Comment on "The Mental Health Act 1987: Quo Vadimus?"

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Pratima Murthy has given an accurate summary of discussions, over the past several decades, in the field of mental health legislation and public policy (1). As she indicates, until recently, the mental health sector was marked by lethargy and lack of commitment. Following the initiation of the United Nations Convention on the Rights of Persons with Disabilities, which India has both signed and ratified, we are now speaking a rights-based language in the current process of amendments to the Mental Health Act (MHA), 1987. It is essential that these rights be suitably represented, to facilitate the provision of optimal mental health services in India.

Pro-poor legislation

Almost half of India's population lives below the poverty line (2), with development taking place in a skewed manner. Further there is a rural-urban divide in all services. In this situation, many people face major barriers in accessing mental healthcare. Not only is the absence of service a hindrance, but the absence of an informed consumer movement weakens the spirit of community activism that should hold the State accountable for the delivery of what is a constitutional right of every Indian - the right to health and healthcare. The very nature of mental illness further complicates the behaviour of clients, and caregivers, and often influences health-seeking patterns.

In developed nations, people are entitled by law to healthcare, and insurance protects them from out-of-pocket expenditure. Such facilities do not exist in India's healthcare system (2). The draft amendments focus on this issue and attempt to bring policy and legislation to view mental healthcare as a basic right.

Mental health policy revamp

The process of drafting amendments should be based on an analysis of the national mental health scenario. The amendments should address the gaps in the existing system and also lay the ground for a policy, based on the lessons learned from the past. As is noted in the commentary, the two activities address challenges that both the sector and people with mental health issues face. Given the high incidence and prevalence of mental illness and disability, this process needs no justification (3). The strengthened National Mental Health Programme, as part of the 11th Five Year Plan, not only allocated an increased budget of Rs 1,000 crore, but also aimed to "decentralise the Programme and synchronize with National Rural Health Mission". (4) However, it is debatable whether this led to any change or had any impact at the grassroots level, resulting in overall improvement of the quality of life of clients and their caregivers. To date only 123 of 626 districts are covered by the District Mental Health Programme (DMHP) and the status of these 123 districts is not entirely satisfactory. It is against this background that we must examine previous legislation and policy and evaluate their effectiveness or competencies.

The relation between poverty and ill health, mental health included, has long been discussed. However, the limited impact of the DMHP as it exists today cannot be attributed to poverty alone. We need to address the need for community services and culturally relevant, inclusive forms of treatment and therapy (5). We need better planned and strategised forms of training that are not entirely medicalised, for both mental health professionals and other management and administrative professionals. We also need additional human resources so that community or health workers are not overburdened. And while many speak of a failed DMHP, states like Kerala seem to have something better to showcase (6) and we should learn from these success stories.

Emergency services and hospitalisation will remain an important part of mental healthcare. The question is not of shutting down mental healthcare institutions but of whether these archaic structures can be made more humane and liveable. The ill effects of the process of unplanned "deinstitutionalisation" in the United States have been captured by Pete Earley, a journalist and a caregiver himself, in his book *Crazy: A father's search through America's mental health madness* (7). Almost overnight, mental hospitals were shut down with negligible community resources to depend on. As a result, many people with severe mental disorders became homeless and would wander the streets, and many finally ended up in prisons. In fact, some of the jails during this period had specific floors assigned for those with mental health issues. Earley speaks of the difficulties of dealing with real world concerns around his son's illness against this background. He speaks of times when he almost hoped that his son would get picked up by the police simply so he could initiate treatment which in his case would be life saving.

While the aim of universal access at the community level is admirable, we must ensure the basics are in place.

Human rights, mental health facilities, and involuntary commitment

The author has rightly stated that the move from being "objects of charity" and "dangerous" to being subjects with rights is a

much needed change, one that took long in coming because of stigma, discrimination, and the burden of the legacy of mental illness from earlier years. The draft amendments have tried to shed the "Mental Hospital Act"' feel and balance the need for emergency services and hospitalisation; while ensuring that mechanisms of checks and regulation are in place. Two provisions are particularly interesting: a client's access to the Mental Health Review Commission (MHRC) via telephone or mail, and the role of the MHRC, through which members are empowered to make unplanned visits to institutions to ensure that basic standards are maintained and the rights of its residents are safeguarded at all points (8).

Mental illness presents complex and unique scenarios. All precautions must be taken to balance the possible tensions between rights and care. The needs of clients must assume paramount importance; their care and well being must be the core of the intervention. The suggestion, in Section 20 of the draft amendments, to decrease the "supported admission period" - the period for which a person can be committed to a mental health facility without his/her consent - from 90 to 30 days is welcome (8). This will work well even for homeless persons with mental health issues, who otherwise may be forgotten within the system. However, the more difficult issue of homeless people with long term care needs may have to be addressed in greater detail. Can open rehabilitation homes in the least restrictive community environment be set up for this purpose?

There is always the fear that these checks remain on paper as part of the Act. After all, not many regulatory bodies have been able to go beyond presenting reports and laying norms and guidelines to actually effect change. One way to encourage this system and create transparency is to go the public-private partnership way and open one's doors to civil society participants.

Women, children and mental health

While some attention has been paid to children with mental health issues, mental retardation has been left out of the scope of the law, as the author notes. This is a vulnerable group and often prone to abuse within custodial institutions. A detailed look may be warranted, at the environment of those referred to as minors in the draft amendments. Similarly, in the case of women, neuropsychiatric conditions are estimated to be the second highest cause of disease burden worldwide (9). A UNDP report indicates that 70 per cent of the poor are women (10) and calls for special approaches to women's mental health. There is a need for an additional focus on women's mental and social health.

Convergence with other laws

While the need for an MHA cannot be dismissed, there is also a need to engage and work in tandem with other processes, be it the Persons with Disabilities Act, the National Trust Act or the National Health Bill. As the author points out, especially in an Indian context, the family or caregiver is affected, almost as much as the person with mental illness. Benefits and welfare measures are needed, especially with the majority of people living in poor socioeconomic conditions. Further, rehabilitation, while dependent on clinical and psychological interventions, also draws heavily from social processes such as inclusion in employment schemes and assistance in housing and hostel facilities.

Conclusion

Mental health issues have initiated extensive debate and continue to do so. Dr Murthy has rightly stated that one can neither over- nor under-medicalise mental illness. The draft amendments draw from this perspective in defining the role of mental health facilities and mental health professionals. Some out of the box thinking is needed to fine tune these definitions and lay down specific protocols, such that the roles of mental health professionals other than psychiatrists and medical practitioners are also specified.

The interests of individual groups should not override the general good, notes the author. There is a pressing need for the mental health lobby to capitalise on this process which has been much delayed and make the best of it, keeping in mind the needs of both clients and caregivers. It is the right time to engage in debate and discussion and contribute to changing the face of mental healthcare in our country.

At Banyan, we run a transit care service for homeless people with mental illness, two community mental health programmes, a long term care centre, and an independent living programme. We also have a large coalition of users/ survivors and caregivers under the fold of Amity, an activist movement, and the Banyan Academy of Leadership in Mental health, our training, research and advocacy wing.

As a service provider and a public health activist, I would like to see policy and legislation improve the lives of people at the grassroots. Access to care, the burden on the family, stigma, lack of emergency services, absence of welfare schemes and entitlements -- all these continue to plague the mental health sector, with the consequent impact on the lives of people with mental health issues and their caregivers. A good healthcare system should be equipped to deal with the needs of the most marginalised as well, more so in the case of mental illness and related vulnerabilities.

We need to be looking at the system with fresher perspectives, not just from a human rights stand (which should be cross cutting), but from the economic and health perspective of a developing country. The concept of a mental health system is still hazily defined with options other than the typical community programmes and mental hospitals scarcely discussed. How then will rehabilitation, allied services and a recovery-based model gain momentum? Critical issues of long-term care, both in the case of homeless persons and the elderly, haven't been dealt with seriously.

This issue must receive the attention that it deserves before it turns into the next crisis. Already we have mental hospitals

that house several residents for as long as 25 years. But merely emphasising the need to discharge is only solving one part of the problem. "Trans-institutionalisation" is another response which again is not a sustainable solution.

There is little or no innovative thinking as a result of which there is a sense of jadedness within the system. Accountability and effectiveness haven't been emphasised enough, and proper monitoring and evaluation is not built into the legislation or policy.

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Amendments to the Mental Health Act, 1987: key controversies

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In a well written article, Pratima Murthy (1) describes the current controversy surrounding mental health legislation in India. This controversy is a result of societal perception of what constitutes mental illness. These perceptions have changed over time, as society has grappled with problems like coming to terms with mental illness, the understanding of what causes it, and how it should be dealt with (2). The constructs of mental illness as a social dysfunction, as a purely a disorder of development, as solely a disability, and as a "mad response to a mad society", have all contributed to the way in which we have looked at different psychiatric disorders (3). This, in turn, has generated positions both supportive of, and hostile to, medical psychiatry, which itself has been developing in different ways, influenced by advances in both medicine and the social sciences.

This is why legislation worldwide, that earlier looked at protecting society from the mentally ill person and dealt mainly with confinement and restraint, now focuses on the rights of the patient with mental illness.

Societies also differ in the importance that they place on personal autonomy and the needs and responsibilities of family network systems. This is further nuanced by the fact that the "rights" of the person can be both the right to appropriate treatment and the right to refuse treatment. This becomes especially relevant in countries like India, where healthcare facilities are grossly inadequate, and, among these, psychiatric facilities are almost nonexistent (4).

There is also the fact that law and policy are inherently different tools. Law may look at safeguarding the rights of persons being admitted to a mental health facility against their expressed desire. Policy may determine the availability of funding for medical staff and supplies in far flung districts. However, we can use legislation as a means of actually effecting changes in existing practice, for example by writing into the legislation the requirement for state participation, and penalty clauses for non-delivery of service. The actual effectiveness of this policy in enforcing social change remains a subject of debate.