

The Mental health Act in India- A Review

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1. Abstract:

This paper tracks the history of Mental Health Legislation (MHL) in India to understand its scope and application in protecting the rights of persons with Mental Illness (MI). Additionally, through an extensive review of literature, the paper identifies current issues with MHL in India, reports on existing gaps and suggests ways to ensure better social and health protection mechanisms for the consumer groups.

2. Objective(s): The paper has two main objectives as follows:

- 1.1** To track the history of MHL legislation in India to understand its scope and application in protecting the rights of persons with Mental Illness (MI)
- 2.1** To recommend ways to create a more inclusive society where the rights of all, including those with MI, are guaranteed and accessed

3. Introduction:

3.1. Background: On the surface, the policies and services for persons with MI in India seem progressive and humane. The Mental Health (MH) Act 1987 attempts to bring in the latest thinking in the sphere of MH services. Following legal precedents, media attention and a growing awareness, new services are emerging, especially in urban areas. India's premier institute on MH service, research and training, The National Institute of Mental Health and Neurosciences (NIMHANS) looks a lot different than the lunatic asylum it was established as in late 19th century. And yet, the formal MH infrastructure is minimal, political will and necessary resources to implement legal provisions are scarce and success remains sporadic, illustrating what is possible if more consistent and committed efforts are employed.

3.2 History of MHL in India: The History of MHL in India dates back to a time before European colonization. Indigenous and traditional medical systems in India diagnosed MI as distinctive but provided for their treatment as part of the general health care systems. Following European influences, separate services for MI began and focused on establishment of lunatic asylums and employed

segregations and institutionalization as chief methods of treatment. The first of these institutions were primarily established to cater to the European residents in India with the first hospital starting in Mumbai in 1745. Soon, such hospitals, asylums and homes were established in other parts of the country and catered mainly to insane soldiers¹.

3.3 Establishment of formal legal framework: The first Lunacy Act was introduced in India in 1858 and provided guidelines for setting up mental asylums and procedural checks for admission and treatment on the patients with a view “to segregate those who by reasons of insanity were troublesome and dangerous to their neighbors.” The amendment to the Lunacy Act in 1912 brought the mental hospital under the charge of Civil Surgeons instead of the Inspector Generals of Prison as in the earlier times. For the first time, psychiatrists were appointed and the control of such asylums handed over to the central government. Unfortunately, colonial conditions of the time provided a certain character to the MH policies in India of those days. While the model was predominantly British, it differed on three aspects: race, higher rate of manual labor and early admissions for the Europeans. Further, the names of all asylums were changed to mental hospitals. Although occupational therapy and family units were introduced, they remained primarily designed for custodial care and detention rather than treatment. The 1912 Lunacy Act essentially remained in effect until the 1987 MH Act was passed by the government of India².

3.4 Issues within the health and legal system: The service providers recognized the gross inadequacy of medical and other rehabilitation personnel in mental hospitals and set to correct the situation following India’s independence in 1947. Thereafter, the emphasis was more on creating psychiatric wards and departments in general hospitals and medical colleges instead of adding more mental hospitals. Unfortunately, the inadequacies highlighted in 1947 continue to characterize the health and legal systems even today³.

4 Review of literature:

A detailed review of literature spanning past three decades was conducted to access all information on the status of MH in India. A further review was done to identify resources elaborating on the MI situation in India. The aim of the literature review was to identify,

from a large pool of resources, specific relevant information on MH Act and MI in India. Important literature published in English was identified by keyword search in the MEDLINE and PUBMED databases. The accessed literature was further reviewed using filters to identify the most appropriate information for the purpose of this paper. Only studies which reported on the Mental Health Act in India in relation to the situation of persons with MI were included. Rest were not considered.

5 Analysis:

1.1 Mental Health Act 1987, India: The MH Act was drafted in 1987 but was implemented in all states and Union Territories in India only in 1993. While there is much to commend in the new Act, merely changing the old terminology for new one may serve as window dressing and be ineffective in making a difference to the MI population of India. According to Rastogi (2005)⁴, most of the act is similar to the MH Act 1959, the MH (amendment) Act 1982, both of England and MH Act 1960 of Scotland with a few changes. Further, the Act fails to address the removal of social stigma attached to MI and educating the society. Failure to mandate medical opinion to licensing authorities of service organizations, more stress on institutionalization, lack of after discharge care and rehabilitation measures, providing for research possibilities as long as guardians' agree, lack of measures to restrict unnecessary detention by families or law agencies and adopting a different view of government and private hospitals are some of the serious limitation of the Act.

5.2 Status of persons with MI within the context of MH Act: Sheshadri and Sheshadri (2005)⁵ elaborate on and criticize the MH Act as suffering from some fundamental flaws. According to them, it seems to be drafted on the premises that persons with MI are violent and dangerous, that mental illness is incurable and the subject loses his/her reasoning and judgment and subsequently the fundamental rights under the Indian Constitution.

5.3 Treatment and care issues: According to Dutta (2007)⁶, approximately 20% of the population of India suffers from some kind of MH problems. Yet, in a country of more than a billion people, there are only 36 state-run mental hospitals only 500 qualified psychiatrists to serve them. Due to excessive red tape facing private institutes following the Erwadi incident and lack of jobs in government run MH

institutions, most fresh graduates of psychiatry either emigrate or work as private practitioners. Moreover, less than one per cent of India's total health budget is spent on mental health, out of which a huge portion is for communicable diseases. Implementation of the provisions of the MH Act has been affected by a greater focus on illness rather than on comprehensive mental well being. This is in the face of inhumane treatment meted out to persons with MI in almost all state run institutions even today. Additionally, according to Pathare (2003)⁷, treatment is based on a purely medical model focusing on the provision of drugs and ECT. There is a dearth of psycho-social therapies, counselling and psycho-therapy services and rehabilitation facilities.

5.4 Human rights of persons with MI: Kumar (2001)⁸, in his paper reports on The National Human Rights Commission (NHRC), which in 1999 made a resounding condemnation of the state of MH in the country. Following an empirical study on the status of MH in India, the commission documented serious human rights abuses in many mental institutions across the country. The MH Act itself is quite narrow in its definition of human rights and its chapter dealing with it contains only one section on research on persons with mental disorders, showing little understanding of the need to protect the rights of persons with mental disorders when treatment is administered without their consent. Furthermore, the situation of women and prisoners with MI is even serious with illegal detention and poor standards of safety and hygiene and unlawful detention orders.

6. Discussion and conclusion:

Undoubtedly, considerable changes have taken place in the Indian MH legislation and policies over the last 2 decades with the introduction of the National MH Programme in 1982 to encourage development of community based model of care. This programme was further modified as the District MH Programme and aimed to improve MH care by training government health professionals in diagnosis, treatment and health promotion activities. It also sought to upgrade government psychiatric wards and hospitals and introduced psychiatry in the medical curriculum.

Following its footsteps, the MH Act was enacted in 1987 which superseded the draconian Lunacy Act of 1912. The MH Act was implemented nationwide in 1993 and introduced

greater regulatory control of psychiatric facilities through judicial and state mental health authorities.

Contrary to these positive developments on paper, sufficient research evidence exists to suggest that the provisions of the MH Act are not implemented and that the current practice pertaining to persons with MI does not adequately protect their human rights. In some instances, it actually permits violation of the right of individual choice. Further, the Act is found lacking on the right to treatment and care for both, simple as well as complex MI, does not exercise equal control on treatment, discharge and quality of care issues in government versus private institutes.

Additionally, a review of litigations in the Supreme Court as well as State High Courts suggest that illegal detention and institutionalization of women, poor facilities and services in government hospitals, unlawful use of detention orders and housing a person with MI in prisons and jails are very common occurrences in the India of present day.

Of greater concern is the fact that even though the Indian common law protects the right to informed consent and the right to confidentiality of a patient, *the MH Act only requires informed consent for experimental treatment if the attending physician fails to show that the research is of direct benefit to the patient.*

Furthermore, the MH Act remains silent on and fails to correct the basic human rights violations of numerous earlier Acts and legislations. Some of these are; precluding the right of mentally ill individuals to marry and sanction divorce if the spouse is likely to remain mentally-ill under the Hindu and Parsi Personal Laws; Forbiddance of voting and standing for elections under the 1950 and 1951 Representation of the People Act, allowing for the subjective bias of the Property and Inheritance Rights under the Indian law to remain in force which increases the possibility that individuals recovered from mental illness will lose control of their own assets.

Thus, in spite of the modern and scientific language used in the MH Act, the law continues to severely curtail the civil, social and political rights of persons with MI.

7. Recommendation:

This paper strives to recommend alternatives in care and rehabilitation of persons with MI from a rights based perspective as the central tenet of the rights discourse is that it empowers the rights bearer and limits the power wielder. As a result, there cannot be real articulation of the rights of persons with MI without their active involvement. Additionally, the participation of persons with MI in decisions affecting their lives, measures for care and rehabilitation attain a charity dimension and do not remain a right.

It is with this that the following measures are suggested to improve the scope and effectiveness of the MH Act in India.

- 1.** Of primary importance in addressing issues of MI in India is educating the population. Information about MI and equal treatment of persons with MI are issues that need to be incorporated in the MH Act. Only with increased awareness, the country will be able to fight long held notions of MI and stigma faced by persons with MI in the society.
- 2.** Additionally, focus of the MH Act needs to change from the treatment of the ill to treatment of the illness and the concept of treatment should be based on the social definition of the illness and not long existing medical definition which mandates exclusive drugs, hospitalization and ECT pathways. Provisions also need to be altered to include private practitioners and general nursing homes, albeit with appropriate measures and controls, to treat persons with MI instead of the current provision authorizing only the government hospitals and institutions. This will lessen the burden on the system and provide for larger coverage.
- 3.** Moreover, licensing regulations within the Act need simplification. There is a need to assess the working of licensing authorities and powers entrusted in them to ensure protection of vulnerable groups and service providers. The licensing authorities must also appoint a medical doctor on the panel of inspecting officers.
- 4.** The MH Act provides for severe conditions and does not take into account other vulnerable groups or different ways of care provision. Along with children and substance addicts, separate places are needed for elderly persons, destitute and women with MI. The Act also needs to reconsider provisions for long term treatment, care and expenses related to these, especially in case of destitute people with MI

who have nowhere to go and remain in these institutes for life. Moreover, the process of discharge and after hospital care need to be aligned to ensure that sufficient support is available to the person to make a new start in life.

5. There is also a need to re-evaluate the role of PHC in providing community based MH care and further provisions should be made to strengthen the PHC system by investing in additional community based rehabilitation centres.
6. Finally, the MH Act needs to provide stricter punitive measures for agencies and families exploiting a person with MI or requesting unlawful detention for reasons other than MI.

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As Amartya Sen, in his book 'Development as freedom' puts it; "Rights assure freedom and freedom assures rights". In today's India, we must ask if all Indians are indeed free...

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