The Mental Health Act 1987: *Quo Vadimus*?

PRATIMA MURTHY

Professor of Psychiatry, National Institute for Mental Health and Neuro Sciences, Bangalore 560 029 INDIA e-mail: pratimamurthy@gmail.com

Abstract

Persons with mental illness have the right to a range of treatment and supportive services in the community. These need to be assured to them by law. While older legislations viewed persons with mental illness either as "being dangerous" or as "objects of charity", the current UN Convention on the Rights of Persons with Disability views them as "subjects with rights". This has led to an urgent relook at the Mental Health Act 1987, which has faced criticism ever since its enactment. The recently proposed amendments enlarge the scope of regulation to include diverse mental healthcare facilities and professionals; seek the setting up of a State Mental Health Review Commission; lay down guidelines for "independent" and "supported" admissions; and propose new sections for emergency and other treatments, physical restraint and discharge. The debate regarding these amendments ranges from whether an amendment of the MHA will suffice or whether a new Act is required; whether the amendments are sufficiently broad-based or excessively focused on inpatient treatment; how mental illness is addressed in other Acts; who are key stakeholders, and, most important, whether the mechanisms for service provision have been adequately thought through. The process of initiating the amendments has been questioned by different stakeholders and highlights the need to bring about legislative change through adequate dialogue and collaboration.

Mental disorders comprise a range of conditions that affect a person's behaviour, mood, thought, perception and cognition, resulting in distress to the sufferer, to those around, or to both. The term encompasses conditions whose risks may be familial and conditions that may follow an insult to the brain, exposure to mind altering substances, physical illness or adverse psychosocial circumstances, or from a combination of these factors. The disorder may present at birth, in early childhood, adolescence, early adulthood, old age, or during physiologically critical periods. The outcome of mental illness may be recovery, episodic recurrence, or a deteriorating course. Recovery may be complete or partial. Chronic mental illnesses are often associated with dysfunction and disability, particularly in the social realm. The stigma associated with mental illness results in a reluctance to report the symptoms of mental illness, timely treatment, and neglect of the condition outside crisis situations. In certain mental illnesses and in the acute phase of others, the person may, on account of impaired judgment and absent insight, be incapacitated medically and legally, with a return of these capacities on recovery. In others such capacity may be permanently lost. These complexities pose multiple challenges in the care of persons with mental illness. While the bulk of caring for persons with mental illness in countries like India still rests with families, social systems of care have a huge responsibility in the care of the mentally ill in some countries. However, terrible tragedies like the Erwadi fire incident, and horrific reports of abandonment of persons with mental illness (1), highlight the crying need for a proper system of care for persons with mental illness. The need for mental health legislation stems from an increasing understanding of the personal, social and economic burden of mental disorders worldwide (2).

Older laws related to mental health the world over were constructed on the premise that persons with mental illness were dangerous, and many of the old mental hospitals in India were established on the rationale that the most humane approach was their confinement in asylums. The Indian Lunacy Act 1912 (ILA) laid out the rules and procedures for admission to and discharge from these institutions. However, the abysmal conditions in many of these hospitals became evident during a National Human Rights Commission evaluation (3). Public interest litigation, directives from the Supreme Court and monitoring have led to slow, nevertheless positive changes in many of these hospitals suggesting that legal directives, stringent monitoring and resource enhancement can have a positive impact (4). However, mental healthcare encompasses several issues beyond institutional care, and mental health laws need to reflect national mental health policies. India launched a National Mental Health Programme (NMHP) in 1982 with the objectives of integrating mental health into primary healthcare and making mental healthcare available, accessible and affordable. Community care was emphasised under this programme. However, little actually changed in terms of improved care for the mentally ill. Only recently, under the 11th five year plan, the NMHP has been strengthened and re-strategised. The last half century has also witnessed a growth of general hospital psychiatry as well as a growing private and non-governmental sector providing mental health services.

The Indian Lunacy Act was repealed with the enactment of the Mental Health Act 1987 (5), which replaced many of the archaic terminologies of the ILA, mandated the setting up of central and state mental health authorities (Chapter 2); established licensing procedures for psychiatric hospitals and psychiatric nursing homes (Chapter 3); regulated admission and discharge procedures of voluntary and involuntary patients, created a category of "admission under special circumstances" which divested powers from the judiciary, and attempted to make admissions easier(Chapter 4); eased discharge procedures (Chapter 5); made provisions for the management of property possessed by a mentally ill person (Chapter 6), and established liability to meet the cost of maintenance of a mentally ill person during admission (Chapter 7). The MHA also has a chapter for protection of the human rights of mentally ill persons,

which seeks to safeguard against any indignity or cruelty during treatment, prevent involvement in research without consent, and safeguard the person's right to communication (Chapter 8), and lays down penalties and procedures in case of contravention of its sections (Chapter 9). A miscellaneous section empowers the government to make rules, protects action taken in good faith and briefly mentions the effect of the Act on other laws (Chapter 10).

Criticisms of the MHA followed fairly soon after and have continued to the current day. The Act has been construed as a "Mental Hospital Act", given its extensive preoccupation with dealing with inpatient care in licensed institutions (6). The terms "licensing" and "inspectors" have gained notoriety in many sectors (7). The Act is viewed as seriously flawed because of its basic assumption that mentally ill persons are violent and dangerous and that mental illness is incurable. Mental retardation, which can be associated with serious human rights violations, has been left out of the Act, as have personality disorders. Government general hospital departments of psychiatry do not come under the purview of the Act. The Act has been criticised for its neglect of community-based mental healthcare and the tenets of the NMPH, lack of attention to WHO guidelines, retention of a "criminal flavour", its lack of attention to discharge care and rehabilitation, as well as its failure to address social stigma and societal ignorance (8, 9). Substantive procedures for emergency treatment have not been laid out. While criticising various provisions of the Act, including the power given to judicial officers to determine the presence and nature of mental illnesses in people, Anthony (7) suggests that we "acknowledge with grace and gratitude, whatever is good and patient-friendly in the 1987 law. After all our fore-fathers in the profession drafted it with an objective of securing a better deal for the mentally ill." But it requires much more than just genuine concern and humanity to formulate a comprehensive law to ensure adequate mental healthcare to the citizens of any country in contemporary times.

The primary aim of modern mental health legislation is to protect, promote and improve the lives and mental well-being of citizens (2). Following the Universal Declaration of Human Rights in 1948, several international treaties, declarations and guidelines have affirmed or reaffirmed the rights of persons with mental illness (10, 11). The most recent United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) marks a paradigm shift in attitudes and approaches to persons with disabilities and views them not as "objects of charity", but "subjects with rights". India is a signatory to the UNCRPD and has an obligation to bring its laws in congruence with this convention. Hence the current change in track from the level of a debate on the MHA to policy oriented action. Being at this crossroads, we need to consider the following points for legislation in the area of mental health:

1. Voluntary treatment of mental illness should be made easier. Mental illness needs to be treated on par with other illnesses, and mental healthcare needs to be integrated with general healthcare. This is necessary to reduce the stigma of mental illness and reduce the public health burden from mental illness. It is especially necessary given the challenge of a huge human resource shortage in terms of specialised mental healthcare professionals (12). Strengthening of primary healthcare and care in the general hospital setting can help to reduce the huge treatment gap for mental illness. Mental health legislation must ensure access for citizens to equitable mental healthcare.
2. Mental illness differs from other illnesses in that the capacity to consent to treatment can be undermined by the very nature of the illness, and involuntary treatment may be necessitated, to prevent harm from the illness either to the individual or others around. However, such capacity needs to be re-evaluated periodically.
3. The current mental health law is preoccupied with licensing and licensing authorities. The focus needs to shift from the needs of institutions to the treatment needs of the person with mental illness: treatment in the least restrictive setting; well laid down procedures for involuntary treatment based on established guidelines; and procedures for appeal including appropriate review bodies.
4. Care needs to shift beyond only medical care (hospitalisation, drugs and physical treatments) to other areas like accommodation, rehabilitation, education and employment.
5. The law needs to regulate care in government and non-governmental sectors, in both institutional and community-based settings – hospitals, specialised institutions, rehabilitation centres, half-way homes and other facilities which care for the mentally ill (including non-allopathic centres, non-governmental sectors, religious centres) to ensure minimal standards of care and to prevent human rights abuse.
6. Family members continue to be the primary carers of persons with mental illness, although the scenario is changing. Support in terms of emergency services, treatment subsidies and insurance are important steps to support care-givers in caring for mental illness. The support must also be counter-poised with strong deterrents if the care-giver or any other person abuses, exploits or denies any person with mental illness their due rights.
7. According to the Office of the UN High Commissioner for Human Rights, exercise of legal capacity involves the ability to understand the meaning of one's action and its consequences and may vary according to the act performed (matrimonial capacity, capacity to own and administer property, contractual capacity, capacity to bring claims before courts, etc). Such capacity can be limited or restricted when individuals become unable to protect their own interests. In these cases, the person remains the holder of substantive rights (e.g. the right to property or the right to inherit), but cannot exercise them (e.g. sell his/her property or accept an inheritance) without the assistance of a third party appointed in accordance with the procedural

safeguards established by law. Protective procedures for this will have to be established in law.

8. Regarding care of persons with mental illness in prison settings, persons in prison settings represent a vulnerable population in need of proper assessment, intervention and aftercare for mental health problems.

9. The litmus test for the mental health services of any country are the procedures in place for treatment of the disenfranchised. The wandering mentally ill, the destitute mentally ill, the abandoned mentally ill possibly represent the most vulnerable group requiring a range of services from identification and treatment to rehabilitation and reintegration.

10. Regarding regulation of professionals, a sensitive but judicious balance is needed between encouraging persons to voluntarily seek care for mental health problems, encouraging professionals in both the government and private sector to provide care in the least restrictive setting, discouraging defensive practice, and increasing professional accountability through consumer awareness and codes of conduct laid down by professional bodies.

11. The playing field for mental healthcare has expanded exponentially since the enactment of the MHA. There is a burgeoning private sector. There are other specialists providing mental healthcare apart from psychiatrists, psychologists, social workers and psychiatric nurses including mental health counselors, rehabilitation specialists, alternative medicine specialists, etc. On the one hand, given the acute shortage of mental health care resources, one could view this development as a welcome step. On the other, it is important to ensure that persons delivering such services are adequately qualified and trained, and maintain certain standards and ethics of care, and that the person seeking or brought for mental healthcare is not exploited. While the legislation may not directly prescribe such standards of practice, it may direct professional bodies to lay down such standards, and develop monitoring mechanisms to ensure maintenance of these standards.

12. Mental healthcare is too important to be left to any single group of mental health carers. Mental health activists and non-governmental agencies working for the mentally ill, although few in number, have an important participatory role in service and policy planning. The judiciary, lawyers, police, caregivers, professional bodies are also critical partners. The last decade has seen the emergence of the voices of users of mental health services. "Nothing about us without us," communicates the need for user participation in drafting policies and programmes.

13. Following the MHA, there have been other laws which are specifically relevant to persons with mental illness (13). In particular are the Persons with Disabilities Act (Equal Opportunities, Protection of Rights and Full Participation Act 1995), and the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act 1999. There are other, much older civil and criminal legislations which continue to retain archaic terminologies and concepts simply incongruent with the basic rights of persons with mental illness. While these are outside the scope of this commentary, it nevertheless highlights the need for a proper review of various legislations to evaluate their positions on persons with mental illness and to bring congruence between various pieces of legislation.

Some of these arguments on the basic flaws in the MHA have formed the basis of advocating a new mental health law. However, in the light of the MHA having taken more than 40 years for the translation of a proposal to the Act (9), an amendment has been considered as an option, perhaps an intermediary one, to a new Act. The arguments have been elevated from an academic discussion to a crescendo following the Ministry of Health initiating a proposal to amend the MHA, in the background of the UNCRPD. A paper on draft amendments prepared by the Centre for Mental Health Law and Policy, Indian Law Society, Pune, on behalf of the ministry, on February 28, 2010 (14) has been circulated through e-mail. The accompanying table summarises the major changes proposed in the amendment.

The positive features of the draft amendment are the "civil rights" language, and greater attention to procedural details, in the spirit of the UNCRPD. Diverse mental healthcare facilities and professionals have been included within a regulatory framework. The major criticisms are that it is still preoccupied with inpatient treatment, does not amply reflect a truly rights-based legislation for mental health, excludes mental retardation, and talks of yet another new commission. It fails to define what care in the community means. It has not paid the necessary attention to the extra treatment needs (shelter, occupation, education etc) of persons with mental illness, particularly of the poor, women, children without parents and the aged.

In the formulation or amendment of legislation, it is important to, a priori, consider the mechanisms for instituting such reform. Else the legislation runs the risk of looking word perfect on paper, while being simply unimplementable in practice. Unless there is strong commitment, monitoring, and strong deterrents for denying care or for exploiting persons with mental illness, neither an amendment nor a new Act will serve any purpose. It is no longer tenable to brush practical considerations aside on the premise that the state mental health rules need to lay down procedures. Many lessons can be learned from the MHA 1987. To date, some states still do not have a mental health authority, and there are still several states which have not formally gazetted the state mental health rules. Setting up a new commission has its own set of bureaucratic complexities. Much can be learnt from the functioning (or lack of) of state human rights commissions, district legal services authorities and similar bodies. The responsibilities of the various government ministries like health, social justice and empowerment, labour, education, women's welfare, etc, in setting up facilities for comprehensive mental care need to be enunciated.

There is a need for a properly formulated plan of action whether it is for a sweeping amendment or for a new Act. Inter-ministerial dialogue and collaboration and high level commitment are critical as a preliminary step to such an initiative. It is important to consider whether the Act needs to be a consolidated legislation where all issues related to mental illness come under a single law, or whether provisions relating to mental illness are inserted into relevant civil and criminal justice legislations. A combination of the two approaches is also possible. It is also important that the process of mental health law formulation is seen as fair and representative of interests of all key stakeholders. Such an approach of inclusiveness is important for a favourable outcome. However, it is imperative that these stakeholders do not assume polar positions. Nor should individual group interests override the general good. The process must be consultative and constructive, not adversarial. The eventual goal of legislation must be the facilitation and strengthening of a mental health policy that provides acceptable, accessible and equitable mental health care, accommodates the entire range of services required by persons with mental illness, and includes provisions for improving mental health resources. Such an opportunity to try to improve care for persons with mental illness through legislative measures must be optimally facilitated by everyone.

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Technology in health care: current controversies

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(summarised from 14)	
Major areas	Proposed changes
Definitions Mental illness Mental health facility Mental health Professional Career	Clarification of the definition of mental illness and laying down of criteria for a legal determination of mental illness (section 2 L). Includes disorders arising out of alcohol and drug use but excludes mental retardation De-addiction centres brought under the ambit of the Act "Psychiatric hospital" and "psychiatric nursing home" replaced by mental health facility with inclusion of a range of facilities (section 2 q) Expansion of the definition of mental health professionals to include non-medical mental health professionals (section 2 v) Proposes new definitions for: "carer" of a person with mental illness (section 2 w) "nominated representative" "special personal representative"
Mental Health Review Commission	In addition to expanding the scope of the Central and State Mental Health Authority, proposes the MHRC, an independent commission
Licensing of facilities	Replaced by registration and standards of mental health facilities (sections 6-9)
Admission	Proposes guidelines for admission (Sections 15,16, 18, 19, 20) of "independent patient", "minor" "supported admission" "Reception order" replaced by "order for supported admission" Review by the Commission for all supported admission orders beyond 30 days
Emergency treatments (new section)	Emergency medical treatment for mental illness to be provided by all registered medical practitioners in both medical facilities and in the community where such treatment is immediately necessary to prevent death, serious damage to person or property
Prohibited treatments (new section)	Direct electroconvulsive therapy Sterilisation for mental illness Chaining in any manner or form
Treatment (new section)	Proposes a new section on conditions for psychosurgery
Restraint (new section)	Proposes a new section on conditions and procedures for temporary physical restraint and seclusion
Discharge (new section)	Proposes that the mental health professional has a responsibility of ensuring aftercare in the community "discharge planning" (section 20.1 to 20.5)
Role of police officers	Elaborates the duties of police officers towards protection of wandering persons with mental illness and person with mental illness who is cruelly treated or not under proper care
Advance directives	In place of "judicial inquisition" as in the MHA (Section 50). Proposes that a person may in advance, indicate how he or she wishes to be treated and cared for, who will be the nominated representative, special personal representative
Special support	"Support arrangements" to replace "guardianship" (Section 52) in consultation with all stake holders Special support arrangements for persons with mental illness requiring very high support for exercise of legal capacity through the appointment of a special personal representative
Costs to be borne by government for Rx	Cost of treatment in cases of persons below the poverty line to be met by the government (Section 78)
Rights of persons in mental health facilities	Elaborated extensively (Section 81) Rights to care and treatment including right against cruel, degrading and inhuman treatment, non-discrimination in the provision of health services, information, confidentiality, personal communication and contact, access to medical records, right to complain about the facilities, free and informed consent for participation in research
Central Mental Health Authority (CMHA) and State Mental Health Authority (SMHA)	Proposes significant changes in composition to include users and care-givers

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