

observations of mood improvement in patients with epilepsy who participated in early VNS studies. Prospective evaluation of epilepsy patients evaluated with standard depression symptom severity rating scales revealed that VNS therapy was associated with statistically significant improvements in mood that was not related to reductions in seizure frequency. The documented efficacy of anticonvulsants, such as carbamazepine, lamotrigine, valproate, and perhaps others, as mood stabilizers and/or antidepressants in bipolar disorder and the anticonvulsant properties of ECT are concordant with the hypothesis that VNS therapy may be a useful therapeutic option for depression. VNS results in markedly increased c-fos expression in forebrain (lateral hypothalamus, paraventricular nuclei, CA3 hippocampal fields, and neocortex) and brain stem regions (NTS, nucleus raphe magnus, PBN, A7 area, locus ceruleus, and periaqueductal gray), resolution of some of the regional cerebral blood flow (rCBF) abnormalities in limbic and cortical structures (eg insula, dorsolateral prefrontal cortex (DLPFC), temporal cortex) that are associated with depression³⁶.

Transcranial Magnetic Stimulation: The most used rTMS strategy for the treatment of depression is high-frequency rTMS (20-HZ) of the left DLPFC, but this strategy has an important cost benefit ratio and it may increase the risk of seizure. Therefore, lower frequency rTMS (1-HZ) strategies are potentially advantageous if clinical efficacy can be demonstrated. The rationale of targeting the left DLPFC is that lesion and imaging studies show that left prefrontal cortex dysfunction is pathophysiologically linked to primary and secondary depression. Because this dysfunction is associated with a decrease in the left DLPFC activity, high-frequency rTMS is used as it induces larger cerebral blood flow in the stimulated area in the majority of subjects³⁷. Indeed, the vast majority of the initial rTMS studies applied high-frequency rTMS on the left DLPFC. It has been speculated that an inhibition of the right prefrontal cortex (based on the inhibitory effects of 1 Hz rTMS and the notion of laterality in prefrontal activity in depression) might correct the interhemispheric imbalance of DLPFC activity in depression. In a sham controlled blind trial by Fitzgerald et al.³⁸ in TRD patients found at the end of study that 44% of patients in active group and 8% of patients in sham group responded ($p < 0.05$).

Magnetic Seizure Therapy: MST or convulsive rTMS refers to the administration of rTMS to the scalp to induce

seizures under general anesthesia. Hypothetically, such magnetically induced seizures can replace ECT (and its associated adverse cognitive effects) in patients with TRD. The feasibility of the procedure has been demonstrated in a female subject with a 3-year episode of TRD³⁹. A decrease in the HAM-D score from 20 to 13 was noted in the latter following MST. A randomized, controlled trial examined the procedure in eight patients with a major depressive episode who were candidates for ECT and found the procedure to be well tolerated⁴⁰. The clinical efficacy of MST in the treatment of TRD and whether MST will be preferable to ECT remains to be established.

Deep Brain Stimulation: In one clinical trial of DBS⁴¹ electrodes were placed in the subgenual cingulate cortex (approximately Brodmann area 25) bilaterally in six patients who had TRD. At 6 months, four of the six patients were classified as responders. Depressive symptoms also improved in the cohort of patients who had intractable obsessive-compulsive disorder undergoing DBS⁴². Clinical trials of DBS in the anterior limb of the internal capsule for major depression are currently underway. To date, this procedure remains an experimental, not approved for general clinical use for this indication.

Natural Remedies

St. Johns wort: There are 37 published trials including 26 placebo controlled studies and 14 with standard antidepressant as the active comparator, but none of these focussed on TRD.

S-Adenosyl Methionine: There are 45 published clinical studies for treatment of depression out of which 8 are placebo controlled and used an active comparator but very few for TRD. One study examined the efficacy of sAMe as an adjunct for partial and non responders to SSRI and found response and remission rates of 50% and 43% respectively and treatment was well tolerated. But still no published studies using placebo control is available.

Omega 3 fatty acids: A randomized, placebo controlled dose finding study of Eicosapentanoate (EPA) as adjunctive therapy with inadequate response on antidepressant trial reported that 1 gm/day of EPA for 12 weeks showed response rate of 53% compared to placebo of 29% with notable improvement of depressed mood, anxiety, sleep disturbance, libido suicidality⁴³.

ROLE OF PSYCHOTHERAPY

Interpersonal, cognitive, and behavioral therapies offer



structured pragmatic methods to evaluate and work with such difficult patients. Although some evidence supports the use of these psychotherapies alone for treatment-resistant depression (in lieu of further trials of medication), data are emerging to suggest a potentially more valuable role when they are combined with pharmacotherapy. The newer depression-focused psychotherapies are relevant and potentially valuable strategies for patients with treatment resistant depression.

Evidence that psychotherapy works: Much of the evidence about the effectiveness of newer antidepressants comes from studies either supported by or directly conducted by the manufacturers of those medications. A large portion of these studies are already convincing evidence that the new treatment works, at least in comparison to placebo. Since psychotherapy is not manufactured nor protected by patents, there are no comparable corporate research and development funds to sponsor research. Moreover, a pill placebo group is not an adequate control group for psychotherapy research. As a result, there will never be the weight of evidence supporting the efficacy of psychotherapy that can be marshaled for antidepressant pharmacotherapy. Nevertheless, a sizeable number of comparative studies have examined cognitive, behavioural and interpersonal therapies in relatively uncomplicated (without severe personality problems or a large number of comorbidities) groups of depressed outpatients and in aggregate, 4 conclusions can be drawn.

1. Depression focused psychotherapies (i.e. cognitive, interpersonal, and behavioural therapies), typically provided across 8 to 16 weeks, are significantly more effective than waiting list or minimal contact control conditions.
2. Depression-focused therapies typically produce response rate comparable to those found with antidepressant medications in randomized clinical trials.
3. There is no compelling evidence that one form of depression focused psychotherapy is superior to another. It has been suggested that cognitive therapy may have more enduring effects following termination of therapy, but one controlled trial directly comparing cognitive therapy and interpersonal therapy did not reveal any advantage for the cognitive therapy condition across a 24 month follow up.
4. The addition of cognitive therapy or interpersonal therapy to ongoing pharmacotherapy increases the likelihood of remission for patients with chronic, severe

recurrent or resistant or partially treatment responsive treatment resistant depression thus represents an important indication for combining psychotherapy and pharmacotherapy.

Suggested guidelines for psychotherapeutic intervention for treatment resistant depression The therapy relationship should be collaborative and centered around the goal of teaching new skills to improve coping with a chronic illness. The therapist must pair core therapeutic skills (e.g. empathy and understanding) with the ability to appropriately select specific, targeted interventions (e.g. relaxation training, activity scheduling, problem solving, or cognitive restructuring).

- The therapist may make judicious use of examples from other medical models in which rehabilitative interventions are used to enhance the outcome of a chronic disorder (e.g. poststroke rehabilitation, pain management, or orthopedic rehabilitation).
- The therapist may express cautious optimism that problems can be addressed with varying degrees of success. However, it is important to be understanding of the patient's pessimism and elicit feedback from the patient about what has not worked well in the past.
- Establish stepwise, short term goals specifically addressing life problems and/or symptoms. Use graded tasks or intermediate assignments to approach more daunting or potentially overwhelming problems.
- Meet frequently and, if necessary, shorten sessions to enhance learning and retention. Keep sessions active and avoid the "silent treatment. Obtain feedback at beginning and end of treatment sessions so that patient's reactions to therapy can be monitored and promptly addressed. Be vigilant concerning subtle affective and behavioural reactions within sessions as an in vivo source of feedback.
- Use homework assignments and in session rehearsal to facilitate development of new coping skills. It is important to avoid implicit criticisms about difficulties in therapy, such as homework noncompliance. The therapist must address his or her own dysfunctional cognitions blaming the patient for "not wanting to get better".
- Involve spouse or significant others to provide psychoeducation and enhance alliance with family members.
- Establish intermediate and long term goals as



symptomatic improvement and short term goals are accomplished.

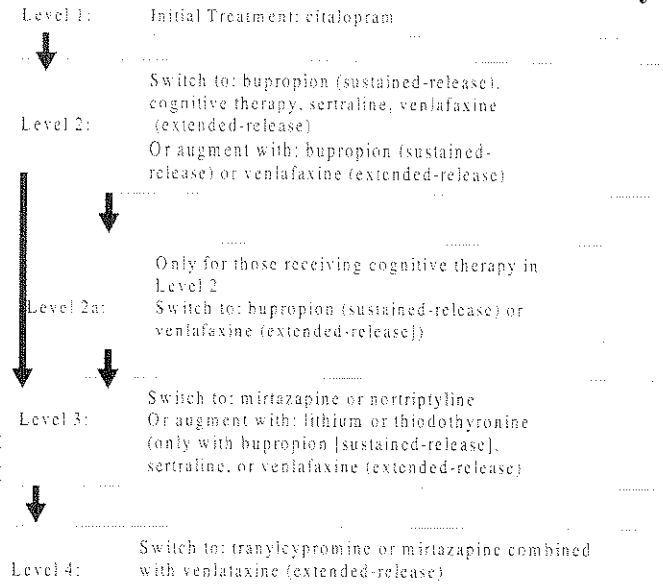
Do not terminate therapy until the patient has achieved a remission and sustained it for at least 4 to 6 months.

Managing the course of Therapy: The depression focused psychotherapies are conducted in both individual and group formats and typically range from 10 to 16 weeks in duration. Individual sessions are typically 45 to 60 minutes in length, whereas group sessions are usually 90 to 120 minutes long. Ideally, we would recommend twice weekly sessions early on to facilitate the process of therapy. Perhaps even more frequent sessions would be helpful, but economic considerations usually make this impossible. We prefer to continue with twice weekly sessions until the patient has achieved at least a 50% reduction in symptom severity, shifting to weekly sessions thereafter. If the patient has not obtained significant symptom relief by the eighth week (i.e., 16th session), a careful evaluation of the continued indications for psychotherapy, as well as possible alternatives, should be undertaken. A successful course of acute phase, focused psychotherapy for treatment resistant depression typically lasts 4 to 6 months. It appears that patients who did not remit fully may benefit from less frequent, continuation phase sessions over the next 6 to 9 months.

SEQUENCED TREATMENT ALTERNATIVES TO RELIEVE DEPRESSION (STAR*D)

This study aims at determining the best subsequent treatment strategies (i.e. identifying which combinations and which sequences of treatment are effective with minimal side effects). This multisite, prospective, sequentially randomized controlled trial targeted 4000 adults with nonpsychotic major depressive disorder. Following treatment failure at each of the 4 sequential levels, patients progressed to the next level, where they were randomly assigned to the various treatment options (Figure 1). Independent evaluators, blinded to level and treatment, conducted periodic clinical outcome assessments. These additional results will provide information on symptom severity, level of functioning, adverse effect burden, patient satisfaction/quality of life, and health care utilization and cost. Once patients have obtained a satisfactory response, follow up assessment will determine the degree and timing of possible relapse.

Fig.1. The four sequential levels of STAR*D study



The remission rates for step one was 36.8%, for step two 30.6%, for steps three 13.7% and step four 13.0%. Remission rate declined significantly after step two. This might support the developing notion that treatment resistant depression can be defined by two prior treatment failure. High remission rates during initial trial were seen in patients who were female, employed or higher level of education and income. The cause of declining remission may be that the remission occurring due to nonspecific effects of patient care, attention, care, reassurance, education and can be called as placebo response, was declining. Khan et al.⁴⁴ showed that about 73% decrease in HDRS score in the drug group could be accounted by these factors. Rate of relapse increases with each step 33.5%, 47.4%, 42.9%, 50.0%. Relapse was even higher in patients who improved but did not achieved remission. Intolerance rate increased after each treatment step. 16.3%, 19.5%, 25.6%, 34.1%. Cumulative sustained recovery was calculated at 43% taking relapse into account and it does not include patients opting out. It pastes a little grim picture in outcome of TRD. Randomization was not done at step 2. Only 1.5% of patients agreed for randomization, so comparison between treatment strategies is difficult. It was found later on that patients entering cognitive therapy were having lower entry scores. It may explain the higher remission rate. According to Rush et al.² the biggest surprise of this study was comparable findings to SSRI-SSRI switch to switch to Bupropion or velafexine. Questions were raised weather longer duration of treatment is just as important to choosing a drug.

The drawbacks of this study are: (1) Only outpatient seeking medical care is included (2) Age limit was restricted to 10-75 (3) Patients with bipolar and psychotic disorder excluded (4) reliance on self report QIDS-SR16 as primary outcome (5) neither clinician nor participants were blind to treatment (6) placebo control was not used (7) dropout rate was quite high and most of the people who exited were not in remission (8) very high quality of care was delivered which may limit its generalibility.

CONCLUSION

Despite the numerous options available for the treatment of depression, many patients do not achieve a partial or full response with an adequate dose of two or more medications of different antidepressant classes, each given for a sufficient duration. Such resistance to psychopharmacologic treatment options challenges the practitioner. A staged approach to TRD includes reevaluation of the initial diagnosis and, when no correctable cause for TRD is found, optimization of the initial regimen. Other pharmacologic treatment approaches include switching antidepressant agents, adding a second antidepressant with a different mechanism of action, and augmenting the effects of the initial antidepressant by adding an agent other than an antidepressant. Although this treatment paradigm provides several management alternatives, depression in many patients remains resistant. Promising new therapies now under investigation may soon be validated and available for use in clinical practice. Efforts to identify true TRD and its definitive clinical diagnostic criteria continue. A better understanding of TRD and the many facets of its etiology, as well as the availability of new and effective therapies, hopefully will decrease the morbidity and mortality associated with depression.

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Socio-Economic and Cultural Aspects of Suicide

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The magnitude of the problem:

Everyday thousands of people commit and attempt suicide all over the world. However, actual statistics about suicide is difficult to obtain. Under-reporting, legal issues and improper record keeping are a few important factors why official statistics appear to underestimate the true rates of suicide and attempted suicide of any given society.

Suicide is considered as a major public and mental health problem. In 2000, approximately 8, 15,000 person committed suicide i.e. 14.5 per 100000 populations¹. On the other hand, approximately 20 million people attempt suicide every year throughout the world¹. In India, suicide is among the top ten causes of death. The current national suicide rate for India is 10.3 per 100000 populations². According to the National Crime Records Bureau, West Bengal (13.3%), Maharashtra (13.1%), Andhra Pradesh (11.2%), Tamil Nadu (10.5%) and Karnataka (10.3%) contributed 58.4% of total suicide in India³. Interestingly, densely populated states like Uttar Pradesh and Bihar contribute relatively less suicides. Under-reporting may be an important cause for this significant difference between different states.

The importance of suicide from the public health point of view is persistently under-recognized even though it is considered as a leading cause of mortality all over the world. Besides biological (including genetic) and psychopathological factors, it has been revealed in researches that the socio-economic and cultural factors influence the risk of suicidal behavior.

Evolution of concept:

The instinct to survive is a very common human behavior. However, the wish towards self-destruction has been reported since the beginning of the civilization in every part of the globe. This peculiar behavior has been found in the ancient scriptures and historical documents written in different languages. According to Edwin Shneidman suicide is associated with thwarted or unfulfilled needs, feelings of hopelessness and helplessness, ambivalent

conflicts between survival and unbearable stress, a narrowing of perceived options, and a need for escape; the person wants to die shows signals of distress⁴.

Human suicidal behavior has been considered as a dreadful and puzzling behavior. The word 'suicide' originated from Latin 'SUI' (of one self) and 'CAEDES' (murder). According to the eminent French Sociologist Emile Durkheim⁵: "suicide is any death that is the direct or indirect result of a positive or act accomplished by the victim himself/herself which, he /she knows or believes will produce this result". The study of suicide and its causes have come a long way since the views of Durkheim. In the present days, it has been revealed in different researches that the personal factors along with the social dynamics play a great role in the causation of suicide.

Suicide is considered as a peculiar behavior because all suicidal people are not death seekers. Before 1950s, not much distinction was made between people killed themselves and who died after such an act. Stengel in 1952 first used the term 'attempted suicide' to differentiate between completed suicidal act from attempted one⁶. It was Kessel and Grossman who changed the concept in 1960, stating the fact that intent was not an essential factor for attempted suicide as most of the attempters did this with the knowledge of their safety⁷. Later, Kreitman and his colleagues introduced the term 'parasuicide' to refer to the non-fatal act⁸. Further modification of terminology evolved when Morgan in 1979 coined the term 'deliberate self-harm' to provide a single term covering all non-fatal suicidal attempts⁹.

Historical background:

Suicidal behavior involves not only the individual concerned; it also affects the community for the socio-emotional dynamics associated with it. Historical analysis of suicidal behavior has shown that it had different meanings in different situations since the birth of mankind. In the ancient world, the voluntary self-killing was honorific and praised by the society. The cause of such act was either personal (for moral value) or collective (species survival value).

Descriptions of suicidal behavior is seen in the ancient Indian epics i.e. in *Ramayana* and *Mahabharata*¹⁰. In the more modern times, *Sati* and *Jaharbrata* are the two important ritualistic self-killings practised by the females

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in the Indian society. Some author considers these two are examples of altruistic suicide¹¹.

Religious background:

Bhagavat Gita is against the self-killing and self-destruction. However, in many Indian mythologies, self-killings were glorified by attaching religious and spiritual values. The self-killing of *Vishma* and *Balarama* (elder brother of Lord Krishna) in *Mahabarata* are the classic examples. In the *Vedic* and *Upanishadic* times, death at the confluences of holy rivers by drowning for achieving 'punnya' (salvation in the next life) was a cultural and religious code prevalent in the society.

Islam clearly mentions that one should wait for his destiny and not to snatch it from the hand of *Allah*. Similarly, it was seen in Bible that Judas (one who betrayed Lord Jesus) was cried and wept with guilt and remorse before hanging himself. Researches have revealed that suicidal behavior was less commonly seen amongst Islam and Catholic communities than Jewish and Protestants communities.

Cultural background:

Durkheim was the first to highlight the influence of social and cultural factors in suicidal behavior. Cultures include all the aspects of living and thus have a complex influence on human behavior. Researches have shown that cultural value system of gender roles and social expectations influence the nature and rates of self-harm behavior¹². Influences of media on suicidal behavior in different countries have been depicted in various researches¹³. In the modern world, more concern for children is seen in most of the nuclear families. At the same time, neglect towards the elderly in the family has been increasing and leads to a feeling of meaninglessness in life, which in turn increases suicidal acts amongst them.

Researches from different parts of the globe have also revealed that suicide by chemical ingestion (e.g. pesticides, insecticides and indigenous poisons like *Oleander* seeds) may be an attempt to seek help by the individual involved in a specified distressed situation¹⁴.

Immigrant population is always at greater stress that involves mainly the struggle between old and new culture – with its attendant problems of poverty, poor housing, lack of social support and unmet expectations. All these may lead to suicidal behavior, especially in the younger age groups. This acculturative stress is also evident even within one country where the traditional groups (e.g. tribal population) are fighting hard for their existence by clinging to their traditional ethos in the face of engulfing dominating culture.

Imitative suicide is a mode of cultural communication where an individual or a group exhibits this behavior in extreme distress. This type of suicide is predominantly

seen in adolescent age groups. It spreads through media publicity and gaining much attention in the recent days¹⁵.

It is a known fact that religion and social cohesion are two cultural determinants that guide the social life in a community. An important study amongst British Columbia's First Nations Women has revealed that how the cultural identity and traditional native spirituality has a healing effect on suicidal ideation and intention¹⁶.

Socio-economic factors:

Age and sex are two important social determinants identified in different suicide researches. The younger (15-30years) and the elderly (above 65 years) age groups are at increased risk of suicide¹⁷. The suicide rates in India also peak for both men and women between the age 18 and 29¹⁸. In most of the countries more males than females commit suicide¹⁷. However, a few studies from China and India have shown higher female suicides than their male counterparts mainly in the rural areas^{19,20}.

Studies have shown that the risk of suicidal behavior increases among divorced, widow and single people^{21,22}. Marriage appears to be protective for males in terms of suicide risk but not so for females.

Certain occupational groups like farmers, dentists and medical practitioners are at a greater risk of suicide^{23,24}. Easy accessibility to lethal means, extreme work pressure, social isolation and economic constraints may be the causative factors that explain the higher suicidal rates amongst them²⁵. Unemployment increases poverty, social deprivation, domestic difficulties and hopelessness, which in turn increases the suicidal rates. Suicide of farmers in different states of India in the recent days probably highlights this association²⁵.

Easy availability of the means of committing suicide and stressful life events are other important social factors in suicidal behavior. A recent study in the remote rural areas of the Sundarban region of West Bengal, India has revealed that the ready availability and improper storage of pesticides in the households as well as the greater life stresses of women both in the outdoor works and in the domestic front increase the chance of suicide amongst them²⁶.

Conclusion:

Suicide is a preventable cause of death and the means of prevention is the ultimate goal of the art and science of suicide research. Strengthening the poverty alleviation projects, proper education for children, ensuring job security and to guarantee economic security for farmers are some of the important aspects of primary prevention of suicide. Minimizing migration related stressors and family conflicts as well as expanding family support are also important socio-cultural issues. Identification of high risk groups and establishment of emergency help lines services (involving



the NGOs) may be a major step to reduce the morbidity and mortality related to the suicidal deaths.

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Mindfulness and Mental Health

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'Mindfulness involves intentionally bringing one's attention to the internal and external experiences occurring in the present moment, and is often taught through a variety of meditation exercises'¹. It includes a kind of meta-awareness, self regulation of attention (to immediate experience) and a certain mindset e.g. being non-reactive, non-judgemental and accepting.

This practice has been derived from Buddhism which originated in India in the 6th Century BC². The Four Noble Truths in Buddhism include the presence of suffering (Diagnosis), its cause (Aetiology), that it can be ended (Prognosis) and the Eight-Fold Noble Path (Prescription). The Eight-Fold Noble Path includes Right Speech, Right Action, Right Livelihood, Right Effort, Right Mindfulness (Sati), Right Concentration, Right Aspiration, and Right View. Mindfulness is also one of the seven factors of enlightenment. These include Mindfulness, Investigation of reality, Energy, Rapture, Tranquility, Concentration and Equanimity.

Mindfulness in the Buddhist practice is like overseeing a situation (for example, a cowherd sits in a relaxed manner and watches his cows over a distance). In the practice of mindfulness there is also a sense of restraint i.e. bare attention and avoiding to get carried away by associations, projections, evaluations, proliferations etc (distractions); focus on here and now and on being non-judgemental. There should be no craving, ill will or ignorance regarding the object of mindfulness. In order to practice or develop mindfulness one could focus on body e.g. breath, posture etc.; sensations or feelings; mind (Chitta) e.g. mental states; and phenomena (Dhammas) e.g. hindrances and aggregates.

As 'Buddha was essentially a psychologist'³ 'It is possible to practice Buddhist-derived meditation, and ascribe to

aspects of the psychological view of the mind from this perspective, and maintain one's beliefs and membership in other religious traditions'⁴. Thus, mindfulness is being applied in a variety of fields including Education and Therapy.

In Education, there is a movement for Mindful learning and teaching⁵ with features such as, Active involvement of the student in the learning process; Student and teacher join each other as collaborative explorers in the journey of discovery; Embrace both knowledge and uncertainty with curiosity, openness, acceptance, and kind regard; Disentangle the mind from premature conclusions, categorizations and routinized ways of perceiving and thinking; Open to novelty, alertness to distinction, sensitivity to different contexts, awareness of multiple perspectives, & orientation to the present. Thus, learning becomes more enjoyable, stimulating and effective.

Mindfulness based therapies and their effectiveness

In the late 1970s, Jon Kabat-Zinn (University of Massachusetts Medical Centre) set up MBSR (Mindfulness based stress reduction) clinics for a wide range of medical conditions from backache to psoriasis. These demonstrated reduction in subjective states of suffering, improvement in immune functions, acceleration in rates of healing, nurturing interpersonal relationships, and overall sense of wellbeing⁶. This led to the application of mindfulness for a variety of mental health problems.

Mindfulness is already assimilated in psychodynamic therapies at many levels. It is integral to well established forms of psychotherapy, as there is an emphasis on the quality of attention in psychotherapy. For example, Nina Coltart (1992)⁷ emphasises the healing potential of bare attention in psychoanalysis. There has also been found an augmentation of therapeutic effect i.e. a potentiating effect of mindfulness training for patients on psychodynamic exploration, as treatment times were significantly reduced during the study⁸. Epstein (1995)⁹, Brazier (2003)¹⁰ and others have thus, promoted Buddhist psychotherapy.

Similarly in Behaviour Therapy there have been 3 waves¹¹:

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- 1st Wave of Traditional Behaviour therapy focused on overt behaviours and their relationship with their environmental events.
- 2nd Wave of Cognitive Behaviour Therapy with an emphasis on the role of thoughts.
- 3rd Wave with Mindfulness e.g. Dialectical Behaviour Therapy (DBT), Mindfulness Based Cognitive Therapy (MBCT), Acceptance and Commitment Therapy (ACT).

DBT involves becoming more aware, and hence more accepting of ones emotional experiences. It has been shown to be effective in treating symptoms of borderline Personality Disorder¹²; co-occurring substance dependence¹³; eating disorders¹⁴; and emotion dysregulation¹⁵.

In MBCT, one learns to see thought as a process and not as a fact, thus, leading to detachment. It has been found to be effective in: prevention of relapse/recurrence in major depression¹⁶; childhood disorders e.g. conduct disorders, anger problems, attention deficit hyperactivity disorder (ADHD), anxiety disorders¹⁷; adolescent externalizing disorders e.g. oppositional defiant disorder, ADHD, behaviour problems in Autism Spectrum Disorder¹⁸; and parent training¹⁹.

ACT involves accepting of experience to reduce avoidance of private experience and accomplishing goals in life that serve higher values. It has been found to be successful in: Substance abuse²⁰; Coping with psychosis²¹; Stigma and burnout²²; and Worksite stress²³.

Other examples of the effectiveness of mindfulness based therapies include:

- Mindfulness based eating awareness training (MB-EAT;²⁴)
- Mindfulness based relapse prevention (MBRP;²⁵)
- Mindfulness based relationship enhancement (MBRE;²⁶)
- Treatment of adolescent sex offenders²⁷
- Treatment of addictive behaviours²⁸
- MAP (Mindful Attention Program) for the treatment of ADHD; a project of the Santa Barbara Institute (UCLA) for Consciousness Studies²⁹

There is also a study of the impact of therapist practicing mindfulness oneself. In a randomised comparative trial of the clinical outcomes of over 120 patients who received psychotherapy from 18 psychotherapists in training, patients seen by 9 therapists (with mindfulness training) did significantly better symptomatically than the patients seen

by the other 9 therapists³⁰.

Mindfulness based therapies have now been demonstrated to be effective in a variety of mental health problems such as, anxiety disorders (including phobias, panic and obsessive compulsive disorder), depression, anger and emotion dysregulation, binge eating & other behavioural problems, substance misuse, suicidal behaviour, trauma, relationship issues and so on³¹. However, there have also been reports of adverse effects³² as well such as, symptoms of restlessness, anxiety, depression, guilt and hallucinosis in vulnerable (e.g. traumatised) individuals in intensive retreats.

The findings in a meta-analysis by Baer (2003)¹ suggest that mindfulness-based interventions may be helpful in the treatment of several disorders. She also points out that there are methodological flaws in the studies on these interventions and because of their promising nature, more rigorous studies are highly recommended.

Measuring instruments

There are already some scales available for measuring mindfulness, for example, The Mindful attention and Awareness Scale (MAAS;³³), The Toronto Mindfulness Scale (TMS;³⁴), The Kentucky Inventory of Mindfulness Skills (Kims;³⁵), and The Freiburg Mindfulness Inventory (FMI;³⁶).

Mechanisms implicated

As regards the mechanisms involved in mindfulness and its effectiveness there appear to be a number of theories. Some of these are briefly outlined below.

- In a study on Zazen meditators, there was a failure to respond to repeated clicks by habituation of autonomic responses (e.g. momentary blocking of alpha frequencies). Thus, they seem to react to stimuli as if for the first time³⁷.
- The act of becoming consciously aware of the stream of awareness has the immediate effect of rendering the dominant EEG patterns stronger & more coherent³⁸. Mindfulness leads to two, ordinarily incompatible, developments: boost of the fast wave activity that is associated with alert states, along with particular kinds of slow wave activity associated with expansion of awareness, creativity and deep relaxation³¹. For example, while resting, meditators (Tibetan method) were found to have significantly greater gamma band (40 c/s) activity relative to slower activity and synchrony than controls.
- In the frontal lobes of the brain, asymmetrical



activation, favouring one side more than the other, is consistently associated with specific mental states in the neurophysiology literature. For example, greater left sided activation has been associated with positive emotion (happiness), enhanced immune function and in those who participated in 8 week training in MBSR i.e. mindfulness based stress reduction³⁹.

There are reports that in subjects practicing mindfulness meditation there is an increased thickness of at least two parts of the brain i.e. middle prefrontal area, bilaterally and a related neural circuit, the insula (more on right side). The degree of thickness correlated with the time spent on practicing mindfulness meditation⁴⁰.

There are individual differences in the neural correlates of voluntary emotion regulation. These are related to endogenous regulatory processes in everyday life. Some individuals when attempting to voluntarily downregulate negative affect using cognitive strategies are poor performers as reflected in less ventro-medial prefrontal cortex activation and more amygdala activation and show a flatter slope of the cortisol rhythm, mainly due to higher evening levels of cortisol⁴¹. Chronic stress can lead to several changes⁴² e.g. increase in the ability of the amygdala to learn and express fear associations, deficiency in the hippocampus function (depriving the subject of the contextual information needed to recognise an environment as safe), and reduction in the ability of the prefrontal cortex to control fear. Thus, a vicious cycle is created in which increased fear and anxiety lead to more stress, which leads to further dysregulation. However, prefrontal activity can be augmented pharmacologically, physiologically (e.g. repetitive trans-cranial magnetic stimulation, deep brain stimulation) and psychologically such as through mindfulness meditation.

According to the 'dynamicist' view of top-down control, spatio-temporal trajectories of neural activity emerge from complex nonlinear neural interactions and follow the rules of dynamical theory⁴³. These large-scale coherent neuronal ensembles (e.g. which emerge during Focused Attention on breath) can influence other local neuronal processes (e.g. evoked by an external distractor) by entraining local ensembles⁴⁴,⁴⁵. The brain goes through a succession of large-scale brain states, with each state becoming the source of top-down influences for the subsequent state. Such large-scale integrative mechanisms may participate in

the regulatory influence of meditative states.

Mindfulness leads to Dechaining i.e. loosening of strong associations e.g. in phobia⁴⁶. Mindfulness also leads to Decentring or disidentification from the activities of our minds as our relationship to our experiences change³¹.

There are 7 common factors between Mindfulness, secure attachment & prefrontal functions: Regulation of body systems, Balancing emotions, Attuning to others, Modulating fear, Responding flexibly, Exhibiting insight, and Empathy. There are two other prefrontal functions found in mindfulness but, so far, not studied in secure attachment: Being in touch with intuition and morality⁴

Other mechanisms implicated include improvement in patterns of thinking, reduction in negative mindsets, capacity to combat emotional dysfunction, and improved capacity to regulate emotion^{4,31,47}.

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VIEW POINT

Era of Evidence Based Medicine: Is clinical expertise outdated?

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Evidence Based Medicine (EBM) is a relatively recent concept. However, it has more than made up for its late entry by showing exponential growth over the past two decades. Pioneered in early 1990s by Guyatt et al, it represents the conscientious, explicit and judicious use of current best evidence in making clinical decisions about the care of individual patients¹. Although new to modern times, its philosophical underpinnings have been traced back to China in older times².

In simple terms EBM helps the clinicians make decisions supported by evidence. The philosophy of EBM can be summed up as follows: if there is evidence that something is of good and of benefit to the patient, then use it; if there is evidence that something is not good for the patient and can be harmful, then do not use it³. In this context Evidence Based Practice (EBP) would pertain to any practice that applies up-to-date information from relevant and valid research about the usefulness of various diagnostic tests or the predictive power of prognostic factors or the beneficence of a particular treatment method.

Multiple ongoing clinical trials, ever increasing number of biomedical journals and thousands of articles published every month have ensured floods of information. Going by most conservative of estimates this is likely to grow exponentially in the coming years. Also growing use of the internet and other modes of communication has ensured that most of this information is easily accessible at the user end point⁴. As an integral component of the professional development clinicians are expected to keep themselves apprised of this enormous amount of information. However, not all available information is

necessarily scientifically valid and reliable. Thus the clinicians have a two-fold task: to go through the available information and simultaneously screen it for scientific validity, applicability and relevance before putting it to practice.

With this explosion of ever evolving biomedical information the age old practice of depending on a combination of informed guesswork, unsystematic observation, common sense, the consensus views of clinical experts, and the so-called 'standard and accepted practice' has been put to question. So does this mean that clinical expertise and opinion is unnecessary or obsolete for patient care? Does acceptance of EBM to guide clinical decision making preclude and forbid the use of clinical judgement and expertise? Is what a clinician has gathered over the years by his/her interaction with patients or professional colleagues no longer relevant in patient care?

We would be able to answer these questions better if we revisit the concept of EBM and EBP. EBM aims at evidence being the driving force behind clinical decision making. If an intervention is supported by evidence for its benefit, then EBM recommends its use. If an intervention is not supported by evidence then EBM does not recommend its use⁵. However, the practice of EBM in no way refutes the importance and value of clinical expertise in decision making. In fact, EBM goes a step beyond. It not only recommends that clinical expertise be integral to effective patient care, it also acknowledges and recommends inclusion of 'patient values' in clinical decision making. EBM is the integration of clinical expertise, patient values, and the best evidence into the decision making process for patient care⁶. These 'patient values' include individual specific personal and social issues, clinical settings etc.

EBM helps foster shared decision making. The importance of shared decision making is of special relevance to our setting where clinicians tend to rely heavily on evidence

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generated in other populations and settings (primarily Western) and need to extrapolate it to a vastly different Indian patient population. The differences are evident in terms of accessibility, acceptability, affordability and applicability of these interventions. As a result when a clinical decision has to be taken for an individual patient, one has to keep in mind certain additional factors along with the level of evidence. At times applicability of intervention best supported by evidence could be put to question because of lack of availability or affordability. Neglect of clinical expertise and 'patient values' could be counterproductive in such scenarios and would defeat the basic principle of patient care- provision of effective, acceptable and affordable interventions. Such a decision calls for sound clinical expertise based on the clinician's accumulated experience, education and clinical skills. A related situation would be to choose from two or more interventions with comparable evidence base. Even in such a situation, clinical expertise could play a key role. A decision guided by astute clinical judgement would ensure judicious use of resources and maximum benefit to the patient.

The process of practice of evidence based medicine follows a systematic approach. It begins with conversion of medical information in to competent, searchable, focused questions⁷. Once the question of interest is ready then one endeavours to search for best evidence to answer the question. Subsequently one has to critically appraise available evidence. This includes ascertainment of the validity and clinical usefulness of the evidence. Following this the evidence is put to clinical practice. The job is not yet completely done and involves a final step - evaluation of performance of the evidence in clinical application.

In order to practice EBM the clinicians need to have access to relevant literature as well as good understanding of the correct strategy to search and then critically evaluate it. However, the most important pre-requisite and potential barrier to the practice of EBM remains the attitudinal change of the clinicians⁸. The clinicians need to realise that it is their professional, moral and ethical responsibility to deliver the most appropriate and effective care to their

patients. Also they have to acknowledge the ever changing and evolving nature of the medical field. What seems to be the most appropriate strategy might not hold good if appropriate search for alternative strategies is carried out. Thus the clinicians need to be open to challenge their knowledge and be on the look out for better alternatives. This would ensure that they choose the most appropriate intervention for their patients and in the process enrich themselves as well.

To conclude, clinical expertise and EBM are complimentary and go hand in hand. Rather, it would be more precise to put clinical expertise as an integral component of clinical decision making based on EBM. EBP has evolved from the application of clinical epidemiology and critical appraisal to explicit decision making within the clinician's daily practice. Practice of EBM would ensure the judicious use of valuable clinical expertise and hence help arrive at sound clinical judgement. While EBM ensures the science of medicine it is finally the experience, knowledge and integrative capacity of the clinician which provides its art, and thus becomes the scaffold on which final clinical decision rests.

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CURRENT THEME

Towards A New Mental Health Act

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INTRODUCTION

Mental health legislation was first enacted in India in 1858 three separate Acts - (1) The Lunacy (Supreme Court) Act, 1858 relating to judicial inquisition as to lunacy in presidency towns; (2) The Lunacy (District Courts) Act, 1858 relating to proceedings outside presidency towns; and (3) The Lunatic Asylums Act, 1858 relating to confinement of lunatics in asylums. These were based on two English Acts namely the English Lunacy Regulation Act, 1853 and the Lunatics Act, 1853¹. The Indian Lunacy Act, 1912 was enacted to amend and assimilate the law relating to custody of lunatics in India with the English law on the subject and to re-arrange and consolidate as far as possible the whole law relating to lunatics (Statement of Objects and Reasons of the Indian Lunacy Bill, 1911).

After Second World War the Universal Declaration of Human Rights was adopted by the UN General Assembly to ensure inherent dignity and the equal and inalienable rights of all people. India was a signatory to the Declaration. The need was felt to replace the Indian Lunacy Act, 1912 and the Indian Psychiatric Society (IPS) realized the need to enact new law in this regard and submitted a Draft Mental Health Bill to the Government of India in 1950. Dr. B.A. Bhagwat took active part in preparation of the draft. In 1978 a Mental Health Bill was introduced in the Lok Sabha and was later referred to a JPC headed by Dr. Sushila Nayyar. The Bill could not be considered due to dissolution of Lok Sabha. The Bill was again introduced in 1981 in the Rajya Sabha and again referred to a JPC headed by Shri Sukhdeo Prasad, M.P. In 1982, National Mental Health Programme was launched by the Government of India. In 1983 Indian Psychiatric Society voluntarily submitted a memorandum to the JPC and Dr. Jaya Nagaraj, the then President of IPS and Dr. A.B. Dutta² represented the IPS before the JPC. The JPC,

which was reconstituted in 1985, submitted its report in May 1986. After being passed by both houses and receiving the Presidential assent, it became Mental Health Act, 1987 in May 1987. It took another three years for the Central Government to frame The State Mental Health Rules, 1990 and The Central Mental Health Authority Rules, 1990. The Government took a further period of three years to issue notification that the Mental Health Act, 1987 would come into force in all States and Union Territories from April 1, 1993. Because of a large number of very complicated procedures, defects and absurdities in the Act and also in the Rules, it can never be implemented properly³. The National Human Rights Commission observed in 1999 that the Act was not implemented in many States even in 1999. The Indian Psychiatric Society voluntarily submitted its recommendations on mental health legislation to the Government of India in January, 2001 urging upon the Government to declare its mental health policy and to repeal the Mental Health Act, 1987 by a new Act based on the mental health policy, modern concept of psychiatry and recommendations of the international bodies and the IPS. After occurrence of Erwadi tragedy in August 2001, the Supreme Court of India initiated a PIL (WP no.334/2001) and a second PIL was filed by a NGO Sarthak (WP 562/2001). Indian Psychiatric Society and Indian Association of Private Psychiatry also represented themselves in these Writ petitions. The Supreme Court in its interim order in April 2002 directed to examine the feasibility of formulating uniform rules regarding public and private sector psychiatric institutions. Human right activist group and NGOs working in the field were also pressing for revision of the Act to ensure protection of the human right aspects of the mentally ill patients. One of them commented "the Mental Health Act is a statute which provides a procedure by which persons living with mental illness can be denied their liberty"⁴.

Major objection of the IPS to the MHA, 1987^{5,6} as summarized in IPS documents are as follows.

1. MHA, 1987 was not based on modern concept of psychiatry with all the attendant scientific and technological advancement which had impacted the

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- management of psychiatric illnesses.
2. Definition of mental illness was unsatisfactory. It excluded Mental Retardation.
 3. Definition of Medical Officer and Psychiatrist was unsatisfactory as it had to be either a gazetted medical officer in service of the Government in the case of former or any medical practitioner to be declared so in the case of latter.
 4. Only Government run and not privately run general hospitals providing psychiatrist service were exempted from the provisions of MHA, 1987.
 5. In MHA, 1987 legal considerations were given too much weightage, whereas, medical consideration was given too little importance.
 6. A Judicial Officer could determine the presence and nature of mental illnesses in people, by personally 'examining' them (diagnosing someone with mental illness requires special training and anybody without that could not be entrusted with that responsibility).
 7. The licensing procedures were found cumbersome.
 8. Nonprofessionals had the access to the confidential records of the patients in the name of inspection.
 9. Inspection and licensing was applicable to mental hospitals and nursing homes even where those admitted were under the supervision of patient's family, which was consulted for all treatment decisions.
 10. Central and State Mental Health Authorities were constituted by the Government, which had set up most of the mental hospitals mainly providing custodial care. This was in conflict with one of the objectives of the MHA viz. to regulate the powers of the Government for establishing, licensing and controlling psychiatric hospitals and psychiatric nursing homes for mentally ill persons.
 11. No budgetary provisions were made available for the functioning of Central or State Mental Health Authority.
 12. The Act had nothing to suggest the role of family in the care of mentally ill subjects.
 13. Although there were provisions for delegating powers to the police officer with respect to bringing the homeless wandering mentally ill for treatment, there was no provision for penalizing the police if it failed to do so.

PROPOSED DRAFT OF AMENDMENTS TO MHA-1987 ^{7,8}

India signed United Nations' Convention on Rights of Persons with Disability (UNCRPD), which was ratified

by the Government of India in May, 2008. It became imperative for the Government to revise all related law on mental health and disability to bring them in harmony with UNCRPD. A National Consultation on the Mental Health Programme was held on 22nd January 2010 with the objective to review and identify gaps in the Mental Health Programme and actions to fill up these gaps. It was felt that the MHA 1987 needs amendments. It should move towards supporting, promoting and protecting the rights of persons with mental illness. Centre for Mental Health Law & Policy, ILS College, Pune was given the responsibility of preparing the draft of the proposed legislation and present it to the Ministry of Health and Family welfare after having nationwide consultation on it. The first draft was circulated on 28-02-10 and after seeking objections and suggestions on the draft, a revised draft was released on 23-05-10. A series of regional and national consultation is planned before the final draft is presented to the Ministry. The salient features of the proposed draft are as follows.

1. Persons with mental illness - The nomenclature has been changed from 'mentally ill person' to 'person with mental illness'. Similarly 'mentally ill prisoner' has been replaced by 'prisoner with mental illness'. It is stated that language has a role in stigma associated with any condition. Hence 'persons with mental illness' is preferred to the term 'mentally ill person'.

2. Statement of objects and reasons - By definition the Act is stated to protect and promote the rights of persons with mental illness. It is stated to create access to treatment, care and rehabilitation and to fulfill the obligations under the Constitution of India and obligations under various International Conventions. It is also stated to ensure that care, treatment and rehabilitation is provided in the least restrictive manner that does not intrudes on the right and dignity of the person. One of the objects of MHA -1987 which is dropped is 'to protect society from the presence of mentally ill persons who have become or might become a danger or nuisance to others'. Facilitation of integration of persons with mental illness into community life is also stated to one of the objects.

3. Mental Health Facility - Psychiatric hospitals and Psychiatric Nursing homes have been described as 'Mental Health Facility'. It is defined to include all facilities either wholly or partly meant for the care of the persons with mental illness, where persons with mental illness are admitted or reside at for care, treatment, convalescence and/or rehabilitation, either temporarily or otherwise and



includes general hospital or general nursing home established or maintained by the Government or any other person. It is obvious that Psychiatric OPD services are not covered by this definition. There is an exclusion criteria which specifies that if the person with mental illness resides with his family, the place will not be regarded as mental health facility and thus exempt from registration. The definition is intended to cover non-medical institutions also, if the persons with mental illness are residing for care, convalescence or rehabilitation.

4. Mental Health Professionals - A new category of 'Mental Health Professional' has been created which includes psychiatrist, clinical psychologist, psychiatric social worker and registered mental health nurse. It is said that the category is created to facilitate involuntary admissions under section 19 of the Act. But they can become professional members in Mental Health Review Commission (MHRC) and also in Central and State Mental Health Authority.

5. Nominated Representative - A new concept of 'nominated representative' has been introduced and a person who has attained the age of 18 years and is competent to do so has the right to appoint a nominated representative and it can be communicated either verbally or in writing to the person in charge of the person's medical care. If no nominated representative has been appointed, family member as described in section 2 (t) will be the nominated representative. If no family members are available, 'carer' (who is not a relative but who normally resides with the person and/or predominantly responsible for providing care to that person) will be the nominated representative. In certain cases nominated representative can be appointed by MHRC also.

6. Mental Illness - It has been defined as a substantial disorder of mood, thought, perception, orientation or memory which grossly impairs a person's behavior, judgment and ability to recognize reality or ability to meet the demands of normal life and includes mental conditions following the use or abuse of alcohol and drugs, but excludes mental retardation. It is stated that the mental illness has been defined for the purpose of the Act in behavioral terms so that it can be understood by non-professionals also. It is obvious from this definition that if the disorder does not involve gross impairment of patient's insight and reality testing, the provisions of MHA will not apply and the disorders can be treated in normal 'doctor-patient' relationship. Thus neurotic and similar types of illnesses are excluded. Mental Retardation has been

excluded from the ambit of the definition. It is pertinent to note here that the National Trust Act covers four illnesses i.e. mental retardation, autism, cerebral palsy and multiple disabilities. It was suggested that WHO definition as given in ICD should be adopted. But if it is adopted all psychiatric illnesses will come into the ambit of MHA.

7. Registration of Mental Health Facility - Licensing has been replaced with registration and for registration, every mental health facility shall fulfill the minimum standards of facilities, minimum qualifications for the personnel, provisions for maintenance of records and reporting and any other conditions as may be prescribed. The registration will be done by State Mental Health Authorities and the application may be furnished in person or by post or online. The Authority within a period of 10 days and without any inquiry issue a provisional certificate of registration, which shall be valid for 12 months from the date of issue and shall be renewable. Permanent registration, which shall be valid for 36 months, shall be granted only when a mental health facility fulfills the prescribed standards for registration by the State Government. Mental health facility shall be classified into different categories and different standards may be prescribed for them. If at any time after registration the SMHA is satisfied that the conditions of registration are not being met or the persons entrusted have been convicted of an offence under this Act or persistently violating the rights of the Persons with mental illness, a show cause notice may be issued. If even after giving reasonable opportunity to the mental health facility, the Authority is satisfied that there has been breach of Rules under this Act or persistently violating the rights of persons with mental illness, the registration of the mental health facility may be cancelled. The Authority shall have right to cause an inspection of or inquiry in respect of any mental health facility, the result of which shall be communicated to the mental health facility. The Authority can issue any directions as it may deem fit and the mental health facility shall have to take action to the satisfaction of the Authority. The Authority or any person authorized by it may enter and search in manner prescribed by the authority at any reasonable time if there is any reason to suspect that anyone is running a mental health facility without registration. Any person aggrieved by any order of the Authority may appeal to the High Court of the State.

8. Inspecting officers and Visitors - Provisions of inspection at anytime by the Inspecting Officer (Sec 13), provisions of visitors for every mental health facility (sec



37 and 38) have been dropped in the draft.

9. Admission to a Mental Health Facility - There are four types of admissions under the proposed draft – Independent admission, Admission of a minor, Supported Admission up to 30 days and Supported admission beyond 30 days.

a) Independent admission – Any person who is not a minor and consider himself to have a mental illness may request the medical officer in charge of a mental health facility to be admitted. The medical officer in charge will admit him if he is satisfied that person has a mental illness of sufficient severity and he will benefit from admission. An independent shall not be given treatment without his/her informed consent and he may discharge himself from the mental health facility without the consent of the medical officer in charge. But a mental health professional may prevent discharge of an independent patient seeking discharge for 24 hours to allow assessment by two mental health professionals necessary for supported admission under sec 19 of the Act, if the necessary conditions are met.

b) Admission of a minor – A minor shall be admitted only in **exceptional circumstances** on application in writing of the nominated representative of the minor. Two mental health professionals, at least one of whom is a psychiatrist or one psychiatrist and one registered medical practitioner shall have to independently examine the minor and both conclude that the minor has a mental illness of sufficient severity, it is in the best interest of the minor, his mental health care needs of the minor cannot be met unless he/she is admitted and all community based alternatives have been shown to have failed or demonstrably unsuitable to the needs of the minor. It is also specified that no irreversible treatment can be provided for the mental illness of a minor. If the nominated representative of the minor no longer supports admission of the minor, he must be discharged. All admissions of minors beyond 30 days must be informed to MHRC and every subsequent 30 days continuation of admission requires approval from the MHRC.

c) Supported admission up to 30 days – A person with mental illness may be admitted in a mental health facility, if two professionals, one psychiatrist and the other being a mental health professional or a registered medical practitioner, each of them have independently examined in the preceding 7 days and both conclude that the person has a mental illness has recently threatened or attempted

or is threatening or attempting to cause bodily harm to himself/herself and/or to another person and/or recently behaved or is behaving violently towards another person and/or has recently shown or is showing lack of competence to care for himself/herself and the mental health professionals certify that admission to the mental health facility is the least restrictive option. The admission under this section shall be limited to 30 days. At the end of 30 days he will cease to be admitted under this section or continue to be admitted as an independent patient or continue to remain admitted under section 20, according to whatever criteria are met at the end of 30 days. If it is assessed even earlier that the criteria as described under this section are no longer met, the medical officer in charge will terminate the admission.

d) Supported admission beyond 30 days – If the person is already admitted under section 19 and the criteria of admission as described above are still valid, the person will have to be independently examined by two psychiatrist in the preceding 7 days and if both certify that admission in the mental health facility is the least restrictive option possible, the person will remain admitted in the facility. But all admissions under this section must be approved by the MHRC within a period of 60 days from such admission or renewal becomes effective. Admission under this section will be limited to 180 days. Further admission beyond 180 days can be renewed for 180 days at each instance upon application of the nominated representative and by following procedures as above.

10. Emergency Treatment – Under section 20.1, treatment can be initiated by any registered medical practitioner with the consent of nominated representative in certain specified emergency situations, at any health facility or in the community. But the treatment under this section will be limited to 72 hours and ECT and irreversible treatments shall not be provided under this section. What constitutes irreversible treatment is not specified.

11. Prohibited Treatments – ECT without the use of muscle relaxants and anesthesia and sterilization of persons with mental illness intended for treatment of mental illness is prohibited in the proposed draft. Psychosurgery may only be performed on approval of SMHA

12. Restrains and Seclusions – It is stated that person with mental illness cannot be chained in any manner whatsoever. Restrains and may only be used if it is authorized by the psychiatrist at the mental health facility and may be used no longer than necessary.



13. Duties of police officers and order in case of person with mental illness cruelly treated - Police officers have been assigned duties to take any wandering person with mental illness to the nearest public mental health facility within a period of 24 hours and the duty of police officer once the person have been conveyed to the facility. In case any person with mental illness is cruelly treated or not under proper care, a police officer or any private person may report the fact to a Magistrate, who will pass appropriate order for proper care of the person after following the specified procedure or may order for conveying the person to a mental health facility for assessment and treatment as per other provisions of the ACT.

14. Mental Health Authorities – Central Mental Health Authority established by the Central Government, in addition to earlier function will also maintain an all India register of mental health facilities and mental health professionals and will also co-ordinate programs run by different ministries. Similarly State Mental Health Authority, in addition to earlier functions, will be in charge of registration of mental health facilities in the State. It has also been assigned duty to register certain mental health profession and make rules and criteria in that respect.

15. Mental Health Review Commission – It will be a judicial body established by the State Government to perform various functions under the Act. President of the MHRC will be a person qualified to become a High Court Judge. There shall be three types of members – Judicial members, Professional members (any mental health professional can be the professional member) and representatives of users or carers and their organizations or NGO working in the field. MHRC may have as many panels in districts depending upon the workload. The panel shall be constituted by the President of the MHRC and shall consist of three members, judicial member, professional member and representative of users or carers or NGOs working in the field. Appeal against the decision of the MHRC shall lie to the High Court.

16. Protection of Rights of Persons with Mental Illness – There is a separate chapter dealing with these rights. It states that persons with mental illness cannot be subjected to cruel, inhuman and degrading treatment and their living environment will be safe and hygienic, with adequate provision of food, facilities for recreation, privacy etc. They shall not be subjected to physical or sexual abuse or forced to compulsory work. There will be **non-discrimination in respect of medical insurance** and

in respect of emergency medical services or any other health services. Free and informed consent is required from them in case research works. If they are unable to give free consent, permission will have to be obtained from SMHA. Persons with mental illness or their nominated representative shall have right to information and right to confidentiality and shall in general be given access to their medical records. But the psychiatrist may withhold information in case of likelihood of harm to the person with mental illness or to other persons.

17. Advance Directives – Every person has a right to make written statement specifying the way the person wishes to be cared for and treated for a mental illness and the individual or individuals he wants to be appointed as his nominated representative or special personal representative. The advance directive should also be signed by a medical practitioner certifying that the person is competent and aware of what he is doing. It may be amended or cancelled by the person who has made it. An appeal can be made by the MHRC for overruling the advance directive.

18. Special Support Arrangements – MHRC may require create special support arrangements in case of persons with long term mental illness requiring very high level of support in decision making. MHRC can also appoint the nominated representative as Special Personal Representative if it is satisfied that all conditions exist and it is in the best interest of the person. Special Personal Representative will be a time limited arrangement, who will decide on behalf of the person in his/her personal matters and property except marriage, sexual relations and voting rights.

CONCLUSION

Many objections were raised on provision of the draft. Some of them insisted on adoption of the WHO definition of the mental illness and inclusion of mental retardation. The concept of nominated representative, carer, inclusion of general hospital psychiatry unit (GHPU) in mental health facility, recognition of so many professionals as mental health professional and prohibition of unmodified ECT were also objected. Advance directive and special personal representative were also the subjects of objection. IPS also insisted for recognition of role of family in care of persons with mental illness and introduction of open and closed ward concepts. Constitution of Central and State Mental Authority was seen to be heavily loaded by non-professionals. In constitution of MHRC also, psychiatrists are not given due weightage. Human right



activist groups protested about dismantling of specific adjudicatory and monitoring power to judiciary and abolition of board of visitors. One of them called it 'Total Empowerment of Psychiatrist Act 2010'. The Act is still in process of consultation at the time of writing this article and comments to the draft may be posted to amendmentstomha1987@gmail.com.

It seems that the objectives of the psychiatrists and human right activist groups are at variance to each other. But primary concern for everyone should be the interest and welfare of the persons with mental illness. Mental Health Act is the Act meant for the persons with mental illness. Naturally, it should be directed towards betterment of their conditions and protection of their rights. But the protection should not be so overstretched that their welfare and proper care is endangered. It is in the interest of everyone if in the new Act, the emphasis is on ensuring easy availability of psychiatric treatment to all, finding ways to promote opening of more and more psychiatric inpatient facility, providing for better care of wandering persons with mental illness and protecting and promoting rights of persons with mental illness.

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