

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

ALOK SARIN

Senior Fellow, Nehru Memorial Museum and Library; Consultant Psychiatrist, Sitaram Bhartia Institute B 16, Qutub Institutional Area, New Delhi 110 016 INDIA email: aloksarin@gmail.com

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.

It is against this background that we approach the proposed amendments to the Mental Health Act, 1987 (5).

One particularly heartening societal change is the attempted transparency of manner with which legislative reform is approached. So, bitter and fractious though the conversations have been, the process of working with the draft amendments has tried to be both transparent and consultative. To this end, two drafts of the amendments have been prepared, feedback has been both invited and incorporated, and regional consultations have been held. The counter argument, however, has maintained that the process has neither been inclusive nor sufficiently consultative.

Murthy, in her article, highlights the main points of the proposed draft amendments. This is a well researched and well articulated piece, and many of the points she makes are valid, and do not need to be either stressed or repeated. As added commentary, the few points that I think need to be brought out are as follows:

The current discussion seems to revolve around a few pivotal issues:

1. Are the proposed draft amendments “rights based”, as required by the United Nations Convention on the Rights of Persons with Disabilities?

Disability activists are of the opinion that the amendments are not rights based. Proponents of the process are equally strongly of the opinion that they are. The positions seem to be defined by ideological differences which lend themselves to variable interpretations of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (6). It is clear that the UNCRPD defines a paradigm shift. It is equally clear that the UNCRPD does not create new rights. On the basic, bitterly-contested issue of involuntary hospitalisation, the issue has arisen out of the understanding of Article 12 of the UNCRPD. The question of involuntary treatment has often been compared to the proverbial “elephant in the room”, which is seen by everybody, but commented upon by none. The proponents of the draft hold that Article 12 does not exclude substituted decision making under certain circumstances and with adequate safeguards. This is an important issue, because one of the main objections has been that the amendments are not UNCRPD compliant; because section 19 and section 20 allow treatment with the consent of the nominated representative when the person is not able to give informed consent. It is my understanding that the UNCRPD is silent on this issue, leaving scope for interpretation. This understanding is also reflected in international dialogue: Canada has entered a “reservation” and Australia has made a “declaration” and “reservation” on Article 12. These essentially state that the two countries understand that Article 12 allows for supported or substituted decision making arrangements, under certain circumstances (7).

2. Are the proposed draft amendments possibly open to abuse?

To my mind, this is a question that needs more serious debate than it seems to have generated so far. The main issues raised in both the regional consultations, and in other such discussions are:

- a. The draft proposes an amended definition of mental illness as a “substantial disorder of mood, thought, perception, orientation or memory which grossly impairs a person’s behavior, judgment and ability to recognize reality or ability to meet the demands of normal life...” (5). Is there, then, a possibility that some centres will claim that there is no need for registration and oversight, because they are dealing only with the less severe, or “less substantial” cases? The proposal to drop the qualifiers “substantial” and “grossly” from the definition will, however, enlarge the purview of the act immensely.
- b. The suggestion of advance directives in the proposed draft has been debated strongly. The use of advance directives in certain conditions like terminal illness and dementia has been tried in different settings. In some psychiatric studies, like the US-based study on antipsychotics, CATIE (Clinical Antipsychotic Trials of Intervention Effectiveness) study (8), it has been used in making treatment decisions in psychiatric illness as well. The doubt has been raised that this provision may be misused by caregivers to usurp the property or other rights of people living with mental illness. Given that there is no widespread experience with this provision, this possibility certainly needs to be discussed in more detail, and appropriate safeguards built in.
- c. The third query has to do with whether the amendments are implementable. The proposed draft leaves oversight of mental health facilities to proposed Mental Health Review Commissions (MHRCs). These are elaborately designed and well conceptualised. However, the fear is that many facilities will be regulated by MHRCs that exist only on paper. We may be paving the way for an even more dismal scenario than exists at present.
- d. There also exist in India many “non-medical” facilities, which cater to people living with mental illness. These include religious shrines, rehabilitation centres, facilities run by non governmental organisations, facilities run by public spirited citizens, and facilities run on purely commercial lines. Not surprisingly, the experience with this diverse group has been mixed. So we have had tragic accidents, as happened in Erwadi on August 6, 2001. We have also had many inspiring examples of selfless service to the homeless mentally ill in Kerala, Karnataka and Tamil Nadu (4). The question remains: what form of legislative or regulatory oversight can be planned to prevent abuse, without curbing the growth of innovative and meaningful models? I believe that the suggestion that local bodies will create locally acceptable guidelines needs to be elaborated further.

3. The caregiver's perspective: The secondary debate in the wake of this process is whether the concerns and rights of caregivers of people with mental illness are adequately addressed in the draft proposal. This is important given that, in Indian society, the bulk of caregiving happens in the domestic space, and Indian society places as much value on the family unit as on personal autonomy. Legislation must reflect people's socio-cultural concerns, so the importance of this cannot be overstressed.

4. The law/policy debate: The final issue about which we need to think is how we visualise legislation as being directive of policy. As access to facilities for mental healthcare is introduced into the legislative process, this change from a "lean" mental health law probably needs some thought. It may be a tool to bring about change, but we need to give more consideration to this mode of policy planning.

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Making can-do into must-do; the way forward to health and wealth?

ARJUN JOSEPH, GAGANDEEP KANG

Christian Medical College, Vellore TN 632 004 INDIA e-mail: arjunkj1993@gmail.com , gkang@cmcvellore.ac.in

The Commission on Social Determinants of Health headed by Prof Sir Michael Marmot set an ambitious agenda to close the health gap between the rich and the poor in a generation (1). Constituted by the World Health Organization in 2005, the Commission submitted its report in 2008 and, in accordance with its recommendations, July 2010 saw the Economic and Social Council of the United Nations, supported by the World Health Organisation, pass resolutions for the adoption of issues related to health equity as a core global development goal (2). These efforts are key to the achievement of the Millennium Development Goals, a set of eight poverty alleviation goals set by the UN at the Millennium Summit in 2000, scheduled to be achieved by 2015 (3). Decision makers, activists, aid organisations and governments have been working towards these goals, and the levels of progress seem directly linked to the attention paid to social determinants of health by each country.

In this context, the Commission's remit is appropriate, if perhaps utopian, given the widening development gap in many parts of the world. The Commission, in its report, discussed how social conditions influence the access to and availability of

healthcare, resulting in differences in measurable, vital, event outcomes. For example, life expectancy is a reflection of per capita Gross Domestic Product with the difference between two Asian countries, Bangladesh and Japan, being 20 years. However, these differences operate on both a macro- and a micro-scale. Incredibly, in Glasgow, Scotland, the difference in life expectancy at birth between men in affluent and deprived suburbs is 28 years. The same story holds good for deaths in children under the age of 5 where the difference between the rates of deaths between the richest and poorest communities is 300% (4).

As the world changes with globalisation, in economics as in health, inequalities are growing. In the rest of the world, infant mortality has fallen to a third of what it used to be in 1970; while in Sub-Saharan Africa, infant mortality rates are those that the rest of the world had in 1970. So what really determines who lives and how long they live? These are the social determinants of health: age, gender, race, education and occupation and the conditions in which people are born, grow, live, work and age. These can also be defined as power, income and access to goods and services. The social determinants of