DISCUSSION

Beyond ECT: priorities in mental health care in India

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The Supreme Court petition (1) by the voluntary organisation *Saarthak* has triggered off a debate on the treatment of persons with mental disorders in India.

Some of the requests made in the petition are: to issue directives banning direct (unmodified) ECT and establishing a process for sanctioning modified ECT without informed consent; to strike down, as unconstitutional, section 81 (2) of the Mental Health Act, 1987 (MHA, 1987) which permits research on persons with mental disorders; to direct states to comply with section 4 of the Act which requires the setting up of state mental health authorities to regulate mental health care; to regulate the use of physical restraints and limit their use to extreme cases; to guarantee proper sanitary facilities to institutionalised persons; to ensure that institutions provide facilities for rehabilitation; to set up a mechanism to protect the rights of institutionalised people; to ensure that essential drugs are made available at all institutions, and to set up a scheme for legal assistance for patients in exercising their right of discharge under section 43 of the MHA, 1987.

Unfortunately, the debate has focused entirely on the issue of ECT. For the uninitiated, direct ECT is the administration of ECT without general anaesthesia, while modified ECT is the administration of ECT with general anaesthesia and muscle relaxants. This debate is a non-starter: it is accepted the world over that ECT must be administered in a modified form. It has been argued that there is a special case for permitting direct ECT in India because of the lack of facilities for anaesthesia, and to reduce the costs of treatment. Both these arguments are spurious. ECT is a major procedure and must be carried out under reasonably safe medical conditions.

An assault on clinical autonomy?

Three demands in the petition have raised the hackles of the psychiatric community: to establish a procedure for administering ECT without consent, for a ban on research on medical research on patients with mental disorders, and for regulating the use of restraints. These have been perceived as an assault on clinical autonomy. One may argue that the procedures suggested in the *Saarthak* PIL are difficult to implement in Indian conditions. However, it is difficult to argue against the principle of regulation of involuntary treatment and of the use of restraints.

Other points in the petition, such as the provision of rehabilitation facilities in all institutions, have attracted little attention, though they are probably the most important and can have far-reaching effects on the quality of life of persons with mental disorders.

The real issues in mental health

Almost everyone agrees that the most important issue in the field of mental health is the lack of access to high quality care for a majority of the population. Treatment, when available, 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. It is well accepted that mental health care needs to be multi-disciplinary, involving professionals such as psychologists, psychiatric nurses and psychiatric social workers. However, such care is limited to a few centres in our country.

Mental disorders account for nearly 15 per cent of health-related disability but most countries, including India, devote less than 1 per cent of the total health budget to mental health services. Mental health services are labour intensive and human resources make up a significant proportion of the costs. However, there is an acute scarcity of adequately trained mental health professionals in the country. This is unlikely to change in the near future given the shortage of training facilities.

Most countries have between two and three times as many psychologists, social workers and psychiatric nurses as psychiatrists. In India, it is estimated that there are more psychiatrists in active clinical practice than there are trained psychiatric nurses, clinical psychologists and psychiatric social workers. No systematic efforts are being made to address this distortion, by professional organisations or by the government.

For mental health care to become accessible within existing resource constraints, it must be provided through primary health services. This approach has many advantages. Clinical outcomes of primary care for most common and acute mental disorders are as good as in specialised psychiatric services, if not better (2). Primary health services are less stigmatising than psychiatric services, and there is also a lower risk of human rights violations. They are geographically closer to the user, increasing the likelihood that people seek help early in the illness. Finally, mental health care through primary health services is less expensive (and more cost-effective) both for service providers and recipients.

However, primary health care professionals will have to be trained to detect and treat mental disorders. It is unreasonable to expect already overburdened staff in the state-run primary health system to take on more labour- and time-intensive interventions. It may be necessary to increase the number of general staff if a mental health care component is to be added. Other issues that need addressing include supervision of

primary health care staff, adequate infrastructure and equipment and, most important, the availability of psychotropic medication.

Internationally, there is a movement away from providing institution-based care. This change will not take place in India unless alternatives are put in place including rehabilitation facilities, long-stay homes in the community and community psychiatric services. The primary health care-based community mental health programme in India covers only 22 districts with a population coverage of 40 million, which is less than five per cent of India's population.

A public health approach needed

Mental health treatment and care must be integrated within and outside the health services. In health care, it needs to be integrated into the various levels of health care. There are also opportunities for integration into vertical health programmes. For example, a programme to tackle post-partum depression (which affects 25-30 per cent of mothers in the first year after delivery), can be integrated into the RCH programme.

Outside health care, mental health services must work in collaboration with agencies dealing with housing, employment, social welfare and the criminal justice system. They can also be integrated into social programmes; for example, a programme to tackle depression among women can be integrated into programmes addressing domestic violence. Finally, integration demands collaboration between the government medical sector, private providers, NGOs and traditional health providers. There are good examples of NGO participation in the provision of good quality mental health care in India; these need to be replicated across the country (3).

Protection of human rights

The National Human Rights Commission's inquiry into the functioning of mental hospitals in India documents serious human rights abuses in many mental institutions across the country (4). International standards such as the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (5), though not legally binding, represent an international consensus on standards of good practice. International human rights covenants provide legally enforceable protection of human rights in signatory states. For example, Article 7 of International Covenant on Civil and Political Rights (6), to which India is a signatory, provides all individuals, including those with mental disorders, protection from torture, cruel or inhuman or degrading treatment or punishment and the right not to be subjected to medical or scientific experimentation without informed consent. The *Saarthak* PIL asks for implementation of many of these internationally agreed standards and covenants.

The role of legislation

Mental health legislation has an important role to play in the protection of human rights. Mental disorders sometimes affect people's decision-making capacities and they may not always seek or accept treatment for their problems. Rarely, persons with mental disorders may pose a risk to themselves and others due to impaired decision-making abilities. Most important, persons with mental disorders face stigma, discrimination and marginalisation.

Legislation must strike a fine balance between the individual's rights to liberty and dignity, and society's need for protection. It must address issues such as integration into the community, access to high quality care,and protecting the rights of persons with mental disorders, including in areas such as employment, education and housing.

From this perspective, MHA 1987, is woefully inadequate as it focuses entirely on the provision of treatment in what it calls psychiatric hospitals and psychiatric nursing homes. The chapter dealing with human rights contains only one section on research on persons with mental disorders. There is little understanding of the need to protect the rights of persons with mental disorders when treatment is administered without their consent.

The *Saarthak* petition mentions only involuntary ECT. Many would argue that it does not go far enough. In most countries, an independent authority (not the family) on a psychiatrist's recommendation must sanction and supervise involuntary treatment of all kinds.

Mental health legislation in many countries also gives persons under involuntary treatment the right to review. Under the MHA 1987, the State Mental Health Authority is charged with this supervisory function. But as mentioned in the *Saarthak* petition, such bodies have not yet been established by many states.

The *Saarthak* petition has to be viewed in the broader context of provision of mental health care in India. The petition and the consequent debate presents an opportunity to discuss the (lack of) provision of mental health care, and related human rights issues. This opportunity should not be lost by limiting the debate to ECT.

References

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