MENTAL HEALTH ACT, SALIENT FEATURES, OBJECTIVES, CRITIQUE AND FUTURE DIRECTIONS

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INTRODUCTION

Mental health legislation is essential for protecting the rights and dignity of persons with mental disorders, and for developing accessible and effective mental health services. Effective mental health legislation can provide a legal framework to integrate mental health services into the community and to overcome stigma, discrimination and exclusion of mentally-ill persons. Legislation can also create enforceable standards for high quality medical care, improve access to care, and protect civil, political, social and economic rights of mentally-ill individuals, including a right of access to education, housing, employment and social security.

Furthermore, mental health law can establish guidelines through which a country develops its mental health policy, or reinforce previously established mental health policies that seek to provide effective and accessible mental health care through the community.

Mental health legislation plays an important role in implementing effective mental health services, particularly by utilizing political and popular will to reinforce national mental health policies. Enactment of mental health legislation can improve funding of mental health services, create accountability for those responsible for providing mental health services and overcome bureaucratic gridlock to ensure compliance with mental health policies and directives.

WHO and international guiding principles for mental health care mandate that all human rights, including the right to privacy, informed consent, confidentiality, freedom from cruel and unusual treatment and nondiscrimination should be guaranteed through mental health legislation.

In WHO HEALTH REPORT (2001) it was reported that 67% of countries in South-Asia have mental health legislation and rest of the 33% have no such law. Mental health care in India over the last 25 years has been an intense period of growth and innovation.

India enters the new millennium with many changes in the social, political, and economic fields with an urgent need for reorganization of policies and programmes. The mental health scene in India, in recent times, reflects the complexity of developing mental health policy in a developing country.

The National Health Policy (2002) clearly spells out the place of mental health in the overall planning of health care. These developments have occurred against the over 25 yr of efforts to integrate mental

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health care with primary health care (from 1975), replacement of the Indian Lunacy Act 1912 by the Mental Health Act 1987, and the enactment of The Persons with Disabilities Act 1995 focusing on the equal opportunities, protection of rights and full participation of disabled persons. The growth of voluntary action for mental health care in the areas of suicide prevention, disaster mental health care, setting up of community mental health care facilities, movement of family members (care givers) of mentally ill individuals, drug dependence, public interest litigation to address the human rights of the mentally ill; research in depression, schizophrenia and child psychiatric problems are other major developments.

The rapid growth of private psychiatry with associated spread of services to peripheral cities and small towns and challenges of regulation is another significant development of the last 10 years.

Against the above positive developments, the main challenges are the extremely limited number of mental health professionals (about 10,000 professionals of all categories for one billion population) and the very limited mental health service infrastructure (about 30,000 psychiatric beds for over a billion population); limited investment in health by the government (estimated public sector expenditure on health is only 17 % of total health expenditure) and problems of poverty (about 30% of population live below poverty line) and low literacy with associated stigma and discrimination for persons with mental disorders (Murthy, 2004).

INDIAN MHA (1987), INADEQUACIES AND SUGGESTED IMPROVEMENTS:

Prior to 1993, Indian Lunacy Act, 1912 was governing the mental health in India. In 1947 when we got independence and Indian Psychiatric society came into existence, ILA, 1912 was considered an inappropriate act for mentally ill. So IPS drafted a mental health bill and submitted it to govt. of India 1950 but it took another 28 years for govt. to present it in the Lok Sabha which was subsequently referred to JPC. Various committees established didn't consult IPS at any juncture though 10 psychiatrists were invited to give oral evidences. After a gap of another 8 years the bill was adopted as Mental Health Bill by Rajya Sabha in 1986 and the Lok Sabha in 1987. This bill received President's assent on May, 1987 but another 6 years were wasted before finally implementing the act in April 1993.

Terminologies used in the act

New term	Previously used terms
Psychiatric hospital	Nursing home Asylum
Mentally ill person	Lunatic
Mentally ill prisoner	Criminal Lunatic

Other important terminologies used in the act

1. Reception order: Means an order for admission and detention of a mentally ill person in a psychiatric hospital or nursing home.
2. Psychiatric hospital or nursing home: It is a hospital for the mentally ill persons maintained by the government or private party with facilities for outpatient treatment and registered with appropriate licensing authority. Admitting a mentally ill to a general nursing home is an offence.
3. Medical officer: A registered medical practitioner.
4. Medical officer in-charge: Is a medical officer who is in-charge of a psychiatric hospital or nursing home.
5. Mentally ill person: Is a person suffering from mental disorder, other than mental retardation,

needing treatment.
6. Mentally ill prisoner: Is a mentally ill person, ordered for detention in a psychiatric hospital, jail or other places of safe custody

Objectives of the act

1. To establish central and state authorities for licensing and supervising the psychiatric hospitals.
2. To establish such psychiatric hospitals and nursing homes.
3. To provide a check on working of these hospitals.
4. To provide for the custody of mentally ill persons who are unable to look after themselves and are dangerous for themselves and or, others.
5. To protect the society from dangerous manifestations of mentally ill.
6. To regulate procedure of admission and discharge of mentally ill persons to the psychiatric hospitals or nursing homes either on voluntary basis or on request.
7. To safeguard the rights of these detained individuals.
8. To protect citizens from being detained unnecessarily.
9. To provide for the maintenance charges of mentally ill persons undergoing treatment in such hospitals.
10. To provide legal aid to poor mentally ill criminals at state expenses
11. To change offensive terminologies of Indian Lunacy act to new soother ones

The advantage of the Mental Health 1987 is that the act is conceptually definitely many steps ahead of ILA (Indian Lunacy Act), 1912, trying to keep pace with advances in psychopathology and psychopharmacology. The fact that even four decades after Indian received its independence, we were continuing with an outdated and anarchic law speaks volumes about the importance of this act. However, whatever fallacies that have come to the fore ever since this law was enforced are due to following facts:

- At the time of conception of law, private psychiatry was still in infancy and the growth and development of private psychiatry was neither foreseen nor predicted. That might be the reason the law in its current form seems to be biased against private psychiatry.
- The field of psychiatry itself has grown by leaps and bounds and the scope of this branch has widened beyond the horizons predicted before. Hence so many changes have crept into this field that the law after two decades already seems outdated.

However all this criticism should not shift our focus from the fact that this law at the time of its enactment, was definitely a breakthrough and distinctly miles ahead of the then obsolete and anarchic Indian Lunacy Act,1912.Various **positive changes** in the MHA, 1987 are:

- More humane approach to problems of mentally ill persons by changing the terminology e.g. lunatics and criminal lunatics have been replaced by the term mentally ill person and mentally ill prisoner etc. and new chapters on management of their property and protection of human rights have been included
- Creation of Central and State Mental Health Authorities- a welcome step to safeguard the interests of the mentally ill person under one authority
- Procedure for admission and discharge of voluntary patients have been simplified and liberalized. In this act, no consent from two visitors is required as well as no written request is required
- Minor can be admitted with the consent of a guardian under this act. This provision is not there in the Indian Lunacy Act, 1912

- Separate provision for admission of involuntary patients under category "Admissions Under Special Circumstances"
- Special centres for special population like drug addicts, under 16 years, mentally ill prisoners etc.
- Establishment and maintenance of psychiatric hospitals and psychiatric nursing homes in private sector which was not in the earlier law
- Discharge procedure have been made easy and more simplified
- There are new different addition in this law like protection of human rights of mentally ill persons, penalties, cost of maintenance and management of properties of mentally ill persons
- Prohibition on any research on subjects without proper consent.

Criticism

Although this act has provided some respite both to the patients and the professionals but has become inadequate with time and has various shortcomings which act as a barrier in providing mental health services (Prateek Rastogi, 2005). The legislation does not promote community-based mental health care and widespread access to mental health services or incorporating mental health care into primary health care. The Mental Health Act should be amended so that it gives priority in protecting the rights of persons with mental disorders, promotes development of community-based care and improves access to mental health care.

Critical aspects of MHA 1987 as a whole

1. The act doesn't reflect the govt. policy on mental health framed in 1978 as well as Mental Health Programme,1987
2. No attention to WHO guidelines
3. Legal considerations have been given more weightage in comparison to medical ones
4. Failed to remove the criminal flavour by keeping the power of criminal court to exert its control over admissions and discharge of non criminal mentally ill persons
5. No importance to family and community psychiatry
6. There are no provisions for punishing the relatives and officers requesting unnecessary detention of a person to such hospitals
7. Once a person is admitted to mental hospital he is termed insane or mad by the society. There should be provisions in the act to educate the society against these misconceptions
8. Much stress is laid on hospital admission and treatment. This again increases the cost of health care. No provisions are made for home treatment
9. The act has no provision for transportation of an unwilling patient except by police

Mental health act is divided into 10 chapters consisting of 98 sections. The short details of the chapters, the inadequacies in them and suggested improvements are being described below:

Chapter I: Deals with preliminaries of the act, definitions and provides for change of offensive terminologies used in Indian Lunacy act 1912.

Suggested changes:

Change of older terminologies to newer ones might be good from practical aspect as it will be helpful in removing the social stigma attached to the illness. This change should be implemented in practice and not on paper.

1. *Medical officer*: "A registered medical practitioner."

- According to law can be even an Ayurvedic or homeopathic medical officer in Government service whereas *Should be a qualified psychiatrist*.

2. *Mentally ill person*: "person who is in need of treatment by reason of any mental disorder other than mental retardation"

   - The definition does not specify the types of mental illness to be included; this can lead to misuse of the term and is attached with stigma for the person labelled "mentally ill".
   - Mentally retarded subjects have been excluded. Mentally retarded subjects need separate services in the form of rehabilitation, prevention etc. A law for helping victims of mental illness should not exclude victims of profound mental retardation from its purview, as they too are in great need for treatment and care. They too should have access to psychiatric Hospitals. If the law presumes that profound mentally retarded persons could be adequately taken care of in the existing institutions for the mentally retarded, it is certainly not based on ground realities.

3. *Licensed psychiatric hospital or licensed psychiatric nursing home: "*means a psychiatric hospital or psychiatric nursing home as the case may be licensed, or deemed to be licensed, under the Act"

   ? Definitions of psychiatric hospitals and psychiatric nursing homes" (Section2q) excludes government hospitals, and is discriminatory. In this case a uniform policy should be adopted.

Chapter II: Deals with the procedures for establishment of mental health authorities at central and state levels.

Suggested changes: Licensing authorities do not have a doctor who may be in a better position to assess the facilities and services of these centers. There should be budgetary provisions in the law.

See appendix I for details

Chapter III: It lays down the guidelines for establishment and maintenance of psychiatric hospitals and nursing homes. There is a provision for licensing authorities to process applications for license which have to be renewed every five years.

Suggested changes: No mention is made of incorporating General hospitals and centers in this act rather they are prohibited. Such hospitals if taken along may provide a better health care. Licensing process should be made simpler. Provision should be there for checking the working of licensing authorities and powers vested in them to be limited.

Chapter IV: It deals with the procedures of admission and detention of mentally ill in psychiatric hospitals.

For a detailed flowchart of admission, discharge and leave for absence procedure see appendix III & IV

Suggested changes:

1. Emergency situations: To be an emergency, it must be demonstrated that the time required to

follow substantive procedures would cause sufficient delay and lead to harm to the concerned person or others

- Involuntary admission and treatment only on the assessment and advice of a qualified mental health/medical practitioner
- Emergency treatment must be time limited (say within one week) and substantive procedures for involuntary admission and treatment if necessary must be initiated as soon as possible and completed within this period
- Emergency treatment should not include: Depot injection, ECT, Sterilization Psychosurgery and other irreversible treatment.

2. Admission under special circumstances (involuntary patients) (Section 19). There should be set Criteria for involuntary admission.

3. Procedure for involuntary admission (suggestions):
   - ? Two accredited medical practitioner, of which one should be a psychiatrist, to certify mental disorder.
   - ? Provision for regular time bound review of involuntary admissions by review body. Discharge procedures to be flexible and easy, to prevent unnecessary detention
   - ? To review processes regarding people who are admitted/treated involuntarily. Establishment of independent and impartial court like body with a judicial function (Mental Health Tribunal). This body to assess each involuntary admission and treatment. In developing countries like ours paper review of straightforward cases can be done and hearings only for more contentious cases to entertain appeals against involuntary admission/treatment
   - ? Further detention requires reception order from a magistrate
     - ? Overly legal, cumbersome and complicated for patients and their family
     - ? Magistrate to take final decision/no mention of a psychiatrist

     Review Body should review the cases at periodic intervals and should have the power to discharge the patients if withheld unnecessarily. Authorize or prohibit intrusive and irreversible treatment for examples Psychosurgery/Sterilization.

     In developing countries like ours with limited resources the review body mentioned previously can perform the following functions:
     - Regular inspection of mental health facilities
     - Regular monitoring of patients welfare and well being
     - Providing guidance for minimizing intrusive treatment
     - Keeping records and statistics
     - To make recommendations to concerned authorities

Chapter V: It deals with the inspection, discharge, leaves of absence and removal of mentally ill persons.

Suggested changes: This section does make provision for appointment of visitors for every psychiatric hospital/nursing home. "Inspecting Officer" means a person authorised by the State Government or by the licensing authority to inspect any psychiatric hospital or psychiatric nursing home. The number of visitors should not be less than five, of whom at least one should be a

psychiatrist or at least a medical officer and two social workers. However most of the time inspecting officer is a medical officer without proper training or guidelines to conduct the inspection of a psychiatric hospital/nursing home.

Although the act provides for a simpler discharge procedure but no provisions are made for after discharge care and rehabilitation, of patients. Much stress is laid on hospital admission and treatment. This again increases the cost of health care. No provisions are made for home treatment.

Chapter VI: It deals with the judicial inquisition regarding alleged mentally ill persons possessing property and its management.

See appendix II for details

Suggested changes: Property and inheritance rights are protected under Indian law although the legal determination of capacity to assume full control of one's property or to control one's inherited assets does not require the opinion of a medical professional, thus increasing the possibility that subjective bias could prevent individuals recovered from mental illness from controlling their own assets.

Chapter VII: It deals with the maintenance of mentally ill persons in a psychiatric hospital or psychiatric nursing homes.

Suggested changes: No provision for patients with no estate and no relative, the state should be made responsible for such patients. Mental health legislation should include integration with NMHP and NGO's to improve community and primary psychiatric services. Legislation should ensure the introduction of mental health interventions into primary health care. In developing countries like ours delivering mental health services through primary health services is the most viable strategy. Integrated care reduces stigma associated with mental illnesses and also promotes mental health

Chapter VIII: It deals with the protection of human rights of mentally ill persons.

Suggested changes: Once a person is admitted to mental hospital he is termed insane or mad by the society. There should be provisions in the act to educate the society against these misconceptions. Indian common law provides a patient with a right to informed consent and confidentiality of patient records, although the Mental Health Act only requires informed consent for experimental treatment. It is provided that research on such subjects can be carried out by consent of guardian or if such research is of direct benefit to him for purposes of diagnosis or treatment. Is it not like treating them as inanimate objects? This provision violates human rights and should be amended.

Indian law severely curtails the civil and political rights of mentally ill individuals. Hindu and Parsi personal laws preclude the right of mentally ill individuals to marry and sanction divorce if the spouse is likely to remain mentally-ill. “Madness certificate” of the mental health professionals are used by husbands to divorce, desert or throw out wives from their matrimonial homes. Women are admitted in the mental asylum as per the directives of the Mental Health Act, 1987.

Chapter VIII & Chapter IX: These sections pertained to “Penalties and Procedures” and “Miscellaneous” no changes are suggested for these.

Other changes that ought to be incorporated into a new law or introduced through

amendments:

There should be provision in the law for treatment of the destitute. The act should also ensure that the Human Rights of the mentally ill patients are protected and that it follows the WHO guidelines. There should be provisions in the law for the after care of the mentally ill after discharge from the hospital to ensure their full integration back into the society.

NATIONAL MENTAL HEALTH PROGRAMME, THE BENEFITS, THE FALLACIES AND SCOPE FOR IMPROVEMENT

India is one of the few countries that have a National Health Policy (NHP, 2002) that mentions mental health, as well as a National Mental Health Program (NMHP) and a dedicated Mental Health Act 1987 (MHA). By identifying PHCs as the epicentre for psychiatric treatment, NMHP (1982) attempted to integrate mental health into general health. It also proposed to deinstitutionalize to a community rather than hospital based model. However, by 2002, only 100 of 600 districts were brought under NMHP. This failure was due to poor funding, inadequate undergrad curriculum in psychiatry, manpower shortage, and poor evaluation, non-implementation of MHA and privatisation of mental health care.

The 11th Plan with a Rs1000 cr. allocation for mental health proposes to cover the remaining 500 districts by the end of the Plan period. However, mental illness is a progressive disorder; for every 100 districts covered each year, there will be a backlog of districts without mental health services *(source www.acmiindia.com)*.

Psychiatrists insist that “Early treatment is early recovery”, but this has escaped the attention of health experts in the Planning Commission: for this oversight, victims in rural areas are likely to pay the price. We do appreciate the manpower constraints- around 4500 trained mental health workers for 40 million mentally disabled patients. That is precisely why global strategies call for integration into general health programs. NHRC (1999) report says that there is on an average, 1 PHC for every 30,000 population, 1 doctor for every 3000 population, one male and female worker for every 3 to 5000 population. NRHM proposes to cover 18 States under the 11th Plan. The ASHA (Accredited Social Health Activists) volunteers are best suited to detect early and typical symptoms of mental disorders seen in the PHCs.

Besides, the need of the hour is suitable and just allocation of resources at grassroots levels, greater number and better trained workers at PHC level, fixing the responsibility for adequate utilization of resources, strong monitoring mechanisms with legal powers and provision of regular review. It would also be highly useful to take help of NGO's and to involve mass media in these endeavors.

CONCLUSION

Mental health legislation should be viewed as a process rather than as an event that occurs just once in many decades. This allows it to be amended in response to advances in the treatment of mental disorders and to developments in service delivery systems. However, frequent amendments to legislation are not feasible because of the time and financial resources required and the need to consult all stakeholders.

A possible solution is to lay down regulations that are separate from legislation but can be enforced through it. Legislation can include provision for the establishment of regulations and can outline the

procedure for modifying them. The most important advantage of regulations is that they do not require lawmakers to be repeatedly voting for amendments.

Mental health legislation is essential for complementing and reinforcing mental health policy and providing a legal framework for meeting its goals. Such legislation can protect human rights, enhance the quality of mental health services and promote the integration of persons with mental disorders into communities.

The basic function of any law is to frame rules and regulations which are least restricting and will enable the weak to enjoy all their civil rights without any hindrances. A more penal and less therapeutic service would only increase the isolation of psychiatry from other clinical specialities.

REFERENCES

- Mental Health Act, 1987. Bare act with short comments; Commercial Law Publishers, Delhi, 2007.
- Park K. Park's textbook of Preventive and Social Medicine. 17th ed., Jabalpur. Banarsidas Bhanot Publisher. 2002.
- Antony J, A decade with the mental health act, 1987. Indian Journal of Psychiatry.
- Prateek Rastogi (2005): Mental Health Act 1987- An Analysis. JIAFM; 27(3).
- WHO (World Health Organization): Mental Health Atlas. (2005). WHO Press, Geneva.
- World Health Organization (2001). The World Health Report (2001): Mental Health: New Understanding, New Hope.
- World Health Organization (2005). WHO Resource Book on Mental Health, Human Rights and Legislation. Part of the Mental Health Policy and Service Guidance Package. Available at: http://www.who.int/mental_health/policy/en/.
- World Health Organization (2005). Mental Health Atlas 2005.
- World Health Organization (2005e). Mental Health Policy, Plans and Programmes. Part of the Mental Health Policy and Service Guidance Package http://www.who.int/mental_health/policy/en/ (accessed July, 2008).
- Murthy RS, Mental Health In The New Millennium: Research Strategies For India, Indian J Med Res 120, August 2004, pp 63-66.