Historically, the concept of legal control over the treatment of the mentally ill has been of recent origin. Perhaps, it became necessary to protect the interests of the mentally ill, they themselves being unfit to ascertain and safeguard their own interests.

Although treatment of the mentally ill has had a long past institutionalisation as a method of handling the mentally ill has a relatively brief history. Deutsch (1949) has brilliantly documented the course of development of the asylum in the USA. The asylum concept developed primarily so as to provide a milieu for a more humane custodial care of the mentally ill as compared to their own homes where they were often maltreated. Often the mentally ill were put under restraint or solitary confinement and subjected to other humiliations and deprivations, partly, no doubt, as the families did not know how else to handle them. The primary objective thus was not of incarceration or to spare the society of their aggression, impulsivity and embarrassment but to safeguard the interests of the mentally ill as much as possible.

In much of the developing world, mental hospitals have been of still more recent origin and their creation can mostly be attributable to the alien colonial influence. To illustrate, although in India treatment of the mentally ill has had a long history, the treatment traditionally has been at an individual, one-to-one basis and the mental hospitals did not spring up till practically the turn of the present century. The impact of the colonial influence is evident by the fact that much of the mental health legislation in the developing countries have been modelled after the European laws like the English, Belgian and French in their respective colonies. Not only that, the legislation in the developing countries which then formed colonies of the European powers temporally followed major European enactments and revisions. At the same time, the countries in the developing world
which were never colonised for any significant length of time do not yet possess formal legislation. The informal system in the middle eastern countries and in Thailand illustrates this point. It is possible that the “asylum concept” emerged in the Northern Europe and North American “largely in response to the needs of the urban poor” (Curran and Harding, 1978, p. 95).

MENTAL HEALTH NEEDS OF THE DEVELOPING COUNTRIES

As mental health legislation must take into account the service needs of the country, it must be useful to review the assessment of such needs in India. Giel and Harding (1976) voiced the opinion of the majority professionals when they stated: “It is now clear that the frequency of seriously incapacitating mental disorders is at least as high in the developing countries as in the developed countries.” Although the need is clear, the differences in the local conditions must be taken into account in organization of services in the developing countries. With regard to the developing countries, the key question is:

“How can mental health care be made available to widely dispersed rural populations, given that resources are seriously limited? The WHO Expert Committee on Mental Health, in its Sixteenth Report devoted to the organization of mental health services in developing countries (WHO, 1975) has provided clear answers to these questions in its recommendations, which have received wide support. As well as strongly endorsing the policy of decentralization of mental health services and their integration into general health services, the Committee advocated the provision of “basic mental health care,” by primary health workers. Another important recommendation made by the Committee concerned the development of collaboration with non-medical community representatives, such as traditional leaders, teachers, police officers, and religious leaders” (Curran and Harding, 1978, pp. 17-18).

In the context of the developing countries, Curran and Harding (1978, p. 95) have called the large, centralized mental hospital as providing “an institutionalised response almost totally inappropriate to the rural agrarian communities” which form the major part of the populations. Lately, there has been “a move towards a much wider and less centralized range of services... Mental health care is also becoming less of a specialized branch of medicine and more of a public health concern” (Curran and Harding, 1978, p. 25).

CURRENT INDIAN LEGISLATION AND GENERAL HOSPITAL PSYCHIATRY

On the Indian scene, much of the advancement in mental health services over the last 3-4 decades has been contributed by the general hospital psychiatric units. This has been in the general direction of decentralization and destigmatization of mental health services making it more readily available and informal. The general hospital psychiatric units have increasingly become more effective in meeting the mental health needs of the community.

It is accordingly useful to review as to how the existing legislation looks at and provides for the general hospital psychiatric units.

In our country, the Indian Lunacy Act, 1912, is mostly addressed to the large, centralised mental hospitals as far as their administration and operation and treatment of psychiatric patients therein is concerned. That the general hospital
units will also play a role in such service programmes was not envisaged.

A study of the Indian Lunacy Act of 1912 brings home the point that the existing law is operating as if it is "unaware" of the existence of the general hospital psychiatric units. To illustrate, let us look at the certain key provisions of the Act.

Section 3(1) of the Indian Lunacy Act defines an asylum as "an asylum or mental hospital for lunatics established or licensed by the Central Government or any State Government. There is no mention of psychiatric units in general teaching hospitals or of psychiatric nursing homes operated by private psychiatrists. Section 84 empowers the State Government to establish or license the establishment of asylums at such places as it thinks fit. Again there is no mention of the general hospital units.

As a matter of fact, to the contrary, it is clearly spelled out in the Indian Lunacy Act, 1912, that admission of the mentally ill persons in places other than the licensed asylums or by procedures other than as specified in the Act are prohibited. Section 4 defines that no person other than a criminal lunatic or a lunatic so found by inquisition shall be received or detained in an asylum without a reception order save as provided by Sections 8, 16 and 93. There is admittedly a provision for taking any voluntary boarders, but with the consent of the two of the visitors of the asylum. Section 93, as a matter of fact, prescribes fines for admission of the mentally ill persons not in accordance with the Act as follows:

"Section 93 : Penalty for improper reception or detention of lunatics—

Any person who—

(a) otherwise than in accordance with the provisions of this Act receives or detains a lunatic or alleged lunatic in an asylum, or
(b) for gain detains two or more luna-

tics in any place not being an asy-

lum,

shall be punishable with imprisonment which may extend to two years or with fine or with both."

It is obvious, therefore, that a question can be raised if by admitting patients to general hospital psychiatric units, the person in-charge is not committing a punishable crime.

GENERAL HOSPITAL PSYCHIATRY IN PROPOSED LEGISLATION

In the proposed Mental Health Bill, 1981, the establishment, licensure and operation of hospital facilities for the mentally ill are defined and covered under the following Sections.

2 (f) "Licensed psychiatric hospital" or "licensed psychiatric nursing home" means a psychiatric hospital or psychiatric nursing home, as the case may be, licensed, or deemed to be licensed, under this Act;

2 (q) "Psychiatric hospital" or "psychiatric nursing home" means a hospital or, as the case may be, a nursing home established or maintained by the Government or any other person for the treatment and care of mentally ill persons and includes a convalescent home established or maintained by the Government or any other person for such mentally ill persons; but does not include any general hospital or general nursing home established or maintained by the Government and which provides also for psychiatric services;

5 (1) The Central Government may, in any part of India, or the State Government may within the limits of its jurisdiction, establish or maintain psy-
atric hospitals or psychiatric nursing homes for the admission, treatment and care of mentally ill persons at such places as it thinks fit...

6 (1) On and after the commencement of this Act, no person shall establish or maintain a psychiatric hospital or psychiatric nursing home unless he holds a valid licence granted to him under this Act;

6 (2) Nothing contained in sub-section (1) shall apply to a psychiatric hospital or psychiatric nursing home established or maintained by the central Government or a State Government.

Thus, as per section 2(q) "any general hospital or general nursing home established or maintained by the Government and which provides also for psychiatric services" does not fall under the definition of 'psychiatric hospital' or 'psychiatric nursing home', and hence evades the licensure and other regulatory provisions applicable to the latter. It may be examined if and how this exemption can also be extended to private, teaching general hospitals meeting certain minimum standards and safeguards.

Furthermore, while section 6(1) lays down that no person shall establish or maintain a psychiatric hospital and psychiatric nursing home without a valid licence granted under this Act, Section 6(2) exempts psychiatric hospitals or psychiatric nursing homes established or maintained by the Central Government or a State Government from the requirement of obtaining such licensure. However, all psychiatric hospitals and psychiatric nursing homes, including those maintained by the Government, are required to be maintained, operated and regulated as per the various provisions of the Act. Section 85(1) prescribes fines for establishing or maintaining a psychiatric hospital or a psychiatric nursing home (as defined in the Act) in contravention to the provisions of the Act.

PRINCIPLES OF MENTAL HEALTH LEGISLATION

Although mental health legislation is important for a number of reasons, it is an error to think that all or even most of the advancement in mental health services have to come through legislative provisions. "There is no doubt, however, that in most countries the change which is taking place in mental health services is not reflected in the law...." (Curran and Harding, 1978, p. 26). In India, most of the advancement in mental health, over the last 30-40 years, has come through the general hospitals which have been functioning in virtually an extra-judicial manner. Legislation, by and large, is meant to tell what must not be done rather than what would be desirable to do. It proscribes rather than prescribe. It thus cannot be a blueprint for future action. It is a misunderstanding of the legal process to expect it to be so. Accordingly, laws should be minimum rather than maximum; and it is just as well that this is so.

In terms of mental health legislation, the above point is very relevant. More than prescribing direction for future advancement, it should desist from constraining desirable activities and change. It should not act as impediment to ongoing, helpful activities and exploitation of available resources. Curran and Harding (1978, pp. 99-101) sum up the criteria for legal provisions as follows:

(a) "Negative criteria (i.e. what the law should not do)

(i) It should not impede desired change.
(ii) It should not require an undue level of resources of staff time in its operation.

(iii) It should not impair helpful responses to mental illness which already exist in the community.

(iv) It should not create a completely separate mental health service.

(v) It should not create or reinforce negative attitudes towards the mentally ill.

(b) “Positive” criteria (i.e. what the law should do)

(i) It should closely reflect the overall direction and approach of the national policy.

(ii) It should exploit available manpower.

(iii) It should require treatment for priority conditions to be available in all parts of the country.

(iv) It should stimulate intersectoral involvement.

(v) Protection of civil rights should be independent of educational status, residence, etc.

The Mental Health Act, 1959, of the U. K. also points in a similar direction where it prescribes:

“Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home... or from remaining in any hospital or mental nursing home...” (cited in Curran and Harding, 1978, pp. 42-43).

The above is especially pertinent as far as general hospital psychiatry is concerned. General hospital psychiatric units in India have been functioning in an extra-judicial and possibly legally-prohibited fashion. While it cannot be expected from legislation to provide direction for its further development in the service of mental health, the law should not unduly constrain its activities. It should accordingly not constrain the activities of general hospitals and, with some safeguards, the psychiatric units in such hospitals should function pretty much as medical and surgical units in terms of admission and treatment of patients, and it should not be unduly encumbered with procedural requirements.

One aspect of health legislation having bearing on the above is worth commenting upon in some detail. Although, to start, with, mental hospitals came up primarily to meet the treatment needs of the patients and to protect them from the society; pretty soon planners, administrators and community leaders became overconcerned lest a person may be unjustly confined into a mental hospital. This phobia of someone being “railroaded” into a mental hospital has continued over practically two centuries of mental health legislation and has been evident in virtually all countries—both developed and developing. It has been possibly a corollary of human “liberation” movement worldwide, starting with the French Revolution attesting to the rights and freedom of the individual. However, it is now being increasingly recognized that in case of the mentally ill “right to treatment” is just as important than “right to freedom”. It may actually be more important in the larger interest of the patient. Hence, undue constraints in provision of treatment should be done away with which point is of greater relevance to general hospital psychiatry.

Judicial vs. extra-judicial systems

In view of the legal situation pertaining to general hospital psychiatric units, especially in India, it may be worth-
while to examine the pros and cons of judicial vs. extra-judicial systems of pertaining to general hospital psychiatry. It has been documented that in the developing countries the judicial system came mostly under the colonial influence and those countries which were never colonised have continued to follow an extra-judicial system as far as mental health care is concerned. It has also been documented that the extra-judicial system has functioned fairly well, at least in many countries. The extra-judicial system has the obvious advantage that it escapes the stigma associated with judicial "commitment" and hospitalization and that the formal procedures are avoided. In this fashion, it may be less stigmatizing as compared to a formal judicial system. However, as has been pointed out by Curran and Harding (1978 pp. 64-65) there are certain advantages of following a judicial system. Mental health legislation, in this context, can be viewed as a rallying point for public opinion and programmes, and as an instrument of public education and attitude development. The law codifies the basic policy as agreed to by the national leaders, planners and administrators and thus purports to be a nationally agreed blueprint for action. Also, "when the new programme is endorsed by a working majority in the legislative assembly, it helps greatly in obtaining the necessary budget support and the cooperation of other independent government units in carrying out the programme” (Curran and Harding, 1978, p. 64). In addition, law facilitates certain amount of accountability as far as the health system is concerned. Finally, the law can be an aid in generation of information and data. In the European context, a working group report from the European region comments on this last aspect as follows:

"The consequences of this dearth of data are considerable. Far from assuming any new responsibilities, the mental health services of most countries are unaware of the extent of their present commitments, and even then data usually relate to in-patients, who represent only a small portion of the total load of a modern community-based mental health service” (cited in Curran & Harding, 1978, p. 78).

Legislation and quality of mental health care

It is an error to think, however, that the mental health law is or should be concerned only with the issues related to hospitalization. The law can and should go much beyond that. To discharge its responsibility to the care of the mentally ill, the law must address itself also to the rights and privileges of the patients and the quality of health care given to them. In this regard, it is heartening to note that our Mental Health Bill of 1981 does not ignore the aspect of quality and accountability of health care. Chapter II, Sections 3 and 4 provide for establishment of Mental Health Authorities at the Central and State levels. Section 84 addresses itself to the protection of human rights of the mentally ill. Section 97(3) (f) specifies the minimum facilities for patient care within the rule-making powers of the government.

It is in terms of the above that the general hospital psychiatric units can play a crucial role. On account of the more favourable staff-patient ratio and availability of other resources, the general hospital units can set standards of quality of patient care and maintain the ethical standards of such care. It can also facilitate availability of mental health care.

In a study on mental health legislation carried out by us in ten selected
developing countries in Asia (Varma et al., 1984), amongst the mental health professionals in these countries there was fairly with agreement that changes were needed in a number of areas. These included admission and discharge procedures and making medical views obligatory to be sought here, giving preference to and simplifying voluntary and informal admissions and discharges, revising the nomenclature and definition of mental disorders, liberalizing licensing and registration of institutions, making the legislation more comprehensive and providing for periodic evaluation and civil rights. Role of psychiatric units in general hospitals was also mentioned among the perceived needs.

CONCLUSION

General Hospital Psychiatry in our country has developed in a practically extra-judicial fashion and has been functioning as if the existing law is "unaware" of its existence. The proposed Mental Health Bill of 1981 is expected to legitimize the functioning of psychiatric units in general and teaching hospitals. It is expected that under the new legislation, general hospital psychiatry will play an increasingly important and singular role in extending mental health services and especially in terms of facilitating the right to treatment and setting standards for quality, ethical treatment.

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