A New Mental Health Act for India: An Ethics based Approach

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ABSTRACT

The paper makes the case for a new mental health act for India in view of the deficiencies of the current act. It argues that any new mental health act must be grounded in sound ethical principles, value basic human rights, provide powers to those who treat mental disorders and reflect the values and trends of the modern world. It favours a quasi-legal system with opportunities for independent scrutiny, allows treatment consistent with ethical and legal principles, one that makes way for a more transparent and accountable system. Such a system, the paper asserts, will be legally, ethically and clinically relevant, responsive, accessible and available at the time of need and therefore user-friendly. It recommends the linkage of the act with existing mental health policies of the government, thereby making the act powerful and interwoven in the tapestry of health care delivery initiatives of the government.

Introduction

The Indian Psychiatric Society (IPS) has decided to draft a new Mental Health Act (MHA) for the country and has constituted a task force for this purpose (Kallivayalil 2004). It is hoped that the draft would reflect the sometimes competing needs of various parties to a MHA, such as patients, doctors and the judiciary. In a country like India with its tradition of family support and help, there must be consideration of the views and wishes of the family too. It is to be hoped that any new MHA would reflect the realities of the 21st century, most particularly in the principles that are enshrined in it and the balance it draws upon the conflicting needs of protecting patients and public as well as safeguarding the human rights of the patients. One of the primary reasons for the potential demise of the Indian MHA of 1987 is the relative paucity in it of some of the key features noted above.

Difficulties with Mental Health Act, 1987

The MHA ‘87 is an advancement on its predecessors, the Indian Lunacy Act 1912, The Lunacy (supreme court) Act, 1853 (Act 34 of 1858), The lunacy (District Courts) Act, 1858 (Act 35 of 1858), The Indian Lunatic Asylums Act (Act 360 of 1858), The Military Lunatics Act 1877 (Act 11 of 1877), The Indian Lunatic Asylums (Amendment) Act, 1886 (Act 18 of 1886), and The Indian Lunatic Asylums (Amendment) Act 1889 (Act 20 of 1889).

In a nutshell, it has been suggested that the progressive features of MHA ‘87 include, relative to its predecessors (a) an incorporation of modern concepts of mental illness and treatment, (b) primacy of the role of medical officers (c) simplification of the rules of admission and discharge (d) protection of human rights of the patients (e) providing for supervision of the standard of care in psychiatric hospitals (by creating the Mental Health Authority) (f) provision of penalties in case of breach of laws in connection with welfare of the patients and (g) care is the ultimate aim and not the custody alone (Banerjee)

However, the MHA 87 has had a troubled life ever since it came into pragmatic being in 1993. There have been substantial critiques of the act, which has been labelled as being i) overly legal in its scope, process and outcome, stressing upon custody with little regard for therapeutic aspects of psychiatric care, ii) establishing similar legal controls upon both voluntary and non-voluntary classes of patients, and iii) being discriminatory towards non-governmental institutions of psychiatric care (Trivedi, 2002).

Another reason for the act’s unpopularity is its relative silence on the more practical aspects of patient care that psychiatrists face on a daily basis. It is also true that many patients in India are regularly admitted against their wishes by psychiatrists on the basis of proxy consent provided by friends and relatives and treated against their wishes without recourse to a legally justifiable means of doing so. Whilst doing so obviously saves the patient, his/her family and the relevant hospital administrative systems the onerous task of navigating through the legal requirements that admitting them using the MHA ‘87 would require, such practices nonetheless tacitly encourages the blatant flouting of some sensible recommendations that the MHA ‘87 contains.

Disregard for the norms and regulations of the act is thought to have led to the horrific incidence of Erawady where over a score of patients were burned to death after they were left overnight, chained to their horrible fates. Erawady awakened the judiciary who thereafter insisted, following directives issued by the Supreme Court, that the MHA ‘87

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be implemented unfailingly in every state. Whilst the judiciary cannot be faulted for such a directive, it has nevertheless led to a prescription of a pedantic adherence to the letter and not the spirit of the act. For instance, the Chattisgarh Government has recently insisted that practicing psychiatrists must obtain a license for running outpatient clinics, failing which they faced the threat of closure (Trivedi 2002). Such legal attention amongst other reasons, has highlighted the multiple shortfalls and lacunae within the MHA ’87 and the practice of psychiatry in India leading to increasing calls from within the psychiatric fraternity, represented by the IPS, for its root and branch reform rather than minor amendments to the existing Act (Kala 2004).

**Basic Principles of Mental Health Legislation**

Promoting liberty, protecting individuals from harm caused by those at liberty, and those not at liberty from abuse by those who are, alleviating suffering, and restoring to health those whose health has declined are all legitimate objectives of a state as they reflect the values embraced by virtually all members of a society (Eldergill 1997). That such values will be reflected in statutes created by parliamentary democracies is laudable, although doing so equally provides the state with opportunities to intervene in people’s private lives. Allowing the state to use its powers in this manner may have a negative impact if it produces erroneous laws (albeit with good intentions) that are more likely to affect the lay citizen than legislators who make them, and who are thus less inclined to repeal them. It is also the case that mistakes made by individuals are relatively easier to rectify than mistakes made by the law (judiciary) and it is well known that politicians are more inclined than citizens to make decisions based upon political gain and prejudice, rather than principle (Constant 1988).

Mental health legislation tends to give power to one (or more) person(s) over another which can be used, often in a paternalistic manner, to abuse. This risk of abuse is multiplied if an individual is not free to escape, is incapacitated or otherwise vulnerable, and/or their word is not given the same weight as that of others. For these reasons, children and adults with mental health problems are particularly at risk, and the law has usually afforded them special protection in democratic western societies. When enacting mental health legislation, parliaments in liberal democracies have generally sought to create a balanced legal structure that harmonises three key issues: individual liberty (of the patient), providing treatment where it is necessary and can prove beneficial, and protection of the public.

This balance is pragmatically achieved by imposing legal duties on those with power, conferring legal rights on those within their power, and independent scrutiny of how these powers and duties are exercised. The effectiveness of such schemes depends on whether, and to what extent, they are observed. This is a matter of constitutional importance, for the observance of legal rights and the rule of law are the cornerstones of liberal democracies. The rule of law implies the subordination of all authorities, legislative, executive and judicial to fundamental principles of justice, moral principles, fairness and due process. It implies respect for the supreme value and dignity of the individual (Walker 1980). It further implies that even beyond a government enforcing and maintaining law and order, the government is itself subject to rules of law and cannot disregard the law or remake it to suit itself (ibid).

**Involuntary Care of Mentally Disordered people**

The foremost function of an MHA is to provide a framework for the involuntary detention of mentally disordered people in places of safety where appropriate treatment can be provided to them. There are many ways of doing so but the most effective, practically and principally, must be one that is rooted in ethical and legal principles, based upon appropriate ethical tests that are clear, precise and subject to legal scrutiny. Any new law should impose the most minimum powers as possible, specify duties and rights, provide mechanisms for enforcing duties and remedies for abuse of powers, be unambiguous, just in plain language, and as short as possible. In the following paragraphs, a range of ethical and legal points are raised and discussed with examples about modes of involuntary detention, treatment against consent by patient, and discharge procedures. The focus is on the more practical aspects of providing mental health care and ease of accessibility and use of the act by all concerned.

1a) Capacity based test

One of the most significant of human rights is that of autonomy. Autonomy represents the inalienable power of a person to make decisions that he believes are in his best interest of his life. Within a health context, an autonomous person suffering from a disorder can choose either to accept (provide consent to the doctor) or refuse treatment even if the decision eventually leads to his death, e.g. a cancer patient refusing treatment due to his unwillingness or inability to tolerate troublesome side effects of treatment. One cannot forcibly treat that person against his will, although professionals may concur that it is an
that he lacks the mental capacity to make that decision. Mental capacity to make a decision on whether to accept (or refuse) treatment is based upon professionals providing information to a patient about appropriate treatment, the benefits and the risks (side effects, complications) associated with such treatment, and any available alternatives to the treatment. A person is said to be mentally capacitous if he is able to understand and retain the health related information provided, believe it and be able to balance the pros and cons of accepting (or refusing) the treatment before arriving at a decision (Re M.B 1997). Such capacity forms the basis for a valid consent regarding any form of treatment, be it for physical or mental disorders. A person with a demonstrably intact mental capacity can even agree to or refuse treatment for physical disorders when mentally disordered, suggesting that capacity is a flexible and can vary in terms of what is at issue (Re C 1994). When a person accepts treatment voluntarily then there ought not to be any need to legally coerce him because he is accepting the advice given. The need to legally sanction the treatment and detain a voluntary patient, a requirement of the Indian MHA ’87, is therefore contrary to ethical notions of what is just, fair and reasonable and can be challenged in a court of law.

A capacity based test to determine involuntary admission will insist that patients are only admitted and treated under compulsion when they do not possess adequate mental capacity. People with dementia, mental retardation and those with severe and florid psychosis are likely to lose their capacity and not be autonomous in their choices as they are unlikely to meet the necessary criteria. However, it is perfectly possible for someone with severe depression who is also suicidal to fulfill all the criteria, be found to be capacitous but refuse the treatment offered and thereby pose a grave risk of self harm and completed suicide. The capacity based model, therefore, will allow a depressed suicidal patient to avoid necessary treatment and be ethically justified in harming themselves. As is obvious this test allows very little discretion to a clinician.

1b) Principle of best interest

When a person is capacitous, no consideration is given to the consequences (to self or others) of their refusal of treatment. It is only when the patient lacks capacity does the law turn towards the principle of ‘best interest’. This determines that although the patient is unable to (e.g due to unconsciousness) or refusing (e.g. mentally ill) to consent, treatment can still be given against his wishes as it is:

a) necessary to save life, prevent a deterioration or ensure an improvement in the patient’s physical or mental health; and

b) in accordance with a practice accepted at the time by a reasonable body (often taken to be more than 50%) of medical opinion skilled in the particular form of treatment in question (Re F 1990).

Treatment in these cases is in the best interest of the patient as determined by professionals, and is also referred to as treatment under common law, i.e. law that is not grounded in statute but one that has emanated on the basis of previous practice. Usually such practice is based upon the first principles of medical ethics, one of beneficence to the patient (Beauchamp and Childress 1989), which emphasises that it is obligatory for a doctor to provide treatment, if it can be provided and will be beneficial to the patient who receives it. ‘Best interest’ treatment is consonant with a doctor’s duty of care towards his patient. Most treatments provided in India, either physical or psychiatric, is based upon this principle where the doctor decides what is in the best interest of the patient, who on his part often remains a passive recipient.

Treatment given to psychiatric patients under ‘best interest’ principle can only be legally defensible if he is floridly ill and is a threat to his own self and that of others (e.g. an extremely violent and psychotic patient brought to the casualty department). However that treatment must be the minimum necessary response to avert any particular danger that non-treatment may lead to, and administration of such treatment cannot be an alternative to giving treatment under the MHA. In Indian MHA ’87, the Order for Admission under Special Circumstances (section 21, Part II), is an example of the use of the best interest principle. It is noteworthy that the Act makes no distinction between patients “who does not, or is unable to consent to admission” (Mental Health Act 1987, pg 15). Choosing not to consent when capable of doing so and not consenting because one is incapacite are obviously two different issues and the law must take cognizance of it.

2) Balance test

This approach recommends drawing a balance of the ethical considerations of autonomy/capacity on the one hand and
consequences of one’s actions on the other (Eastman and Hope 1988). In this approach, a capacitous refusal would be respected where the consequences of doing so were not adversely very grave, but not where the consequences were grave, thereby negating any primacy of the patient’s best interests. There would then be a trade-off between autonomy and consequences and the extent of the trade-off would depend on whether the adverse consequences were for the patient or for others, with more weight being given if the risk of adverse consequences were for others rather than the patient. For example, a man with schizophrenia would be detained involuntarily if there were risks of harming others violently but another patient with a similar severity of illness but without the specific risk of harm to others will not be so detained. There would no doubt be a grading of risks on a spectrum rather than a dichotomous determination – risk present or absent, such that the risk of completed suicide would override the risk of slapping someone in the face.

A variant of the balance model, described as a ‘discontinuous balance model’ (Eastman and Dhar 2000), was recommended to the UK government for consideration in its proposed amendment of the existing MHA of that country. It was argued that capacitous refusal should be respected unless there was “… a substantial risk of serious harm to the health or safety of the patient or to the safety of other persons if s/he remains untreated and there are positive clinical measures… which are likely to prevent deterioration or to secure improvement in the patient’s mental condition” (Department of Health 1999). The key words are substantial and serious and their definition must be determined if this test is the basis of any new MHA. In general, substantial means ‘very large in amount or degree’, and in this case should represent a moderate to severe risk. Definition of what constitutes serious harm is one for debate, but it can be taken to represent any harm to members of the public who will be unlikely to recover from it, either in physical or psychological terms. In terms of harm to self, seriousness will be determined by the risk of suicide and/or self harm, e.g. the possibility of genital mutilation by a psychotic patient must be more serious than that of occasional head banging. As would be evident, it is difficult to define these terms and it is best left to individual clinical judgment with any definition acting merely to serve as guidance.

3) Status test

The status test allows detention of persons against their will even if they have a proven capacity to make a decision, and when involuntary detention may not be in their best interests. In the English and Welsh MHA 1983, for instance, the status is:

i) suffering from one of four recognized categories of mental disorder (see under What is mental disorder?)

ii) that the disorder is of a nature or degree that makes it appropriate for the patient to receive such treatment in hospital, and

iii) that it is necessary in the interests of his/her health or safety or for protection of others that s/he should receive such treatment, which cannot be provided unless s/he is detained.

It is possible that a patient may be suffering from a recognized mental disorder but need not be treated in hospital because he can be treated in the community. As is readily apparent, the status test grants substantial discretion to those determining detention.

The application for a Reception Order (Section 22) of Indian MHA ’87 (Mental Health Act 1987, pg 17) uses a status test. Clause 2a of this section specifies that patients must be suffering from a disorder of a nature and degree to make him liable to a reception order for involuntary treatment, while clause 2b establishes the necessity test where detention is ordered in the interests of patient’s health and safety or protection of others.

What is mental disorder?

Every psychiatrist knows what mental disorder is. However, a stringent definition of this term is necessary for legal purposes, the thrust and outcome of which can be very different to clinical purposes. Any legal definition of ‘mental disorder’ must reflect a realistic understanding of what is being defined and for what purposes. An MHA is created for the purpose of treating people against their will as they have lost the capacity to make rational choices as regards the need for and acceptability of treatment. The definition must be such so as to exclude those types of mental disorder where treatment is impossible or ineffective, beyond which any continued hospital detention will only amount to incarceration. At the very least, the definition acts as a sort of entry into an MHA. Only persons whose disorders meet the legal definition can be considered for treatment under the act.

The MHA ’87 defines a “mentally ill person” as “a person who is in need of treatment for any mental disorder other
than mental retardation”. (It also defines a “mentally ill prisoner” as a mentally ill person for whose detention in, or removal to, a psychiatric hospital, psychiatric nursing home, jail or any other place of safe custody, an order under a relevant section of the Act has been made). Merely being in need of treatment is what constitutes mental illness in the Indian MHA ’87. Clearly, there are grave problems with this definition because it casts the entry net far too wide and arguably almost anybody who displays slightly abnormal behaviour can be deemed to be detainable as long as two doctors certify that he is in need of treatment and a magistrate accepts their recommendations. By making a person detainable merely because it is felt that he may be susceptible to treatment is a legally unsound strategy because without a reasonable definition of what mental disorder is, the law would be open to abuse. The history of psychiatry reveals that mental health laws can be used to masquerade incarceration as treatment and show psychiatrists more as agents of social control than healers. The experience of Soviet psychiatry of the communist era demonstrated for posterity the risk of having definitions that are open to misuse, where thousands of political dissidents were admitted involuntarily to psychiatric hospitals in the name of ‘treating’ them. More recently the abuse of psychiatry continues in China (Human Rights Watch 2002, van Voren 2003). Substantial criticism and resistance to proposed changes to the existing MHA of a country has been mobilized, where the government is proposing a definition similar in its scope to the one within the Indian MHA ’87 (Royal College of Psychiatrists 2002).

There are different types of disorders with different treatment outcomes to which a legal definition of mental disorder must apply. The principle of beneficence in medical ethics (Beauchamp and Childress 1989) emphasises that in the treatment of a disorder, a cure should be pursued ideally where attempts are made to remove the cause of an illness. Where this is not possible, control or remission of the condition is desirable, failing which mere prevention of deterioration of the condition can be a legitimate aim of treatment. Merely detaining someone in the hope that some improvement can be demonstrated by virtue of being in a secure environment in the absence of effective treatment is unethical and cannot be allowed by law. In view of a changeable notion of what constitutes appropriate and effective treatment of a condition, it then becomes necessary to incorporate different categories of mental disorder when a statutory definition is attempted.

A close look at the international classificatory system of psychiatric disorders, ICD-10 (WHO 1993) reveals that there are primarily four different classes of mental disorders. These are:

1. Disorders of adults that are generally characterized by periods of relative well being interspersed with manifest symptomatology. The commonest examples include the affective disorders and schizophrenia even though there is often a progressively deteriorating course. These are conditions that are largely treatable with medications, often alone or in conjunction with psychosocial treatments.

2. Organic brain disorders, either congenital or acquired, where the damage is irreversible. The prototypical disorders in this category are the dementias (acquired) and mental retardation (congenital). Treatment can either control certain undesirable symptoms of these disorders (e.g. mental retardation) or arrest the progression of the disorder (for a while) but not reverse the deterioration (dementia).

3. Disorders of adult personality and of lifestyle (including substance misuse, sexual preference, and some impulse control disorders) which are only inadequately managed with pharmacotherapy, often requiring specialized psychological input to bring about symptom control, harm minimization, or both. Patients with substance misuse problems that lead to frank Axis I disorders would fall into both categories of 1 and 3.

4. Childhood disorders where the nature and treatment strategies are different to those of adult disorders, where patients are most often dealt with outside of a legal framework unless their disorders have features of adult disorders and they are no longer minors.

The English and Welsh MHA ‘83 has four categories of mental disorder, where a specific clinical diagnosis of mental disorder is not required for involuntarily detention in hospital. These categories are i) mental illness, ii) mental impairment, iii) severe mental impairment and iv) psychopathic disorder. The other three categories apart from mental illness have the common feature of being associated with “abnormally aggressive or seriously irresponsible conduct” and can also include “impairment of intelligence” (Jones 2003, p 12). Psychopathic disorder in this act is a legal definition and does not translate into clinical psychopathy (Hare1991). It is merely the legal terminology for clinically diagnosed personality disorder that has been associated with violence. Under the English and Welsh MHA ’83, patients with mental impairment and psychopathic disorder can only be detained involuntarily if it thought that medical treatment is likely to alleviate or prevent a deterioration of their condition, reflecting the limitations of effectively treating
these conditions. Any definition of mental disorder in a new MHA in India must also recognise and reflect the different categories of mental disorder and the differing thresholds for treatment. This would not amount to merely emulating what exists elsewhere but would be a reflection of the reality of psychiatric practice.

**Difficulties with procedural rules in Indian MHA ‘87**

India has a long tradition of families carrying out many of the responsibilities and duties that in a developed country would properly be the role of the social services. The primacy of family (and indeed friends) has been recognized in the MHA ’87 where except for patients who are detained by the police (Section 25) and prisoners who are diverted into the mental health system by court rulings (Sec 27, 29), most other applications for involuntary hospitalization become the responsibility of the family or friends of the patient.

Despite the ready availability of the family to share the burden of caring for the mentally ill, the process of seeking and receiving treatment under the MHA ’87 is exceedingly arduous, appears to be more penal and less therapeutic, and can lead not only to isolation of patients and professional alike, but also stigmatize them (Trivedi 2002). Conversely, it is also not unknown for families/relatives to abandon patients in psychiatric institutions and never to take them back again (Trivedi, 2001). An MHA, by implicitly discouraging mentally ill patients’ and their families from using it due to procedural difficulties that it poses for users, will lead to increasing stigma for the patients and their families, thereby encourage the pursuit of alternative and dubious forms of ‘cures’ and may lead to desertion of the patients by their families.

**Recommendations for change**

**a) A court based system:**

One of the many requirements of the new act should be the relative ease of navigation through it by patients, their carers and professionals. One of the major difficulties for relatives is accessing the judicial system, particularly if they are from rural backgrounds, ensuring in the process that the appropriate court having jurisdiction for the area where the patients hail from must be the one to be approached. Should a new act persevere with the legal-heavy approach of its predecessors, a major innovation could at least pave the way for a simplified process of admission. This could be achieved to a substantial degree by ensuring easy availability of the judiciary when it is needed. Just as there exists ‘lokadalats’ (although the rough and ready translation is ‘public courts’, the real meaning of the term is courts that are readily accessible by members of the public) for certain kinds of disputes, a similar arrangement could be made for mental health purposes. The experience of one non-governmental organization (NGO) suggests that such an innovation is possible within existing resources. This particular NGO, with unprecedented support from the local judicial system, was able to provide a magistrate on its premises, and more recently the chief justice of the Madras High Court inaugurated the world’s first permanent and continuous ‘lokadalat’ for mentally challenged persons at this site (Sridhar 2003).

**b) A doctor based system (quasi-legal model):**

An alternative strategy to the above and one that seeks to i) incorporate safeguards into the act, and ii) recognizes the special expertise of psychiatrists in the treatment of people with mental disorders, could form the basis of a new act, one that dramatically shifts the locus and focus of the act from courts and judges to hospitals and doctors respectively. Such an act would be accessible by patients and their families, easy to use, responsive to their needs, and involve handing powers to those professionals who actually treat the patients so that they can make applications (and indeed recommendations for eventual detention) should family members be unavailable or unwilling to do so. Such an approach will not only prevent any potential for abuse or desertion of patient by relatives, either during admission and/or discharge, but also make the decision making process much more transparent and clinically expedient.

Psychiatrists are especially trained and skilled in the assessment and treatment of the mentally disordered. Beyond pandering to a school of thought that may apprehend abuse of powers, should certain members of the society be bestowed with legal authority to detain other members of public, there seems little logic and propriety that a judge make an order for admission (and discharge) when s/he is usually entirely dependent upon doctors, in order to arrive at this conclusion. The only exceptions must be cases where the patient is involved in the criminal justice system, either as an undertrial or convicted prisoner, and when he is a person of no known abode and has been detained by police. Such changes will attempt to reverse the tone of the current MHA being archaic, seemingly rooted in spirit to the asylum acts of the previous centuries, anachronistic and appearing to implicitly prioritise detention and custody over treatment.
c) **Safeguards to quasi-legal model:**

Safeguards ought to be built into the act such that legitimate concerns within the judiciary (and possibly other sections of society) about the potential for misuse of powers of detention by psychiatrists, can be laid to rest by the availability of a mechanism which would allow later independent scrutiny. Such scrutiny can be the role of a tribunal whose primary function will be to review the justification for the patient’s continued detention at the time of hearing which should be reasonably close to the date of detention. This safeguard against potential unjustified detention envisages independent review from both medical and non-medical points of view and is best carried out by a multi-member panel where a man of law (at least of the experience of a senior solicitor) would preside over such proceedings. Such tribunals would have no jurisdiction over voluntary patients who will be free to admit or discharge themselves based upon capacitous decision-making ability (Eldergill 1998). Whilst the medical member will determine the case for detention from a clinical point of view, the legal member will review the case in light of the legal definitions of mental disorder, and whether the legal tests of detainability are met at the time of deliberations. The third member of the tribunal, a lay member of neither medical nor legal background, will appraise the case as a representative of the public reflecting the view of the laity. This role can be conceivably carried out by social workers, for example. The tribunal ideally should arrive at a unanimous decision, failing which the legal member must have the power of veto in recognition of the legal primacy of the body. If the tribunal is not satisfied that the legal criteria necessary for detention are met at the time it deliberates, then it must recommend the discharge of the patient. Alternatively, it can allow the detention to continue.

A due legal process would consolidate the advantage to the patient of having an easily accessible clinically driven and legally sanctioned admission procedure, by simultaneously making the decision making process transparent, thereby making it ‘safer’ for the patient whose liberty has been taken away. The current act ignores this aspect of safety to a person’s liberty as most often the magistrate making the order does not examine the patient, relies excessively on recommendations of doctors who can often be non-psychiatrists with little or no expertise in the assessment and treatment of people with mental disorders, and without any scope for an independent scrutiny later. The procedure recommended for change is therefore both clinically and legally more sound and transparent.

**Detention serves many purposes**

Mentally disordered patients are admitted to hospitals for many reasons. They may be admitted for assessment of their conditions, to determine whether they would benefit from treatment through its trial, either in an elective and planned manner or as an emergency, and perhaps also to determine to what extent treatment is beneficial by determining whether it brings about tangible benefit or acts merely to prevent deterioration. As discussed earlier these are all desirable goals to strive for. Some patients may wish to discharge themselves after having initially agreed to receive treatment voluntarily in hospital, or refuse treatment once admitted even if they do not express a desire to leave hospital. Appropriate orders must also be available for use against prisoners, either undertrial or convicted. A MHA should lend itself to the various clinical and practical realities that a psychiatrist faces in treating his patient and make available a range of statutory detention orders to manage such contingencies as noted above.

Broadly, three separate sets of orders can feature in any new act. One set of orders would apply to those who have are not involved in the criminal justice system (civil patients), the other set for those who are (offender patients), and a third set for patients who wish to leave hospital once they are admitted. The third option will not be available for obvious reasons to those who are routed through the criminal justice system.

**Assessment orders for civil patients:**

Assessment orders will allow the examination and monitoring of a patient over a specific period of time in order to arrive at a clinical diagnosis. As stated before, it is not necessary to provide a clinical diagnosis for the purposes of detention, but it is inevitable once treatment options are considered. Duration of an assessment order must be commensurate with the purpose for which they have been made. These should therefore be significantly shorter than orders for treatment. Patients detained under this order should not be forced to accept treatment against their wishes because the order is purpose-specific, i.e. assessment, although should patients agree to receive treatment voluntarily then it would be legally and ethically justifiable to provide them so. If provision of treatment is felt to be necessary and unavoidable with the patient not consenting to it, then it can only be given under the principles of ‘best interest’ (of the patient) and ‘duty of care’ (towards the patient of the treating doctor) for such treatment to be ethically and legally justifiable. As always, treatment under
Treatment orders for civil patients:

Treatment orders must extend for periods longer than that of assessment orders. In many countries the initial order is for a period of 6 months and is renewable thereafter; six months in the first instance and then for periods of one year (Jones 2003). A separate order must be available to cover for contingencies where patients need swift admission from the community and insufficient time is available to arrange a proper assessment. Such an order (an emergency order) can be made by any doctor (not necessarily a psychiatrist in recognition of the necessary expediency) and a relative/social worker but should not exceed for more than 48-72 hours. This would allow the necessary time to convey the patient to hospital and arrangements to be made for conversion into an assessment order (if still felt to be necessary). The emergency order will allow rapid institution of treatment for patients who require swift removal from the community. The equivalent of a treatment order in the Indian MHA ‘87 is a ‘reception order’ although there is no specific time frame for it, the order tending to run indefinitely, until a decision to discharge is made (Mental Health Act 1987, p 19). There is no equivalent to an emergency order in the MHA ‘87.

Holding powers:

There are occasions when patients having agreed to voluntary admission initially, refuse to remain in hospital, against professional opinion. In such cases it has most often been the case in India that patients are discharged against medical advice (DAMA), a term that many would be familiar with. This practice is unethical and often allows a vulnerable, needy (of appropriate treatment), and potentially dangerous patient to be at large in the community. A decision to DAMA can only be legally defensible if the patient does not meet the statutory criteria for detention at point of discharge. If he does, then either the duty doctor or the nurse in charge of the ward must have powers to hold the patients until such time that a detailed assessment under the act is possible. Such holding powers are necessary for members of hospital staff for brief periods of time as senior psychiatrists can often be unavailable (during nights, for instance). A time period of 48-72 hours is a reasonable time frame within which arrangements must be made by the treating hospital for statutory assessment to determine further detainability. Nursing powers must be less than that of junior doctors in terms of the length of time that a patients can be detained for so as to reflect the differences in legal responsibility of the two professions.

Orders for mentally disordered offenders:

There are two categories of patients that are involved in the criminal justice system, those who have been convicted, and the undertrials. Whilst the former have been tried and found guilty, the latter must be considered innocent until proven guilty. Different orders for transfer to a psychiatric facility must be available to reflect this difference in legal status. Due to the involvement in the criminal justice process orders for transfers to psychiatric hospitals must be made by judges trying their cases in courts and not anybody else. Similar types of orders as exist for civil patients, like assessment, treatment and urgent treatment can be created for this category of patients.

In view of the security that such patients would require, certain hospitals can be identified in advance so that the judge can direct the patient there, rather than to a general hospital psychiatric ward with little or no security, for instance. The security of such places can either be provided by the police or nursing staff. The former option allows therapeutic relationship between staff and the patient to develop and hopefully flourish, but brings with it the presence of policemen in a clinical setting with obvious implications for privacy, stigma and inadvertent anxiety to other patients. The latter option does not carry these disadvantages but requires training nursing staff in security measures and providing secure wards. Experience within maximum secure hospitals in England seems to favour the later option. However, any parole outside of locked wards or discharge from hospital must be decisions that are made by the judiciary or nominated substitutes of the judiciary, e.g. the state home ministry. Any unreasonable delay in making such decisions can also be a subject for scrutiny by an independent tribunal in order to minimize the effects of bureaucratic red-tape.

Consent to treatment

While detaining a patient under a mental health act will allow treatment to be provided to him under the aegis of
the act (except when it is under common law in patients admitted under admission order), such detention cannot translate into indefinite treatment of the patient against his will. The patient must have the unalienable right to either allow or refuse another person to introduce what actually amounts to a foreign substance (a prescription drug) into his body. Treatment against the patient’s wishes should be possible when treatment (or emergency) orders have been issued but only for a specified period (say three months) in the act. Beyond this period if the patient continues to refuse treatment, a second opinion must be sought.

Second opinions must come only from a psychiatrist, of sufficient seniority and experience, whose name belongs to a list that the local mental health authority can create for this express purpose. Second opinion should ideally not be sought from one who is a staff of the hospital where the patient is being treated. When second opinion is sought, then a written treatment plan can be made available to the second opinion doctor, which will specify the preferred group of drugs (antidepressants, antipsychotics, ECT), the number of drugs to be used, and the likely duration (number in case of ECT) of treatment. Ideally and where possible the second opinion doctor must speak with a qualified nurse, the treating doctor (or his nominated deputy), another professional who may have been involved in the patient’s care (psychologist, social worker, occupational therapist, etc) and review case notes, peruse the detention order and treatment plan and examine the patient.

The need to seek second opinion is one of the mechanisms that MHA in developed countries have created to enforce duties on doctors, to ensure that proposed treatment is consistent with what a majority of professionals in that particular field would have recommended, and thereby remedy any abuse of power. It is conceivable that in the absence of such a mechanism, a patient is liable to be provided sub standard, experimental, out-dated or even harmful treatment by doctors who may either be negligent or overenthusiastic with an axe to grind, and thereby (in)advertently abuse their authority, as has been the view of many with the use of electroconvulsive therapy all over the world. Ethically based MHA are created in a manner such that more invasive and permanent a treatment and its effects are, the more stringent the objective tests needed to demonstrate the potential benefits of such treatments to patients. Thus, it is recommended that treatments like psychosurgery or hormonal implants should require both patient’s consent and second opinion. Drug treatment of mental disorder after the expiry of a pre-determined duration (either by law or through guidelines by mental health authority) must require either consent of the patient or a second opinion. For all other forms of treatment mere consent should suffice.

Recently it has been claimed that there is an avoidable overuse of electroconvulsive therapy in India and a public interest petition has been lodged which seeks banning of physical restraints and use of unmodified ECT in India (Mudur 2002). The petition is opposed by the Indian Psychiatric Society (Dutta 2003), perhaps so as it may be “often considered better to treat a severely ill, suicidal, psychotic, catatonic, or drug-resistant patient with a suboptimum form of ECT than to leave the patient with a prescription which is likely to be less effective, and with which he may not comply” (Andrade 2002). This view emphasises that a person potentially non-compliant with drug medication can be forcibly given ECT against his wishes. Any suggestion or attempts to do so is unethical and legally amounts to assault and battery even if the intention is to bring benefit to the patient. On an erroneous basis a further argument has been made that many physical procedures in other branches of medicine are “overenthusiastically conducted” with “proven adverse … consequences”, the implication being that if provision of such treatments are deemed just and proper, the same standards should apply to unmodified (my words) ECT, otherwise “dangerous legal precedents could be set” (Andrade 2002). Such concerns are based upon ignorance of the law and ethics of medical practice and tend to mislead. Decisions to undergo medical and surgical procedures, even if felt to be unnecessary by some, are made by patients who are deemed to be mentally capacitous to make such health related decisions. A severely mentally ill person who is arguably not capacitous cannot be equated with such a group of mentally sound patients and needs all the legal and ethical protection that a society can provide him for reasons that should be readily evident.

A proposal that would allow use of ECT in a legally consistent manner is as follows. If a person requires ECT treatment, has demonstrably the mental capacity to make that decision and is consenting to it, then he can be provided this treatment even if it involves the use of unmodified ECT. If he is incapacitous and/or refuses treatment, then treatment can be provided under the ‘best interest’ principle in urgent cases only, if it can be demonstrated that the benefits far outweigh the consequent harm (primarily of possible muskulo-skeletal damage and cognitive deficits). Urgency can be defined as the need to save the patients’ life or for the safety of others. Treatment thus provided should be the minimum necessary (not more than two, for
instance), before arrangements are made to provide treatment under the aegis of the mental health act. If treatment is not required on an urgent basis, then it can only be given under statutory orders of a mental health act. Whether unmodified ECT should be pursued is a matter for the Indian psychiatric fraternity to deliberate upon. Whilst there are short term gains for the individual who is in need of urgent ECT treatment, the fear and stigma that forcible treatment of this nature can create will in the longer run deter all but the most courageous of patients to approach psychiatrists in future for treatment.

The above guidelines seek to ensure proper legal and ethical checks whilst allowing necessary treatments to be provided. Hence, whilst a tribunal acts as the legal checkpoint to test the validity of detention, second opinion and consent to treatment acts as a clinical checkpoint to ensure the delivery of high quality treatment, whilst simultaneously respecting the patient’s autonomy (to refuse treatment). As additional guideline to practicing psychiatrists, the various mental health authorities can specify treatments for which sufficient and rigorous data exists, and one that a reasonable body of medical opinion skilled in the particular form of treatment in question would use under the circumstance (Re F 1990). Thus if a majority (more than half) of Indian psychiatrists favour the use of unmodified ECT then that position should be steadfastly adhered to, only if rigorous data of the highest order can demonstrate that there is no significant disadvantages in unmodified over modified ECT. Equally relevant to this debate is the view of the patients and their families and a proper balance must be sought. For instance, tubal ligation and/or vasectomy are effective ways to control an ever burgeoning population such as India’s but to achieve population control one cannot forcibly use these procedures on non-consenting subjects even if the outcome would be beneficial to them and the society at large. Similar arguments can be made in relation to the use of unmodified ECT for those deemed to be in need of it.

Integration with government’s health policies

The treatment of a person does not end when he leaves the safety of hospital. The lack of meaningful community health services for psychiatric patients in developing countries (WHO 2001) means that they become non-compliant relatively quickly and hasten rapidly towards relapse, whereupon they may be brought back to hospitals under detention again. We have a special duty towards patients who have been detained, more so than others. Those that have required involuntary detention suffer from a more virulent form of disorder, have greater disturbance of insight, can be relatively resistant to treatment and demonstrate probably higher rates of violence directed towards self and/or others. They constitute the most severely ill and therefore in need of assertive follow-up when discharged from hospitals. Whilst provision of any community care is worthwhile, these patients (and their families) can ethically demand in a compensatory manner a higher quality of follow-up than what may be routinely provided. Such demands, were they to be made, would be just as under a principle of reciprocity, one ought to provide better standards of care than usual to those whose liberties have been stripped. It would be desirable for the new act to specify that all those who have been detained must be provided compulsory community care under the provisions of the National Mental Health Programme [NMHP] (Department of Health and Family Welfare 1982). Failure to provide such care can highlight deficiencies in service availability and put pressure on government agencies to fill such lacunae in health care delivery. Community care can be made a reality in India by means such as exploration of the role of NGOs, local self governments institutions (Panchayati Raj Institutions) and the potential for partnerships between the public and private sectors in delivery of mental health services (Lal and Vashisht 2002). The right to have access to treatment in community under the NMHP and National Health Policy can be interwoven into a new mental health act such that the act does not stand in isolation but is intricately interlinked with government policies. One of the many drawbacks of MHA ’87 is its relative isolation from governmental health strategies and policies. Reversing this trend will not only help provide seamless and continuous health care services to patients (including support and information to their families) but also seek to make the act more a relevant and powerful tool for its users (primarily mental health professionals) and its intended beneficiaries (the patients), not least through its ability to destigmatis the pursuit of mental healthcare.

Conclusions

There is a need for a new mental health act for India. There are multiple deficiencies in the current act of 1987. These deficits are primarily due to the act being court and judiciary centered with the attendant problems of bureaucracy, delays and complications due to the enormous pressure on Indian judiciary. The current act gives little or no recognition to the ethical principles of autonomy and reciprocity (providing as good care as possible for persons whose liberty has been curtailed) and appears to prioritise custody over any meaningful treatment of the patient.
Jaydip Sarkar

Any new act must seek to redress the balance and incorporate within it the notions of fairness, sound ethical principles with adequate opportunities for the provision of high standards of clinical care. It must clarify the entry and exit points in law of patients from hospitals and must demonstrate equality to all classes of patients. Most of all it must safeguard the rights of the patient and impose certain minimum duties on those providing care and treatment and in doing so, recognize, acknowledge and prioritize the role played by psychiatrists (as opposed to medical officers of other persuasions and specialties). Commensurate with the duties of psychiatrists (and others) the act must also give psychiatrists the powers to determine what is needed to treat a patient (including the power to detain) such that the act becomes more relevant to the daily clinical activities of a psychiatrist, thereby ensuring a higher rate of usage of the act.

Families and the community are two of the biggest resources available to patients in India and all efforts must be made to make the act easily accessible to them, at a time when they need it and in a way that they can make use of it meaningfully. Equally, the act must also seek to prevent any abuse and abandonment of patients by families. The primary health (and social) care infrastructure must support the family to develop and sustain their capacity to identify and manage the mental health problems within available means. Building knowledge and awareness of families can make a real difference and to that end resourceful use of health guides, anganwadi and health workers as also NGOs can help raise awareness as well as provide advocacy, support and even financial aid in certain deserving cases.

The new Prime Minister of India, Manmohan Singh has assured the nation that his government will aim to press on with economic development policies with a “human face”. He and his government must be reminded that economic development must parallel developments in other spheres of Indian life, particularly that of social equality. This vision can be achieved by providing support and aid to the mentally disordered people as they represent perhaps one of the most socially disadvantaged groups in India. As India drives itself into the 21st century, it must update some of its laws so that these reflect the needs of modern times. Any affirmative action on issues of social development and justice will repay the effort many times over by minimizing if not preventing the huge economic burden that mental illness creates for society that contains it.

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