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REVIEW ARTICLE

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Mental health legislation: does it facilitate or hinder mental healthcare in countries of South Asia?

Abstract

Research and clinical information pertaining to mental health needs of South Asians countries (SEAR) is limited but growing. There is a tendency to group all persons of Asian descent together and, therefore, the empirical literature does not sufficiently address the mental health needs in specific subgroups. The focus of this article is to understand the mental health needs of SEAR and to understand the present legislation by examining historical, cultural, and contextual challenges. Despite the well-documented mental health needs for these countries, most do not present for mental health services.

Keywords: Social Stigma. Human Rights. Developing Countries.

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Context of mental health legislation

Mental health legislation is necessary for protecting the rights of people with mental disorders, who are a vulnerable section of society. They face stigma, discrimination, and marginalisation in all societies, and this increases the likelihood that their human rights will be violated. Mental disorders can sometimes affect people's decision-making capacities and they may not always seek or accept treatment for their problems. Rarely, people with mental disorders may pose a risk to themselves and others because of impaired decision-making abilities. The risk of violence or harm associated with mental disorders is relatively small. Common misconceptions on this matter should not be allowed to influence mental health legislation.

Mental health legislation can provide a legal framework for addressing critical issues such as the community integration of persons with mental disorders, the provision of care of high quality, the improvement of access to care, the protection of civil rights, and the protection and promotion of rights in other critical areas such as housing, education, and employment. Legislation can also play an important role in promoting mental health and preventing mental disorders. Mental health legislation is thus more than care and treatment legislation that is narrowly limited to the provision of treatment in institution-based health services. Developing countries find it difficult to create a coordinating agency because of a lack of human resources. In some countries this role is assumed by the people in charge of mental health policy and planning in ministries of health, with help from review bodies and advocacy organisations.

The existence of national mental health legislation does not necessarily guarantee respect for and protection of the human rights of people with mental disorders. Indeed, in some countries the provisions of mental health legislation result in the violation of the human rights of such people. There is no national mental health legislation in 25% of countries with nearly 31% of the world's population. 91.7% of countries in the European Region have national mental health legislation, whereas in the Eastern Mediterranean Region only 57% have such legislation. In 50% of countries, laws in this field were passed after 1990, while in 15% there is mental health legislation dating from before the 1960s, when most of today's treatment methods were unavailable.[1]

Mental health legislation should be viewed as a process rather than as an event that occurs just once in many decades. This allows it to be amended in response to advances in the treatment of mental disorders and to developments in service delivery systems. However, frequent amendments to

legislation are not feasible because of the time and financial resources required and the need to consult all stakeholders. A possible solution is to lay down regulations that are separate from legislation but can be enforced through it. Legislation can include provision for the establishment of regulations and can outline the procedure for modifying them. The most important advantage of regulations is that they do not require lawmakers to be repeatedly voting for amendments. In some countries, executive decrees and service orders are used as an alternative to regulations. Mental health legislation is essential for complementing and reinforcing mental health policy and providing a legal framework for meeting its goals.

Persons with mental disorders need legislative protection in their interaction with the general healthcare system. The low priority given to mental health issues in most countries results in mental health services receiving inadequate financial and human resources. In order to promote fairness and equity, therefore, general healthcare legislation should also include provisions for adequate resources and funding for mental health services both in institutional settings and in the community. This would result in the same level of access and quality of care for people with mental disorders as for those with physical disorders.

In many countries, people need health insurance in order to obtain access to healthcare. General healthcare legislation in such countries should contain provisions for preventing discrimination against people with mental disorders in respect of obtaining adequate health insurance from public and private providers for the care and treatment of physical and mental disorders. Countries can formulate legislation that provides for the introduction of mental health interventions into primary care. For instance, early intervention, including the availability of essential psychiatric drugs, should be included in any basic health plan for the purposes of reimbursement or coverage of services.[2]

South Asia scenario

South Asia comprises one of the largest areas of the world, where 20% of the world population live. South Asia comprises of Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka. It has more than 2000 ethnic entities and innumerable languages are spoken. The inhabitants practice several religions and come from diverse economic backgrounds. Majority of the governments are democratically elected.

Mental healthcare faces massive constraints here, due to inadequate infrastructure and due to lack of trained mental health professionals. The number of psychiatrists varies from one per 300,000 populations in India to even lesser numbers in some of the neighbouring countries.[3] One fifth of psychiatrically ill patients live in South Asia. Despite vast diversity, geographically, ethnically, politically, and culturally, the factors effecting mental health in this vast area remains the same as highlighted in the slogan 'one vision, one identity, one community' in one of the Association of Southeast Asian Nations (ASEAN) summits.[4]

Mentally ill patients are included among the most disabled patients. People with mental disorders experience some of the harshest living conditions in South Asian countries. These patients are prone for various human rights violations. Discrimination, stigmatisation, and misconception regarding mental illness play a major role in denial of basic human rights to these patients. They face economic marginalisation, at least in part because of discrimination and the absence of legal protections against improper and abusive treatment. They are often denied opportunities to be educated, to work or to enjoy the benefits of public services or other facilities. Mental health legislation in these countries is limited to the provision of institution-based health services. High rates of suicide and alcohol/drug abuse makes the area of South East Asia more problematic. Despite all this any judgement on mental health legislation in South Asia should be seen in the background of mental health professionals making great efforts in the face of severe difficulties and constraints.

Mental health legislations around the world[5]

Regions	With legislation (%)	No legislation (%)
Africa	59	41
The Americas	73	27
Eastern Mediterranean	59	41
Europe	96	4
South-East Asia	67	33
Western Pacific	72	28

Why do South East Asia need mental health legislation?[6]

The need for mental health legislation in this region has arisen from a growing awareness amongst psychiatrists for a reappraisal of mental health problems of the region with a 'native' vision untainted by Western influence.[7] The main reasons are:

1. Mental healthcare has had a long history of neglect.
2. Stigma associated with mental disorders leads to discrimination.
3. Persons with mental disorders may lack the capacity to make informed decisions.
4. Prevalence of mental health problems in the society is increasing.

Mental health legislations guarantee that the dignity of patients is preserved and their fundamental rights are protected.[8]

What mental health needs should be fulfilled?[6]

Medical/public health needs

(a) Promotion of mental health

Improvement of mental health is becoming increasingly important and its responsibility extends beyond the health

sector to various other sectors. Therefore, facilitation and provision of opportunities to promote mental health must be integrated within all service programmes.

(b) Prevention of mental disorders

Prevention of mental disorders is an integral part of mental health services. This need should be addressed through community awareness and through clinical, counseling, and educational services provided on a continuing basis.

(c) Mental healthcare and treatment

Provision of a range of clinical services including outpatient, inpatient, day-patient, and outreach facilities at primary, secondary, tertiary/specialised levels is important.

(d) Rehabilitation and social integration

Persons who suffer from mental disabilities or do not fully recover from mental disorders require psychosocial interventions - both in the community and at residential facilities - so that the development of competencies needed to achieve their potential is secured.

(e) Access to mental health services

A common problem faced by developing nations is the lack of resources to ensure that all persons have access to health care. Thus, in creating, facilitating and providing opportunities for persons with mental disorders to access the health system and experience equity in the distribution of services, community-based and decentralised mental health services are important.

(f) Quality of care

Both technical and consumer aspects of the quality of mental healthcare should be made comparable with the quality of general health services. There must be no discrimination in the allocation of resources and training of personnel (doctors, nurses, social workers, and community carers, including families). In relation to the mental healthcare sector, licensing and monitoring of mental healthcare facilities would contribute to maintenance of satisfactory standards of services.

Civil/legal needs

(a) Preventing marginalisation/discrimination

Since a culture of stigmatisation surrounds mental disorders, persons with mental disorders need to be prevented from being exposed to marginalisation and discrimination on account of their mental health status. Such persons, especially those who are suffering from chronic conditions, should be allowed integration into the society in so far as the welfare of both parties may be secured. Deprivational laws discriminating against the civil and political rights of persons with mental disorders or any other policy which denies education to such children or employment to such adults or restrict rights relating to franchise, marriage, custody of children, etc. without reasonable justification should be revised.

(b) Human rights

Human rights should be an integral dimension of the design, implementation, monitoring, and evaluation of mental health policies and programmes. They include, but are not limited to, the rights to: equality and non-discrimination, dignity and respect, privacy and individual autonomy, and information and participation. Mental health legislation is a tool for codifying and consolidating these fundamental values and principles of mental health policy. Recognition, preservation, and enforcement of human rights of persons with mental disorders are necessary. This includes the right to non-discrimination and all other rights founded upon the basic notion of the three-fold fundamental human rights, i.e. dignity, autonomy, and liberty.

(c) Involuntary admission and treatment

Provision of involuntary care and treatment is sometimes necessary for reasons of health and deterioration of conditions of persons with mental disorders. However, medical personnel should act in accordance with professional and human rights standards so that such patients are not subject to health, social, economic and other disadvantages and disabilities.

The laws should encourage voluntary admission and, in exceptional circumstances, should permit involuntary admission. Where there is a potential for involuntary admission, this should only be used in very specific circumstances and in accordance with the law. In this connection the key issue involves outlining circumstances in which involuntary admission is considered appropriate and laying down the procedure for invoking powers for involuntary admission. Involuntary admission is permitted only if both the following criteria are met:

I) there is evidence of mental disorder of specified severity as defined by internationally accepted standards, and
II) there is a likelihood of self-harm or harm to others and/or of a deterioration in the patient's condition if treatment is not given.

A good example of this is legislative provision for certification from at least two psychiatrists before involuntary admission to hospital takes place. However, low-income countries with few psychiatrists find it extremely difficult to implement this kind of provision. In these circumstances, a better option would be to request certification by two doctors or two mental health professionals, of whom at least one should be a psychiatrist. Where there is a shortage of psychiatrists it may be necessary for other professionals to undertake the assessment and make the decision. These professionals could be social workers, psychologists, or nurses who have received the required training. This increases the pool of mental health professionals available to provide certification and helps to meet the need for adequate protection of persons with mental disorders.

Because acute episodes occur in most serious mental disorders, the law should contemplate emergency procedures. These should allow the compulsory evaluation of persons with mental disorders and/or admission for 48-72 hours to allow assessment by a mental health specialist if there is a reasonable suspicion of an immediate risk to their health or safety. The law should also include provisions regarding the rights of individuals who are deprived of their liberty. All patients admitted involuntarily should have a specific right

to appeal against their involuntary hospitalisation both to the managers of the institution concerned and to a review board or tribunal.[9]

(d) Voluntary and involuntary treatment in hospital settings

Voluntary treatment is associated with the issue of informed consent and all treatments are provided on the basis of free and informed consent except in rare circumstances. In the case of involuntary patients, important issues arise when procedures are being considered for both involuntary admission and involuntary treatment. It is sometimes argued that the purpose of involuntary admission should be to provide treatment. Two separate procedures, the first for involuntary admission and the second for administering involuntary treatment, could act as a barrier to treatment or delay it. Developing countries with limited resources may have difficulties in performing separate examinations for admission and treatment. It has also been argued that the task-specific and time-specific nature of competence means that patients who are not competent to decide about their admission may nevertheless be competent to give consent to treatment and make decisions on their treatment plans. In such cases, it is crucial that a person's competence to give consent to treatment is determined before any decisions on treatment are made. However, it remains essential that, in either case, sufficient safeguards are put in place to protect patients' rights and prevent abuses of the procedures.

If it is found that a patient lacks the capacity to give consent, involuntary treatment should be considered only if (1) the patient is admitted involuntarily to hospital and (2) the treatment is necessary to bring about an improvement in the patient's condition and/or restore her or his competence to make decisions about treatment and/or to prevent significant deterioration in the patient's mental health and/or to prevent self-harm or harm to other people.

In the case of involuntary treatment, procedures should be established to protect the human rights of the person concerned and to provide protection from possible harm and misuse of the powers being used. The mechanisms may include obtaining a second opinion on the need for involuntary treatment, obtaining independent permission from judicial sources and/or patients' representatives, and appeal by the patient against involuntary treatment to an independent review body.

For certain treatments, legislation makes it compulsory to obtain informed consent. Examples include psychosurgery, implantation of medications to reduce sex drive, and seclusion procedures. These safeguards are generally applied to treatments which are considered irreversible and/or carry a relatively high risk of physical or mental harm for the patient.

(e) Treatment in community settings

As much as the needs of persons with mental disorders as being paramount are emphasised, the needs of the community cannot be ignored. In instances where persons with mental disorders may be likely to inflict harm upon other persons in the community, protective measures should be imposed to ensure the welfare of the latter. However, the least restrictive alternative principle must be applied towards persons with mental disorders so that they are not unfairly disadvantaged. The combined need of the two groups, therefore, is to strike a reasonable balance between the needs of each others. The need of the hour is a modern mental health law that gives priority to protecting the rights of people with mental disorder, promotes development of community-based care and improves access.[8]

(f) Access to review

Persons with mental disorders, by reason of the nature of their mental health status, are a vulnerable group requiring added safeguards in respect of their affairs. Such persons or their representatives should have access to review of decisions or acts of mental healthcare authorities affecting them.

(g) Regulatory mechanisms

Provision of mental healthcare services should be subject to the procedural regulation of overseeing authorities, rules, codes of practice, etc. so that persons with mental disorders are enabled to sustain their right to due process.

(h) Care and custody of person and property

Persons who are not competent to take care of themselves or their property as a result of mental disorders require guardianship of person and property. Due diligence should be observed in the appointment of such guardians in order to secure the best interest of persons with mental disorders.

(i) Needs of special categories of persons with mental disorders

For criminal offenders and prisoners with mental disorders provisions for evaluating the mental health status in relation to competency to stand trial, criminal liability, and continuance of sentences of imprisonment are required.

For persons particularly vulnerable to mental disorders such as victims of war, children of migrant workers, street children or those who are victims of political, domestic or any other type of violence or turmoil are concerned, special preventive and rehabilitative measures should be taken.[10]

Recent developments

India

- India is in the threshold of making a very progressive legislation- the Mental Health Care Bill. The 2011 draft has now been circulated and now with the Law Ministry of India for their approval. The bill is placed before Parliament for adoption. Some of the highlights of this bill are-
- It is modern in terminology and its approach is progressive.[11]
- The provisions regarding government's obligation to provide mental health services and free psychotropic medications are laudatory. The Indian Psychiatric Society fully supported the Ministry of Health, Government of India on these provisions in the bill.

- The provision regarding exemption from prosecution to those who attempt suicide is much needed and most welcome. It could include all those who attempt suicide since insurmountable mental distress is undeniably present in all those who attempt suicide.
- Regarding prohibition of administering unmodified electroconvulsive therapy (ECT) and giving ECT to children under 18 years, Indian Psychiatric Society has submitted, the whole idea of prescribing or prohibiting any particular form of treatment in mental health legislation is anachronistic. However safeguards for particular treatments can be prescribed. This is also the way it is done in most other countries.
- While the advance directive theoretically is a highly desirable clinical tool for collaborative decision making between the person with mental illness and the treatment provider, at this time more needs to be done before legal enforcement is considered in India.
- Indian Psychiatric Society has demanded that General Hospital Psychiatry Units should be outside the purview of this Act because they are small sized (20-30 bedded usually) and have open ward system like other medical specialties and are always under eyes of the community.
- Nominated representative

Pakistan

Pakistan recently enacted new mental health legislation in the form of Mental Health Ordinance 2001, which replaced the Lunacy Act of 1912. The new legislation emphasises the promotion of mental health and the prevention of mental disorders and encourages community care. It is hoped that it will help to establish national standards for the care and treatment of patients and that it will help to promote public understanding of mental health issues.[12]

Conclusion

Mental health legislation is still neglected in most parts of South Asia. But some countries are realising the imperative need for people friendly legislation in this area. Notably, India is making big step forward by preparing to enact a very progressive Mental Health Care Bill in 2013. We only hope this legislation will not be unduly delayed.

Implementing an adequate mental health act will go a long way in fulfilling the criteria of the World Health Organization. Any new mental health act must be grounded on sound ethical principles, value basic human rights, provide powers to those who treat mental disorders, and reflect the values and trends of the modern world.[13] Any good mental health act will not have an absolute and unbridled authority vested in the hands of the government.[14] All laws should have the basic definition of mental illness whether to be a broad definition to cover even the minor illness or a narrow one to include only the grossest psychotic illness.[15]

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