MENTAL HEALTH LAW PROFILES

Introduction

George Ikkos[1] and Manohar Dhadphale[2]

[1]Consultant Psychiatrist in Liaison Psychiatry, Royal National Orthopaedic Hospital, London, UK, email ikkos@doctors.org.uk

[2]Professor and Academic Head, Kamala Nehru Hospital, Pune, India

Britain owes a substantive debt of gratitude to the Indian subcontinent. Though its practice did not start with nor stopped with the end of colonialism, the word 'loot' originates in that region and found its way into the English language because it aptly summarised the activities of the directors and employees of the East India Company (Erikson, 2014) and other traders and colonialists in the area from the 17th century onwards. Furthermore, contemporary British debt does not exhaust itself in historical events (Taylor & Esmail, 1999). It is doubtful that today's mental health services would have continued to serve the way they do without the significant and not infrequently distinguished work of doctors and others who have emigrated from the region to work in the UK, as we are reminded by Tareen & Tareen in this issue in their mental health law profile of Pakistan.

Of course the debt is not only one way. We immigrants who arrive on these shores are grateful to have an opportunity to serve in an internationally pioneering health system in an advanced economy and, although the problems of racism and discrimination persist (West *et al*, 2016), we benefit from practices which are often more transparent and meritocratic than those we have left behind. Those of us most lucky also find ourselves able to give back to our motherland, as also suggested by Tareen & Tareen. Indeed, in relation to doctors from countries that have suffered a massive brain drain (as highlighted in this issue's theme), there is an obligation to do so, even if sometimes entrenched local interests can make this difficult.

The complexity of interpenetration and mutual influence between different, even distant, countries and cultures has always been significant and is easy to underestimate. When the first European explorers (Portuguese, Dutch, British) sailed around the Cape to South East Asia at the dawn of the 16th century, they encountered a highly sophisticated trading system of seaports which extended further east to the Asia Pacific region and already had well established sea links with Iran and the Arab world (Pain, 2013). Overland routes to Turkey and the Middle East had also long been present. It has been argued that the region was economically more advanced than Europe at the time of early encounter and the colonialists and their emergent empires would not have been able to achieve the outcomes that they did had it not been for this ready-found wealth and sophistication of existing networks as well as natural resources.

The complexity of interpenetration is further illustrated by the significance of the East India Company and its activities for the development of the British state and public life. Specifically, some of the venal activities of the Company and others in the region outraged ethically motivated opinion leaders back home, for example the political philosopher and parliamentarian Edmund Burke, who considered British rule in India a 'peculating despotism' and pursued the then India Governor Lord Hastings to impeachment in 1787 and trial in the House of Lords, which did not end until 1795 (Kidd, 2016). Such events have played an important role in the development of the modern British state and the regulation of private enterprise and civil society. Furthermore, this development has left a legacy to former colonies. Without in any sense serving as justification or compensation for past loot and 'peculating despotism', this legacy is valued by some today, nevertheless. Reference may be made here to the railway, education, civil service and judicial systems in India, for example (Lalvani, 2016). The mental health law profiles by Tareen & Tareen (Pakistan) and Firdosi & Ahmad (India) published in this issue remind us of the mixed legacy in mental health law.

With respect to developments in mental health since the liberation of the subcontinent and the partition of India and Pakistan, the picture presented by the authors is disappointing, to say the least. For example, the continuing administration of unmodified electroconvulsive therapy (ECT) in India, a country that boasts nuclear weapons, is an affront to reason and dignity. This state of affairs indicts not only psychiatrists but also anaesthetists, who obviously share in the obligation to ensure what are simple standards to fulfil through provision of modified ECT. Indeed, one might argue that this state of affairs shames world psychiatry and medicine as a whole and not only on the Indian subcontinent, particularly as such practice continues in other countries as well.

The World Health Organization Global Action Programme stipulates that 'service coverage for severe mental disorders will have increased by 20% by 2020' and 'the rate of suicide will be reduced by 10% by 2020' (see Crisp, 2016). It is time to translate such objectives into action, for example through providing modified ECT for people with severe depression worldwide, as well as implementing mental health law compatible with human rights and developing effective primary care mental health services. World psychiatry should be actively attending to this, as failure to make change is a threat to the sustainability of this highly effective treatment worldwide (Maughan & Burgess, 2016). Such failure will also continue to expose the profession to stigma, which on this matter will be justly and widely endorsed.

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MENTAL HEALTH LAW PROFILE

Mental health law in India: origins and proposed reforms

Muhammad Mudasir Firdosi[1] and Zulkarnain Z. Ahmad[2]

[1]ST6 Specialist Registrar, South London and Maudsley NHS Foundation Trust, London, UK, email muhammad.firdosi@kcl.ac.uk

[2]Locum Consultant Psychiatrist, South West London and St George's NHS Trust, London, UK

Although mental health legislation has existed in India since the mid-19th century, it has gone through various changes over the years and the Mental Health Care Bill 2013 has generated a lot of debate and criticism. Despite its shortcomings, the general expectation is that this bill will usher in a new era of proper care and allow people with mental disorders to lead a dignified life.

Early legislation

The first law in relation to mental illness in British India was the Lunatic Removal Act 1851, which ceased in 1891. This law was mainly enacted to regulate the transfer of British patients back to England. After the takeover of Indian administration by the British crown in 1858, many laws were introduced for the care of people with a mental illness, including:

- the Lunacy (Supreme Courts) Act 1858
- the Lunacy (District Courts) Act 1858
- the Indian Lunatic Asylum Act 1858 (with amendments passed in 1886 and 1889)
- the Military Lunatic Act 1877.

Under these acts, patients were detained for an indefinite period in poor living conditions, with little chance of recovery or discharge. This led to the introduction of a bill in 1911 that consolidated the existing legislation and led to the Indian Lunacy Act (ILA) 1912 (Somasundaram, 1987). The ILA 1912 was essentially the first law that governed mental health in India. It brought in fundamental change for the management of asylums, which were later termed mental hospitals. However, this act focused on the protection of the public from those who were considered dangerous to society (i.e. patients with a mental illness). The ILA 1912 neglected human rights and was concerned only with custodial sentences. As a result, the Indian Psychiatric Society suggested that the ILA 1912 was inappropriate and subsequently helped to draft a mental health bill in 1950 (Trivedi, 2002).

It took more than three decades for this bill to receive the President's assent (in May 1987); it was finally implemented as an act in 1993. The advantage of the Mental Health Act (MHA) 1987 was that it defined mental illness in a progressive way, placing emphasis on care and treatment rather than on custody. It provided detailed procedures for hospital admission under special circumstances and emphasised the need to protect human rights, guardianship and the management of the property of people with a mental illness.

The criticisms of the MHA 1987 are mainly related to the legal procedures of licensing, admission and guardianship. Also, human rights and mental healthcare delivery were not adequately addressed in this Act (Narayan *et al*, 2011). Human rights activists have questioned the constitutional validity of the MHA 1987 because it involved the curtailment of personal liberty without the provision of a review by any judicial body. The MHA 1987 was also silent about the rehabilitation and treatment of patients after their discharge from hospital (Dhandha, 2010). In addition, insufficient treatment facilities posed financial, social and emotional burdens on carers and family. These criticisms led to the amendment of the MHA 1987, which eventually culminated in the Mental Health Care Bill 2013, which was introduced in the Rajya Sabha (upper house of parliament) on 19 August 2013. This bill repeals the MHA 1987, but is yet to come into force as an act. (The text of the bill is available at http://mohfw.nic.in.)

Provisions of the Mental Health Care Bill (MHCB) 2013

Under the MHCB 2013, every person shall have the right to access mental healthcare and treatment from services run or funded by the government.

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