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Why We Should Opt For a New Mental Health Act, and Not Tinker with the Old One?

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Mental Health Act (1987) was notified by the Central Government in 1990.It took several more years for the State Governments to notify the rules required for its implementation. Even then actual implementation was delayed in most states till about four years back when Supreme Court during its hearings of the Public Interest Litigation (Writ petition 334 of 2001) on Erwady tragedy found that the Act had hardly been implemented.

Although the profession has been aware and critical of some provisions of the act right since 1990 (Kala,1997),its actual implementation in the field has thrown up many more incongruities(Trivedi,2002) .The Indian Psychiatric Society, during 1999 held a a series of seminars around the country on the subject which culminated in a national seminar. The consensus was overwhelmingly for a change. Since the actual implementation of the act, this consensus has evolved into a clamour. However two myths about Mental Health Act have managed to persist in the collective mind of the profession.

The first of these two myths is that it is unkind to the psychiatrists in the private sector (implying that psychiatrists in government hospitals have no problem with it). Till some years back at professional fora, a well meaning colleague in a government hospital would advise his counter-part in private practice " It is a good Act; you should not resist it." The fact of the matter is that while private psychiatrists have more or less weathered the storm of compulsory licensing even though, in place like Chhattisgarh, authorities in a bizarre blitzkrieg wanted even OPD's to be licensed, the reality is dawning only now that Mental Health Act is so irrational towards Government psychiatric services that it simply cannot be followed.

Section 19 & 20 of the Act which govern the involuntary admissions lay down that, involuntary admissions can be done only at psychiatric hospitals and section 2(q) of the Act specifically excludes psychiatric wards of government general hospitals from definition of psychiatric hospitals or nursing homes. Thus we have a situation where involuntary admissions are illegal in all the 100 odd departments of psychiatry of government medical colleges and several non-teaching government general hospitals. Thus, hundreds of involuntary admissions of acutely disturbed patients done in government GHPU's throughout the length & breadth of the country on the basis of a relative's signature are illegal (unless the patient is a minor) and the psychiatrists who enforces any such admission is technically committing a criminal act of wrongful confinement. I am not advising that it should be stopped, i am just pointing out the degree of absurdity of the situation.

Infact MHA is deterrent to general hospital psychiatry movement as such, which is one of the succes stories of post- independence psychiatry scene in the country. It dents the government general hospital psychiatry by banning involuntary admissions there and it has already harmed the private general hospital psychiatry because both corporate & charitable general hospitals have stopped having separate psychiatry beds because it invites licensing & visitors board which are perceived as harassing.

The second myth is that, while most of the members of the profession have come around to the view point that the law needs to be changed, the belief is that amendments to the existing law would be better and easier than asking for a whole new law. I submit that these presumptions are wrong. Both amendments & new law have to be debated & passed by parliament. The only difference is that drafting a new law takes a bit longer but if we start right away and have a national debate on it within and outside the profession within the next year or so, it would definitely be worth it.

Second reason why amendments should not be opted for is that, the basic philosophy of Mental Health Act (1987) is flawed and institutional in approach. Not for nothing, it has been cynically called " Mental Hospital Act". A good law should address situations rather that structures. The flaws are so much inbuilt that even if piecemeal amendments were done, we would still end up with a bad law. An analogy from architecture is not wholly out of place. If the design of a house is basically wrong, then it is much easier to pull it down and make a new house rather than make patch work alterations.

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If we opt for the amendments, next obvious question is what amendments? If the profession were asked to come up with a wish list, we would come up with amendments to Section 6 and Section 37 (which deal with licensing and visitors board) making these sections inapplicable to short stay , acute care setups because these are anyway transparent settings since families stay with the patients and since members of visitors board particularly from same community are perceived by families as intrusive on privacy of treatment and deterrent to treatment with dignity and thus stigmatizing.

We could also ask for amendment to Section 2-q, clipping its tail which contains the clause excluding Governments GHPU's from definitions of a psychiatric hospital thus paving way for legalising involuntary admission to government general hospitals.So, why do we not ask for these amendments.? Because it would be so politically naive to do it that it would border on being suicidal. Because the perception of rest of the society, particularly of human rights activists and NGO's to such amendments will be entirely different & derogatory to us.We as a profession would be projected as trade unionists who don't want regulation and monitoring. This would result not only in the amendments being blocked but the profession being maligned irreparably in the process.It would have been one thing to not have included over-regulatory clauses before 1987; it is quite another to remove them now that these are there. Hence we come to the inescapable conclusion that a new Mental Health Act would not only give us for more opportunities for basic structural changes in legislation but also that it is the only practical alternative.

So it is time to shed cynicism that a new Law would take thirty to forty years in being formed like the current Act. We live in different times with a much better networked and faster communicating world. If we can have a Juvenile Justice Act (1986) and Juvenile Justice Act (2001), why cannot we have a Mental Health Act (1987) and Mental Health Act (2006)! We should also shed complacence which we have lately slipped into.As far as acute care is concerned the really intrusive provisions of MHA,namely visitors board have not been even implemented fully.

The most logical question of course is what radically different Law should be there once we have decided that there should be a new Law since the old one is beyond redemption. One can at least examine various constructs and models which are possible.

The first model is of 'No law'. After all, there are 40 countries in the world which have no mental health legislation (World Health Report,2001). But these countries never had a law and no body would advise to abolish an existing Mental Health Legislation since it is bedrock of human rights of the mentally ill in a society.

The second model would be to have a law of an all encompassing and omnibus nature which includes (to regulate) mental health services of every kind including community care, primary care, general hospital care, acute care, long term care and rehabilitation. Even outpatient care has been covered in New York State and lately some other States of USA, and orders can be issued for involuntary out- patients treatment. It is called Assisted Outpatients Treatment (AOT) or Kendra's Law and was named after Kendra Webdale,a young woman who died in Jan.,1999 after being pushed in front of a New York city subway train by a person who failed to take the medication prescribed for his mental illness.

As opposed to this we can have a minimalistic law which deals only with involuntary treatment or restraint of the mentally ill which in any case is by far the most significant issue in any Mental Health Legislation and leave all other situations and issues to be governed by separate rules for each situations.

We can also have a model where the law enforces availability & adequacy of treatment wherever treatment is required. Examples are most States of USA where incidentally each State has a different Act, which again is something to think about (Pennsylvania's Mental Health Act,2001)

Still another important issue would be the definition of mental illness. While one could have a narrow definition which would cover the grossest of psychotic disorders or to have a broad definition to include even the personality disorders. Example of the latter would be the UK Government's controversial white paper which seeks to restrain persons with severe personality disorders even before they had committed a violent act (Grounds, 2001).

One of efficient ways would be to delink licensing provisions of MHA,1987 from its provisions for involuntary admissions. Licensing of premises of psychiatric hospitals can be left to State Governments which may result in different norms for different states depending upon availability of manpower resources.Licensing & monitoring requirements can also be different for acute care, and long term care. While even at present, norms for licensing psychiatric hospitals can be

changed by state governments,these changes require to be approved by central government which makes these very difficult.

Involuntary admission procedures can be the central core of the Act and would apply throughout the country irrespective of the setting; it should be possible in primary care, general hospital,psychiatric hospital, rehab centers, an army base hospital etc., as long as the provisions are met and procedures followed. This would be a welcome and radical departure from the current law where involuntary admissions are possible only at centers designated as psychiatric hospitals or psychiatric nursing homes.

Involuntary admission should be governed by a cascade of rules becoming progressively more stringent with the duration of admission. For example, a single psychiatrist should be able to restrain a patient for a short duration of 48 hrs during which he can be given immediate required treatment and is transported for a long involuntary admission elsewhere unless he is well enough at the end of 48hours to be treated in OPD or consents to voluntary treatment .Admission for upto 28 days may require consent of two psychiatrists and for upto 6 months three psychiatrists.This model is similar to the mental health acts of U.K. This slew of rules is ideally suited for Indian setting where patients in remote locations some times need involuntary treatment and nearest psychiatric hospital is far off. Incidentally Mental Health Act (1987) of India has no provision for transportation of an unwilling patient except by police.

MHA (1987) lacks on human rights front because every complaint of perceived wrongful restraint has to go to the courts which are clogged with mainstream cases and magistrates are not sensitized to psychiatric patients or disorders. A major correction will be to have full time Mental Health Tribunals for each State to adjucate such complaints like in U.K. (Eldergill,1997)

Lastly the new law should have an in built provision for a compulsory review every 10 years that takes into consideration the social changes and advances in treatment which are bound to occur over a period of time necessitating fine tuning of legislation every decade or so.

Because of infirmities of MHA,because of un-implementability of some of its parts and because of its un-amendability, we have a historic opportunity to opt for a law which would conceptually and philosophically be in tune with real life psychiatry as it is actually practiced in the country. Let us take it.

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