Mental health legislation: an Indian perspective

Suresh Bada Math, D Nagaraja

Introduction

People with mental disorders are particularly vulnerable to abuse and violation of their rights (1). If a protective mechanism is not in place, they can be susceptible to abuse by anyone in society including family members, spouses, caregivers, professionals, friends, fellow citizens and even law-enforcing agencies. Legislation is an important mechanism to ensure appropriate, adequate, timely and humane health care services. It also helps in the protection of the human rights of the disadvantaged, marginalised and vulnerable citizens. Ensuring human rights of these groups is reflective of a civilised society that respects and cares for its disabled and marginalised citizens. This, in turn, clearly reflects high values, morals, attitudes, culture, traditions, customs, aspirations and practices.

In a country like India, mental health care is not perceived as an important aspect of public health care. Hence, mental health legislation will play a very important role in upholding the rights of the mentally ill (2). The fundamental aim of mental health legislation is to protect, promote and improve the lives and mental well-being of citizens. In the undeniable context that every society needs laws to achieve its objectives, mental health legislation is no different from any other legislation (1). It also plays a vital role in dictating the terms and conditions of mental health care and protecting the human rights of people with mental disorders.

Principles of mental health care law

The World Health Organization (1996) prescribes ten basic principles for 'Mental Health Care Law' (3) that has been outlined in Chapter 1.

Mental health legislations were initially drafted with an aim or safeguarding members of the public from dangerous patients and isolating them from the public when there was no treatment or minimal treatment available. A paradigm shift from custodial care to community care has occurred because of the following reasons: a) Proactive legislation; b) advances in

medical technology in assessment and treatment of mental disorders; c) human rights movement; d) WHO's definition of 'health' (4) and e) promotive, preventive, curative, rehabilitative approaches and mitigation of disability. This shift has given a new perspective to the care of mental disorders and has led to the review of mental health legislation (5).

Preventing discrimination

The available laws should address not only curative but also preventive, promotive and rehabilitative aspects. Legislation is needed to prevent discrimination against persons with mental disorders (1). Discrimination takes many forms, affects several fundamental areas of life and is pervasive. Discrimination and stigma may impact access to adequate treatment and care as well as other areas of life, including employment, education, marriage and shelter. The inability to integrate into society as a consequence of these limitations can increase the isolation experienced by an individual, which can, in turn, aggravate mental disorder. The presence of mental health legislation, however, does not in itself guarantee respect and protection of human rights (1) until there is commitment from political and social structures as also the people concerned in implementation.

Mental Health Legislation in India

Worldwide, mental health legislations are concerned mainly with: (i) rights of the mentally ill (right to care and human rights), (ii) quality of care, (iii) the use of administrative and budget control measures, and (iv) consumer participation and involvement in the organisation and management of mental health care services (6). There have been significant advances with respect to mental health legislation in India. These achievements include legislations and case laws. The purpose of this chapter is to briefly review important legislations of India. Legislations that come under the purview of mental health in chronological order include:

1. Narcotic Drugs & Psychotropic Substances Act, 1985 (NDPS 1985)
2. Mental Health Act, 1987(MHA 1987)
3. Rehabilitation Council of India Act, 1992 (RCI 1992)
4. Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995(PWD 1995)

5. Juvenile Justice (Care and Protection of Children) Act, 2000 (JJA 2000)
6. National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 (NTA 2001)
7. Protection of Women from Domestic Violence Act, 2005 (DMV 2005)

All the above legislations have one common objective, which is providing dignified living, protecting human rights, and addressing the promotive, preventive and curative aspects of mental health. Almost all the above acts have excellent vision and many positive aspects. We discuss below the main features of the act and focus on their shortcomings and possible remedies.

Mental Health Act 1987 (MHA 1987)

As this is the primary act relating to mental health, it is discussed first and in relatively more detail.

THE MENTAL HEALTH ACT (7) was enacted in 1987, and came into force in 1993, replacing the Indian Lunacy Act, 1912. It has been described as "*An Act to consolidate and amend the law relating to the treatment and care of mentally ill persons, to make better provision with respect to their property and affairs and for matters connected therewith or incidental thereto*".

MHA is divided into 10 chapters consisting of 98 sections (7). The following are the chapters - I-Preliminary, II-Mental Health Authorities, III-Psychiatric hospitals and psychiatric nursing homes, IV-Admission and detention in psychiatric hospital, or psychiatric nursing home, V-Inspection, discharge, leave of absence and removal of mentally ill persons, VI -Judicial inquisition regarding alleged mentally ill person possessing property, custody of his person and management of his property, VII-Liability to meet cost of maintenance of mentally ill persons detained in psychiatric hospital or psychiatric nursing home, VIII-Protection of human rights of mentally ill persons, IX Penalties and procedure and X-Miscellaneous.

To summarise, the objectives of MHA are to:

1. Establish a Central Authority and State Authorities for Mental Health Services.

2. Regulate the minimum standards for establishing, licensing and controlling psychiatric hospitals and psychiatric nursing homes for mentally ill persons.
3. Regulate the procedure of admission and discharge of mentally ill persons to the psychiatric hospitals or nursing homes either on voluntary or involuntary basis.
4. Protect the rights of such persons while in custodial care.
5. Protect society from the violent mentally ill persons.
6. Provide facilities for establishing guardianship or custody of mentally ill persons who are incapable of managing their property.
7. Provide free legal aid to mentally ill persons at state expense in certain cases.
8. Avoid offensive terminologies (like lunacy, asylum, wandering lunatics and so forth) and to use neutral terms (Mental hospital, mentally ill patient, wandering mentally ill patient) thus upholding the dignity and respect of mentally ill persons.

MHA has its own merits and demerits. The present MHA gives an easy-to-use approach for admission and discharge procedure of mentally ill persons. However, some of the provisions in the MHA need review and amendments.

Hospital Standards

MHA is a proactive legislation to achieve the ideal minimum standards of mental hospitals but is difficult to implement pragmatically because of acute shortage of manpower resources. MHA excludes government mental hospitals from obtaining licenses, as they are under the direct supervision of the Central and State Mental Health Authorities (Chapter 2, sections 3 and 4). The issues relating to government hospitals have been taken up by the National Human Rights Commission (8) and state mental health authorities and state administrations have become actively involved in monitoring the functioning of the government psychiatric hospitals.

Psychiatry units in general hospitals are kept out of the purview of the MHA. This is an essential and positive step for two reasons: it encourages voluntary treatment of persons with serious mental disorders; common mental disorders like anxiety and depression, which do not come under the purview of the MHA are effectively treated in these settings. Proper

utilisation of general hospital psychiatric services can decrease discrimination and stigma, and increase utilisation of mental health services.

'Convalescent home' vs 'psychiatric hospital'

A convalescent home is a facility for the care of individuals who do not require hospitalisation and who cannot be cared for at home. This is similar to the concept of a 'halfway home' – a rehabilitation centre where people who have left an institution, such as hospitals are helped to readjust to the outside world. However, in the, MHA, definitions of 'convalescent home' and 'psychiatric hospital' and 'psychiatric nursing home' are clubbed together and both the terms are equated for legal purposes. The definition (7) of '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. This implies that the minimum standards applicable to psychiatric hospitals which deal with acutely disturbed patients with severe illness also apply to convalescent homes, where the focus is on rehabilitation and reintegration into the community. This has lead to an outcry among private convalescent homes and rehabilitation centres operated mainly in the non-governmental sectors whose aims and functions are distinct from psychiatric hospitals. It is a matter of debate whether these organisations should be brought under the purview of the Mental Health Act, or whether their monitoring should be brought under alternative Acts like the Rehabilitation Council Act.

The MHA sets minimum standards for institutional care. Lack of standards and monitoring mechanisms can give rise to disasters, best exemplified by the horrific incident at Erwadi in Ramanathapuram (9). Ensuring adequate standards of care both in institutions and in the community requires active public-private linkages, as only governmental agencies cannot comprehensively shoulder the responsibility of the care of the mentally ill. Epidemiological data suggests that 6 to 7% of mentally ill persons need active professional mental health assistance at any point in time (10).

Choice of treatment

MHA has clearly laid down the procedures of admission and discharge of mentally ill persons. However, when it comes to intervention, the Act is

silent regarding the choice of treatment, consent for treatment, and the method to be adopted when a severely ill patient refuses well established treatments like medication or modified electroconvulsive therapy (ECT). Some psychiatric hospitals continue to use unmodified ECT, without the consent of the patients or the legal guardian. This is common in situations when a patient is admitted to a mental hospital in a closed environment and family members are not available to give informed consent on behalf of the patient. Some hospitals have evolved standardised protocols for patients unable to provide consent for ECTs. One method has been to obtain the opinion of two independent psychiatrists and the consent of the hospital RMO or superintendent who acts as a surrogate guardian.

Available evidence clearly documents the efficacy of ECT. Hence, this treatment continues to exist in many developed and developing countries. The debate is whether to consider modified ECT (under anesthesia) or unmodified ECT (without anesthesia). While modified ECT is preferred over unmodified ECT, non-availability of anesthetists poses a practical difficulty as does the relatively greater cost of ECT (Rs 300 to Rs 900 more per patient per ECT). Overall, the cost difference for one course of ECT is approximately Rs 2500 to Rs 7000. The issue of anaesthetist unavailability has led to some facilities continuing with direct ECT. The issue of cost should not be a factor for considering unmodified ECT treatment which, even if effective is inhuman. Consider the same issue in a different perspective: if it were proposed to conduct a surgical operation without anesthesia, how many would consent to it? Use of unmodified ECT has resulted in severe stigma attached to this potentially useful treatment. Considering the well established efficacy of modified ECTs and from a human rights, perspective, modified ECT's should be mandated, unless specifically contraindicated (in situations of hypersensitivity or delayed recovery from the pre-ECT drugs used).

Psychiatric Emergency Services

De-institutionalisation, ie., minimising custodial care and encouraging treatment of the patient in the community is a wonderful concept, but can only occur if community outreach services and resources are strengthened. There are many helpless families requesting emergency ambulance services to escort or shift a violent patient to psychiatric hospital. Unfortunately, there are no guidelines or provisions under MHA for crisis intervention to help these families. There are many instances in which helpless family members have approached the nearest police station seeking help to

transfer a disturbed person to the hospital. These requests are ignored without any thought of helping them. Finally, helpless family members are sometimes forced to file complaints against the individual for petty crimes like violence, assault, property destruction and so forth. Under such circumstances, law-enforcing agencies file an FIR for the petty crime, arrest the the mentally ill person and have him/her referred to a psychiatric hospital. It is ironic that there should be such a complicated approach and the, accusation of a petty crime be thrust on a mentally ill person just to provide emergency treatment!

Rehabilitation of mentally ill persons

Though MHA elaborates on the admission and discharge procedures, there are no provisions available for rehabilitation/aftercare of the mentally ill persons under this Act. This requires to be addressed because treatment of mentally ill persons does not end with hospitalisation and medication. They require social and vocational rehabilitation.

Placement of mentally ill persons

There are many mentally ill who are admitted to hospital and later abandoned by their family members. Their discharge is difficult and they are detained indefinitely inside the hospital. Often, especially in the case of women, they cannot be sent home alone. There are no provisions in the Act for placing these treated and stable persons in other social welfare institutions. This issue calls for inter-sectoral coordination between the Departments of Health, Women and Child Development, and Social Welfare.

Dumping of the mentally ill

Psychiatric hospitals have become 'dumping grounds' for families to abandon their mentally ill members. This occurs either due to economic reasons or because of a lack of understanding and awareness of mental illness. The ill individuals are kept in hospitals for longer periods than required by their family members. MHA does not discuss about the placement and rehabilitation of these cured mentally ill persons. It should also state that family members must also shoulder the responsibility of care along with the necessary help, support and guidance from the state.

Death and mental illness

Mental illness carries an increased risk of mortality when compared to

general population. On an average mental health problems like depression or schizophrenia are associated with higher rates of suicide (approximately 10% with these illnesses commit suicide) when compared to the general population. However, the issue of death during custodial care of a mentally ill person is not addressed in MHA (11).

The following factors can contribute to increased mortality (8):

a) Known risk of mortality in mentally ill persons;

b) Lack of manpower (Doctor/nurse/attendent to patient ratio) to monitor persons at risk;

c) Absence of training of the other (non-medical) staff on how to restrain a violent individual;

d) Greater vulnerability of mentally ill persons to physical illness;

e) Disease outbreaks in hospitals;

f) Non-availability of life-saving medicines and general medicines;

g) Poor protective clothing especially in adverse climatic conditions;

h) Violence among in-patients;

i) Suicide or deliberate self-harm.

Many of the mental hospitals in India do follow good clinical practice by conducting a postmortem to ascertain the cause of death. Good clinical practice should be fostered without undue threat to the existing staff of possible legal action. Otherwise they may adopt defensive practices as are sometimes seen in private hospitals, where serious cases/patients are referred to other centres.

Substance Dependence

There is a provision for establishment of separate psychiatric hospitals and psychiatric nursing homes for *children*, those who are *addicted to alcohol or other drugs which lead to behavioural changes* and *convicted persons*. It is not uncommon to get repeated requests from the family members of substance users for admission and treatment against the consent of the users. However, MHA remains silent on the issue of admission and treating persons with substance dependence *without any behavioural changes* who refuse consent for treatment.

Mentally ill Prisoners

Such persons can be admitted and detained at psychiatric hospitals under MHA, Sec 27 (7). However, no provisions have been made for a baseline assessment (during induction into prison) and periodic examination of all the prisoners for mental illness. Many international studies have shown a high prevalence of mental disorders among prisoners. There are many public interest litigations regarding the issue of detaining mentally ill persons in jails. Unfortunately, only a few prisons in India have attending psychiatrists. This issue of mental health examination and assessment of prisoners requires to be streamlined and a system should be developed in which a copy of the FIR and charges framed against the referred mentally ill prisoner are made available to the treating psychiatrist. This will not only help the psychiatrist in understanding the mental condition of the prisoner during the crime, but also enable proper precautions to be taken with regard to his/her treatment and care. Another important issue from a human rights perspective is fitness to stand trial. If an accused is suffering from mental illness at the time of trial, the presiding judge will not be able to proceed with the case until the accused becomes mentally fit to stand trial. There is no clear provision in the MHA with regard to further proceedings if a patient is chronically ill, treatment resistant and never likely to be fit to stand trial. For such mentally ill prisoners arrested for crimes for which they will never be fit to stand trial, there must be provisions in law for further care outside the prison setting.

The National Institute of Mental Health and Neuro Sciences, Bangalore in collaboration with the Department of Prisons of Karnataka has recently launched a project titled "Mental Health: Assessment and Approach in Prisons", with financial support from the Karnataka State Legal Services Authority, Bangalore. One of the expected outcomes of this project is the development of minimum standards for mental health care in prisons and guidelines for the assessment of prisoners (12).

Poor knowledge and implementation

Some of the judiciary and law-enforcing agencies have limited knowledge of the existence and provisions of the Mental Health Act leading to its poor implementation and utilisation. It is the duty of the police officer in-charge of a station to take into protection any person within the limits of his station whom he/she has reason to believe to be dangerous by reason of mental illness and to make necessary arrangements to admit wandering

mentally ill persons to a psychiatric hospital. In the absence of comprehensive awareness-raising activities, there is little scope for the scenario to change in the near future. MHA implementation and human rights for the mentally ill will remain a distant dream if the judiciary and executive are not adequately sensitised.

Media and mentally ill persons

Media including television, cinema and newspapers use mental illness as a means of publicity, sensationalism or misplaced humour. This includes caricaturing mentally ill persons by portraying them as dangerous, violent, serial killers, criminal or objects of ridicule. Such depictions continue to contribute to stigma and negative attitudes among the public. This negative depiction of mentally ill persons should be actively discouraged. There is no provision to take action against such human right violations of the mentally ill.

Guardianship for persons with mental illness

A person of unsound mind may not be capable of managing his affairs and property. The MHA has provision for appointing a guardian for care and a manager for management of property of mentally ill persons. However, this provision is rigid and cumbersome. This aspect requires simplification at least for the natural guardian on the lines of the procedure outlined in the National Trust Act 1999.

Persons with Disabilities Act (Equal Opportunities, Protection of Rights and Full Participation) *(PWD Act 1995)*

Persons with Disabilities Act (Equal Opportunities, Protection of Rights and Full Participation) 1995 (Act 1 of 1996) was unanimously passed by both the houses of Parliament on 22nd December 1995, but came into force only on February 7, 1996 (13).

This Act consists of 14 chapters and 74 sections (13). Each section is further divided into several subsections. I – Preliminary, II - The Central Coordination Committee, III - The State Coordination Committee, IV - Prevention and Early Detection of Disabilities, V – Education, VI – Employment, VII - Affirmative Action, VIII - Non-Discrimination, IX - Research and Manpower Development, X - Recognition of Institutions

for Persons with Disabilities, XI - Institution for Persons with Severe Disabilities, XII - The Chief Commissioner and Commissioners for Persons with Disabilities, XIII - Social Security and XIV - Miscellaneous

Salient features of the Act

This Act is an important landmark and is a significant step in the direction of ensuring equal opportunities for people with disabilities and their full participation in nation-building. The Act provides for both preventive and promotional aspects of rehabilitation. Areas covered include education, employment, vocational training, job reservation and research and manpower development. It seeks to create a barrier-free environment, rehabilitation of persons with disability, securing unemployment allowance for the disabled, providing special insurance scheme for disabled employees and establishment of homes for persons with severe disability.

Poor knowledge of the Act

The Disability Act of 1995 defines 'disability' as (i) blindness; (ii) low vision; (iii) leprosy-cured; (iv) hearing impairment; (v) locomotor disability; (vi) mental retardation, and (vii) mental illness. There was much ignorance among policy makers and administrators about mental illness as a disability, but this is slowly changing. Comprehensive awareness-raising activities regarding the Act must be undertaken. Though the Act came into force in 1996, the disability assessment for mental illness was procedurised only in 2001. The Indian Disability Evaluation and Assessment Scale (IDEAS) (14) was accepted and published in 2002.

Representation for mentally ill persons

There have been no representatives or representation for persons with mental illness in the Central Coordination Committee. Sufferers and users of services must be included in such committees to ensure fair and equitable delivery of mental health care (15).

Discrimination with regard to employment

The disability associated with chronic mental illness is invisible and the impact on family members and the community is enormous. Most of the welfare work with regard to mentally ill persons has been undertaken as a 'knee jerk reaction' to certain situations or public outcry. There is a wrong notion that a person with mental disability is incapable of working. Hence,

mentally disabled persons are either discouraged or not allowed to apply for a job. This is a delicate issue which needs to be debated.

Rehabilitation of mentally ill persons

Community Based Rehabilitation (CBR) has been advocated by WHO and by many international agencies for more than two decades. CBR improves self-esteem, empowerment, self-reliance and social inclusion, which improves the quality of life of persons with disabilities. Despite this, the majority of government psychiatric hospitals or medical colleges do not offer rehabilitation facilities for mentally ill persons. Though chapter IV (Prevention and Early Detection of Disabilities) and chapter VII (Affirmative Action) discusses promotion and prevention, the curative and rehabilitative aspects are missing. Unfortunately rehabilitation of mentally ill persons, which is highly essential, has been ignored. This aspect has not been captured either in MHA or PWD Act. Development of halfway homes, vocational training centres, social-skill training centres, cognitive retraining centres, day-care centres and long-stay centres requires advocating and initiating at regional levels.

Indian Disability Evaluation and Assessment Scale (IDEAS)

The Rehabilitation Committee of the Indian Psychiatric Society evolved an assessment tool called the Indian Disability Evaluation and Assessment Scale (IDEAS) (14, 16). This has been field-tested in eight centres in India. This instrument is simple and comprehensive in quantifying mental illness. It assesses disability on five dimensions, namely, 'Self-Care'; 'Work' ,'Interpersonal Activities', 'Communication and Understanding'; and 'Duration'. Initially IDEAS was devised and advocated for four important psychiatric disorders: Schizophrenia, bipolar disorders, obsessive compulsive disorders and dementia. However, as per the gazette notification, disability certificates can be issued for all mental disorders.

The Ministry of Social Justice and Empowerment, Government of India gazetted it in 2002 after certain modifications in the scale (14, 16), with respect to duration of illness. The original version had a simple method called MY 2Y (16) – months of illness during the last two years. For certification it was necessary that the total duration of illness should be at least two years. The original IDEAS adopted 'duration of continuous illness' rather than 'duration of illness' as a criterion to determine disability. In its modified form, it becomes difficult to compute total duration of illness for episodic disorders.

Temporary Disability certificate

The PWD Act makes a provison for providing temporary disability certificates in certain situations. The treating professional can indicate the duration for which the certificate is valid, and may suggest periodic re-evaluation. When not specified, it is assumed that such a certificate is valid for five years. This information is not widely known, and in several instances such certificates have not been honoured by concerned administrators, and patients have been denied their rights.

Quantification of disability

The disability scores for mental retardation are expressed in terms of mild, moderate, severe and profound disability as follows (14): Mild Disability (d"40%), Moderate Disability (40-70%), Severe Disability (71-99%) and Profound Disability (100%). Although these ranges have been notified in the gazette, in many cases, administrators still insist on a specific percentage (above 40%) to provide benefits. They need to be educated about the provisions. An alternate option would be for persons providing certification to express the calculated score in median percentage rather than on a range.

Travel concession

While knowledge of travel concession benefits for mental retardation is more widely known, that persons with mental illness are also eligible for the same concessions is little known. This concession will greatly help people who often have to travel long distances for consultation.

PWD Act 1995 is a milestone in the history of Indian legislation. This legislation has moved beyond the concept of charity for the disabled by rewriting it into their individual rights. However, the main weakness of this legislation is the absence of a strong monitoring and implementing system.

National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 *(NTA 1999)*

NTA 1999(17) provides for the constitution of a national body for the welfare of people with autism, cerebral palsy, mental retardation, and multiple disabilities. The Act mandates: a) promotion of measures for their care, b) protection of persons with these disabilities in the event of the

death of their parents, c) procedures for appointment of guardians and trustees, and d) support to registered organisations to provide need-based services in times of crisis to the families of the disabled (18). This Act also encourages and supports the formation of Parent's Associations where persons with intellectual, severe and multiple disabilities are themselves unable or unwilling to engage in self-advocacy.

One of the criticisms that the National Trust Act has been facing is regarding the appointment of guardians for taking care of and making proxy decisions on behalf of the disabled. This, it is argued, defeats the very purpose of empowerment, equality, rights and full participation goal. Asserting that each individual should make their own decisions does not mean that each individual does not need help, assistance and support in doing so. It should rather be a 'shared decision' making or 'assisted decision' making or 'informed decision' making. The combination of ownership (patients) and responsibility (guardians) is most empowering.

Recognising and responding to the need to provide facilities to persons with disability help them live with their own families in the community, providing protection/care/support when family members are unavailable is definitely a boon to mentally ill persons and their family members.

Rehabilitation Council of India Act 1992 (RCI 1992)

The RCI (19) is responsible for standardising, regulating and monitoring training courses for rehabilitation professionals, granting recognition to institutions running courses, and maintaining a Central Rehabilitation Register of rehabilitation professionals. The RCI Act was amended in 2000 to give RCI the additional responsibility of promoting research in rehabilitation and special education (20). This Act contains only three chapters, I-Preliminary, II-Rehabilitation Council of India & III-Functions of the Council.

A person possessing the necessary qualification has certain rights and can practice rehabilitation (Sec 13). The Act regulates the standard of education, training and examination (Secs 14, 15). Recognition of the Institution (21) can be withdrawn if it does not fulfill requirements as specified in the Act (Sec. 17). Infamous conduct or any illegal practice done by such a person may cause the removal of his/her name from the register (Sec. 21) (21).

The Protection of Women from Domestic Violence Act 2005 (DMV 2005)

As per the DMV 2005 Act **(22)**, domestic violence is defined in terms of mental, physical, sexual, verbal, emotional and economic abuse. This legislation recognises a woman's right to live free from violence (23) and is critical to a person's mental health.

Disputes, differences of opinion, economic difficulties, criticisms and gender differences occur in every family. Previously, a majority of these problems were solved by families themselves or by the elders of the family. Now, these family differences and difficulties have reached new legal dimensions. DVA may help many women who are silently undergoing domestic violence to get help. The Act if utilised in a proper manner, can prevent domestic violence and can be a boon for Indian women. For example, a lady lodged a case against her husband for beating her with an umbrella, as a result of which she sustained injuries on her face. This violent act took place when the man demanded money from her for alcohol and on her refusal, decided to punish her. This man was arrested under DVA and subsequently referred for counseling (24).

There are many instances during which the Anti Dowry Act has been misused and then the whole family has been punished. This new legislation leaves the male members unprotected in circumstances of a woman mounting an attack on men. On the contrary, this Act may be misused in situations where family ties have weakened (for example, between brother and sister), because of greed for property or just to harass, punish or blackmail a family member.

In domestic violence, the weaker gender requires more than just legislation. Victims will need shelter, food, social support, emotional support, legal aid, financial aid and above all, safety. The important question which requires to be answered is whether we have a system to support and empower women.The government should work towards improving the social, health, economic, educational and occupational status of all women. This will lead to true empowerment.

As with any law, there will always be a possibility of its misuse. All members of society need to look at this Act from a different perspective. This Act will provide relief and support to millions of abused women.

Narcotic Drugs and Psychotropic Substances Act, 1985 (NDPS ACT 1985)

Drug abuse has become a major social, economical, health and crime related issue. It destroys not only the individual, the family, and society but also adversely affects the economic growth of the country. Drug use is no more an individual problem but a global issue. To combat this problem, the Indian Government took a first step by enacting the Narcotic Drugs and Psychotropic Substances Act, 1985, also known as the NDPS Act (25). Under this Act, the cultivation, production, manufacture, possession, sale, purchase, transportation, warehousing, consumption, inter-state movement, trans-shipment, and import and export of narcotic drugs and psychotropic substances is prohibited, except for medical or scientific purposes. The NDPS Act focuses on three different categories of persons liable for prosecution. They are:

a) Drug manufacturers / Cultivators

b) Dealers / Traffickers /Transporters

c) Consumers (Substance users / addicts)

Under section 27 of the Act, who so ever consumes any narcotic drug or psychotropic substance shall be punished (26). This clear prohibition and penalty for personal consumption raises important issues in terms of mental health treatment and rehabilitation. The legal implication when a person comes to a rehabilitation centre directly for treatment reporting that he/she was consuming banned drugs is unclear. Should the mental health professional treating him/her inform the law-enforcing agencies? If mental health professionals start informing law-enforcing agencies, then the people who seek voluntary treatment will decline rapidly. The Act has partially addressed this issue by providing once in a life-time immunity against conviction for undergoing de-addiction treatment if he/she is willing to execute necessary bond prescribed under the Act.

This Act does not differentiate between the offender groups. The first two groups (manufacturers and traffickers) have monetary motives, whereas the third group (consumers) is a drug dependent group, which does not have any profit-making motive but requires treatment. Research has proven beyond doubt that substance dependence is an illness and requires treatment for long duration.

Section 27 of the NDPS Act states that individuals found to be in illegal possession of drugs in a small quantity for personal use are liable to punishment up to six months of imprisonment or fine or both, which, in case of hard drugs like heroin would be up to one year's imprisonment or fine or both. Section 27 of this Act requires amendment because of the following reasons:

a) Substance dependence syndrome is a life-long illness like diabetes and hypertension. In substance dependence, relapse is a rule rather than an exception. Hence, provision like once in a life-time immunity for treatment is simply not practical.

b) Treatment is made available only after executing a necessary bond in the court as prescribed under the Act. Seeking courts' permission before treatment is impractical. It also goes against the concepts of right to health and confidentiality.

c) NDPS Act may itself act as a deterrent for people seeking treatment when they relapse.

d) The quantity fixed is so small that it may not suffice for even a single use and such provisions make it difficult for persons with addiction to openly seek medical help and rehabilitation.

The NDPS Act should act as a facilitator for treatment for persons with substance use. Amendment of Sec 27 is necessary to facilitate treatment especially for users. In practice, this section is rarely seen in operation. This Act's emphasis should be on stringent action against people involved in manufacturing and trafficking of drugs.

The Juvenile Justice (Care and Protection of Children) Act, 2000

The JJ Act 2000 (27) came into force in Feb 2001, repealing the earlier Act of 1986. This Act focuses on two different types of child populations: a) juveniles in conflict with law (law offending children) and b) children in need of care and protection (neglected children). This Act ensures protection, proper care and treatment by catering to the developmental needs of this population. This Act also promises a child-friendly approach in the adjudication and speedy disposition of matters in a newly formed juvenile jurisprudence. In this Act, every human being below the age of 18 years is treated as a juvenile and this group is exempt from death penalty and degrading punishment.

This Act has a serious drawback of falling back on the same old custodial centres. Instances of children being ill-treated, physically and even sexually assaulted by the staff or by older residents (seniors) of these institutions, are not uncommon. This issue needs to be addressed seriously. However, there is provision in the Act for social reintegration through restoration (back to home), adoption, foster care, sponsorship and sending the child to after-care organisations. It also attempts to develop a greater co-ordination and collaboration through joint ventures between the governmental and non- governmental agencies, families, corporate and other stake holders.

The JJA 2000 provides for the rehabilitation and social integration of children in conflict with law as well as children in need of care and protection (27). There should have been more emphasis on investing in the establishments of institutions governed under JJA. Many of the institutions established under this Act only provide some shelter but have no quality of care is missing. This ultimately defeats the very purpose of the Act to protect and promote the rights of children by providing safe, protective, rehabilitative and social reintegration for full participation.

Conclusion

People with mental disorders are one of the most vulnerable populations in society. They are often isolated, stigmatised, discriminated, humiliated and marginalised. They often end up in unhygienic and inhumane living conditions either in the community or in the mental hospitals with increased likelihood of human rights violation. Hence, mental health legislation acts as an important means of protecting the rights and dignity of persons with mental disorders. It also provide a legal framework for addressing issues such as admission, treatment, care in institutions and discharge; civil, political, economic, social and cultural rights; and implementation of mental health policy and programmes. Ultimately, objectives of all the mental health legislations are to ensure equal access to mental health services, protection of human rights and reintegration of person with mental disorders into the mainstream of society.

Significant changes in Indian mental health legislations have occurred over the last two decades. Though there may not be a single comprehensive legislation, various acts have addressed many critical issues of mentally ill persons, like provision for treatment, protection against discrimination, providing equal opportunities, promoting mental health of high risk population groups like women and children, prevention and regulation of

narcotics and psychotropic substances and providing guardianship. Human right issues of persons with mental illness have, however, not been covered comprehensively in any of the acts.

A majority of the Indian legislations have focused on institutional treatment but failed to address community-based mental health care. Provision to address vital issues in the promotion of mental health and prevention of mental disorders is almost absent. Similarly, our legislation has failed to emphasise that 'family of mental ill persons' and 'caretakers' (including the state) assume major responsibility for looking after people with mental disorders.

There is no doubt that the Indian mental health legislative framework is comparable to the legislative framework of a developed country. However, due to ineffective implementation, the measures taken have not been effective to realise the envisaged vision. Much more can be achieved by rigorously implementing the existing laws than prematurely looking for amendments or new laws. Hence, the rule of thumb should be '*implementation first, amendments should follow next'.* Although there are a number of laws that are made to protect persons with mentally illness, no law will help unless each and every citizen is educated about legal provisions. Nonetheless, implementation, monitoring and regulation of mental health legislation remain an important challenge.

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