, who may not be a psychiatrist or may be a physician from alternative medicine (not qualified in modern medicine). In this case, there is possibility of missing out the signs/symptoms of severe mental illness. This has more relevance in the Indian context considering limited awareness, sensitization or exposure to psychiatry of our general physicians or nonpsychiatric specialists. Considering the mental health resource constraint in our country, though we do not assure mental health care, we give an option to a person to refuse treatment. This gives too much importance to an individual autonomy for making a choice about treatment, when none may actually be available. Thus, the concept may not have any utility in our country, unlike the West. More so, the Indian society is collectivistic and promotes social cohesion and interdependence. The traditional Indian joint family, which follows the same principles of collectivism, has proved itself to be an excellent resource for the care of the mentally ill. The collective goals and rights of the family are culturally considered at par with individual rights.[48] Furthermore, this will increase legal hassle and increase the load of pending cases.

In a randomized controlled trial involving adults with severe mental illnesses, comparing any form of advance directive with standard care for health service and clinical outcomes, no significant difference in hospital admissions or number of psychiatric outpatient attendees was found between participants who had given an advanced treatment directive and the others. No significant difference was observed in mean bed days, compliance with treatment, self-harm or number of arrests. However, participants who had given advanced treatment directives needed less use of social workers time than the usual care group, and violent acts were also lower in the group. The number of people leaving the study early was not different between the two groups.[49,50] A recent Cochrane review does not recommend advance treatment directives for people with severe mental illness due to the lack of supporting data.[51] As there are no Indian studies available on this, the role of psychiatric advance directives in treatment process needs to be researched.

The provision of nominated representative in the MHCB also makes the issue of service provision a bit complicated. As per the concept, every person who is not a minor shall have a right to appoint a nominated representative. The nominated representative shall not be a minor, be competent to discharge the duties or perform the functions assigned to him under this Act. Hence, during treatment process, many times the nominated representative will be asked to initiate relevant treatment. The concept of nominated representative and advanced directive is discussed in detail in another paper in this issue by Sarin.[52]

Conclusion

There are many flaws in MHCB. However, if it comes into force, it is expected to protect the rights of the patients with mental illness which will prevent their exploitation and abuse. This has particular relevance in the Indian context considering the poor socioeconomic status of the people and limited awareness regarding mental illness

[Downloaded free from http://www.indjsp.org on Friday, August 10, 2018, IP: 137.97.82.183]

in the community. The new mental health law will also be in harmony to the UNCRPD. However, considering the drawbacks, it may legalize and bureaucratize most of the treatment process, which may become a hassle to the patients, family members, and the treating doctors, hampering the community mental health movement.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

References

1. Isaac M. Introduction. In: Chavan BS, Gupta N, Arun P, Sidana A, Jadhav S, editors. Community Mental Health in India. New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.; 2012. p. xxxv-xli.
2. Thornicroft G, Tansella M. Balancing community-basedand hospital-based mental health care. World Psychiatry 2002;1:84-90.
3. Sharma SD, Chadda RK. Mental Hospitals in India: Current Status and Role in Mental Health Care. Delhi: Institute of Human Behaviour and Allied Sciences; 1996.
4. Murthy RS. The relevance of community psychiatry in India. In: Chavan BS, Gupta N, Arun P, Sidana A, Jadhav S, editors. Community Mental Health in India. New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.; 2012. p. 3-22.
5. Murthy RS. Mental health in the new millennium: Research strategies for India. Indian J Med Res 2004;120:63-6.
6. Murthy RS. Mental health initiatives in India (1947-2010). Natl Med J India 2011;24:98-107.
7. Agarwal SP, Ichhpujani RL, Shrivastava S, Goel DS. Restructuring the national mental health programme. In: Agarwal SP, Goel DS, Salhan RN, Ichhpujani RL, Shrivastava S, editors. Mental Health: An Indian Perspective (1946–2003). New Delhi: Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India/Elsevier; 2004. p. 119-22.
8. Goel DS. Why mental health services in low- and middle-income countries are under-resourced, underperforming: An Indian perspective. Natl Med J India 2011;24:94-7.
9. Available from: http://www.mohfw.nic.in/WriteReadData/l892s/9903463892NMHP%20detail.pdf. [Last accessed on 2015 Apr 18].
10. Murthy RS. From institutions, to clinics to community: Development of community mental health in the last 50 years and looking to the future. In: Malhotra S, Chakrabarti S, editors. Development in Psychiatry in India: Clinical, Research and Policy Perspectives. New Delhi: Springer; 2015. p. 419-37.
11. Patel V, Thara R. Meeting the Mental Health Needs of Developing Countries: NGO Innovations in India. New Delhi (India): Sage; 2003.
12. Malhotra S, Chakrabarti S, Shah R. Telepsychiatry: Promise, potential, and challenges. Indian J Psychiatry 2013;55:3-11.
13. Math SB, Chandrashekar CR, Bhugra D. Psychiatric epidemiology in India. Indian J Med Res 2007;126:183-92.
14. Kulhara P, Avasthi A, Sharma A. Magico-religious beliefs in schizophrenia: A study from north India. Psychopathology 2000;33:62-8.
15. Khandelwal SK, Jhingan HP, Ramesh S, Gupta RK, Srivastava VK. India mental health country profile. Int Rev Psychiatry 2004;16:126-41.
16. Saravanan B, Jacob KS, Johnson S, Prince M, Bhugra D, David AS. Belief models in first episode schizophrenia in South India. Soc Psychiatry Psychiatr Epidemiol 2007;42:446-51.
17. Savarimuthu RJ, Ezhilarasu P, Charles H, Antonisamy B, Kurian S, Jacob KS. Post-partum depression in the community: A qualitative study from rural South India. Int J Soc Psychiatry 2010;56:94-102.
18. Patra BN, Grover S, Aggarwal M, Avasthi A, Chakrabarti S, Malhotra S. Explanatory models in patients with obsessive compulsive disorder: An exploratory study. Indian J Soc Psychiatry 2013;29:38-45.
19. Chadda RK, Agarwal V, Singh MC, Raheja D. Help seeking behaviour of psychiatric patients before seeking care at a mental hospital. Int J Soc Psychiatry 2001;47:71-8.
20. Faizan S, Raveesh BN, Ravindra LS, Sharath K. Pathways to psychiatric care in South India and their socio-demographic and attitudinal correlates. BMC Proc 2012;6 Suppl 4:13.
21. Lahariya C, Singhal S, Gupta S, Mishra A. Pathway of care among psychiatric patients attending a mental health institution in central India. Indian J Psychiatry 2010;52:333-8.
22. Mishra N, Nagpal SS, Chadda RK, Sood M. Help-seeking behavior of patients with mental health problems visiting a tertiary care center in North India. Indian J Psychiatry 2011;53:234-8.
23. Pradhan SC, Singh MM, Singh RA, Das J, Ram D, Patil B, *et al.* First care givers of mentally ill patients: A multicenter study. Indian J Med Sci 2001;55:203-8.
24. Grover S, Patra BN, Aggarwal M, Avasthi A, Chakrabarti S, Malhotra S. Relationship of supernatural beliefs and first treatment contact in patients with obsessive compulsive disorder: An exploratory study from India. Int J Soc Psychiatry 2014;60:818-27.
25. Chatterjee S, Naik S, John S, Dabholkar H, Balaji M, Koschorke M, *et al.* Effectiveness of a community-based intervention for people with schizophrenia and their caregivers in India (COPSI): A randomised controlled trial. Lancet 2014;383:1385-94.
26. Gupta N, Srinivasamurthy R. The COPSI trial: Additional fidelity testing needed. Lancet 2014;384:1572-3.
27. Chatterjee S, Pillai A, Jain S, Cohen A, Patel V. Outcomes of people with psychotic disorders in a community-based rehabilitation programme in rural India. Br J Psychiatry 2009;195:433-9.
28. Patel V, Weiss HA, Chowdhary N, Naik S, Pednekar S, Chatterjee S, *et al.* Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): A cluster randomised controlled trial. Lancet 2010;376:2086-95.
29. Patel V, Weiss HA, Chowdhary N, Naik S, Pednekar S, Chatterjee S, *et al.* Lay health worker led intervention for depressive and anxiety disorders in India: Impact on clinical and disability outcomes over 12 months. Br J Psychiatry 2011;199:459-66.
30. Kala A. Contemporary debates about mental health legislation: A summer and a winter of discontent. In: Chavan BS, Gupta N, Arun P, Sidana A, Jadhav S, editors. Community Mental Health in India. New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.; 2012. p. 161-8.
31. Chaturvedi SK, Basavarajappa C, Ahamed A. Mental Health Care Bill, 2013 and United Nations Convention on the Rights of Persons with Disability – Do they go hand in hand? Indian J Soc

[Downloaded free from http://www.indjsp.org on Friday, August 10, 2018, IP: 137.97.82.183]

Psychiatry 2015;31:107-111.

32. Narayan CL, Shikha D, Narayan M. The Mental Health Care Bill 2013: A step leading to exclusion of psychiatry from the mainstream medicine? Indian J Psychiatry 2014;56:321-4.
33. Kala AK. Why we should opt for a new Mental Health Act, and not tinker with the old one? Indian J Psychiatry 2004;46:96-8.
34. James BO, Morakinyo O, Lawani AO, Omoaregba JO, Olotu OS. Unmodified electroconvulsive therapy: The perspective of patients from a developing country. J ECT 2010;26:218-22.
35. Shah N, Mahadeshwar S, Bhakta S, Bhirud M, Fernandes P, Andrade C. The safety and efficacy of benzodiazepine-modified treatments as a special form of unmodified ECT. J ECT 2010;26:23-9.
36. Rajkumar RP. Unmodified electroconvulsive therapy: A false dilemma. Indian J Med Ethics 2014;11:89-93.
37. Andrade C, Shah N, Tharyan P, Reddy MS, Thirunavukarasu M, Kallivayalil RA, *et al.* Position statement and guidelines on unmodified electroconvulsive therapy. Indian J Psychiatry 2012;54:119-33.
38. Jacob P, Gogi PK, Srinath S, Thirthalli J, Girimaji S, Seshadri S, *et al.* Review of electroconvulsive therapy practice from a tertiary child and adolescent psychiatry centre. Asian J Psychiatr 2014;12:95-9.
39. Grover S, Malhotra S, Varma S, Chakrabarti S, Avasthi A, Mattoo SK. Electroconvulsive therapy in adolescents: A retrospective study from North India. J ECT 2013;29:122-6.
40. Balhara YP, Mathur S. ECT prohibition for children and adolescents in mental health care act of India: A step in the right direction? J ECT 2012;28:1-2.
41. Gangadhar BN, Kumar CN, Thirathalli J. Mental Health Care Bill 2013: The Place of Electroconvulsive Therapy. Indian J Soc Psychiatry 2015;31:148-52.
42. Kala A. Time to face new realities; Mental Health Care Bill-2013. Indian J Psychiatry 2013;55:216-9.
43. Loke J, Patel V. Mental health in developing countries. Student BMJ 2007;15:344-6.
44. Saxena S, Thornicroft G, Knapp M, Whiteford H. Resources for mental health: Scarcity, inequity, and inefficiency. Lancet 2007;370:878-89.
45. Varma VK, Gupta N. Changing mental health services. In: Varma VK, Kala AK, Gupta N, editors. Culture, Personality and Mental Illness. New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.; 2009.
46. Sarin A, Murthy P, Chatterjee S. Psychiatric advance directives: Potential challenges in India. Indian J Med Ethics 2012;9:104-7.
47. Jankovic J, Richards F, Priebe S. Advance statements in adult mental health. Adv Psychiatr Treat 2010;16:448-55.
48. Chadda RK, Deb KS. Indian family systems, collectivistic society and psychotherapy. Indian J Psychiatry 2013;55 Suppl 2:S299-309.
49. Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K, Szmukler G. Effect of joint crisis plans on use of compulsory treatment in psychiatry: Single blind randomised controlled trial. BMJ 2004;329:136.
50. Papageorgiou A, King M, Janmohamed A, Davidson O, Dawson J. Advance directives for patients compulsorily admitted to hospital with serious mental illness. Randomised controlled trial. Br J Psychiatry 2002;181:513-9.
51. Campbell LA, Kisely SR. Advance treatment directives for people with severe mental illness. Cochrane Database Syst Rev 2009;1:CD005963.
52. Sarin A. The curious case of the advance directive in psychiatry. Indian J Soc Psychiatry 2015;31:119-22.