

# Mental Health Ordinance 2001- Is it really being used?

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The right to be free is one of the most basic and fundamental human rights. These civil liberties can be subjugated only under exceptional circumstances and this can include the following instances: as a result of a criminal act (prison sentence), in a national emergency (situations like war) and for the treatment of a mentally disordered person. After the creation of Pakistan most of the laws practiced in the British Sub-continent were taken in toto and implemented. The mental health legislation did not lag behind and the Lunacy Act 1912 was used for psychiatric patients. Apart from being draconian, the terminologies used within the law were also insensitive and archaic. The definition of a Lunatic under that act was as follows "an idiot or person of unsound mind."<sup>1</sup> So terms like 'lunatics' and 'asylums' were part of our mental health law as far as 2001, when the government at that time had enough insight to produce the Mental Health Ordinance Pakistan, bringing it some what at par with the 21st century.

Historically the development of a legal frame work to detain psychiatric patients in Britain can be traced back to 1324, the assumed date of the 'Statute de Prerogativa Regis.' This limited King Edward II's jurisdiction over the estates of idiots or natural fools, whose profits he was to take, but for whom he was to find essentials. "For anyone 'that beforetime hath had his wit and memory' and should 'happen to fail of his wit'... the King was to keep his estate safe and maintain him and his household competently out of his profits, but the King was to take nothing for his own use."<sup>2</sup> This further developed into the criminal lunatics act in 1800, then into county asylums act in 1808 and in 1890 the lunacy act was approved. The powers within this act were later changed in 1913 under the mental deficiency act which also established a board of control to monitor asylums. After World War II the act was upgraded in 1959 and then this was later repealed in 1983. The present Mental Health Act (MHA) came into existence on the 30th of September 1983. One important point to understand is that the mental health act in the UK is used to detain patients with suspected or diagnosed mental disorder in order treat their mental disorder or prevent further deterioration and not for medical treatments (apart from a very few exceptions e.g. parenteral feeding for anorexics). The MHA is divided into four parts but it is very important to note that there are different sections for civil and

criminal detention orders. This not only safeguards the vulnerable mentally disordered patient in the court of law but also has power to keep them in secure forensic hospitals for longer periods of time.

The state should also try and help the patient gain sovereignty again, with appropriate statute laws. We should be able to balance the patient's right to autonomy and doctors' duty of care to patient and the right of society to protection. These laws should be based on such principles that patients who are detained are able to appeal against it if they feel the detention was unlawful. For this purpose in Britain the patient can appeal either to the managers of the hospital (local) or to a Mental Health Review Tribunal (Regional). A three member panel in either review, then sits in a hearing to listen to both sides (Patient vs medical team) with evidence and comes to a conclusion of either continuing or discharging them from the detention. The medical team has to prove to the members that the nature and degree of the mental disorder is such, that it warrants further detention of the patient against his/her desire to treat or prevent further deterioration. The 'lay' members within the managers' panel are appointed by the Hospital who should receive a report from the treating consultant prior to the hearing. The members of the MHRT are appointed by the Ministry of Justice and they consist of an independent psychiatrist, legal member and a 'lay' member. The patient is usually represented by a solicitor during the hearings of the MHRT. The MHRTs also have a statutory duty to hear appeals and to review detention under the MHA at certain mandatory periods.<sup>3</sup> These hearings always take place within the setting of the hospital where the patient is admitted. The nearest relative also plays a vital role in all this process.

There have been instances where the use of the act has impinged in the human rights of the patient and this has been challenged in the courts under the European Convention on Human Rights.<sup>4</sup> The case of Rv. MHRT North and East London Region resulted in a declaration that certain sections of the Mental Health Act 1983 England and Wales were incompatible with the European Convention on Human Rights. An order for rewording of these sections was made, so that a mental health review tribunal could now direct the discharge of a patient if it was not satisfied that the conditions for detention are met.<sup>5</sup> Community based

psychiatry is also an essential component of patient care within the mental health services. Therefore the MHA also covers treatment of patients in the community known as supervised discharge from hospital with an agreement with the patient to engage in the community for their treatment.

Pakistan has an ever growing population which is estimated to be above 160 million presently. About 70% of our population live in rural areas and many people (even those living in cities) know little about mental diseases or its treatment. This results in many of them turning towards 'holy men' and 'holy shrines' for therapy. According to Naqvi<sup>6</sup> there are 342 registered Psychiatrists with the Pakistan Medical and Dental Council, out of which only 150-200 have adequate training. This would show a distressing ratio of one psychiatrist to a million people in Pakistan.<sup>7</sup> Now turning our attention to mental health care here; we can see that there has been great progress in terms of legislation. We finally moved onto the Mental Health Ordinance (MHO) for Pakistan on 20th of February 2001 (<http://www.emro.who.int/MNH/WHD/Pakistan-Ordinance.pdf>), from the obsolete and inadequate Lunacy Act which was enacted in 1912 for British India. But as you read through the MHO it is hard not to notice its uncanny resemblance to the MHA 1983 of England and Wales ([http://www.wikimentalhealth.co.uk/Mental\\_Health\\_Act\\_1983](http://www.wikimentalhealth.co.uk/Mental_Health_Act_1983)). However, it does manage to cover all essential components of a statute law for detaining mentally disordered patients in an emergency and for assessment and treatment and also ensures that their rights are safeguarded. The ordinance is unclear in terms of the paper work that needs completing on detaining a patient in a hospital and neither does it mention which authority shall overlook these proceedings. It is clearly evident from reports that the MHO remains poorly implemented and a disparity exists between the stated policy and services delivered to the patient.<sup>8</sup> The other factor which is imperative for any mental health legislation is a statute law for dealing with the criminal aspect of mental disorder. In order to be convicted of a crime, we need to prove beyond reasonable doubt that the person had both *actus reus* (guilty act) and *mens rea* (guilty mind). If a person had been suffering from a mental disorder whilst committing the criminal offence they cannot be held accountable due to the absence of *mens rea* but would be prosecuted for *actus reus*. In Britain, they would receive a smaller sentence due to "diminished responsibility" and in certain cases the courts can transfer them directly to a forensic hospital with restrictions on their discharge. A study<sup>9</sup> in Britain suggested that 9 out of 10 prisoners showed evidence of one or more mental disorder. About 10% men and 14% women had signs of a psychotic illness. While 59% men and 76% women on remand had signs of a neurotic illness. The risk of suicide also increases in prisons.

There are also confounding factors within the prison environment which can exacerbate mental disorders. Unfortunately the MHO was unable to address this issue and mentally disordered prisoners continue to suffer within the criminal justice system of our country. The magnitude of psychiatric morbidity is unknown in our prisons therefore it should be the priority of the mental health services to attend to this problem and develop appropriate laws and secure hospitals to deal with this patient group.

There are two facts which we need to address if we are to benefit from the full potential of this ordinance. The first and foremost are the ground realities. How can we make sure the legal requirements under the ordinance are completed prior to detaining a patient? Is the MHO really being used to detain mentally disordered patients? If so, is any authority checking whether the patients that are admitted in the numerous psychiatry 'units' in our country are being legally detained and provided with the appropriate rights and legal representation? The second aspect is to also develop the criminal sections of the ordinance which should clearly outline the procedures to follow in case a mentally disordered person commits a crime or if someone becomes mentally disordered whilst in prison. We also need to know how many patients have been allowed to appeal to the magistrate against their detention. The Federal Mental Health Authority which was established with the ordinance, needs to look closer at its actual role and should have psychiatrists who are "up-to-date and properly qualified" rather than "eminent psychiatrists of at least 10 years good standing." Being a doctor or a Psychiatrist does not automatically qualify you to understand legal issues. In fact in the British MHA it states under section 12(2) that one of the medical practitioners recommending involuntary admission should be approved by the secretary of state as having 'special experience in the diagnosis or treatment of mental disorder.'<sup>10</sup> Therefore, all psychiatrists should be advised to attend MANDATORY workshops on mental health law and be approved by the state before they take up the posts of consultants in Pakistan and are allowed to use the MHO on their patients. The course should be extensive for first-time approvals and everyone should be reminded to attend a refresher course every five years.

It is said that in order to judge the civility of a society all you have to do is see how they treat and manage their vulnerable members. I wonder where we stand.

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