

FORENSIC PSYCHIATRY

(Psychiatry and Law)

S NAMBI

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4 Chapter

Mental Health Legislation in India

EVOLUTION AND EVALUATION OF THE VARIOUS ACTS

Almost every aspect of life in the modern days is regulated or affected in some way by law. All civilizations in the world have enacted laws to regulate human behaviour so that the weakest can live freely and enjoy all his human rights. Legislation forms an important component in the implementation of mental health care. There is a dynamic relationship between the concept of mental illness, the treatment of the mentally ill and the law. "Forensic psychiatry is a poorly defined speciality, with little organised training in most countries."—(WHO Working Group, 1975). A working knowledge of the Mental Health Act, 1987 is essential for all psychiatrists in India.

In the Indian Context, many acts are directly related to mental health. Among them, the Mental Health Act, 1987 is a Major legislation and it has become operational in 1994 in all States of the Indian Union. The Act replaces the Indian Lunacy Act, 1912.

The various enactments controlling the care and treatment of the mentally ill of the British India could be enumerated as follows:

1. The Lunacy (Supreme Courts) Act, 1858 (Act XXXIV of 1858)
2. The Lunacy (District Courts) Act, 1858 (Act XXXV of 1858)
3. The Indian Lunatic Asylums Act, 1858 (Act XXXVI of 1858)
4. The Military Lunatics Act, 1877 (Act XI of 1877)
5. The Indian Lunatic Asylums (Amendment) Act, 1886 (Act XVIII of 1886)
6. The Indian Lunatic Asylums (Amendment) Act, 1889 (Act XX of 1889)
7. Chapter XXXIV of the Code of Criminal Procedure, 1898
8. Section 30 of the Prisoner's Act, 1900.

The first three Acts were enacted immediately after Queen Victoria's proclamation and India came under the rule of the British Crown. In her proclamation, she promised, amongst other things, "By the blessing of providence internal tranquility, it is our earnest desire to stimulate the peaceful industry of India to promote the works of public utility and improvement and to administer

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the government for the benefit of all subjects." (I presume she had the interests of the mentally ill in India in her mind!)

A short review of the following three Acts including the Mental Health Care Act Draft, 2012 is to be discussed:

1. Indian Lunacy Act, 1912.
2. Mental Health Act, 1987.
3. Mental Health Care Act Draft, 2012.

THE INDIAN LUNACY ACT, 1912

With this British background, the curtain rises in the Viceregal Lodge of Shimla on Monday the 18th September 1911 with Baron Harding of Penshurst presiding over the Council of the Governor-General of India. The honorable Mr Jenkins moved to introduce a bill to consolidate and amend the law relating to Lunacy. He observed, "We propose to consolidate these enactments and to introduce certain amendments and especially to bring the Law in certain important particulars into line with the Modern English Act." The Lunacy Act, 1890 as amended by the Lunacy Act, 1891. The Legislative Department of the Council was complimented for its painstaking labor. He considered that it is more fit for careful examination with regard to all details in the Select Committee, than for general discussions in the Council. The Council met on Wednesday the 10th January 1912, under the presidentship of the hon'ble Sir Guy Fleetwood Wilson and referred the Indian Lunacy Bill to the Select Committee.

EARLY MENTAL HOSPITALS

During the middle ages, a few monasteries harboured lunatics, but it appears that the first asylums for their care were built by the *Moslems*, whose ideas on the treatment of mental patients were derived from Eastern physicians. In Europe, the Bethlem Royal Hospital (the original Bedlam) was first used as an asylum in 1247, the second was opened in 1448 at Valencia in Spain. Further asylums were established in Europe during the following century. In America, the first hospital for insane was opened in Virginia in 1773 (WHO, 1955; Bluglass, 1984). Although, hospitals in India were popular since the time of Ashoka the Great (274–235 BC), the first mental hospital was probably established by Mahmood Khilji (1436–1469) at Dhar near Mandu in Madhya Pradesh and the second one was built in Calcutta in 1787 (Verma, 1953). The first unaided private mental hospital in India was established in Calcutta in 1935 by Kaviraj Atul Behari Dutt.

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HIGHLIGHTS OF THE INDIAN LUNACY ACT, 1912

Repealed	The Indian Lunacy Act, 1977 (Jammu and Kashmir Act)
Policy	Not based on any mental health policy or program.
Main objectives	1. Protection of society from the presence of mentally ill persons who have become or might become a danger or nuisance to others.
	2. Protection of the citizens from being detained in psychiatric facilities without sufficient cause.
Mental retardation	Excluded from the purview of the Act (The expression mentally ill person means person suffering from any mental disorder excluding mental retardation).
Psychiatric nursing home and residential home	Included
Board/Authority	Mental Health Authority without any fund established.
Appointment of visitors	Old provision retained and extended to psychiatric nursing home.
Voluntary admission	Formal
Services of magistrates for involuntary admission	Retained except for admission under special circumstances for a period not exceeding 90 days.
Mental health review tribunal	No provision
Rules	Rules u/s 91 (mandatory legal aid to mentally ill persons in Court) not made in any state. Principles of rule of construction not followed.
Forms	No provision for use of forms for orders. All forms mentioned in the Act have not been prescribed, some are inconsistent with the Act.

THE EVOLUTION OF MENTAL HEALTH ACT, 1987

The enactment of Mental Health Act, 1987 is a landmark in the history of care of mentally ill in India. This Act is not simply a cosmetic improvement over the outdated Indian Lunacy Act, 1912, but represents the conclusion of Lengthy persuasion by Indian Psychiatric Society to Government of India.

Establishment of Lunatic asylums was primarily a British concept. The rule and laws relating to mentally ill were much influenced by European ideas and concepts at that time. The British enacted the first Indian Lunacy Act in 1858 in India, which was modified in 1883 the objective was simple.

Insane persons are troublesome and dangerous to the community. Thus asylums were considered as simple places of detention and not for treatment. In early 20th century, there was adverse publicity about the condition of Mental Institutions in India as well as abroad. Due to this awareness, British brought out the Indian Lunacy Act in 1912, (ILA). In early 20th Century, the names of all lunatic asylums were changed to mental hospitals.

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Before the Independence of India, "Bhore Committee" was asked to survey mental hospitals in India. The committee recommended that ILA 1912 was outdated and outlived its usefulness. As a follow-up, the Indian Psychiatric Society appointed a three member adhoc committee, consisting eminent psychiatrists of yester years like Dr Roy of Nagpur, Dr RB Davis, and Dr Hasib of Ranchi.

This committee prepared a draft: Indian Mental Health Act. Later repeated attempts were made by IPS to enact new Mental Health Act. The Ministry of Health introduced Mental Health Bill first in 1980 and later in 1981. The Bill was referred to the joint committee of parliament members in 1982. The committee held 22 meetings in various places and submitted its recommendations. But the Lok Sabha was dissolved in 1984. Later, a joint committee was formed in 1985. This suggested some amendments to the original Bill. Finally, the two houses of parliament passed the Bill in 1986. The present Mental Health Act was enacted in May 1987. The Central Government passed orders that this Act would come in force with effect from April 1, 1993 in all the States. The Central and State Mental Health Authority rules were framed in 1990. Thus, such a long and tiresome process was involved in the enactment and implementation of the MHA, 1987.

Definition of Mental Health Act, 1987

"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."

The Objectives of The Mental Health Act, 1987

1. To regulate admission to psychiatric hospital of psychiatric nursing homes, of mentally ill persons who do not have sufficient understanding to seek treatment on a voluntary basis, and to protect the rights of such persons while being detained.
2. To protect society from the presence of mentally ill persons, who has become a danger or nuisance to others.
3. To protect citizens from being detained in psychiatric hospitals or psychiatric nursing homes without sufficient cause.
4. To regulate responsibility for maintenance charges of mentally ill persons who are admitted to psychiatric hospitals or psychiatric nursing homes.
5. To provide facilities for establishing guardianship or custody of mentally ill persons who are incapable of managing their own affairs.
6. To provide for the establishment of Central Authority and State Authority for mental health services.
7. To regulate the powers of the Government for establishing, licensing and controlling psychiatric hospitals and psychiatric nursing homes for mentally ill persons.
8. To provide legal aid to mentally ill persons at State expense in certain cases, Government of India has constituted a Central Mental Health Authority.

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Before implementing Mental Health Act in the States, the States have to take action regarding the following:

- Establishment of State Mental Health Authority.
- Spell out guidelines for establishment of private psychiatric hospitals and Nursing Homes.
- Formation of Board of Visitors.

Salient Features of Mental Health Act, 1987

The Mental Health Act, 1987 has 10 chapters in total:

1. *Definitions*: The Mental Health Act, MHA 1987 brings out number of changes based on newer concepts and knowledge in mental health field. It modified certain terms and definitions. The Act uses the term,

ILA	MHA
• Lunatic	Mentally ill person.
• Criminal lunatic	Mentally ill prisoner.
• Asylum	Psychiatric Hospital.

2. *Mental health authorities*: A provision of establishing Mental Health Authorities at centre and state levels have been made for the first time. This will facilitate better implementation and monitoring of various aspects of Mental Health Act, such authorities may also advise the Government on matter related to mental health activities in the country.
3. *Establishment and Maintenance of Psychiatric Hospital and Psychiatric Nursing Homes:* MHA lays down guidelines for establishment and maintenance of psychiatric hospitals and nursing homes. Also, there is a provision for a Licensing Authority, who will process application for licenses. No private Psychiatric hospital or nursing home will be allowed to function without a valid licence, which has to be renewed every 5 years. There is a provision for an Inspecting Officer who will inspect these institutions to prevent irregularities. Mention has been made about the establishment of separate psychiatric hospitals for children, addicts, and psychopaths.
4. *Admission Procedures*: Admission procedures are simplified and more progressive concepts have been incorporated. Medical officer in charge of psychiatric hospitals are given more powers and the powers of judiciary and visiting committee members relating to admission are minimized. The admission procedures are:
   a. Admission on voluntary basis.
      - By the patient
      - By the guardian (for minor)—A new provision.
   b. Admission under special circumstances: (A new provision). Admission of a mentally ill person who does not or is unable to express his willingness for admission may be admitted and kept for maximum 90 days. Admission can be made at the request of a relative or friend of the mentally ill person.

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c. Admission through reception orders—
   - Reception order or application:
     – Application can be made by a medical officer or a relative along with medical certificates, on production of mentally ill person before magistrate, a reception order may be issued for admission.
   - Reception order on production of mentally ill person before magistrate. (Admission of a dangerous wandering mentally ill person)

     On production of a wandering mentally ill by the police before the magistrate, a reception order for admission may be made.
   - Further provision regarding admission and detention of mentally ill persons:
     – Admission as inpatient after inquisition
     – Admission of mentally ill prisoners:
       - Convicts (Under section 30 of the Prisoners Act, 1900 (3 of 1900)
       - Undertrial prisoners (Under section 330 of code of criminal procedure, 1973 (2 of 1974)
       - Guilty, but mentally ill (Under section 335 of code of criminal procedure, 1973 (2 of 1974)
   - Admission of military persons:
     — Under Section 144 of Air Force Act, 1950
     — Under Section 145 of Army Act, 1950
     — Under Section 143 and 144 of Navy Act, 1957.

d. Inspection, discharge, leave of absence and removal of mentally ill person: This chapter deals with the formation and functioning of visitors to the psychiatric hospital or nursing home. This chapter deals with procedures for discharge of mentally ill persons admitted in the psychiatric hospital. There is a provision for Leave of Absence for patients admitted under reception orders. The maximum duration of leave of absence is 60 days. The application may be made by the relative or through magistrate.

5. *Judicial Inquisition and Appointment of Guardian and Manager:* Inquisition is an investigation or examination whether the person who is alleged to be mentally ill and incapable of managing his affairs. An application for judicial inquisition may be made by his relatives, public curator (prosecutor), Advocate General of the State or by the District Collector.

   Guardian to be appointed by the court for a mentally ill person who cannot look after himself and his properties. Manager to be appointed for a person who can take care of himself, but unable to manage his properties.

6. *Maintenance of Mentally Ill Persons in a Psychiatric Hospital or Psychiatric Nursing Home:* Chapter VII of MHA, 1987 deals with the liability to meet the cost of maintenance of mentally ill persons detained in hospital or nursing homes by the relatives or by the government.

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7. *Protection of Human Rights of Mentally Ill Persons:*
   a. This is a humanitarian approach of MHA, 1987 towards the unfortunate, underprivileged mentally ill persons.
   b. No mentally ill person shall be subjected to any indignity (whether physical or mental) or cruelty during treatment.
   c. No mentally ill person, under treatment, shall be used for the purpose of research unless.
      - Such research is of direct benefit to him
      - A consent has been obtained in writing from the person (if a voluntary patient) or from the guardian/relative (if admitted involuntarily).
   d. No letters or communications sent by or to a mentally ill person shall be intercepted, detained or destroyed.
8. *Penalties and Procedures:* In chapter IX MHA, 1987 deals with penalties and procedures for establishment or maintenance of psychiatric hospital or nursing homes in contravention of the Act.
9. *Miscellaneous:* Here the Act deals with matters not covered in other chapters, like keeping medical report about the patients, etc.

The Positive Qualities of the Mental Health Act, 1987

Mental Health Act, 1987 represents a pleasant departure by incorporating the latest scientific knowledge and social concepts. A modest attempt has also been made to bring mental illnesses at par with physical illnesses thus reducing the stigma attached with the mental illnesses (Sharma, 1991).

1. The definitions in this Act are in a progressive way, e.g. mentally ill persons is one who is in need of treatment by reason of any mental disorder other than mental retardation. Hence, "treatability" is considered as a major criterion. Hence, the Act does not apply to untreatable conditions like mental retardation and dementia.
2. The Act does not apply to general hospitals or general nursing homes which also may provide psychiatric services.
3. The formation of mental health authorities in the centre and state level provides opportunities for monitoring and suggesting improvements in the mental health care of patients.
4. Out patient services should be available at every psychiatric hospital or nursing home—A welcome approach.
5. Admission procedures are simplified and made more convenient to the relatives. A voluntary patient can be admitted or discharged merely on request. Minors can be admitted by the guardians. A relative or a friend can admit a mentally ill person who does not or who is unable to express his willingness under special circumstances. The two medical certificates required can be made by the doctors working in the psychiatric hospital or nursing home. Any private person can report to the magistrate if a mentally ill person is not under proper care. Inclusion of such a provision brings out the role of community for the welfare of the mentally ill.

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6. Discharge procedures are made easier. A person admitted through reception order need not be discharged by the visiting committee; on the recommendation of two medical officers the patient may be discharged.
7. Provisions have been made for establishing separate hospitals for those under 16 years, addicts and psychopaths.
8. Due to growing global human right concerns, efforts have been made to safeguard the human rights of the mentally ill person, stringent punishment has also been provided for those who subjects the mentally ill to physical and mental indignity.

Criticism Against Mental Health Act, 1987

1. The notion of a care in the community has not been addressed to in the current legislation. No effort has been made to provide after-care services for the discharged patients. There seem to be no thinking over the alternative to the hospital care. No mention is made about rehabilitation.
2. Psychiatrists running private psychiatric nursing home are facing too many medicolegal problems, difficulties and interference in the administration with regard to:
   a. Getting and renewing licence.
   b. Board of visitor's control over their nursing home.
   c. Consulting a medical board for their day-to-day hospital procedure like issuing certificates for admission, discharge, and leave of absence, etc.
   d. Inspecting officer can unnecessarily intervene the functioning of the hospital.
3. Patients examined by psychiatrists and admitted in a psychiatric nursing home should not be compelled to undergo further examination by medical and/or non-medical visitors. It goes against the fundamental rights of a citizen or his family and such a exposure of any responsible citizen or his family and disclosure of his psychiatric illness to the knowledge of the public may amount to indignity and cruelty.
4. In the Mental Health Act, 1987, the matter of consent and competence has not been adequately addressed to.
5. Does an involuntary admission (For example, Admission through reception order) necessarily imply incompetence? Can drugs and ECT be given without any informed consent? What is the statuary criteria for competence? Who will judge the competence, doctors or the judges? These questions are to be answered.
6. The Act presumes that there are sufficient hospital beds for all the psychiatrically ill. Reality do not substantiate this presumption. There are hardly 20,000 hospital beds for a population of 900 million people. The need for more provisions for long-stay patients is not taken care of. The Act mostly talks about patients in hospitals. Thus keeping the realities of the Indian situation in mind, one is forced to say that the Mental Health Act, 1987 should be more appropriately called the Mental Hospitals Act.

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7. For the patients admitted under special circumstances, no provisions has been made for continuation of his treatment beyond the period of ninety days. The only way left to the relative is to make an application before a Magistrate for a reception order, severe penalty may be imposed upon the Medical Officer in-charge for improper detention beyond a period of 90 days.

MENTAL HEALTH ACT: A REITERATION OF INSTITUTIONALIZATION

Involuntary commitment to mental hospitals is presently regulated by the Indian Lunacy Act of 1912. The Indian Lunacy Act antedates both current human rights thinking and therapeutic developments in the realm of mental health. In tune with times in which it was enacted, the ILA views mental illness as a "Law and Order" problem. Therefore, the procedure of involuntary commitment is required to be activated in order to protect society from the disruptive and dangerous manifestations of mental illness. Mental hospitals are in the main, required to function as custodial houses and not treatment centres (Dhanda, 1985).

This predominantly custodial policy of the ILA is obviously at odds with the NMHP. This legislation, however, is the prevailing law only as long as the Mental Health Act of 1987 is not brought into force. As the MHA is the incoming law, any strategy of coordination has to be dealt with in the context of this statute.

The MHA alters the predominantly custodial functions allocated by the ILA to mental hospitals and requires involuntary commitment for therapeutic considerations. However, despite several studies on the harmful effects of institutionalization and long-term stay in mental hospitals the MHA addresses the issue of compulsory care and treatment only in the context of "Psychiatric Hospitals" (Dhanda, 1985; 1986).

There is no provision which requires that commitments to a psychiatric hospital should be ordered only if less restrictive alternatives are inappropriate. Though Central and State Mental Health Authorities are to be established to regulate and superintend all mental health services in the country, there are no provisions whereby an inter-referral system is set up between these various services.

Section 5 of the MHA empowers the government to set up institutions such as halfway houses after-care homes, but there are no provisions spelling out the inter-relationship of these institutions and "psychiatric hospitals", in order to lessen the institutionalizing rigour of psychiatric hospitals.

Along with deinstitutionalism, the NMHP also advocates deprofessionalised delivery of mental health care. On this aspect, a curious position is adopted in the MHA. General practioners of *Allopathy*, *Ayurveda*, *Unani*, and *Homeopathy* systems of medicine have been empowered to issue medical certificates to a "mentally ill person". For purposes of seeking admission in a psychiatric hospital the responsibility for providing mental health treatment has been exclusively accorded to psychiatrists. The role of other mental health

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professionals such as clinical psychologists, psychiatric social workers, and psychiatric nurses has been accorded no recognition either for certification or for care and treatment.

CONSEQUENCES OF LACK OF COORDINATION

The consequence of the non-recognition of the deinstitutionalization programs of the NMHP in the MHA is that the poor and vagrant, mentally ill persons, who is routed to the mental health system from the criminal justice system is deprived of access to the less restrictive services. Authorities empowered to make compulsory commitment decisions are not authorized to refer them to the less restrictive services even if appropriate (Dhanda, 1988). Since compulsory admission to mental hospitals is controlled, legislatively any change in the functional role of these institutions cannot be achieved without amending the statutory regime.

Studies on mental hospitals (Gupta, et al. 1968; K Bhaskaran, 1970; Gupta, et al. 1980; Sharma, 1990), show that the inmate population can be broadly divided into three categories;

- Persons, who need active treatment
- Chronically ill persons, who need no active treatment but require custodial care
- Psychiatrically fit persons, who need after care and rehabilitation.

Mental hospitals can acquire their NMHP designated status of "active treatment centers" only if services are established for fulfillment of the other needs, and distinct grounds and procedures for the use of those services are articulated. In order to remodel mental hospitals as active treatment centres, it is essential that the other functions fulfilled by these institutions are reallocated both in law and in policy.

Due to the amalgamated role of "therapist cum custodian" being performed by mental hospitals, a number of these institutions have come to function as dumping houses for the rejects of society (Kalbag, 1982; Sagar, 1983; Singh, 1984; Bonnerjee, 1985; Munshi, 1987; Hindustan Times, 1988; Philips, 1988; Times of India, 1990). Commitment to such an institution deprives a mentally ill person of his life and personal liberty without any attendant benefits of treatment or care.

Through delivery of mental health care is not exclusively provided by mental hospitals, they are the most visible caretakers of the mentally ill. Hence the abysmal conditions prevalent in these state-administered and funded institutions becomes a major indicator of societal attitudes towards the mentally ill. For promotion of community care of the mentally ill, it is essential that stigma-promoting or perpetuating agents should be deactivated. The continuance of mental hospitals as custodial houses both strengthens the stigma of mental illness and obstructs social reintegration of the mentally ill. In order to protect the constitutional rights of the mentally ill and to promote their social acceptance, the restructuring of these institutions needs to be accorded high priority.

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THE ADVANTAGES OF CONSONANCE

The NMHP adopts the policy of deinstitutionalization and deprofessionalization on an "inadequate resources logic". The policy of deinstitutionalization cannot be supported only because the country does not possess adequate resources to deliver mental health services through specialist institutions and personnel. This rationale can be criticized as being discriminatory to the poor sections of the populace, who are being provided substandard care without any safeguards against misuse.

This criticism could have been obviated if the program makers had adopted the logic of constitutional rights as the basis of the program. This logic would require the program to state that the policy of deinstitutionalization was being advocated because institutionalism entails a deprivation of life and personal liberty of the mentally ill persons. As the process harms the personality of the mentally ill person and obstructs his reintegration into society. Article 21 of the constitution requires that the denial should not be greater than is required for fulfilling objectives of either therapy or custody. The constitutional principle of "least restrictive alternative", could have been the reason for constructing the inter-referral system of the program.

If the NMHP has been based on a "constitutional rights logic" the program makers would have clearly made the point that the policies of the program are motivated by the best interests of the mentally ill and not a compromise with an inadequate resources position. A constitutional basis to the program would have increased its implementational priority. Also a statutory incorporation of some of the policy thrusts of the program would have been greatly facilitated.

A statutory incorporation of the policy preferences of the program should increase its implementation momentum, such a statute could introduce mechanisms to monitor the quality of mental health care and thus obviate one of the major criticisms against the NMHP.

It may be feared that if the "least restrictive alternative" principle is inducted in legislation, an integration of all mental health services will result. Such integration whether it benefits the institutionalized patient or not, can stigmatize the remaining mental health services and the legal restrictions which at present operate for treatment in mental hospitals could extend to all other services.

It cannot be denied that till date, legislation in our country has emanated from a coercive model and constructed a negative image of the mentally ill. Whilst it has provided procedures for making treatment inaccessible, it has provided procedures for making treatment inaccessible, it has offered little or no protection against wrongful confinement. However, such use of the legislative instrument does not have to continue. A facilitative legislation promotive of the treatable nature of mental illness can also be made. The need for such legislation is underscored by the above analysis which shows that lack of coordination between law and policy makes the law insular and lessens the efficacy of the policy.

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RECOMMENDATIONS OF THE INDIAN PSYCHIATRIC SOCIETY ON MENTAL HEALTH LEGISLATION

1. The professional Bodies are given importance in other countries. Likewise, Indian Psychiatric Society, the National Organization of Psychiatrists in India, should be consulted in the matters related to Mental Health Policy and Mental Health Legislation by the Government.
2. Since the Mental Health Act, 1987 is not based on any Mental Health Policy and plan of the Government of India is urged upon to declare its Mental Health Policy and the plan and program based on the said policy. The policy should be drafted in consultation with the Indian Psychiatric Society.
3. The Mental Health Act, 1987, be repealed by a mental health legislation based on:
   a. Mental health policy of the Government.
   b. Modern concepts of psychiatry.
   c. Basic statutory structure of Mental Health Legislation as laid in the guiding principles and alternative approaches recommended by the WHO in 1978.
   d. Recommendations of the British Royal Commision of Law relating to Mental Deficiency based on which the English Mental Health Act, 1959 was framed.
   e. Principles, guidelines and guarantees for the protection of persons detained on grounds of mental ill health or suffering from mental disorder adopted by the UN in 1991.
   f. Changes made in the English Mental Health Act, 1959 (repealed by Mental Health Act, 1983), especially regarding dispensing with the services of the magistrate in matters relating to admission of mentally ill patient to any medical facilities, dispensing with the services of the visitors and formation of Mental Health Tribunals.
   g. Memorandum of the Indian Psychiatric Society on the Mental Health Bill, 1981 suggesting large number of specific amendments (Annexure B).
4. Among others the following changes should be made:
   a. Inconsistencies between the provisions made in different sections and subsections of the Act must be corrected and the rules made under the Act must be consistent with the provisions of the Act and all the rules (including rules regarding aid to mentally ill persons) must be framed before the Act is given effect to.
   b. The expression "mentally ill persons" should be redefined as suggested by the WHO Expert Committee on Mental Health, 1955. A single Mental Health Act covering both mentally ill and mentally retarded persons is the most useful form of legislation. Minimum qualifications of all Mental Health Personnel mentioned in the Act and rules should be clearly stated in the definition.

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S Nambi MBBS MD (Psychiatry) DPM is currently Professor and Head, Department of Psychiatry, Sree Balaji Medical College and Hospital, Chennai, Tamil Nadu, India. Formerly, he was Professor and Head, Department of Psychiatry, Chettinad Medical College and Research Institute, Chennai. Earlier, he was the Professor of Psychiatry, Madras Medical College (MMC) and Consultant Psychiatrist at Institute of Mental Health, Chennai. He is a Practising Psychiatrist in Chennai for more than three decades. He is the past president of the Indian Psychiatric Society, National Body. He is also the past Honorary General Secretary and past Chairperson of the Forensic Psychiatry, Specialty Section of Indian Psychiatric Society. He is the past Secretary of the State Mental Health Authority and Chief Nodal Officer for District Mental Health Program in Tamil Nadu. He has been the principal investigator for two Indian Council of Medical Research (ICMR) projects on Mental Health. He twice won the coveted Marfatia Award of the Indian Psychiatric Society. He has presented scientific papers mostly in the area of forensic psychiatry in the state, regional, national and international psychiatric conferences. He has authored four books on mental health. His area of interest is forensic psychiatry.

Shelving Recommendation
PSYCHIATRY

ISBN 978-93-5090-625-5
9 789350 906255

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