



LEGISLATION OF MENTAL HEALTH

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Abstract

Mental health legislation plays an important role in implementing effective mental health services, particularly by utilizing political and popular will to reinforce national mental health policies. Enactment of mental health legislation can improve funding of mental health services, create accountability for those responsible for providing mental health services and overcome bureaucratic gridlock to ensure compliance with mental health policies and directives. WHO and international guiding principles for mental health care mandate that all human rights, including the right to privacy, informed consent, confidentiality, freedom from cruel and unusual treatment and nondiscrimination should be guaranteed through mental health legislation. . The growth of voluntary action for mental health care in the areas of suicide prevention, disaster mental health care, setting up of community mental health care facilities, movement of family members (care givers) of mentally ill individuals, drug dependence, public interest litigation to address the human rights of the mentally ill; research in depression, schizophrenia and child psychiatric problems are other major developmentsThe advantage of the Mental Health 1987 is that the act is conceptually steps ahead of ILA (Indian Lunacy Act), 1912, trying to keep pace with advances in psychopathology and psychopharmacology Mental health legislation should include integration with NMHP and NGO's to improve community and primary psychiatric services. Legislation should ensure the introduction of mental health interventions into primary health care. In developing countries like ours delivering mental health services through primary health services is the most viable strategy. Mental health legislation is essential for complementing and reinforcing mental health policy and providing a legal framework for meeting its goals. Such legislation can protect human rights, enhance the quality of mental health services and promote the integration of persons with mental disorders

KEYWORDS: Legislation, Mental, Health, Who, Community, National Health Policy

INTRODUCTION

Mental health legislation is essential for protecting the rights and dignity of persons with mental disorders, and for developing accessible and effective mental health services. Effective mental health legislation can provide a legal framework to integrate mental health services into the community and to overcome stigma, discrimination and exclusion of mentally-ill persons. Legislation can also create enforceable standards for high quality medical care, improve access to care, and protect civil, political, social and economic rights of mentally-ill individuals, including a right of access to education, housing, employment and social security. Furthermore, mental health law can establish guidelines through which a country develops its mental health policy, or reinforce previously established mental health policies that seek to provide effective and accessible mental health care through the community. Mental health legislation plays an important role in implementing effective mental health services, particularly by utilizing political and popular will to reinforce national mental health policies. Enactment of mental health



legislation can improve funding of mental health services, create accountability for those responsible for providing mental health services and overcome bureaucratic gridlock to ensure compliance with mental health policies and directives. WHO and international guiding principles for mental health care mandate that all human rights, including the right to privacy, informed consent, confidentiality, freedom from cruel and unusual treatment and nondiscrimination should be guaranteed through mental health legislation.

WHO HEALTH REPORT (2001) it was reported that 67% of countries in South-Asia have mental health legislation and rest of the 33% have no such law. Mental health care in India over the last 25 years has been an intense period of growth and innovation. India enters the new millennium with many changes in the social, political, and economic fields with an urgent need for reorganization of policies and programmes. The mental health scene in India, in recent times, reflects the complexity of developing mental health policy in a developing country. The National Health Policy (2002) clearly spells out the place of mental health in the overall planning of health care. These developments have occurred against the over 25 yr of efforts to integrate mental Dr. J. K. Trivedi health care with primary health care (from 1975), replacement of the Indian Lunacy Act 1912 by the Mental Health Act 1987, and the enactment of The Persons with Disabilities Act 1995 focusing on the equal opportunities, protection of rights and full participation of disabled persons. The growth of voluntary action for mental health care in the areas of suicide prevention, disaster mental health care, setting up of community mental health care facilities, movement of family members (care givers) of mentally ill individuals, drug dependence, public interest litigation to address the human rights of the mentally ill; research in depression, schizophrenia and child psychiatric problems are other major developments. The rapid growth of private psychiatry with associated spread of services to peripheral cities and small towns and challenges of regulation is another significant development of the last 10 years. Against the above positive developments, the main challenges are the extremely limited number of mental health professionals (about 10,000 professionals of all categories for one billion population) and the very limited mental health service infrastructure (about 30,000 psychiatric beds for over a billion population); limited investment in health by the government (estimated public sector expenditure on health is only 17 % of total health expenditure) and problems of poverty (about 30% of population live below poverty line) and low literacy with associated stigma and discrimination for persons with mental disorders (Murthy, 2004).

Prior to 1993, Indian Lunacy Act, 1912 was governing the mental health in India. In 1947 when we got independence and Indian Psychiatric society came into existence, ILA, 1912 was considered an inappropriate act for mentally ill. So IPS drafted a mental health bill and submitted it to govt. of India 1950 but it took another 28 years for govt. to present it in the Lok Sabha which was subsequently referred to JPC. Various committees established didn't consult IPS at any juncture though 10 psychiatrists were invited to give oral evidences. After a gap of another 8 years the bill was adopted as Mental Health Bill by Rajya Sabha in 1986 and the Lok Sabha in



1987. This bill received President's assent on May, 1987 but another 6 years were wasted before finally implementing the act in April 1993. Terminologies used in the act new term previously used terms Psychiatric hospital Nursing home Asylum Mentally ill person Lunatic Mentally ill prisoner Criminal Lunatic Other important terminologies used in the act 1. Reception order: Means an order for admission and detention of a mentally ill person in a psychiatric hospital or nursing home. 2. Psychiatric hospital or nursing home: It is a hospital for the mentally ill persons maintained by the government or private party with facilities for outpatient treatment and registered with appropriate licensing authority. Admitting a mentally ill to a general nursing home is an offence. 3. Medical officer: A registered medical practitioner. 4. Medical officer in-charge: Is a medical officer who is in-charge of a psychiatric hospital or nursing home. 5. Mentally ill person: Is a person suffering from mental disorder, other than mental retardation, (12) needing treatment. 6. Mentally ill prisoner: Is a mentally ill person, ordered for detention in a psychiatric hospital, jail or other places of safe custody Objectives of the act

To establish central and state authorities for licensing and supervising the psychiatric hospitals. 2. To establish such psychiatric hospitals and nursing homes. 3. To provide a check on working of these hospitals. 4. To provide for the custody of mentally ill persons who are unable to look after themselves and are dangerous for themselves and or, others. 5. To protect the society from dangerous manifestations of mentally ill. 6. To regulate procedure of admission and discharge of mentally ill persons to the psychiatric hospitals or nursing homes either on voluntary basis or on request. 7. To safeguard the rights of these detained individuals. 8. To protect citizens from being detained unnecessarily. 9. To provide for the maintenance charges of mentally ill persons undergoing treatment in such hospitals. 10. To provide legal aid to poor mentally ill criminals at state expenses 11. To change offensive terminologies of Indian Lunacy act to new soother ones T.

The advantage of the Mental Health 1987 is that the act is conceptually steps ahead of ILA (Indian Lunacy Act), 1912, trying to keep pace with advances in psychopathology and psychopharmacology. The fact that even four decades after Indian received its independence, we were continuing with an outdated and anarchic law speaks volumes about the importance of this act.

Anarchic Indian Lunacy Act 1912, various positive changes in the MHA, 1987 are: More humane approach to problems of mentally ill persons by changing the terminology e. g. lunatics and criminal lunatics have been replaced by the term mentally ill person and mentally ill prisoner etc. and new chapters on management of their property and protection of human rights have been included • Creation of Central and State Mental Health Authorities- a welcome step to safeguard the interests of the mentally ill person under one authority • Procedure for admission and discharge of voluntary patients have been simplified and liberalized. In this act, no consent from two visitors is required as well as no written request is required • Minor can be admitted with the



consent of a guardian under this act. This provision is not there in the Indian Lunacy Act, 1912 (13) • Separate provision for admission of involuntary patients under category “Admissions under Special Circumstances” • Special centers for special population like drug addicts, under 16 years, mentally ill prisoners etc. • Establishment and maintenance of psychiatric hospitals and psychiatric nursing homes in private sector which was not in the earlier law. • Discharge procedure have been made easy and more simplified • There are new different addition in this law like protection of human rights of mentally ill persons, penalties, cost of maintenance and management of properties of mentally ill persons

Mental health legislation should include integration with NMHP and NGO's to improve community and primary psychiatric services. Legislation should ensure the introduction of mental health interventions into primary health care. In developing countries like ours delivering mental health services through primary health services is the most viable strategy. Integrated care reduces stigma associated with mental illnesses and also promotes mental health: It deals with the protection of human rights of mentally ill persons. Suggested changes: Once a person is admitted to mental hospital he is termed insane or mad by the society. There should be provisions in the act to educate the society against these misconceptions. Indian common law provides a patient with a right to informed consent and confidentiality of patient records, although the Mental Health Act only requires informed consent for experimental treatment. It is provided that research on such subjects can be carried out by consent of guardian or if such research is of direct benefit to him for purposes of diagnosis or treatment. Is it not like treating them as inanimate objects? This provision violates human rights and should be amended. Indian law severely curtails the civil and political rights of mentally ill individuals.

NATIONAL MENTAL HEALTH PROGRAMM

India is one of the few countries that have a National Health Policy (NHP, 2002) that mentions mental health, as well as a National Mental Health Program (NMHP) and a dedicated Mental Health Act 1987 (MHA). By identifying PHCs as the epicenter for psychiatric treatment, NMHP (1982) attempted to integrate mental health into general health. It also proposed to deinstitutionalize to a community rather than hospital based model. However, by 2002, only 100 of 600 districts were brought under NMHP. This failure was due to poor funding, inadequate undergrad curriculum in psychiatry and manpower shortage, and poor evaluation, non-implementation of MHA and privatization of mental health care. The 11th Plan with a Rs1000 cr. allocation for mental health proposes to cover the remaining 500 districts by the end of the Plan period. However, mental illness is a progressive disorder; for every 100 districts covered each year, there will be a backlog of districts without mental health services (source www.acmiindia.com). Psychiatrists insist that “Early treatment is early recovery”, but this has escaped the attention of health experts in the Planning Commission: for this oversight, victims in rural areas are likely to pay the price. We do appreciate the manpower constraints- around 4500



trained mental health workers for 40 million mentally disabled patients. That is precisely why global strategies call for integration into general health programs. NHRC (1999) report says that there is on an average, 1 PHC for every 30,000 population, 1 doctor for every 3000 population, one male and female worker for every 3 to 5000 population. NRHM proposes to cover 18 States under the 11th Plan. The ASHA (Accredited Social Health Activists) volunteers are best suited to detect early and typical symptoms of mental disorders seen in the PHCs. Besides, the need of the hour is suitable and just allocation of resources at grassroots levels, greater number and better trained workers at PHC level, fixing the responsibility for adequate utilization of resources, strong monitoring mechanisms with legal powers and provision of regular review. It would also be highly useful to take help of NGO's and to involve mass media in these endeavors.

CONCLUSION

Mental health legislation should be viewed as a process rather than as an event that occurs just once in many decades. This allows it to be amended in response to advances in the treatment of mental disorders and to developments in service delivery systems. However, frequent amendments to legislation are not feasible because of the time and financial resources required and the need to consult all stakeholders. A possible solution is to lay down regulations that are separate from legislation but can be enforced through it. Legislation can include provision for the establishment of regulations and can outline the (18) procedure for modifying them. The most important advantage of regulations is that they do not require lawmakers to be repeatedly voting for amendments. Mental health legislation is essential for complementing and reinforcing mental health policy and providing a legal framework for meeting its goals. Such legislation can protect human rights, enhance the quality of mental health services and promote the integration of persons with mental disorders into communities. The basic function of any law is to frame rules and regulations which are least restricting and will enable the weak to enjoy all their civil rights without any hindrances. A more penal and less therapeutic service would only increase the isolation of psychiatry from other clinical Specialties.

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