C. B. (II) No. 318

LOK SABHA

JOINT COMMITTEE

ON

MENTAL HEALTH BILL, 1978

EVIDENCE

LOK SABHA SECRETARIAT
NEW DELHI

November, 1978/Kartika, 1900 (Saka)

Price : Rs. 5.00

JOINT COMMITTEE ON THE MENTAL HEALTH BILL, 1978

CORRIGENDA

to

The Record of Evidence tendered before the Joint Committee on the Mental Health Bill, 1978.

Page 3, col.2, line 17 from bottom
for 'refrence' read 'reference'
Page 4, col.1, line 22, for 'one' read 'some'
Page 5, col.2, line 2, for 'seprate' read 'separate'
Page 5, col.2, line 16 from bottom
for "form" read "from"
Page 7, col.1, line 2, for "priveds" read "provides"
Page 15, col.1, line 25, for "en" read "and"
Page 15, col.2, line 12 from bottom
for "is" read "in"
Page 17, col.2, line 17, for 'श्री कंवरलाल है'
read 'श्री कंवरलाल हेमराज जैन आपके
Page 18, col.1, line 3, for 'त'
read 'लत'
Page 20, col.2, line 15, for "clincial" read "clinical"
Page 22,
(i) line 2, for "tenbred" read "tendered"
(ii) line 4, for "13.50" read "13.15"
Page 24, col.2, line 26, for "denition"
read "definition"
Page 25, col.2, line 3, for "hiness" read "illness"
Page 26, col.2, line 13 from bottom
for "distrubed" read "disturbed"
Page 30, col.2, line 17, for "thisk" read "think"
Page 38, col.2, line 7 from bottom
for "professional" read "profession"
Page 45, col.2, line . from bottom,
(i) for "deen" read "deem"
(ii) for "discuss" read "dismiss"
Page 46, col.1, line 8, for "tempoorry" read "temporary"
Page 47, line 12, for "Ch. Hari Ram Makkasar Codara"
read "Ch.Hari Ram Makkasar Godara"
Page 49, col.2, line 6 from bottom
for "treatd" read "treated"

Page 57, col.2, line 1, for "Medicial" read "Medical"
Page 60, col.2, line 6 from bottom,
for "boarder" read "border"
Page 70, col.1, line 16 from bottom,
for "thiuk" read "think"
Page 79, col.2, line 2 from bottom,
for "caict" read "cannot"
Page 80, col.2, line 27, for "Mediceal" read "Medical"
Page 87, col.2, line 8, for "Wtness" read "witness"
Page 91, col.2, line 4 from bottom
for "recommendtions" read "recommendations"
Page 93, col.1, line 19 from bottom
for "adidtion" read "addition"
Page 95, col.2, last line from bottom
for "phrace" read "phrase"
Page 97,
(a) col.1, (i) line 30, for "paient's"
read "patient's"
(ii) line 35, for "radily" read "readily"
(b) col.2, line 3, for "divulge" read "divulge"

Page 105, col.1, line 7 from bottom,
for "psychiarist" read "psychiatrist"
Page 110, line 15, for "Shri K. haamurthy"
read "Shri K. Hamamurthy"
Page 11-, col.1, line 7, for "phychiatric"
read "psychiatric"
Page 114, col.1, line 6 from bottom
for "Scheduule" read "Schedule"

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JOINT COMMITTEE ON MENTAL HEALTH BILL, 1978

COMPOSITION OF THE COMMITTEE

Dr. Sushila Nayar—*Chairman*

MEMBERS

Lok Sabha

1. Shri Subhash Chandra Bose Alluri
2. Dr. Baldev Prakash
3. Shri K. B. Choudhari
4. Shri Anant Dave
5. Shri Raj Krishna Dawn
6. Ch. Hari Ram Makkasar Godara
7. Shri Harikesh Bahadur
8. Shri S. Jaganathan
9. Shri Kacharulal Hemraj Jain
10. Shri Hukam Chand Kachwai
11. Shri Ramachandran Kadannappalli
12. Dr. Bapu Kaldate
13. Shri Rajshekhar Kolur
14. Dr. Sarojini Mahishi
15. Shri Mallikarjun
16. Dr. Bijoy Mondal
17. Shri S. G. Murugaiyan
18. Shri T. A. Pai
19. Shri K. Ramamurthy
20. Shri Rudolph Rodrigues
21. Dr. Saradish Roy
22. Shri Sakti Kumar Sarkar
23. Shri Shrikrishna Singh
24. Shri H. L. P. Sinha
25. Shri Suraj Bhan
26. Shri N. Tombi Singh
27. Shri Jagdambi Prasad Yadav
28. Shri Yuvraj
29. Shri Raj Narain

Rajya Sabha

30. Shri R. D. Jagtap Avergoankar
31. Shri G. C. Bhattacharya
32. Shri Swami Dinesh Chandra

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34. Shri Krishna Nand Joshi
35. Shri Robin Kakati
36. Shri Ibrahim Kalaniya
37. Shri Maqsood Ali Khan
38. Shri B. V. Abdulla Koya
39. Shri Khyomo Lotha
40. Shri Harekrushna Mallick
41. Shri Kalraj Mishra
42. Shrimati Purabi Mukhopadhyay
43. Shrimati Noorjehan Razack
44. Shrimati Ushi Khan
45. Shri Bhagwati Charan Varma

SECRETARIAT

Shri Y. Sahai—*Chief Legislative Committee Officer*

LEGISLATIVE COUNSEL

1. Shrimati V. Ramadevi, *Joint Secretary and Legislative Counsel*
2. Shri Y. P. Sud, *Assistant Legislative Counsel*

REPRESENTATIVES OF THE MINISTRY OF HEALTH AND FAMILY WELFARE

(DEPARTMENT OF HEALTH)

1. Shri K. P. Singh, *Additional Secretary*
2. Dr. J. S. Neki, *Advisor and Director, Post Graduate Institute of Medical Education and Research, Chandigarh*
3. Shri R. K. Singhal, *Joint Secretary*
4. Dr. I. D. Bajaj, *Additional Director-General of Health Services.*
5. Shri Anand Prakash Atri, *Deputy Secretary*

WITNESSES EXAMINED

Sl. No.	Name of Association, Organisation Psychiatrist etc.	Date on which evidence taken	Page No.
1	2	3	4
1.	Federation for the Welfare of the Mentally Retarded (India), New Delhi.	3-11-1978	2
	Spokesmen.		
	(i) Shri G. B. Pai—Vice President		
	(ii) Shri K. N. Bhat—Advocate		
2.	Dr. Deva Prasad Sen Mazumdar, Associate Professor & Head of the Department of Psychology, Ex-President, Indian Association of Clinical Psychologists, Central Institute of Psychiatry, Kanke, Ranchi.	3-11-1978	2
3.	Delhi Association of Clinical Psychologists.	3-11-1978	19
	Spokesman:		
	Dr. S. Dube, Assistant Professor of Clinical Psychology, All India Institute of Medical Sciences, New Delhi.		
4.	Indian Association of Clinical Psychologists, Lucknow . . .	3-11-1978.	19
	Spokesmen:		
	(i) Dr. S. B. Singh, President		
	(ii) Shri R. Kishore, Vice President		
	(iii) Shri Ram Akshaibat Yadav, General Secretary		
	(iv) Shri M. V. Singh, Special Member		
5.	Dr. Narendra N. Wig, Professor and Head of Department of Psychology, Post Graduate Institute of Medical Education and Research, Chandigarh.	4-11-1978	23
6.	Dr. B. M. Dabholkar, Director, Kripmayee Nursing Home and Honorary Lecturer Miraj Medical College, Miraj.	4-11-1978	33
7.	Dr. Shanti Sheth, Consultant Psychiatrist, Bombay . . .	4-11-1978.	40
8.	Dr. C. K. Parikh, Medico Legal Consultant, Corresponding Member (Forensic Pathology) American Academy of Forensic Sciences, Bombay.	5-11-1978	49
9.	Dr. K. C. Dabe, Consulting Neuro-Psychiatrist, Sr. Medical Superintendent (Retd.), I/C. Research Unit Mental Hospital, Agra.	5-11-1978	54
10.	Dr. S. S. Jayaram, Consultant Psychiatrist, Bangalore Nursing Home, Bangalore.	5-11-1978	64

JOINT COMMITTEE ON MENTAL HEALTH BILL, 1978

RECORD OF EVIDENCE TENDERED BEFORE THE JOINT COMMITTEE ON THE MENTAL HEALTH BILL 1978

Tuesday, the 3rd October, 1978 from 11.00 to 13.00 hours and again from 15.00 to 16.00 hours

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PRESENT

Dr. Sushila Nayar—*Chairman*

MEMBERS

Lok Sabha

2. Shri Anant Dave
3. Ch. Hari Ram Makkasar Godara
4. Shri Harikesh Bahadur
5. Shri S. Jaganathan
6. Shri Kacharulal Hemraj Jain
7. Shri Hukam Chand Kachwai
8. Dr. Bapu Kaldate
9. Shri Rajshekhar Kolur
10. Dr. Sarojini Mahishi
11. Shri Mallikarjun
12. Shri S. G. Murugaiyan
13. Shri K. Ramamurthy
14. Shri Rudolph Rodrigues
15. Shri Sakti Kumar Sarkar
16. Shri Shrikrishna Singh
17. Shri H. L. P. Sinha
18. Shri Suraj Bhan
19. Shri N. Tombi Singh
20. Shri Jagdambi Prasad Yadav

Rajya Sabha

21. Shri G. C. Bhattacharya
22. Shri Krishna Nand Joshi
23. Shri Robin Kakati
24. Shri Ibrahim Kalaniya
25. Shri Maqsood Ali Khan
26. Shri B. V. Abdulla Koya
27. Shri Khyomo Lotha
28. Shri Harekrushna Mallick
29. Shri Kalraj Mishra
30. Shrimati Purabi Mukhopadhyay
31. Shrimati Noorjehan Razack

32. Shrimati Ushi Khan

33. Shri Bhagwati Charan Varma

SECRETARIAT

Shri Y. Sahai—*Chief Legislative Committee Officer.*

LEGISLATIVE COUNSEL

1. Shrimati V. S. Rama Devi — Joint Secretary and Legislative Counsel.

1. Shrimati Y. P. Sud—*Assistant Legislative Counsel.*

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1. Shri K. P. Singh—*Additional Secretary*
2. Shri R. K. Singhal—*Joint Secretary*
3. Dr. I. D. Bajaj—*Additional Director-General of Health Services*
4. Shri Anand Prakash Atri—*Deputy Secretary.*

WITNESSES EXAMINED

I. Federation for the Welfare of the Mentally Retarded (India) New Delhi.

1. Shri G. B. Pai—*Vice President.*
2. Shri K. N. Bhat—*Advocate.*

II. Dr. Deva Prasad Sen Mazumdar—*Associate Professor and Head of the Department of Phychology, Ex-President, Indian Association of Clinical Psychologists, Central Institute of Psychiatry, Kanke, Ranchi.*

III. Delhi Association of Clinical Psychologists.

Spokesman:

Dr. S. Dube—*Asstt. Professor of Clinical Psychologist, All India Institute of Medical Sciences, New Delhi.*

IV. Indian Association of Clinical Psychologists, Lucknow.

Spokesmen:

1. Dr. S. B. Singh—*President*
2. Shri R. Kishore—*Vice-President*
3. Shri Ram Akshaibat Yadav—*General Secretary*
4. Shri M. V. Singh—*Special Member.*

MR. CHAIRMAN: Gentlemen, I am sorry, I am a little bit late.

SHRI G. C. BHATTACHARYA: We want to bring to your kind notice that from tomorrow we are having Janata Parliamentary Party meeting for three days but it is important that we should not miss the committee meetings. So, Mr. Chairman, if you kindly agree and if the hon. friends also agree, we may meet every day from 8 to 10 in the morning and thereafter we can go to the Party meeting. Otherwise it will be very difficult for us.

MR. CHAIRMAN: I agree with you. I am myself in a dilemma over this. But you must understand that almost 50 per cent or so of the members do not belong to the Janata Party and they are not willing to change the

dates that were fixed long before the Janta Parliamentary Party meeting was called. Even if they are willing to accommodate us to the extent that we may meet early, the witnesses have been told to come at 11 O' clock.

SHRI MALLIKARJUN: There is no question of changing the schedule or the time. We are entering into a new atmosphere and the winter is fast approaching. So it will be very difficult for us if you change it from 11 a.m. to 8 or 9 a.m.

SHRI G. C. BHATTACHARYA: Just that will enable us to participate in the party meeting.

SHRI MALLIKARJUN: There is no question if any party meeting or any such thing. Since you have referred to it, I mentioned it. Please do not bring in any party things here.

SHRI G. C. BHATTACHARYA: I am only saying certain facts.

SHRI MALLIKARJUN: If you are so keen and interested in participating in the proceedings of the Party, you are welcome to go there and you can be absent here.

SHRI G. C. BHATTACHARYA: What my friend is saying is quite all right, but it should be reasonable also.

SHRI MALLIKARJUN: What is unreasonable is for the Chair to say.

SHRI G. C. BHATTACHARYA: What we are saying is only this much. If you insist, then let us meet for certain fixed hours. Of course, today witnesses might have come but this request is only for tomorrow and the other two days.

The witnesses may be requested to accommodate and what my hon. friend is saying is not reasonable. After all we did not know that our committee will be meeting.

SHRI MALLIKARJUN: The witnesses may be prepared to adjust themselves but we are not prepared to adjust.

MR. CHAIRMAN: Mr. Bhattacharya, I also belong to the Janata Party and I would like to be present in these meetings. Yet, I find that these witnesses are coming from outside. One person is to come tomorrow from Lucknow and the other person is coming from Meerut. Another person is coming from Pantnagar. Now they have been given a certain time. I have no way of getting in touch with them and informing them of the change of hours. Therefore, we will go to the Janata Party meetings to the extent we are free from these meetings and I do not think it will be possible to change the schedule of these meetings much as I would like to do it in my own interest and in the interests of my colleagues from the Janata Party, we are in a fix.

SHRI G. C. BHATTACHARYA: It means you want to deprive the Janata Party members of their effective participation in the Select Committee which will be doing injustice to them.

SHRI S. K. SARKAR: We have seen so many committee meetings but we have not seen that hurry that we see here that you are going to finish it in 3-4 days' meetings.

SHRI RAJSEKHAR KOLLUR: Please do not try to impose your decision on other members. The refrence made by Mr. Bhattacharya is very bad.

SHRI S. K. SARKAR: That is not the point. We are submitting to you to consider it.

SHRI RAJSHEKHAR KOLLUR: Don't you have any consideration for other members who have come from their places. So, we have to waste our time? We do not want to be at your mercy. We cannot tolerate this.

SHRI G. C. BHATTACHARYA: But you are getting two hours every day.

SHRI ABDULLA KOYA: Madam Chairman, having summoned all these witnesses from different parts of

India, it would not look nice if we make any change now. It will rather tell upon the reputation of our committee before such eminent people. Therefore, we should adhere to the programme already arranged.

SHRI G. C. BHATTACHARYA: I only wanted the adjustment of the timing of the meetings but not postponement.

MR. CHAIRMAN: But how can you inform them?

SHRI G. C. BHATTACHARYA: They will be in the capital.

MR. CHAIRMAN: I do not have their addresses. I do not know where they are staying. They have not furnished us with their addresses. For the sake of our party meeting, if you want to adjust these things I do not think it will be a good precedent ome others may say in the next meeting, 'we have our party meeting, so please change the timings.'

SHRI G. C. BHATTACHARYA: These are genuine things. I do not know how can any motive be imputed here? We are expressing our genuine difficulties.

SHRI MALLIKARJUN: I do not know what is the meaning of genuine difficulties. We will give him a free hand to go and attend the party meeting and you can take advantage of the intermediate journey facility also.

SHRI G. C. BHATTACHARYA: Almost half of the members of the Committee would like to participate in the party meeting also. It is a reasonable request. You may accede to the request. We do not want postponement, we only want shifting of the time a little earlier from 11 to 8 a.m. and if necessary, in the evening also. Otherwise. you will be denying the right of Janata Party members to participate.

MR. CHAIRMAN: They will be meeting according to the circular from 9 a.m. to 6 pm. What will be the exact hours—I do not know.

SHRI HARIKESH BAHADUR: 10.30 a.m. to 1 p.m. and then 3 to 6 p.m.

SHRI MALLIKARJUN: From 10.30 a.m. to 11 hours you can attend and from 5 to 6 p.m. we will attend. Within that time you can contribute to party meeting.

It will be a very bad precedent if the Select Committee were to adjust itself according to the convenience of the individuals.

SHRI G. C. BHATTACHARYA: This sort of thing has happened in earlier times also. We have postponed meetings. It is not a new thing. This is unforeseen.

MR. CHAIRMAN: May I say this to you? The hon. Minister for Health has requested us that we may change the schedule because they have called meetings of the Central Health Council and we have had to regretfully say that we could not change the schedule because there are half a dozen committees and it will be very difficult to change the dates. Unfortunately we have no control over the meetings of the other people. These party meetings have been fixed from 4th to 6th. They are extremely important and I have no doubt in my mind. At the same time, the fact remains that we are not in a position to change the dates or the timings of the Joint Select Committee meetings for the simple reason that we have informed these witnesses coming from all-over India. May I further say that we are at present taking evidence from these parties; the record of the evidence will be available for all those hon. Members who wish to see it? They may go over it and know that for themselves as to what anybody has said before us. I go further and say that if anyone wants a cyclosyled copy of the evidence will be supplied to him. You may go through it

leisurely and you may know what the witnesses have said. In the light of it, you can formulate your own amendments. I may tell you that this is not a Clause-by-Clause Consideration in which all of us have to be present.

SHRI G. C. BHATTACHARYA: Let me tell you one thing. After all this is a Select Committee before whom the experts give evidence and we may want to have some clarifications from those experts. It is not enough that we go through the record of evidence. We have already seen their written opinion circulated to us. When they are tendering evidence before the Committee we would like to seek some clarifications from the learned witnesses. What we want from the hon. Members of this Committee is that they may be pleased to adjust the timings of the meetings.

SHRI MALLIKARJUN: Those members who are interested in examining the witnesses may remain present—not all the members should put questions at the same time while examining the witnesses.

SHRI G. C. BHATTACHARYA: Everybody is not interested.

SHRI MALLIKARJUN: Once the Select Committee has fixed its business how can you expect it to adjust the timings? You should be firm.

SHRI G. C. BHATTACHARYA: We do not want to quarrel or enter into discussion on this.

SHRI MALLIKARJUN: For the convenience of the party you want to adjust these things.

SHRI G. C. BHATTACHARYA: Why do you get mentally upset?

SHRI MALLIKARJUN: It is not a question of my mental upset. Here the principle is involved. What I am stating here is absolutely rationale and reasonable.

MR. CHAIRMAN: May I request the hon. Members not to have seprate conversations ?

SHRI MALLIKARJUN: This cannot be changed for your sake.

SHRI G. C. BHATTACHARYA: You ignore us. There are several other hon. Members who are Members of the Janata Party who want to go and participate in the meetings.

SHRI MALLIKARJUN: If they want to go and participate there is no bar on that. Mr. Bhattacharya, you should know that we are sitting here for seven days or so. I would like to be present here.

MR. CHAIRMAN: Will you please stop this? I have heard your views. Please leave it to us to see if there is any possibility of any adjustment that we could make.

SHRI MALLIKARJUN: There is a least possibility of adjustment.

MR. CHAIRMAN: Why don't you allow me to speak? It is not fair.

SHRI MALLIKARJUN: I am telling here that there is a least possibility for the adjustment.

MR. CHAIRMAN: Let me finish. I have told you that as for myself I would like to make an adjustment. We have given the timings to the witnesses who are coming form outside—from all over India. We have no idea as to where they will be staying when they come to Delhi; unless they contact us, we have no way of intimating to them any change of timings. In view of the strong opposition by the non-Janata Party Members, I wonder if it is worth making this effort without a likelihood of our succeeding in making the change. All that I can say is this. Let us proceed to-day. I was hoping that the party meeting would be from 9 to 11 so that We could at least be there for two hours and then we come over here.

SHRI MALLIKARJUN: You may make a request that the party meeting might commence from 9 O'clock and then it will be possible for you to come and attend this meeting.

MR. CHAIRMAN: Please do not give the advice unsought for. Let us proceed.

SHRI MALLIKARJUN: I am not trying to give you any advice. You must understand that I am absolutely a non-entity to give you any advice.

MR. CHAIRMAN: You go on irritating other members by going on talking.

SHRI MALLIKARJUN: If they get irritated in what way I am responsible for it?

MR. CHAIRMAN: Let us proceed. Shall we call the witness? Before I call the witness, let me make it clear. Those who wish to ask any question will be free to do so. You may do so by asking a brief question. May I further request that we are fortyfive in number on this Committee. It is not necessary that everyone of us should ask a question from every witness. I request that you should not ask the same question. The question asked by another Member should not be repeated. With this request I now ask the office to please call for the witnesses.

1. SHRI G. B. PAI

1. SHRI K. N. BHAT

(The Witnesses were called in, and they took their seats).

MR. CHAIRMAN: Mr. Pai and Mr. Bhat, I, on behalf of this Committee, welcome you both and express my gratitude that you have come here to give evidence before this Committee. There is a small formality which I must mention at this point. That is, I would like to make it clear to you that your evidence shall be treated as public and is liable to be published unless you specifically desire that all or any part of the evidence given by you is to be treated as confidential. I will also like to explain to you that even though the evidence is desired to be treated as confidential, such evidence is liable to be made available to the Members of Parliament. It cannot be kept confidential from Members of Parliament. Members will be free to make use of your evidence and you should be prepared for that. Having said that I would request you to please go ahead and let us know whether you wish to say anything. You have sent your memorandum. I think you have sent your memorandum No. 3. That is regarding mentally retarded people. You are representing the Association for the mentally retarded. You may briefly state what you wish to say and then hon. Members will put brief questions to you which, I hope, you will be good enough to reply.

SHRI G. B. PAI: Madam Chairman and hon. Members, we are both greateful to you for the opportunity given to us to come and give evidence before this august Committee.

The statement I wish to make is very brief and that is the inclusion of mentally deficient and retarded persons in this Mental Health Bill. The point I am making here is that mentally retarded and mentally deficient people are not suffering from any disease. They cannot be cured by psychiatric treatment which the Bill contemplates. The mentally deficient people are born with less intelligence than other normal people. In other words their IQ is lower. This is a disability and not disease.

The mentally retarded are assessed to be 3 to 5 per cent of the population. That means these unfortunate people are 18 to 25 million of the Indian population. The Bill contemplates segregation, namely, putting them into institutions and trying to cure them.

MR. CHAIRMAN: May I clarify? The Bill does not contemplate that

they should be put in institutions for treatment. What the Bill priveds is that as of today, there is no separate Bill for the mentally retarded. If there is a mentally retarded person witout anybody to take care of him, then somebody may bring such a person to a mental Hospital and that person need not be refused admission by the institution. There is no intention that they should be necessarily segregated and put in the institutions.

SHRI G. B. PAI: Even then I say that there should be a separate all-inclusive Bill provisions of which may require a different type of handling of the retarded persons. As far as a retarded person is concerned what he requires is special training and some rehabilitation. There should be training in simple avocation and assimilation in the society.

Madam Chairman, this is provided in Article 46 of the Constitution of India where it talks of weaker sections of society. 'Weaker sections' is a very wide term. Considering the number of these retarded in this country it is our social duty to pass legislation with a view to protect and assist these people. Legislation should mainly deal with some sort of specialist education, training and teaching them repetitive and simple vocations and then rehabilitating and assimilating them in the society. If you were to treat these mentally retarded with mentally ill people that will be doing great injustice to this class of people. International conventions have been held on this subject both in Rome and Manila. With your permission may I pass one copy thereof.

SHRI K. N. BHAT: Apart from endorsing every word which my friend has stated, I would like to make some suggestions in the Bill itself on the basis that you are agreeable to leave out the mentally retarded from the ambit of the proposed enactment. The definition in Clause (2m) includes mentally deficient, mental sub-normality, etc. and such other like thing as may be prescribed. The word 'prescribed' means as prescribed by rules. As a lawyer I suggest that this is very defective. By way of subordinate legislation you cannot give power to State Government to define what mental illness is. It has got serious consequences. A particular State in India may prescribe 'a' illness as mental illness which the other State may not do. This has got particular significance because once a person is brought within the definition of mental illness so many consequences happen notwithstanding the very good intention behind the law. I say with greatest respect to this august body that this has a potential mischief in the Act which we must avoid. As I have already pointed out in a note to the Chairman of the Federation in furtherance of this good intention we may not unwittingly bring another MISA. I say this with all sense of responsibility. Since you are in the process of making a law, I request that this aspect may be considered by you.

MR. CHAIRMAN: Rules are to be framed by the Government of India in consultation with State Governments.

SHRI K. N. BHAT: You may please see Clause 97. It is provided that the State Government may by notification in the official gazette make rules for carrying out the provisions of this Act.

AN HON. MEMBER: It is a contradictory feature.

MR. CHAIRMAN: You want that there should be one set of Central rules.

SHRI K. N. BHAT: In respect of Mental Health, let India have one standard. That is our submission.

My next point is this. Here you recognise only one class of professional, the psychiatrists. I have had discussion with people in the field. I learn that psychiatrists have no more greater role to play than the ophthalmologist, in a blind school, for instance.

They just need ordinary medical practitioners.

MR. CHAIRMAN: You have started by saying that mental retardation may be taken out.

SHRI K. N. BHAT: In case you don't accept that this will be stressed. If once you decide to take it out, then, I have nothing further to add. I will say, I am extremely obliged to this Committee; and I will say thank you very much. But in case you are not able to do that, this is the suggestion that we are making. You have got a class known as clinical psychologist. There are institutions providing specialised training. For example, you have National Institute of Mental Health, Bengalore. They have got Post-Graduate Diploma for people who have passed M.A. in psychology. Diploma is given in the institute. This is useful in any future programme. There are psychiatric social workers from the institute in Bengalore. The Institute provides them the basis for communicating between the institute and the persons concerned. These specialists are not recognised in this Act which we are enacting even as late as 1978. This is our submission. Some State Government may refuse to recognise them under its rule-making authority. We should not be doing something which is only on paper, but which is not based on facts. You have defined psychological hospitals and nursing homes. I am speaking on behalf of the Federation. We have several sheltered workshops and several other centres where some help is available to the retarded. As much training as possible is given to them, so that this may be useful to them in their work. They all have to be now licensed. Clause 2(g) says that the licensing authority may be such officer or authority as may be prescribed by the State Government. I say, when you are making this law, please involve the professional bodies. Please don't leave it to the executive Government. Today one IAS officer may be Health Secretary. Tomorrow he may be posted to Industries Department as its Secretary. You may have another person belonging to Banking and Finance as Health Secretary. You have established bodies and societies like the Medical Council. There are voluntary organisations, who can be of help. You should not treat this legislation just like the Rent Control Act, for instance. This is our submission. The way this is drafted, it seems, the draftsmen think there is no difference between an Act like this and the Rent Control Act. They say the same thing, same rules, same condition saying, 'notwithstanding anything contained in these rules, the State Government may' etc. etc. I say this because the whole world is watching us. I know this because I attended the ASEAN conference for the welfare of the mentally retarded which was held in Bengalore. Certain discussions were held there. We told them that we are in the process of having a legislation in the Indian Parliament. Let us bring about a proper law not just a change and I have stated about this in detail in my note which I have submitted to you earlier. There are certain important provisions. Even in England, after 1959, fifty decisions have come from courts of appeal and even the House of Lords, arising under the Mental Health Act, 1959.

In regard to improper detention, I will give you an example. It happened in England. There was a quarrel between two neighbours. Only lady was fed up with the act of dumping rubbish at the doors of her house by the neighbouring lady. So, this lady next day collected all the rubbish from the area and dumped them at the other's door step. On this, the first lady went to the Police and complained about this. Now the question came whether that lady was to be charge-sheeted and produced before the court. Then a question also arose whether improper detention would involve or whether it was done, all these provisions are there.

MR. CHAIRMAN: Now, we will ask you some questions.

SHRI SAKTI KUMAR SARKAR: Do you suggest that there should be two bills for two separate cases?

SHRI PAI: It is our submission that there should be two separate enactments—one for mentally ill and the other for the mentally retarded because the mentally retarded are not ill. They are just deficient. And what requires is the education of a special nature, training them to suit and rehabilitate them in the society so that they can be usefully employed.

SHRI SAKTI KUMAR SARKAR: You want that both these persons should be treated separately.

SHRI PAI: It is better to have two enactments because they stand on different footing and cover defferent fields.

MR. CHAIRMAN: There has been a feeling that the word mental retardation is not the correct word. Mentally retarded means they are slow to reach the same place. So we should use the word "mental subnormality".

SHRI PAI: That may be correct. I cannot condradict you because you have a special knowledge in this field. I am just a lawyer I agree with the definition that you have just now mentioned. But even then my point is clear because subnormality is not a disease. Subnormality is congenital. Some of us are extremely intelligent, others are average. But both are normal persons. They are not diseased persons. They are unfortunate human beings. They have to be sympathised with.

SHRIMATI PURABI MUKHOPADHYAY: Mentally retarded should not be mixed up with mentally ill persons. Mentally retarded people get a lot of other type of education. We should not club them together. I agree with what they have interpreted and their suggestion.

SHRI MAQSOOD ALI KHAN: So far as the definition regarding mentally ill persons are concerned, do you agree that this bill sufficiently covers the cases of all persons who are mentally ill?

SHRI BHAT: I cannot say whether from the technical aspects this is an adequate definition of mental illness or not. But I think that it must be left to the experts in the field. I would only say, from the lawyers' point of view, that it should not be left to the State Governments to enlarge the definition. What is to be included and also my friend Mr. Pai has suggested, is that instead of words "mental deficiency" and "mental subnormality", perhaps a proviso is added as "provided that it shall not include mentally retarded" I think that in so far as the hon. Member's question whether it fully covers or not, is concerned, the best thing would be to take the assistance of some professors who are dealing with the subject of psychiatry/Psychology.

SHRI MAQSOOD ALI KHAN: According to Section 9 of the Bill, the rule making powers have been vested with the State Governments only, not the Central Government and the State Governments are to follow the advice on matters of health by the Health Boards and by the Experts. The fear is that the State Government will rather have such a definition that a person who is innocent or a person who is not mentally ill, is put in the hospitals or in clinics.

SHRI BHAT: I think it is too late to think of it. I suggest very respectfully that we should not leave it to the discretion of an executive Government more than what is actually needed. Let me say that if the hon. Members of Parliament and the representatives of our country have enacted the provisions like 31-D regarding anti-national activities and giving powers to ban to them, I would not be surprised if a day comes when the mental illness is defined and enlarged and lawyers wearing black coat are treated as mentally ill. So, my respectful submission is please do not give the powers to the executive Government or the State

Government to declare somebody as mentally ill.

SHRI G. C. BHATTACHARYA: I totally agree that the definition cannot be left to people doing subordinate legislation. I have not come across any instance where the job of definition in a Central law was allotted to others—i.e. powers given to the State governments either to enlarge or add to it. That is the basis. When you are laying some foundation for something, you cannot leave it to subordinate legislation or to State governments. He may be saying something, but it does create anomaly and contradiction. If you leave the very basis viz definition to the State Governments, how can you have uniformity?

MR. CHAIRMAN: Whatever opinions hon. Members have, we will discuss them amongst ourselves when we take up clause-by-clause consideration. We should not now take up the time of the witnesses.

SHRI HAREKRUSHNA MALLICK: Can we not deal with mental illness and mental retardation as two separate subjects, in two different bills?

SHRI PAI: I have already answered the question. I said it covered two different fields.

MR. CHAIRMAN: You say that two separate Acts are better.

SHRI RUDOLPH RODRIGUES: Our witnesses have rightly objected to the words 'deficiency' and 'sub-normality'. There is another phrase which is equally dangerous—which they have not looked at, viz. "or any disturbance in his behaviour or mental state."

SHRI PAI: I agree. I am most grateful.

SHRI RAJSHEKHAR KOLUR: In clause 9 it is said that the assessing authority means such officer or authority as may be specified. You have given the example of one IAS officer being posted to different departments. Don't you think that it would happen thus, viz. as private individuals they might be running institutions where they would give employment only to some communities. For example in Karnataka, you have the syndicate Bank and the Canara Bank, where jobs will not be given to others.

SHRI BHAT: Madam Chairman, it is for you to consider my suggestions. Of course, it is not relevant for me to defend Syndicate Bank and the Canara Bank. Even there, more than 60 per cent of the people working are from all over India.

SHRI MALLIKARJUN: I would like to have a clarification, or a proper interpretation of the terms psychogenesis, psycho-neurosis, mental illness and lunacy. If you make a comparison, we will be in a position to think about the comments that have been given to the Committee.

MR. CHAIRMAN: The witnesses represent the Association of the Mentally Retarded. They would not be able to answer this.

SHRI MALLIKARJUN: Since they have made asuggestion viz. to formulate a separate legislation, and since they may probably also give an amendment, they may be able to do this. Because of certain genetic imbalances, there is a certain lack of development in the brain. Psycho-genesis is the thing which affects the perfect development of the brain. But here, we have linked them. Do you want people affected by mental illness, mental retardation or subnormality due to genetic deficiency, in whatever form it is, to be kept completely away from the environment of luffatics and psychiatric patients? You have been speaking about a separate legislation. It is difficult to understand it, unless you draw a complete contrast between these 3 terms. Lunacy is caused by a certain environment, so also psychoneurosis etc. This Bill pertains to mental illness or subnormality. What you have been trying to impress this Committee is that in the case of this

mental subnormality, we can give some training, which they can pick up. But if they are kept in a psychiatric nursing home, they will have a different kind of environment. Can you elaborate on this?

SHRI PAI: I am most grateful. I did not make the point clear. The point is well made. The real, important point is about the environment in which these children or adults who are mentally retarded are given training and are brought up. To put them with people who are really mentally diseased, means that a normal person, because of supervening circumstances, becomes ill. That is the main argument of the Act. A lunatic person becomes so, because of various tensions and pressures of life. His normal brain may stop functioning. It would be a great harm to the children or adults. That is a very well made out point. I must asknowledge gratitude.

DR. SAROJINI MAHISHI: The representative of the federation said that it was too late for them to say whether the State Government was going to define in this way and all that. Did he mean it was too late to say or too early to say?

SHRI BHAT: In this Committee I can express my views as frankly as I can. I just said: I cannot trust.

SHRI S. K. SARKAR: You had mentioned that the State Governments had only the executive power. You mean to say that they have no power to legislate.

SHRI BHAT: Any executive head takes this power from the State Government. You see rule 97. I do not bring any particular State or present Government or the future Government because from 1912 we have got a law dealing with the lunatics. We can more or less admit it because these things are very rarely receiving the attention of the Government. This type of law very rarely gets the attention of the Government.

SHRI S. K. SARKAR: Have you come across any example in your life where the executive misused the old Lunatic Act for his own purpose?

SHRI BHAT: One of the things I had earlier quoted from the English Law. Here I have not made any detailed study. But we do come across some cases. For example, everybody knows that the children of the rich men normally say that their fathers are made. What is the test of madness? I would again say that this has been misused on a number of occasions in one way or other.

श्री सुबत चन्द्र बख्शायी : जैसा आपने अभी बताया कि न्यायपालिका, राज्य सरकार पर नहीं छोड़ना चाहिये यह प्रमाण-पत्र देने के लिये कि यह पागल हो गया है, बल्कि इसको केन्द्र के हाथ में रखें। तो यह संदेह है इसलिये कह रहे हैं या कोई वास्तविकता भी है इसमें ?

SHRI BHAT: We must avoid it.

SMT. PURABI MUKHOPADHYAY: In the case of tumour or something like that, if anything goes wrong, the person becomes helpless, he loses control over his limbs. His brain does not function. Will you include those cases, post-surgery cases in that category as mentally ill?

MR. CHAIRMAN: There are cases which are not considered as mentally retarded or mentally deficient but they become so as a result of surgery or any other accident. Would you include them in the mentally retarded category?

SHRI PAI: We would include them.

श्री सुबत चन्द्र बख्शायी : यह जो कहा जाता है कि यह पागल है, यह न कह कर मानसिक पीड़ा से पीड़ित है यह शब्द ज्यादा

उपयुक्त होंगे, या पागलपन ज्यादा उपयुक्त होगा, इस सम्बन्ध में आपका क्या मत है ?

SHRI BHAT: The word 'pagal' equivalent to lunatic is not being used in the definition. So, the question does not really arise. In the old Act of 1912, there were words like lunatics and idiots. Such expression was defined there. It is not here.

सभापति महोदय : इस वक्त तो कोई पागल शब्द ही इस्तेमाल नहीं हो रहा है, न लूनैटिक हो रहा है। अभी तो मानसिक रोग से पीड़ित की चर्चा है।

श्री हुकम चन्द कछवाय : आज सारे देश में जो चल रहा है कि पागलों का सवाल, इसे बन्द करने के लिये कोई विशेष व्यवस्था करेंगे क्या ?

यह बिल तो इसीलिये है।

MR. CHAIRMAN: Thank you very much for taking the trouble of coming over here and assisting the Committee. Let us adjourn for tea. You are also welcome to join us. During tea the Members may also clarify their minor doubts from the witness. I would like to inform the hon. Members that the second witness has not been able to come. He will come at 3 P.M. So, after the tea we will adjourn the meeting and will meet at 3 P.M.

(The Committee then adjourned)

II—Dr. Dev Prasad Sen Mazumdar

(The witnesses was called in, and he took his seat).

MR. CHAIRMAN: Dr. Mazumdar, I am glad to welcome you on behalf of this Committee. It is very kind of you to have come here and spared some time to appear before this Committee to help us. There is a small formality which I will now perform.

I would like to make it clear to you that your evidence shall be treated as public and is liable to be published, unless you specifically desire that all or any part of the evidence given by you is to be treated as confidential.

I would also like to explain to you that even though you might desire your evidence to be treated as confidential such evidence is liable to be made available to Members of Parliament. It will not be confidential for them. Now, you have sent us your memorandum. To refresh the memory of the honble Members would you like to repeat its salient features?

DR. MAZUMDAR: Thank you, Madam Chairman.

Any kind of enactment depends on the social aspirations and what Nani Palkhiwala wrote in the Illustrated Weekly of India it crystalises the hopes and aspirations of the people. We are calling it Mental Health Bill. Unfortunately, in this Bill we have not explained mental health but only mental illness. Mental illness is not an ordinary illness. For example, when you call a person abnormal there is no absolute yardstick about that. In other words what may be called abnormal behaviour in America may not be called so in India. There is no universal criteria. Much depends on our social expectations and social conventions. There are no absolute yardsticks. These are all social expectations, norms, etc. which are codified or not codified depending on the expectation of the community or society at large.

मेरा कहने का मतलब यह है कि वास्तविक रूप से ठोस रूप से इसका कोई मतलब नहीं है सिर्फ इसी चीज को कि मैंटली एबनार्मलिटी हो, एक संस्कृति से दूसरी संस्कृति में चलाये या जिन्दा रहे तो उसके साथ साथ मैंटल हैल्थ की परिभाषा भी बदलती रहती है।

The present Bill has overlooked the obvious contributions and ex-

ceedingly important role of clinical psychologists as they find no mention anywhere in the Bill. The present Bill is, therefore, highly discriminating and unfair by ascribing absolute authority to medical officers, medical attendant and psychiatrist to the total exclusion of clinical psychologists. If it can be done in a conservative country like U.K.—where certain traditions counts more than other countries—there is no reason why in our Bill clinical psychologists who have contributed so much cannot be included.

Lastly, Madam Chairman, I would like to say a few words about civil rights.

मान लीजिये किसी का पेट खराब हो जाये तो उसको किसी इंस्टीटयूशन में भर्ती नहीं कर लेता है। सिविल राइट चला नहीं जाता है। अगर मान लीजिये किसी की दिल की धड़कन हुई, तो उसका सिविल राइट चला नहीं जाता है।

If you look in the Bill large part is about detention of mental illness patients. There is a tremendous world-wide movement about misuse of mental hospitals. It hardly needs reminding that it will be misused in crushing civil rights and human rights by sending dissident intellectuals, artists and scientists to psychiatric hospital and nursing homes. These hospitals are used for certain other purposes. We have also seen in the newspaper reports what has happened in some of the East European countries. The matter has gone to such an extent, particularly infriction of civil rights in 1977 that in December I was in Zurich and the Professor in-charge told me that a Resolution was passed in Honalulu that such inhuman in-question should be stopped.

This was carried by a slim majority vote..

हमारा विवेक क्या कहता है ? यदि इस ढंग का मौका लग जाये किसी भी कंट्री में तो इसको बचाने के लिये हम क्या करना चाते हैं। इन लोगों ने यही समझा कि साइकैट्राक इंस्टीटयूशन्ज का मिस-यूज नहीं करना चाहिये।

I am an Indian citizen and I have seen the whole gamut of transition from democracy to something else and back to democracy, the twists and turns so to say, over the years and over the months. There should be these checks and balances and as I have already submitted. magistrates are not competent authorities in this respect. They administer justice. But they should be helped by those professionals in the line. Our Constitution recognises rights of individuals. This democracy functions in terms of compromise, in terms of advice, in terms of consent and so on. You cannot have any dictatorial powers centered in one profession or one community. These checks and balances should be there so that this Bill becomes an instrument of social welfare and not an instrument of oppression. Thank you, Madam. That is all that I have got to say.

SHRI SAKTI KUMAR SARKAR: You said about checks and balances and you stressed that there should be adequate checks and balances. You said about the misuse of the Mental Health Bill. What are the checks and balances which you think should be taken into consideration? What is your suggestion in this respectc? What is the machinery that you would contemplate for these things?

DR. MAZUMDAR: You have raised an important question and I had a talk with eminent members. I talked with those members who came with your Inspection Group No. I. I have suggested a couple of things. I think they have noted those down. This is regarding admission, discharge and inspection. This is put down in my Memorandum. In Chapter II, I have said, on 6(c) you may substitute line 2, page 5 and put it saying this

will be under the charge of a medical officer who is a psychiatrist or a clinical psychologist. In its present form the provision in the clause is highly discriminatory. It is they alone who are competent to say who is normal and who is not normal. The point is, we have not been consulted right in the beginning.

SHRI SAKTI KUMAR SARKAR: Do you think this Bill will not cover those patients suffering from mental illness? We have given importance to 'mental retardation'..

DR. MAZUMDAR: I think Mr. Kolur also put this question. Please see the provision under (m): It says:

> 'Mentally ill person means a person who is in need of psychiatric treatment by reason of mental disorder or mental dificiency or of any disturbance in his behaviour or mental state and includes a person who has all or any of the clinical conditions known as psychoses, psychoneurotes, psychopathic state addition, mental subnormality or psychosomatic disorder or such other condition of the like nature as may be prescribed.'

The last condition includes everybody, you and me and all. All of us can land ourselves under this definition. I think I have given it in detail in my own memorandum. This is overextended, I said. This is loaded with subjective interpretation and arbitrariness. I said that you may omit 'psychiatric', 'mental deficiency', 'psychopathic state', 'mental subnormality' and the words 'such other conditions of the like nature' etc. I said therein that a separate legislation for mentally handicapped including mental deficiency and mental subnormality will be quite meaningful and proper. I have stated all these things in my memorandum.

SHRI RAJSHEKHAR KOLUR: You are in favour of the views of the professional community. What are your views about one thing which I am going to ask now? Please refer to your own remarks on the major clauses in the Bill, about the bias in favour of the professional community. Will you give us some suggestions on this point?

DR. MAZUMDAR: I think I can be quite frank with you. At the first round of things we are not at all consulted. That is the point. When this Bill was thought of, we have not been consulted. We are actively associated with research and the rest of it. We have all India standing. We did not get even a copy of the Bill but hon. Chairman Dr. Sushila Nayar was kind enough to send us a copy of the Bill, asking us to send our suggestions within 7 days. At that time the Institute was running the examination. But somehow we could do it. At least some professionals could have been consulted. The point is that we have to make a number of changes here and there. We definitely suggest that there should some major changes like the one page 2 (J), it has been mentioned "a medical officer incharge". I think the word 'medical' should be left out and only 'Officer In-charge' who may be psychiatrist or clinical Psychologist or a Psychiarist social worker. So, you will find that the animus goes.

SHRI RAJSHEKHAR KOLUR: Here in your Memorandum, it was suggested that you must be consulted before the admission of the patients. Can you tell us at what stage they must consult the experts?

DR. MAZUMDAR: There are three points. As I discussed with Dr. Mandal, I think the timing is important. I think it should be at the time of admission and this should require again changes in the number of places because the Medical Officer Incharge should go and examine and when it is Officer-Incharge, naturally he may

be a clinical psychologist, may be a psychiatrist, or may be a psychiatrist social worker who has enough expertise on the mental health.

SHRIMATI PURABI MUKHOPADHYAY: You have been associated with mental hospitals for quite a long time and you have vast experience in the field. Can you point out what are the loopholes which can be plugged so that those who are not suffering from mental illness or mentally retarded are not taken into custody?

DR. MAZUMDAR: In regard to the admission procedure, it has been clearly mentioned in it, like voluntary admission, admission under special circumstances, admission under necessary orders, admission under emergencies, temporary admission, etc. All kinds of admissions are there. But admissions are qualified if they are voluntary and under the special circumstances, the person has to be produced before a Magistrate an the Magistrate has to judge whether he is mentally abnormal or mentally suffering. For example, we got a reference like this. Sometimes, the court cases come to us. Usually what we do is that we see the patient is independently assessed both by the psychologist and by the pyschiatrist.

SHRIMATI PURABI MUKHOPADHYAY: Do you think that at the stage of remaining the patient, the case must be referred to psychologist or the psychiatrist?

DR. MAZUMDAR: I think that will give you an absolute check. If you say in terms of absolute check, this will work well.

श्री सुरेन्द्र पाल: आपने जो सिविल राइट्स के बारे में कहा और ऐक्सप्लेन किया मैं उससे सहमत हूं। लेकिन यह पिक्चर का एक पहलू है। सिविल राइट्स कुछ लोगों के महफूज रहें इसके लिये कुछ लोगों को डिटेंशन में रखना जरूरी है। क्या ऐसे लोगों को भी ऐडमिशन में न डालें।

डा० मजूमदार : यह तो कहना सही है क्योंकि सिविल राइट्स के बारे में बहुत सी बातें कही जा रही हैं और ह्यूमेन राइट्स के साल में जो यू० एन० ए० को० की तरफ से चला था उसको हमने भी माना। ऐबसोल्यूट टर्म्स पर तो नहीं कहा जा सकता है, लेकिन रिलेटिव टर्म्स पर कहा जा सकता है। यदि आप पूछें कि रिलेटिव का क्या मतलब हुआ तो मैं कहूंगा, जैसा मैंने पहले ही कहा था, कि चैक्स और बैलेंस होना जरूरी है। किसी इंडिपेंडेंट सोर्स से चैक करा लीजिये जिस अथारिटी को आप भेजना चाहते हैं। हमारे यहां क्लीनिकल कानफ्रेंस होती है जिसमें यह जरूरी नहीं है कि साइकोलाजिस्ट और साइकेटरिस्ट दोनों एक मत के हों। लेकिन हम रीकन्साइल करना चाहते हैं।

DR. SAROJINI MAHISHI: I want to know whether you have experienced any difficulty in discharging the patient, after the treatment was over, particularly in the case of those patients who have been referred to by the Magistrate.

DR. MAZUMDAR: I think you have opened the Pandora's Box.

इसके बारे में मैं क्या कहूं, यह तो हमारे लिये बहुत बड़ी समस्या है, अस्पताल में। मरीज ठीक हो जाते हैं. हम लोग भी समझते हैं कि ठीक है, लेकिन घर वाले लोग लेने नहीं आते हैं। और इस बीच में कुछ भी हो सकता है। He might have relapsed, but unfortunately, even though is the Object and Statement of the Bill you have stated, I would like you to refer to the Statement of Objects and Reasons of the Bill. It is mentioned therein that the environment around them should be made as normal as possible.

DR. SAROJNI MAHISHI: A case has been referred to you by a Magistrate. You treat him. After some time, you feel that adequate treatment has been given to the patient, and that

he could be discharged. Do you experience any difficulty in discharging him at that time?

DR. MAZUMDAR: There is a lot of difficulty. In some cases, the family members simply take the patients away. There is a legal point. So far, they have had to execute the bond to take the patients away. When they do it, it is not simply the execution of a bond, but how it should be implemented. But about implementation we are facing difficulties, because there is a backlog. There is a sizeable number of chronic patients who should have gone away, but they are not going.

DR. SAROJINI MAHISHI: What is the way out?

DR. MAZUMDAR: A chapter should be written on social rehabilitation of patients. Most of the work now is concentrated on it, and not on treatment alone.

MR. CHAIRMAN: Her point is that when you say that the patient is all right, does the Magistrate automatically, without any difficulty, accept your advice that the patient should be discharged? Or are there any difficulties from his side?

SHRI SURAJ BHAN: Is your opinion binding on the court?

DR. MAZUMDAR: It is not binding.

MR. CHAIRMAN: In order to admit the patient, there have to be two certificates from the doctors, according to this Act—one of whom should be a psychiatrist. At the time of discharge, is not the Magistrate bound by the advice of the doctors that the patient is all right and can go away? How can the Magistrate refuse such advice?

DR. SAROJINI MAHISHI: Even after the patient has received adequate treatment and even after the expert medical adviser feels that the patient no longer needs to be kept inside the hospital, and the medical adviser makes a reference to the Magistrate accordingly, is there any difficulty experienced?

DR. MAZUMDAR: I think some kind of a legal, statutory provision can be made, enabling the Magistrate to order the family to take the patient back home.

DR. SAROJINI MAHISHI: If you are not experiencing any difficulty in this matter, we need not go into the matter.

MR. CHAIRMAN: There are two things. One thing is that the family is not willing. It is not the fault of the Magistrate. When you say the patient is ready to go, the former will agree with you. will he not?

DR. MAZUMDAR: I think the Magistrate says yes, because of expert opinion.

SHRI RUDOLPH RODRIGUES: The problem is not whether the Magistrate may say yes or no, but that he might not answer for months together. Now about another point: in your memorandum at page 3 in regard to clause 2; you have said that certain things are to be excluded from the definition of 'mentally ill'. You have said that the definition should be re-drafted. You have not given a new definition yourself.

DR. MAZUMDAR: We discussed with the team which came. We suggested that this tautology should be removed; i.e. 'mentally ill persons' meant people mentally diseased. I have to go into a lot of technical details; about the terms psychosis; psycho-neurosis etc. If you like I will do it.

MR. CHAIRMAN: It is all right.

SHRI KRISHNA NAND JOSHI: We had visited your Ranchi hospital. The difficulty experienced by some of the doctors was that 60 per cent of the patients are there, who could have been discharged; but because of some reason or the other, they continue to be there. Do you suggest anything in the Bill to solve this difficulty

DR. MAZUMDAR: I can tell you what is happening at present; so that we can think of a certain resolution. As the Chairman and Dr. Mahishi said; when both the psychologist and the psychiatrist give a clean chit that the patient is in a condition to go; the matter is taken to the Visitors' Board. They also give their opinion; after interviewing the patient for a few minutes. The fact is that the family is written to; but they do not turn up. It is a question of implementation. We send a legal notice. It is never served.

SHRIMATI PURABI MUKHOPADHYAY: Suppose we do a way with the provision that the family must take them back. If a person is all right, he can go away. I also want to do away with the provision to refer against to the Magistrate.

DR. MAZUMDAR: To some extent, it will ease out the difficulty—certainly. The reason for the family not being willing to take the patient back home is the fear of relapses. They ask: in case of a relapse, shall we again get a bed? In that case, things might perhaps become easier—i.e. if the case is an old one, and we say that he may be having a chance of relapse—the patient can be admitted again without going through the Magistrate. If we go through the magisterial part again, it will mean a lot of inconvenience.

MR. CHAIRMAN: There are too many types of admissions. There should be only voluntary admissions and admission under extraordinary circumstances, where the relative or friend or somebody else can bring in the patients. Thirdly, for dangerous cases, compulsory magisterial order for admssion can be there. Do you agree with this point of view? There is provision for emergency admission and there are various kinds of admissions. We should simplify this; and a whole chapter which is there can just be deleted. This idea has been suggested to us.

DR. MAZUMDAR: I think you have made a very important point. The present admission procedure is cumbersome. There is an overlapping also. I made a note of it. You see page 15. You also see para 2, clause 9. I say, yes, it has been made too complicated. We can help to curtail it. This is again by an eminent jurist. We have unfortunately adopted the British model which is far worse than European counterpart. For instance, British Law runs into 92 pages. French Law could be contained in 20 pages. Swedish Law is contained in 13 pages. It can be compressed.

श्री बचकलाल हेब

सामने मुख्य सवाल यह है कि जो लोग अच्छे हो गये हैं उनके परिवार के लोग उन्हें वापस नहीं ले जाते हैं जिसके कारण बैड्स खाली नहीं होते। तो जिनके परिवार ही नहीं है या कुछ परिवार ऐसे हैं जो आज सुधरे लोगों को ले जाने में सक्षम नहीं हैं क्योंकि खुद परिवार के लोगों का पेट नहीं भरता जो मरीज को कहां से खिलायेंगे। तो ऐसी हालत में जैसा हमने देखा शासन के द्वारा उससे ही कुछ लिंक लगा कर उनको बांधा जाय, इस बारे में आपका क्या सुझाव है ? लगातार अस्पताल के नियंत्रण में ही उनके जीवन की देख-रेख हो सके, जिससे अस्पताल भी खाली हो जाये और प्रोबलम भी हल हो जाय। इस बारे में आपका क्या सुझाव है।

डा० मजूमदार : मैंने पहले ही कहा कि जितने प्रोग्रेसिव अस्पताल हैं दुनिया भर में इसी पहलू पर जोर दे रहे हैं कि कैसे आंशिक असमर्थ लोगों को जो भी उनकी समर्थता है उसको काम में लगा कर कैसे रिहैबिलिटेट कर सकते हैं। लेकिन दुर्भाग्य से प्रोबजैक्टिव एक है और बिल दूसरा है। इसीलिये आप जो चाहते हैं उसकी पूर्ति वर्तमान सैक्शन द्वारा नहीं होती है।

सभापति महोदय : हमें समझ लेना चाहिये कि इसमें रिहैबिलिटेशन की जो बहुत बड़ी

जवाबदारी है उसे टालने की बात नहीं है। लेकिन ऐडमिशन में दुरुपयोग न हो सके, उसको मत तरीके से हस्पताल में न रखा जा सके, किस प्रकार के किन हालात में अस्पताल में भेजना है, इसकी चर्चा है, उसकी प्रापर्टी वगैरह का कैसे संरक्षण हो सकता है, इसकी बिल में चर्चा है। रिहैबिलिटेशन का समाज में बहुत बड़ा माल है, उसको कानून में डालने की बात नहीं है।

श्री कृष्णानन्द जोशी : जैसे मैजिस्ट्रेट के यहां से रिसेप्शन आर्डर आता है, और अस्पताल वाले कह देते हैं कि हमारे पास जगह नहीं है, तो वैसी हालत में क्या किया जाय ?

सभापति महोदय : अस्पताल में तो मानसिक रोगी को ही भेज सकते हैं जिसको दो डाक्टरों ने सर्टिफाई किया है। और जब वह डाक्टर कहते हैं कि मरीज ठीक है तो वह डिचार्ज होता है। लेकिन गरीब परिवार मरीजों को लेने नहीं आते हैं और वह नहीं ले जाते हैं जो यह सारा सवाल समाज का सवाल बन जाता है।

SHRI KRISHNA NAND JOSHI: In Dum Dum Jail, there are 900 patients, because they are not put in the mental hospital.

DR. MAZUMDAR: You look at page 13, section 25.

आपका कहना ठीक है। हमें ऐसा ही अनुभव है खास तौर से कलकत्ते में इस तरह की समस्यायें हैं। और वह इसलिये हैं कि :

This is on page 13 of the Bill—Reception orders before Magistrate.

"Every officer in charge of a police station,—

(a) may arrest or cause to be arrested any person found wandering at large within the limits of his station whom he has reason to believe to be so mentally ill as to be incapable of taking care of himself, and

(b) shall arrest or cause to be arrested any person within the limits of his station whom he has reason to believe to be dangerous by reason of mental illness."

यह जो पुराना ऐक्ट है उसी को करीब करीब बोडिली इनको रपोरेट कर दिया गया है।

Now it has become a Pandora's Box. It is very good that you have pointed it out. I have already made a note. I have discussed this clause. Too wide powers have been given.

सभापति महोदय : डेंजरस को तो ले जाना ही चाहिये। लेकिन जो वाण्डर अबाउट कर रहा है कोई ले जाने वाला नहीं है और उसकी मानसिक स्थिति ठीक नहीं है तो उसको भी वह लाते हैं तो उसमें आप क्या करेंगे ? जो डेंजरस नहीं है लेकिन मानसिक रोगी है उसको छोड़ देंगे ?

डा० मजूमदार : हम तो समझते हैं कि यह एक समाजिक उत्तरदायित्व है। क्योंकि वह अभी जेल में सड़ रहे हैं और कमेटी ने वहां जा कर देखा भी है।

सभापति महोदय : रांची वालों की परिस्थिति हमें मालूम नहीं है। मद्रास में हमने देखा जितने उनके यहां हर साल आते हैं उतने ही हर साल जा रहे हैं।

They have made special efforts to send home their patients. So, it depends upon the institute also.

We thank you DR. Mazumdar for having taken the trouble of coming over here and giving evidence before the Committee. We shall bear in mind the things which you had told before us. If there is anything which you would like to add or give by way of suggestions, you may kindly send it to the Committee as early as possible.

DR. MAZUMDAR: Thank you Mr. Chairman and hon. Members of the Committee.

(The witness then withdrew)

III—DR. S. DUBE

(The witness was called in, and she took her seat).

MR. CHAIRMAN: Dr. S. Dube, we are grateful to you for appearing before us. Your evidence shall be treated as public and is liable to be published unless you sepcifically desire that all or any part of it should be kept confidential. Further I may explain that even though you might wish your evidence to be kept confidential it is liable to be made available to the Members of Parliament.

You have sent your memorandum. Would you like to say anything more before the Members ask questions?

DR. S. DUBE: If my memorandum had already been circulated, I will not take up your valuable time.

MR. CHAIRMAN: Your main point is that more emphasis is laid on the medical people, psychiatrist and not on other members of the team.

DR. S. DUBE: There is scope for the members of the team for team work; there are other members of the team besides the psychiatrist; in our country we have already started doing good team work. This Bill is a retrograde step.

MR. CHAIRMAN: It may not be possible to have a team in every place. In some places only one person may be available. Would you wish to say that that one person may be a psychiatrist or a clinical psychologist or a social worker.

DR. S. DUBE: I want that in the Bill itself the team concept should be defined. In many hospitals in India we are having a good team; in future only one psychiatrist will be appointed and the others will be left out; all the others will have no place in the legislative history of India.

MR. CHAIRMAN: If you make it legally binding, then it becomes difficult. In some places there may be a team; in other places there may be one individual. In hospitals where other members are available, it will be for the psychiatrist or the medical officer-in-charge to consult the other members of the team and come to a conclusion.

DR. S. DUBE: We are training clinical psychologists in the same rate; the country is investing a lot of money on them.

MR. CHAIRMAN: We have gone round the country. If you want us through this Bill to force the institutions to employ clinical psychologists and other people when they are not there . . .

DR. S. DUBE: I am sorry if that is the impression. My point is that you have already recognised them; you are investing so much money on them. You are giving them job satisfaction. Then why not include them in the Bill? This Bill is coming in 1978. I was trained in 1957; for so many years I have been working. So, let us include them also. I do not force anything; I only want that there should be a proper place for other people also.

MR. CHAIRMAN: We thank you very much for coming before us and giving evidence before the Committee.

(The witness then withdrew)

IV—1. DR. S. B. Singh
2. Shri R. Kishore
3. Shri Ram Akshaibat Yadav
4. Shri M. V. Singh

(The witnesses were called in, and they took their seats).

(Direction No. 58 was read out to the witnesses).

MR. CHAIRMAN: We have received your memorandum. If you wish

you may highlight any point made therein. You need not read the memorandum. The members would put certain questions and you may answer them.

श्री सूरज भान : आपकी कोई संस्था है, वह क्या काम करती है ।

श्रीमती पूर्बी मुखर्जी : हम जानना चाहते हैं कि एसोसियेशन के बिहाफ पर इनका क्या काम होता है ?

SHRI SINGH: Actually when the profession of clinical psychologists and psychiatrists started, we were very few in number. Our duties and others were not clearly specified. We thought through this association we could reach the people and let them know what exactly we want to do. This was one objective. Another was, for our own inter-communication and having some sort of research orientation, we felt the need of the association.

MR. CHAIRMAN: We are convinced of the utility of the clinical psychologists. I am a medical woman and I know how much clinical psychologists contribute both at diagnostic stage and at a later stage in the care of the mental patients. Clinical psychologists is an important member of the team, of which the psychiatrist is the leader. In some places, there may not be a trained psychiatrist. So, the law says that who is a psychiatrist can be prescribed by the Government. Is it necessary that in the law we should include all members of the team? Is it not enough that psychiatrist, the leader of the team, is there? He can consult other members of the team. Why do you think it is necessary to mention the clinical psychologists in the body of this Bill?

SHRI SINGH: Our submission is that a clinical psychologist can work as effectively as a psychiatrist as the leader of the team. He should also be given the same legal protection by being included in the Bill.

MR. CHAIRMAN: We are not giving any legal protection either to psychiatrists or to psychologists. This is only a Bill to give legal protection to the patients. That is all. How can we go into the professional rivalry as to who is the leader and who is not the leader of the team?

SHRI SINGH: Our only submission is, if the psychiatrist could be there, why not psychologists also? That is all.

SHRI RUDOLPH RODRIGUES: In clause 2(q) psychiatrist hospitals and psychiatrist nursing homes are mentioned. They only want to enlarge the scope of the Bill to include clincial psychological guidance, counselling and so on. That is what they are driving at.

SHRI S. B. SINGH: I think, he has said the same thing.

डा० सरोजिनी महिषी : आपने कहा मैडिकल साइकोलोजिस्ट की एक जगह नहीं है । यह बात ती ठीक है, लेकिन अभी तक पेशेन्ट की दृष्टि से, एडमिनिस्ट्रेशन की दृष्टि से डिसचार्ज करने की दृष्टि से, सेवा की दृष्टि से आपने क्या सोचा है, इसके बारे में क्लिनीकल साइकोलोजिस्ट की तरफ से क्या सोचा है, यह बिल ठीक है या निकाल देना है ।

श्री एस० बी० सिंह : अभी जो हमने अपना मेमोरेंडम भेजा है, उसके अलावा हम यह सोच रहे हैं कि इस बिल में यह भी मैंशन होना चाहिये था कि अभी पेशेन्ट को डिसचार्ज करने के लिये हमारे यहां कोई ऐसी एजेन्सी नहीं है कि उसको फैमिली तक ले जाये । वह भी होना चाहिये । फैमिली के लोग पेशेन्ट को ले जाने से इन्कार करते हैं । इसमें ऐसा कोई प्रावीजन होना चाहिये जिससे हम पेशेन्ट की देखभाल कर सकें । जब तक दोनों यह नहीं समझ लें कि पेशेन्ट ठीक है, फैमिली में एक्सैप्टेबल है, उसको कोई डिफिकल्टी नहीं है, तब तक ऐसी व्यवस्था के लिये इसमें कुछ होना चाहिये ।

. . . . हाफ-वे-होम से बहुत जगह की समस्या सुलझ सकती है ।

सभापति महोदय : लेकिन वह कानून में तो नहीं आ सकते । वह सुविधा अलग से हो सकती है । वह सजैशन हो सकता है जिसको स्वास्थ्य मंत्रालय या दूसरे लोग जो समाज सेवी संस्थाएं हैं, वह उन पर विचार कर सकती हैं, लेकिन कानून में इसको रखने की कोई जगह नहीं हो सकती है ।

श्री एस० डी० सिंह : यह अगर कहीं मैंशन होगा तभी इम्प्लीमेंट होगा, नहीं तो नहीं होगा ।

सभापति महोदय : आपकी सलाह है कि हाफ-वे-होम जैसी संस्थाओं का भी कानून में स्थान होना चाहिये ।

श्री एस० डी० सिंह : जी हां,

If the patient is not willing to go or his family people are not willing to take him, how long we can keep him in the hospital. So, in between some arrangement like half-way-home should be there.

SHRI KISHORE: We have to see the basic problem as to how much the patient has suffered mentally, what sort of rehabilitation should be given, how much personality of the person has been affected. At the time of discharge it is necessary that the patient has to be evaluated psychologically so that proper rehabilitation is made

(The Committee then adjourned)

JOINT COMMITTEE ON MENTAL HEALTH BILL, 1978

Record of evidence tendered before the Joint Committee on the Mental Health Bill 1978

Wednesday, the 4th October, 1978 from 11.00 to 13.50 hours and again from 15.00 to 16.00 hours.

PRESENT

Dr. Sushila Nayar—*Chairman*

MEMBERS

Lok Sabha

2. Ch. Hari Ram Makkasar Godara
3. Shri S. Jaganathan
4. Shri Kacharulal Hemraj Jain
5. Shri Hukam Chand Kachwai
6. Dr. Bapu Kaldate
7. Shri Rajshekhar Kolur
8. Dr. Sarojini Mahishi
9. Shri Mallikarjun
10. Shri S. C. Murugaiyan
11. Shri Rudolph Rodrigues
12. Shri Sakti Kumar Sarkar
13. Shri H. L. P. Sinha
14. Shri Suraj Bhan
15. Shri Jagdambi Prasad Yadav
16. Shri Yuvraj

Rajya Sabha

17. Shri G. C. Bhattacharya
18. Shri Krishna Nand Joshi
19. Shri Robin Kakati
20. Shri Ibrahim Kalaniya
21. Shri Khyomo Lotha
22. Shri Harekrushna Mallick
23. Shri Kalraj Mishra
24. Shrimati Purabi Mukhopadhyay
25. Shrimati Noorjehan Razack
26. Shrimati Ushi Khan
27. Shri Bhagwati Charan Varma

SECRETARIAT

Shri Y. Sahai — *Chief Legislative Committee Officer*

LEGISLATIVE COUNSEL

1. Shrimati V. S. Rama Devi — *Joint Secretary and Legislative Counsel*

2. Shri Y. P. Sud — *Assistant Legislative Counsel*

REPRESENTATIVES OF THE MINISTRY OF HEALTH AND FAMILY WELFARE (DEPARTMENT OF HEALTH)

1. Shri K. P. Singh, *Additional Secretary*

2. Shri R. K. Singhal, *Joint Secretary*

3. Dr. I. D. Bajaj, *Additional Director-General of Health Services.*

4. Shri Anand Prakash Atri, *Deputy Secretary.*

WITNESSES EXAMINED

1. Dr. Narendra N. Wig, *Professor and Head of Department of Psychology, Post Graduate Institute of Medical Education and Research, Chandigarh*

2. Dr. B. M. Debsikdar, *Director Kripmayee Nursing Home and Hony. Lecturer, Miraj Medical College, Miraj.*

3. Dr. Shanti Sheth, *Consultant Psychiatrist, Bombay.*

DR. NARENDRA N. WIG

(The witness was called in, and he took his seat.)

MR. CHAIRMAN: Dr. Wig, on behalf of the Committee, I welcome you and thank you for appearing before the Committee to help and guide us in making this Bill as satisfactory as possible.

As a small formality which I must perform, I would like to make it clear to you that your evidence shall be treated as public and is liable to be published unless you specifically desire that any or all it should be treated as confidential. I would, however, explain that even though you may want it to be kept as confidential, it is liable to be made available to the Members of Parliament. It is no confidential for them because it is for their benefit that this evidence is being recorded.

Now, I would like to ask you whether you would like to make a preliminary statement. I might say that there are two or three things that are bothering us on which we would very much like to have your help. One is the definition of mental illness which, as has been pointed out by a number of people, is unsatisfactory and is to be changed. So, you have to throw some light on the desirability of inclusion of conditions like psychoneurosis, psychopathy and psychosomatic etc. in the definition. And the other is that it is suggested that mentally retarded or mental subnormality is not a disease. It should not be included in this Bill. This is with regard to the definition.

Then, it has been suggested that the admission should be of three types, voluntary type, under extraordinary circumstances, and commitment by the Magistrate in case of unwilling and dangerous patients and all the rest should be removed and the Bill should be greatly shortened.

The third aspect that has been brought out before us is that a number of institutions are rendering treatment and some people have opened their own outpatient clinics and some hospitals also have outpatients clinics etc. The issue is, what should be done to them in this Bill, so that the very meagre services that are available already do not get further restricted as a result of this Bill. Instead of being helpful it should not cause more difficulties. These are some of the

problems that are puzzling us and we would like you to throw light on these as well as give your own views on these points. After you finish your statement, our Members would like to ask you a few questions.

DR. N. N. WIG: Thank you very much. I am glad you have referred to the points which I have already submitted in writing The two main submissions which I have made in writing are firstly, that this New Mental Health Bill should, in no way, hamper the growth of psychiatry in general hospitals. My submission is that when the Bill is conceived by some of us long time back, at that time the main focus of attention was on mental hospitals. Since 25 years. the position has been changed. A number of new drugs and new methods have come into force and no psychiatric treatment is being given by general practitioners and others. So, my submission will be that it should not hamper the growth of psychiatry in general hospitals and outdoor clinic and even in the villages where some of the new experiments are being carried on.

MR. CHAIRMAN: We want you to clearly and specifically tell us what provisions should be made or omitted in order to ensure this.

DR. WIG: My suggestion is, do not in any way force this Bill on general hospitals and in respect of outpatients clinics and villages where new experiments are going on. The scope of the Bill should be limited only to psychiatric hospitals where a patient is admitted forcibly without his desire.

The second point is on the question of admissions. I was uneasy when I saw the definitions which have been mentioned here. The definitions from general psychiatry point of view are fine that this is the scope of what you call mental health, and there should be the psychosis, neurosis, psychopathy and all other things that are mentioned. But for the purpose of the Bill we must narrow this definition. Otherwise my fear is, that problem will be like the Hindu Marriage Bill—I do not know whether the attention of the Committee has been drawn to this—I am referring to the new divorce Bill passed by Parliament in 1976. I do not know who has defined mental illness there. This seems to have been taken from the Mental Health Bill passed inu England in 1959. My limited experience suggests that this is creating confusion in the courts. If anybody has made the diagnosis of illness as psychopathy, then the court can says that this is a mental illness and this person can get divorce. Whatever you are going to make in this new Mental Health Bill, it is going to be used by a number of other people for their benefit. So, my suggestion is that you should restrict the definition. If you define this, as it exists in the draft, there is a danger that a person with hypertension might be taken to a mental hospital. This is my other submission that the denition should be clear. Don't give scope to any such thing. The position in our country is different from what it is in England and USA. The number of psychiatrists persons is very small few. There is so much confusion about the many psychiatric terms like psychopathy, psychosomatic disorder and all that. So, my point is that it should be restricted clearly to those who are dangerous to themselves or to others.

The third point which I did not write in my statement, but I would like to submit here, Madam, is that this Bill should do something more than restrict itself to the admissions and discharges from mental hospitals. Some positive thing for mental health should be included in this Bill and I suggest that you incorporate some kind of new chapter at the end of the Bill which should contain the commitment by the State, what the State is supposed to do to implement this Bill and what kind of services the State will provide. You are making the police and the magistrate responsible for certifying and giving opinion about mental illness.

MR. CHAIRMAN: But they will be guided by two doctors, whose certificates are there.

DR. N. N. WIG: That certificate alone will not be enough. The magistrate will be taking a decision on legal grounds. So, some training for police officers and the magistrates who deal with this Bill would be essential.

MR. CHAIRMAN: Mental patients are everywhere. So, any magistrate may have to deal with a case. That means some training will have to be given to every magistrate.

DR. N. N. WIG: Yes. Otherwise, you are giving the responsibility to somebody who is not trained. He does not know his job, and he is likely to make more mistakes.

There should also be some built-in mechanism to evaluate the working of the Bill after five or ten years. Otherwise, there is no way of knowing it. For example, Somebody has introduced in the Divorce Bill this definition of mental health. I would like to know how this has functioned, if it has been satisfactory or not. Is there any information on the basis of which the next Bill might be strengthened? I do not think there is such a machinery. I do not know whether this Bill can do it, but I think there should be a Department of Legal Psychiatry in some universities which especially take up this kind of study of the working of the Bill, the impact of the law etc.

MR. CHAIRMAN: We have been told that we are wrong in giving so much prominence to the psychiatrist, and that the clinical psychologist and psychiatric social workers, who are also very important limbs of the whole treatment team, should be given recognition by this Bill. Do you think it is necessary? I ask this particularly because you have emphasized outpatient treatment. Some of these people may be in a position to extend treatment where there are no psychiarists.

DR. N. N. WIG: Psychiatrists are still looking after a very small part of the total mental illness in the country, about 5 per cent or so, that is my guess. Even the doctors are looking after only a small part. The rest, in the villages and the rural areas, is not being looked after by any qualified person. Clinical psychologists, even if you give them scope in this Bill, will add only a fraction. It is not very important to bring them under the provisions of this Bill. If they want to practise or do whatever they are doing already, nothing in this Bill prevents them from doing it But what is more important is to help the health workers in the villages to treat the mental patients. I have not studied it, it is a much bigger problem, which will involve millions. The village health workers can use one or two drugs and treat the mental patients.

MR. CHAIRMAN: There is also no register of clinical psychologists from which we can pick and choose, but in Bangalore we saw Kapur using a large number of parameds and school teachers after some preliminary training and reaching a large number of mentally sick people in the community. They are being given medicines by these people under the over-all supervision and guidance of the psychiatrist and his colleagues.

DR. N. N. WIG: We are doing a new experiment in Chandigarh under the auspices of WHO. We are training health workers in the villages to recognise a number of ordinary mental illnesses. I personally think they can use one or two drugs. I honestly do not know what the impact of this law will be on that. I think this law should be restricted only to psychiatric hospitals so designated under the law and for admission into them. This law should not cover anybody else, and it should leave them to the treatment as it is going on now.

DR. SAROJINI MAHISHI: Supposing a case is referred to a magistrate and he approves of admission of the

patient to a mental hospital. Such an institution is not there in the area, and he has necessarily to be admitted in the particular ward of the general hospital. What will be the position at that time?

DR. N. N. WIG: If the magistrate forces a patient on the general hospital, the danger is that you will totally spoil the atmosphere of the general hospital and more and more people will shy away from those units. So, do not give permission to the magistrate to declare any general hospital to be a psychiatric hospital under this Bill and force a patient with police, shackles, locked doors etc. That way you will stop the progress of the general hospitals.

MR. CHAIRMAN: You would like this facility to be confined to voluntary cases.

DR. N. N. WIG: Purely voluntary.

DR. SAROJINI MAHISHI: A magistrate cannot force a patient on a hospital. It is in the interests of the patients only that all these things are done.

DR. N. N. WIG: He can declare a general hospital to be a psychiatric hospital, he can order the person in charge to take the patient, and that will be a bad thing.

DR. SAROJINI MAHISHI: There is another type of service, In the rural areas, rendering service at the patient's house can be done. Many psychiatrists are practising privately and doing that sort of service. In addition to doing all these things, if a hospital can expand its services to all such fields and do this type of service also, how the work of the hospital in the psychiatric ward is hampered by admitting those people, we are not able to understand that. I am giving you an example. There are certain hospitals where we saw people coming from different parts of the country. Of course, there are no hospitals in those areas. Otherwise, they would go without treatment. Under such circumstances they have been admitted in particular hospitals and afterwards when they are cured and when the doctors feel that they can be discharged, there is nobody to take care of them and rehabilitate them in their family. If they get some help from some hospital, what objection can there be? s

DR. WIG. If you compare, how many patients of the kind which you have mentioned with those who are coming for voluntary treatment, the difference will be one to hundred or even five hundred. There are thousands of patients who are coming every year, for treatment. Now if the Magistrate says "Admit this person under the order so and so", then this person cannot run away. We have to make arrangements for lock and key of the person and all these things would spoil that hospital and no longer other patients will be coming and the whole thing will become a kind of mental hospital as it existed in the past.

MR. CHAIRMAN: Apart from that there are no facilities for locking up the patients.

DR. WIG: Yes. I will not be able to do that even if somebody asks me to do that.

DR. SAROJINI MAHISHI: Are the patients not becoming violent?

DR. WIG. There are many distrubed patients who are taking treatment even in my unit. They come with their relatives, their relatives say that he needs treatment and the relatives also stay with him.

MR. CHAIRMAN: Is it true that by modern medicines you can sedate any patient within a few hours? You do not really need the old method of lock and key and so on.

DR. WIG: By and large it is true. Somehhing very rarely in a General

Hospital also the patient has to be restrained physically. But this can happen not only in psychiatric ward but in surgical ward also. The patient after operation becomes violent sometimes, you will have to tie him down to the bed for a few hours till he is calmed down and he is given treatment. This happens in any hospital anywhere. This kind of restraint is understandable. I agree with you when you say that if we now bring an element of law and magistrate and other things, in a General Hospital unit, that is not desirable.

श्री हुकम चन्द कछवाय . आपने अपने बयान में यह बताया कि मजिस्ट्रेट का भी ट्रेण्ड होना आवश्यक है, तो आप उन्हें किस ढंग से ट्रेण्ड करना चाहते हैं ? वह एम०बी० बी०एस० हों या मानसिक बीमारी की उन्हें परिपक्व जानकारी हो । कौन सी बात आप चाहते हैं ?

डा० खिंग : मेरा अपना विचार यह है कि जो मजिस्ट्रेट हैं, जज हैं, वकील हैं या पुलिस वाले हैं, उनको मानसिक बातों का, मनोविज्ञान का जानना बहुत आवश्यक है । मुझे भी कई बार कचहरी और पुलिस वालों के पास जाने का मौका पड़ा है, बड़ा दुःख होता है कि मनोविज्ञान के साधारण से नियम भी उनको मालूम नहीं होते हैं । इसी कारण जो इस प्रकार के फैसले होते हैं या दूसरी बातें करते हैं, वह मनोवैज्ञानिक न होने के नाते बड़े गलत और अजीब फैसले लगते हैं । इसलिये मैं प्रार्थना करूंगा कि इन पुलिस वालों, जजों, मजिस्ट्रेटों वगैरा को जिनको फैसला देना है, उनको आधुनिक मनोविज्ञान की बातों की जरूर जानकारी होनी चाहिये मेरी मंशा यह नहीं है कि वह एम०बी०बी०एस० हों, लेकिन आधुनिक मनोविज्ञान की आभा उन्हें समझ में आनी चाहिये । अगर मस्तिष्क से संबंधित रोग की बात को वह बिल्कुल नहीं समझते हैं बीमारियों के नाम भी उनकी समझ से दूर की बात है तो वह कैसे सही फैसला कर सकेंगे । इसलिये निवेदन है कि जो इस तरह की एजेन्सीज हैं उनका आधुनिक मनोविज्ञान जरूर आना चाहिये ।

श्री हुकम चन्द कछवाय : आपने अभी एक पुस्तक का हवाला देते हुए यह उल्लेख किया कि हिन्दू विवाह के कानून का मिसयूज किया जा रहा है कहने का उद्देश्य यह है कि यह जो बिल बनने जा रहा है, इसमें कुछ बातें ऐसी हैं जिनका गलत उपयोग होगा । आप क्या चाहते हैं, इस बिल में कौन-कौन सी बातें हैं जिनका गलत उपयोग हो सकता है ? इसके कौन से खंड में आपको संदेह है ?

डा० खिंग : जी डैफीनेशन का चैप्टर है, उसमें संदेह है । जो मैंटल बीमारी की डैफीनीशन बनेगी उसी का सब जगह इस्तेमाल होगा । मैंटल इलनैस की डैफीनीशन का बारबार प्रयोग होगा । डाइवोर्स के मसले में छोटी-छोटी बातों में मैंटल इलनैस आयेगी, कहा जायेगा यह बीमारी ठीक नहीं हो सकती है ।

श्री हुकम चन्द कछवाय : आप चाहते हैं कि पूरा खंड इसमें से निकाल दिया जाये ?

डा० खिंग : मेरा कहना यह है कि उनको सिम्पलीफाइड कर दिया जाये ।

SHRI KRISHNA NAND JOSHI: You have in your definition mentioned this metal ill-health and psychoneurosis. Some other definition is that mental deficiency and mental sub-normality can also be there. Will it be possible for you to give specifically what should be the definition from your point of view to straighten this things.

MR. CHAIRMAN: If you cannot give it now, think about it and send it to us. We would like to have it when we take up clause-by-clause consideration on the 18th.

DR. WIG: I will do that. But is it essential for you to give the definition? You have accepted that we have to define it. But it is something which is very difficult to define. Why should you spend that much time in defining it if your purpose can be served without a definition? In some of the mental Health Acts of the world, the definition is not there. If you go through the various provisions of the definition of USA, Trinidad, America or England, you will find that they are considerably different. Why enter into that controversy? By and large, mental illness will cover psychosis. Even if somebody has epilapsy, he will have psychosis if he goes to mental hospital. For neurosis alone you cannot force him there. If you have to give a definition probably you will have to give some kind of definition of phychosis. But I would say that we need not unnecessarily define it, we can by-pass it and use the main operating portion rather than going further.

श्री मुकुल चन्द कछवाय : दुनिया के देशों ने जो परिभाषा नहीं की है, क्या उसको देखकर हम करें ?

डा० विग : मैं यह कहना चाहता था कि जिन कंट्रीज में साइकैटरिस्ट संस्थाएं बहुत आर्गेनाइज्ड हैं, वहां यह प्राबलम बहुत कम होगी, लेकिन हमारे देश में और ऐसे देशों में जहां साइकैट्रिस्ट बहुत कम हैं, कचहरियों में इस बारे में डिसीजन लेने के लिये साधारण डाक्टरों को जाना पड़ेगा । इसलिये आप डैफीनीशन को जितना रिजिड बनायेंगे, उतना मुश्किल होगा ।

SHRI KRISHNA NAND JOSHI: You have said that in general hospitals the psychiatric wards are there but there cannot be a proper arrangement for keeping the hospital patients. There may not be many cases of hostile nature. In a district, there may be five or six or seven cases. We have just visited the eastern zone. In the whole of the eastern zone, there is only one mental hospital in Tezpur. That is also in a primitive condition. The clinical psychiatrists are not there. They have to send all their cases to either Calcutta or to Ranchi. You can imagine the difficulties of the guardians and the patients. Will it not be advisable to have in each district hospital sufficient arrangements to keep these hostile patients? In 1968, Dr. Jain submitted a report to the Government of India in which he recommended that a mental hospital in each district should be set up. An effort has to be towards that direction. But that will take a long time. From your evidence, it appears that general hospitals should be kept away from the hostile mental cases.

DR. WIG: You have recently visited some of the mental hospitals and you must have become aware of this problem. There are not enough mental hospitals. I understand this problem and I am in full sympathy with them. But this kind of a patient will be one in 500 or 1000. The total number of mental patients in the country, by a very rough estimate, will be about 1 to 2 per cent of the population. If you take even 1 per cent of the population, the figure will be about 60 lakhs out of which this kind of a hostile case will be 1 in 500 or 1000, something like that. If you admit such a case in the general hospital, it will interfere with a large interest of millions of patients. That will be bad enough. This is my main argument. Don't force admissions on these general hospitals. May be, psychiatrist can go to the patient and treat him as an out patient.

MR. CHAIRMAN: There is a practice commonly followed in many places. It was done in Delhi also sometime back. That is that a magistrate sends a mental case to jail.

DR. WIG: Keeping any patient in jail for any length of time is bad. I will not support it.

MR. CHAIRMAN: What to do then? You say, the general hospital

should not take him, he should not be kept in jail. There is no other place where this man can be kept. He is a danger to himself as well as to others.

DR. WIG: There are two ways of doing it. One is a difficult one. The logical thing is that the Government should have more mental hospitals.

MR. CHAIRMAN: They cannot come up overnight.

DR. WIG: That is a long-term plan. But the Government has never given any priority to it. The other way is to treat him as an out-patient. A psychiatrist can go to the patient and treat him. That might be a short cut to tackle this problem. But to admit him to a general hospital will be at the cost of many who will suffer.

MR. CHAIRMAN: Can't you have one or two special rooms for such hostile cases in the general hospitals where a psychiatrist can go and see them?

DR. WIG: In a general hospital, a room of this kind will quickly spoil the atmosphere.

MR. CHAIRMAN: I am afraid, you are making it very difficult for these people. What to do about them?

DR. WIG: Normally, only one or two cases may come in two or three months. You can treat him as an out-patient.

MR. CHAIRMAN: You cannot go by statistics. Each human being, each family, is important. When they are faced with this problem, where should they go? What should they do?

DR. WIG: But there are others who are involved also? By doing that. You will spoil the case of many others.

SHRIMATI PURABI MUKHOPADYAY: Regarding the definition, I want to know whether the word "mental disorder" only will suit the purpose.

DR. WIG: As I have already said, we should reduce the definition to the barest minimum. Possibly, the word "mental disorder" alone might be sufficient. But I will have to study this problem in a little more detail.

MR. CHAIRMAN: You study it and then advice us.

SHRI RAJSHEKHAR KOLUR: You have referred to magistrates and police. Where the evidence is being recorded, at the Munsif's court level or at the Session's court level, the magistrate or the Session's Judge testifies the veracity of the witness and also the mental condition of the patient. Some questions are put to the person suffering from mental illness to see if he is in a position to understand them and to reply them. Then only the magistrate will come to a conclusion. The magistrates and the advocates are supposed to know all these things. They may not be perfect. But in some cases, they are much more perfect than the experts who claim themselves to be experts. A number of medico-legal cases have been decided by the Supreme Court and the High Courts where they have shown that the doctors have gone wrong, that they have done something wrong. It is a general practice that wherever a dead body, after murder, is sent for a *post mortem*, it must be washed. But a majority of doctors are not washing it. It also happens that after 90 hours, they give the cause of death. In such circumstances, why should a person concerned trust only an expert, the doctor, and not the magistrate?

DR. WIG: It seems that I have been misunderstood all along the line. What I said was not that a doctor should take the role of a magistrate

or that a doctor is superior to a magistrate. That is not at all my submission. My submission on the basis of whatever little experience I have got, is that the modern psychology and psychiatry is very little known to the magistrate. Since they have to deal with these kind of a cases, they should have a better knowledge of what is the current concept of "mental illness" and various other related things. Then only they will be able to do the job better.

SHRI RAJSHEKHER KOLUR: So, every Act must have the definition in clause 2.

DR. WIG: We should reduce it to the minimum necessary; we should not go beyond what is necessary.

SHRI RAJSHEKHER KOLUR: For anyone it is very easy to explain, but difficult to define, any matter. But here we have to define it in exact words. How can we introduce that definition in the Bill?

MR. CHAIRMAN: He said he will study the problem and let us know.

SHRI MALLIKARJUN: Your deposition has created more confusion in my mind. Of course, you have promised to go into it in detail and give us a definition. How does psychology or psychiatry come into the picture for a person who has born with an embryonic lesion which ultimately culminated in physiological disorders and change in behaviour, who fall under the category of psycho-neurosis, psychopathy or psychosomatism. You have mentioned that they cannot be admitted in the general hospitals. But the mental hospitals cannot be built immediately. A proper classification of mental illness is a necessary ingredient of this Bill. Psychology is different from psycho-neurosis or psychosomatic conditions, where while one has perfect physiological conditions, the human personality as such has been affected. Once that human personality is developed, he gets psychological satisfaction. Every human being is psychogenic. We cannot deny it. Any treatment for mental illness without a definition of embryonic lesion will be suicidal. Can you throw light on this?

DR. WIG: I am sorry. The question is not very clear to me.

MR. CHAIRMAN: He wants to know where the mentally retarded cases should be sent. The last part I also could not get. Let him put a question instead of making a statement.

SHRI MALLIKARJUN: How does psychiatry come into the picture in the treatment of mentally ill patients?

DR. WIG: I think this elaborate definition should not confuse this august gathering in thinking that in an average case the psychiatrist has any difficulty in saying that a person is mentally ill. That is not true. Any definition of a mental behaviour is difficult. I can throw a challenge that you will have difficulty in doing it. So, let us not bother about it too much. However, in an average case the definition is not a serious problem. A doctor can say "this man is mentally ill". He is specially trained to look after mental illness. There are a number of mental illness where the treatments are very easy and a psychiatrist can make a tremendous difference to the happiness of the patient and his family and their future life. Though there are a number of illnesses there are three or four major categories. The first major category is psychosis, which in layman's language is referred to as insanity, madness or **pagalpan**. This is the broad area which we are talking about for admission in mental hospitals. In that specific area there are a number of drugs and the method of treatment has been revolutionised. That constitutes about one per cent of the general population, which sometimes or other gets this kind of illness. Then there are other types of illness. I need not go into the

details. A psychiatrist is a medical person who knows the treatment, I am convinced that he can do tremendous good to a vast majority of the patients who are suffering from mental illness.

SHRI MALLIKARJUN: What about psychogenic diseases, hyper-tension and all that. How are you going to take those things into consideration when he is a neurologist and not a psychologist?

DR. WIG: In any speciality there are borderline cases. In some areas you know your competence, what you can do. There are other areas, borderline cases, where you are not sure. In any psychiatric illness, say psychosis or neurosis, we are more comfortable and we know what to do. But there are border line cases—psychosomatic cases, peptic ulcer or hypertension—for which we do not have an answer. Unfortunately, at this moment with the current knowledge we cannot make any dramatic cure.

MR. CHAIRMAN: There are a certain number of cases in which psychiatry can give an insight so that the patient can help himself. Is that not so?

DR. WIG: That is quite true. As the hon. Member rightly pointed out, there is no disease which is purely physical or purely psychological. All diseases have some component of both. Any intelligent doctor or psychiatrist can help that unfortunate individual.

MR. CHAIRMAN: In other words, are you suggesting that a sound training in the basic concepts of psychiatry for the general medical practitioner?

DR. WIG: If you will permit me to say so, psychiatry is too important to be left to psychiatrists alone. Mental health should be the concern of every doctor and every human being. This kind of training in mental health should be a part of the training of the doctors, and not merely psychiatrists.

SHRI MALLIKARJUN: You have come nearer to my thinking. So, may I know from you that suppose if some persons who are born with embryonic lesions...

MR. CHAIRMAN: You mean, an early disease?

SHRI MALLIKARJUN: For various reasons there are some lesions in the development of brain and the nervous system. Because of this, it will be ultimately resulting in the disease. You will see that later. When such a person sees the surroundings and environments, it leads him to depression and he cannot perform normal functions. So, such persons whom we think are mentally retarded are not psychoneurotic or psychiatric persons. Such persons are large in number and their mortality is more.

MR. CHAIRMAN: Please try to be brief and ask the question.

SHRI MALLIKARJUN: This is what I have been trying to impress upon you. Kindly say something about these persons born with genetic defects ultimately getting into depression due to environment and so on and so forth. Should such persons be classified or not?

SHRIMATI PURABI MUKHOPADHYAY: I will answer this question. Why classify?

SHRI MALLIKARJUN: I want to know it from the hon. doctor himself because there are thousands of people who are mentally retarded and they are not taken into consideration.

DR. WIG: Whatever I have been able to understand, my response to this question is that genetic factors are very important in some forms of mental illness. In the classification. this comes under a special category of defects. But I would say that by and large each one of us is

the product of genetic background and environment. What we have developed today is what we have been given by our parents and how our environment from childhood changed our behaviour and personality. This is a combination of genetic and environmental factors. Sometimes genetic factors are more prominent and sometimes environental factors are more prominent. In a given case the psychiatrist usually decides which factor is more prominent.

SHRIMATI NOORJEHAN RAZACK: Dr. Wig said that the Magistrates and Judges should have better knowledge about psychology and psychiatry. I would like to state here that once a case is brought before a Judge or a Magistarte, he does not give his orders as he pleases. He will be having a general idea about it. Unless and until the case is very clear and it is proved that the patient is unable to become normal, a Judge does not give orders for divorce. I would like to know from Dr Wig in what way Judges should have a better knowledge of psychology and psychiatry.

DR. WIG: When I made that statement there was no intention of any kind to belittle the judiciary and police at all. My own knowledge in this respect is much less. I only say that those who have to deal with mental health problems anywhere must have knowledge of what is the current thinking in contemporary psychology and psychiatry.

SHRIMATI NOORJEHAN RAZACK: You mean to say, knowledge in the sense that they must be assisted by a psychiatrist or they must have a thorough knowledge of this?

DR. WIG: I would suggest that in the training programme of the lawyers and Magistrates, there should be a better representation at the theoretical as well as practical level. How many times a policeman or a Magistrate or a Judge is given knowledge about mental illness, I do not know. But I would like that there should be some component of this in the training programme.

SHRI HAREKRUSHNA MALLICK: Do you agree that a psychiatrist also should be called to plead on behalf of a particular case in question to help the court as well as the person concerned? For example, a person is unlawfully going to be confined and the entire judiciary and everybody else are mobilised. In that event, can a case be fought with the help of a psychiatrist? In other words, in every case the psychiatrist must be present in the court?

MR. CHAIRMAN: I think that is a very unfair question. The Magistrate has committed a person on the basis of the report of a psychiatrist. Now you want to bring in another psychiatrist to confront him and counter the opinion of one with that of the other? Dr. Wig, if you want to say anything about it, you can. What he is saying is that just like I hire a lawyer in the court, in the same fashion he wants a psychiatrist to be hired by a party

DR. WIG: I would briefly say it like this that if a Judge or a Magistrate, in many of the cases, takes the opinion of the psychiatrist into consideration while taking a decision, probably he will be able to arrive at a better decision in the totality of the picture. But what happens is that a psychiatrist is only called on behalf of one party or the other and not called by the court to give his advice. If a Magistrate or a Judge calls the psychiatrist to give him the advice about a case, it might be a healthy way of arriving at a correct decision.

SHRI HAREKRUSHNA MALLICK: You mean, the presence of a psychiatrist in a court of law is helpful?

DR. WIG: Yes. Many times it will be helpful.

SHRI HAREKRUSHNA MALLICK: Should drug addicts and alcoholics be confined to mental hospitals or be

treated in ordinary hospitals in separate wards?

DR. N. N. WIG: Mental illness, broadly, is of five kinds. The first is psychosis, generally called insanity or madness. It is characterised by abnormal behaviour. The person has lost contact with reality. For example, he sees and hears things which are not there. He has paranoid ideas, he feels that he is being poisoned, that others are trying to humiliate him etc. The second type is neurosis. Here, the symptoms are both physical and psychological. He has fear, anxiety, tension, depression, he cannot sleep. He has pain, headache, weakness etc. A careful examination does not reveal any basis for this, and the assessment is that probably psychological reasons are producing the symptoms. The difference between psychosis and neurosis is that in the former the person has lost contact with reality, while in the latter it is maintained, but he does not like it.

The third broad group is personality or character disorder, where a person repeatedly does crime or drinks again and again, becomes a drug addict or is unduly aggressive or violent. He is not otherwise abnormal, he has not lost his mind. He has some peculiar abnormalities of his personality, and does not learn from experience.

The fourth is mental retardation. Intelligence is low right from the beginning and does not come up to the normal level. The fifth is psychosomatic. Outwardly it is physical, but the suspicion is that it is due to psychological factors.

SHRI RUDOLPH RODRIGUES: I am not clear whether you want to exclude the psychology units of the general hospitals entirely from the purview of this Bill or only from certain provisions of it.

DR. N. N. WIG: When I came here, I was convinced that they should be kept out, but I can see the point of view of the Committee. So, I would say you should be careful. As far as possible, do not change the working pattern of these units; otherwise, unknowingly you may damage them.

SHRI RUDOLPH RODRIGUES: Bring them within the purview, but limit the application of the provisions.

(The Committee then adjurned.)

II—Dr. B.M. Debsikdar,

(The witness was called in, and he took his seat).

MR. CHAIRMAN: I welcome you and I thank you for taking the trouble of appearing before the Committee.

(Direction 58 read out).

We have received your Memorandum. Would you like to say anything more about it before we put questions?

DR. DEBSIKDAR: At the outset, I would like to say that I feel privileged to appear before the Committee, particularly to be associated with this work which was pending for quite some time.

If I quote the Mental Health Bill, 1978, last page, it says:

> "The spirit of the Bill is to consolidate, amend, the law relating to treatment and care of mentally ill persons."

I also wish to focus the very commendable and learned observation of the hon. Minister in the Statement of objects and Reasons of the Bill. I quote:

> "The mentally ill persons are to be treated like any other sick persons and the environment around them should be as normal as possible."

Another fact that I wish to bring to the notice of the Committee is that in the Indian Lunacy Act, 1912,

the major principle underlying the Lunacy Act was the prevention and the detention of lunatics or alleged lunatics in unlicensed and unauthorised places or institutions.

My opinion will be based on these points. The Mental Health Bill which has been framed does not fully satisfy the promise given on the last page of the Bill, that is. "The mentally sick person should be treated like any other sick person." I whole heartedly appreciate that the Parliament at last is thinking of finding out some way so that the treatment reaches the masses.

MR. CHAIRMAN: In your Memorandum you have stated that you want private nursing homes to be treated as automatically licensed homes without applying for it. The whole idea of licensing the nursing homes is to see that there are adequate facilities for the care of patients. Therefore, would you not agree that even the existing nursing homes should be inspected to ensure that they have adequate facilities? Why do you want to deny the patient of having adequate facilities simply because a nursing home was established long ago? Most of them are likely to have adequate facilities. But there may be some which are not adequate and, therefore, they should not be allowed to continue.

Secondly, we have provided in the Bill that the license is not transferable. You say that it should be made transferable and that the successor should not have to apply again. Your point is, what is licensed is a nursing home, not an individual. If one individual dies, there may be other competent people in that nursing home and nobody is going to take away the licence. But it has to be ensured that the services are satisfactory and they must apply. If a nursing home is sold away to another person who may not be a competent person, a trained psychiatrist, how can a licence be transferred? Why do you want a provision that it should be transferables?

Thirdly, you have said about the difficulty of admissions. That is there. It has been suggested to us that there should be only three types of admissions. voluntary admissions, admissions under extra-ordinary circumstances where the relatives or friends can bring the patients and commitment by magistrates in the case of violent patients who are a danger to themselves or to others. You have said that "others" should be eliminated. I would like to have your opinion on these three points.

DR. DEBSIKDAR: As regards the first point, I did not mean that all nursing homes should be automatically licensed. There should be a restriction. But once they are licensed, they should be given the liberty, as any other nursing home run by the Government, to run like that.

MR. CHAIRMAN: You do not mind nursing homes being inspected for adequacy of facilities and services before they are licensed.

DR. DEBSIKDAR: I don't mind; it should be done.

As regards the second point, my feeling is that when a person is becoming in-charge of the responsibility and the fate of so many patients—anything may happen to his life all of a sudden—and if the nursing home is in the name of a particular person, then that person becomes indispensable to that institution and, therefore, a provision should be made simultaneously that in the absence of this person or in the case of demise of this person, there should be another person who can take it over.

MR. CHAIRMAN: Instead of a nursing home being in the name of a person, say, Mrs. Mukherjee Nursing Home, it may be called the Calcutta Nursing Home. Mrs. Mukherjee is in-charge of it today and Mrs. Khan may be in-charge of it tomorrow. They are both trained psychiatrists. Nobody is going to say no, to their continuing. But if the wife of the psychiatrist, as the inheriter of the

property, takes over that and thinks that licence should automatically continue without there being a qualified psychiatrist, etc., surely that is not right.

DR. DEBSIKDAR: My feeling was that, if only a psychiatrist was in charge of the nursing home, the nursing home would be recognised. I want that these two have to be separated. In the section it is said that licence will be given to a person who is a psychiatrist. That means, both the person and the institution are going together. I do not want that.

SMT. PURABI MUKHOPADHYAY: That is exactly what we want. Otherwise, there would be exploitation. Suppose you are a trained person and you sell it out. Another person takes over and he is not a properly trained person. Whenever it is sold or transferred, a fresh licence has to be applied for, and there will be a proper inspection and then only the person will be allowed to run that.

DR. DEBSIKDAR: I apprehended a gap. Suppose a person suddenly dies and another person takes over. There is likely to be a gap and during that gap, a number of mentally ill patients will be under the charge of nobody. There is a risk. That was my point. Therefore, a provision should be made that, in the absence of the person concerned, automatically a second man has to be there to take it over.

SHRI RAJSHEKHAR KOLUR: You have said that this Bill deviates from the Statement of Objects and Reasons given. In the Statement of Objects and Reasons it is said:

> "...Thus the mentally ill persons are to be treated like any other sick persons and the environment around them should be made as normal as possible."

I would like to know the reasons for your conclusion that this Bill is deviating from the Statement of objects and Reasons. I am referring to the treatment part of it.

DR. DEBSIKDAR: Unless the person comes to the specialist, the treatment cannot start. Unless the person is made available to the specialist, how can the treatment start? We are barring the patients from coming to the specialist by many sections. How will the treatment start? When the actual treatment comes, just like surgical treatment, consent can be taken. Before that we are barring the mentally-ill patients from coming to the specialists by many provisions in the law.

SHRI RAJSHEKHAR KOLUR: You want those provisions to be excluded?

DR. DEBSIKDAR: Yes.

MR. CHAIRMAN: What provisions do you want to be excluded?

DR. DEBSIKDAR: The patients should not be barred from coming to the specialist—private or government or any other agency.

MR. CHAIRMAN: Which provision is barring him from coming to the specialist? So far as I know, there is none.

DR. DEBSIKDAR: There are many. If a patient has to come, he has to come through a Magistrate.

MR. CHAIRMAN: His relatives can bring him, his friends can bring him, the patient can come himself. What is the provision that you want to be deleted, I do not understand. There is no restriction at present. The patient can go to the psychiatrist if he wants to. There is nothing in this which prevents him from doing that. I think there is some confusion in your mind.

SHRI KRISHNA NAND JOSHI: You have made some reference about inspection of psychiatric nursing home. You have said:

> "The qualities of the inspecting officer should be determined by the Committee, so that the inspecting officer so selected should have suffi-

cient orientation about the need, nature and value of psychiatric treatment."

Would you kindly elucidate as to what sort of inspector should be there?

DR. DEBSIKDAR: I want that the inspecting officer should be such a person who has the basic knowledge of psychiatry and is familiar with the modern trends of treatment.

MR. CHAIRMAN: I did not catch your point. What is it that you want?

DR. DEBSIKDAR: About the Inspecting Officer who comes to inspect the Nursing Home, he should be a person who understands the nature of the illness, the merits, demerits and the benefits of the treatment. He should be a knowledgeable person.

MR. CHAIRMAN: The State Government, I presume, will appoint knowledgeable and competent persons to be Inspecting Officers.

SHRI KRISHNA NAND JOSHI: He wants qualified doctors should be included there. No provision is there in the Bill that they should be particularly experienced people.

MR. CHAIRMAN: 'Inspecting Officer' means any person authorised by the State Government or the licensing authority to inspect any psychiatrist or psychiatric nursing home. Surely they cannot send somebody, they cannot send a clerk to go and inspect the Mental Hospital. They will have to send somebody who is eligible.

You want it to be prescribed in the law that he should be an experienced psychiatrist?

DR. DEBSIKDAR: Or a Medical Officer who has some knowledge of psychiatry.

SHRIMATI PURABI MUKHOPADHYAY: You yourself are a doctor. Suppose you go to visit a hospital. If you inspect the operation theatre, with the basic knowledge of psychiatry, don't you think that you can see if the shadow lamp is all right, whether emergency operation can be undertaken and whether all the equipments are there and whether the anaesthetist is quite qualified etc. So any intelligent persons having the basic ideas can be an inspecting authority. You need no medical qualification for that. Tell me which State Government has enough of psychiatrists or medical officers trained in psycho-analysis and psychological treatment or neurological treatment?

MR. CHAIRMAN: Would you like to answer that?

DR. DEBSIKDAR: Yes, I think. The Madam is supporting my point of view. That is what I feel. She wants somebody who knows the job.

MR. CHAIRMAN: We do not need anybody who has special knowledge. Anybody can go see and inquire. It does not need a surgeon to inspect an ordinary nursing home. Similarly, the inspecting officer of a nursing home for the mentally sick need not be a psychiatrist. An intelligent person, whatever the laws that are prescribed, can go and inspect and decide whether things are as prescribed or not.

SHRI KRISHNA NAND JOSHI: Provision has been made that if the inspecting Officer is a psychiatrist he can meet and have discussion with the patient himself.

SHRIMATI PURABI MUKHOPADHYAY: He is going for licensing to see whether the licence will continue. He need not meet any patients. He has to inspect whether the basic requirements for treatment and the necessary equipment are there or not.

SHRI KRISHNA NAND JOSHI: If he is a qualified person, he can discuss the matter with the patient.

DR. DEBSIKDAR: Not only qualified but he should be sufficiently

oriented also to understand what is going on. He should understand what are the implications in the treatment and what are the requirements. Otherwise, there may be a report which may not be beneficial. That is why he should be at least oriented about the subject. He need not be a psychiatrist as such, he may be a Medical Officer.

MR. CHAIRMAN: Here the point is that there may be aspects which are administrative. There may be aspects which are technical. Now, please see the Bill. Clause 13(2) says:

"The Inspecting Officer may interview in private any patient receiving treatment and care therein—

(a) for the purpose of inquiring into any complaint made by or on behalf of such patient as to the treatment and care, or

(b) in any case where the Inspecting Officer has reason to believe that any inpatient is not receiving proper treament and care, and where the Inspecting Officer is a medical practitioner, he may also examine the patient in private and may require the production of any medical records relating to the treatment and care of the patient in the psychiatric hospital or psychiatric nursing home and inspect the same."

From this I understand that the Inspecting Officer may sometimes be just an administrator, if the problems are of an administrative nature. Otherwise the Inspecting Officer may be sent to inquire into complaints etc. and in any way he will be a person with a scientific background. In the law we cannot prescribe what the qualifications of the Inspecting Officer should be. We have to leave it to the discretion of the Health Department of the State concerned.

DR. DEBSIKDAR: It is fairly enough. What I mean is that he should be oriented with the administration of the treatment.

MR. CHAIRMAN: Don't you think that the Health Department is responsible to ensure that the Inspecting Officer has the necessary competence?

DR. DEBSIKDAR: I do not doubt that.

DR. SAROJINI MAHISHI: Please let me know the definition. You are having a private Nursing Home. On what basis are you categorising the patients and what type of cases you are admitting and we also would like to know whether the definition which is there in the Bill is adequate or not

MR. CHAIRMAN: A lot of objections has been raised to this definition.

DR. DEBSIKDAR: Can I get a little guidance from you?

MR. CHAIRMAN: Item (m) on page 3 of the Bill.

DR. DEBSIKDAR: I think this should be adequate for practical purposes.

MR. CHAIRMAN: I would like to ask you. It says:

"...psychosomatic disorder..."

Now, anybody with hypertension, asthma may be branded as mentally sick if somebody wants to have somebody put behind the bar of a mental hospital for property reasons or for various other reasons or somebody may file a divorce suit.

DR. DEBSIKDAR: They should not be admitted. We face such situations. But I think no psychiatrist who has got a clear conscience will admit a patient if he is not suffering from any mental illness or so. But she has to apply his discretion and conscience and if it is done purposefully for some malicious and nefarious purpose, then action should be taken against him. Under medical ethics, everything is punishable.

श्री हुकम चन्द कछवाय : आपने इस विधेयकको देखा है पूरी तरह से। क्या आपको ऐसा लगता है कि इसमें जितने खण्ड दिए गए हैं इनका गलत उपयोग हो सकता है ?

डा० दबसिक्दार : हमको ऐसा मालूम होता है कि साधारणत: ऐसा नहीं होगा। जो होता है वह बहुत एक्सप्शनल होता है। साधारणत: जो लोग प्राइवेट प्रैक्टिस करते हैं वे अगर मेल-प्रैक्टिस करते हैं तो दे आर पुनिश्ड....

सभापति महोदया : आप चाहें तो उत्तर अंग्रेजी में दे सकते हैं।

DR. DEBSIKDAR: They are punished as per the Act. The person who does malpractice has to be paid by his own coin in due course. That is my feeling. It is an exception and it is not a rule. Anybody may admit a person for a malicious purpose, but I think he will not be able to practice in that area in due course. There is a code of conduct under the Indian Medical Association.

For example, a man with poison, if he has been admitted without any information to the proper authority or a man with head injury is admitted without informing the proper authority, then that is wrong and he should be punished. But in general, it does not happen. So, it is an exception and it is not a rule.

श्री हुकम चन्द कछवाय : जेलों के अन्दर जो मानसिक पीड़ित लोग रहते हैं उनका ठीक प्रकार से इलाज नहीं होता है। तो क्या आप इस बात को मानते हैं कि वहां जिस ढंग से व्यवस्था है उस व्यवस्था में वहां मरीज अच्छे नहीं होते बल्कि उनकी बीमारी और बढ़ती है ? क्या आपकी ऐसी मान्यत है ?

DR. DEBSIKDAR: I believe so, because we do not have sufficient facilities for giving treatment to the patients and moreover we do not treat the patients. The disease may be chronic and may become incurable in due course but if the patient is treated early in time, then he may be cured. I have got statistics of my own hospital where 80 per cent of the patients got the treatment within three months' time. We are lacking in this profession in so far as psychiatrists are concerned, because in rural areas if a person is suffering from mental illness and if it is detected in early times, then he can be fruitfully treated within three months.

श्री हुकम चन्द कछवाय : आप अधिक जोर दे रहे हैं कि प्राइवेट अस्पतालों में अधिक मात्रा में इलाज होना चाहिए, ऐसा आपका मत है, तो यह पांच छः प्रकार की मानसिक बीमारियां होती हैं, क्या आप ऐसा नहीं मानते हैं कि अभी जो शासकीय व्यवस्था है वह पर्याप्त मात्रा में नहीं है, लेकिन यह रोग दिन प्रति दिन बढ़ता जा रहा है, इसीलिए प्राइवेट लोगों को भी इलाज करने की अनुमति दी जाय, ऐसा आप मानते हैं ?

DR. DEBSIKDAR: You are perfectly right. If I can quote the Bhore Committee, in 1946, they estimated that there were one million people suffering from mental illness and there were about 1.2 per cent of the total population having mental defect. In the All India Phychiatrists Society conference, I estimated that there were only 24,500 beds available in the country whereas when the country's total population was 660 million or so, there are enormous number of mental patients who do not have provision for treatment at all. We have about 650 professionals and about 50 more who are not registered as members of this professional. So, there are about 700 professionals. Our morbid population is very huge in mental hospital. In the Government Institutions there are only about 100 posts and the rest of the 600 professionals are maintaining the mental health of the coun-

try. Either they do private practice or some other profession. If more posts are created in the Government institutions, the mental illness that is largely prevalent in the country does not go without attention and care. The statistics of ICMR 1961—64, given by Dr. Dubey, in Agra, will show that there are about 18.2 mentally sick persons in Delhi area and nearabout. This does not include other sick persons. We cannot say that India has less number of mental sick persons. I feel private practice should be encouraged or just like the primary health centre is permitted outside, some provisions should be made, for example, I tried to contact psychiatrists in different parts of the country. I have examined so far about 3000 cases. 40 to 50 per cent of the cases were discharged at a very early time. But many cases remained undetected, even though they were established mental case patients. That is why I feel that there should be some law introduced in regard to the private practice. Even then there are a lot of barriers put in this law. You have mentioned about three places for giving treatment to these patients. One is psychiatric hospital, second is psychiatric nursing home run by the Government and the third is the private psychiatric hospital. Here I would submit that nursing home is not existing at all. That is why I told you I am very happy about it. But it has to be more liberalised.

श्री हुकम चन्द कछवाय : आप यह कहना चाहते हैं कि वर्तमान जो विधेयक है यह अत्यन्त कठोर है, इससे अधिक लोगों को लाभ नहीं मिल सकता है ? इसको अधिक लचीला और अधिक मुलायम बनाया जाय तो अधिक से अधिक लोग इसका लाभ उठा सकते हैं, ऐसा आपका कहना है ?

डा० देबसिक्दर : जी हां ।

श्री हुकम चन्द कछवाय : दूसरी बात मैं यह जानना चाहता हूं कि भारतवर्ष में कितने प्रतिशत लोग मानसिक रूप से पीड़ित हैं ?

डा० देबसिक्दर : प्रति हजार 18 से 20 लोग तक मानसिक रूप से पीड़ित हैं ।

SHRIMATI PURABI MUKHOPADHYAY: He has mentioned that there are only 700 properly trained psychiatrists in this country. His claim is that 700 people for running hospitals, for running the nursing homes and doing private practice are inadequate and he knows that there is no register number or licence number being given to them like those given by the Indian Medical Council Research which has given degrees and registration number. But here unless the psychiatrists get the registration number, nobody can claim that he is a registered practitioner.

DR. DEBSIKDAR: There is a classification laid down and there is also membership system in Indian Psychiatric Society.

SHRIMATI PURABI MUKHOPADHYAY: Are they registered as medical practitioners?

DR. DEBSIKDAR: No separate registration is there. But now recently there is an academy for specialists run by Medical Council and some of us have been included in that but not all.

श्री हुकम चन्द कछवाय : आप इस बात पर जोर दे रहे हैं कि मानसिक चिकित्सा के लिए यदि अधिक प्राइवेट अस्पताल होंगे तो अधिक मानसिक रोगी उनका लाभ उठा सकेंगे । मैं यह जानना चाहता हूं कि जो प्राइवेट इलाज करते हैं वे यदि गलत काम करें सिलसिला करें तो क्या उन व्यक्तियों के लिए इस बिल में कठोर दण्ड की व्यवस्था की जानी चाहिए ? क्या आप इससे सहमत होंगे

DR. DEBSIKDAR: I am in favour of giving heavy punishment. But there is in the law if the motive is good, if the act is done with good motive, that is to be properly assessed before giving punishment. My hospital is listed in the Government Register. It is published by the Central Government in

their Book and I enjoy all the facilities as Government hospital enjoys. I can do as much work as a person in a Government hospital does. I have got 100 beds in my hospital and I have got various branches in our clinic. I have got Nuero Physicians, Nuero Surgeons, 6 Psychiatrists, 5 Medical Officers and nurses. I have got 10 nurses out of those 4 are post-graduates. If you give incentive, there are many people who will take up this profession and do private practice.

MR. CHAIRMAN: I thank you very much for the trouble you have taken in coming here and having enlightened us.

DR. DEBSIKDAR: Thank you very much for giving me the opportunity to explain my viewpoints.

(The Committee then adjourned)

III. Dr. Shanti Sheth

(The witness was called in, and he took his seat)

MR. CHAIRMAN: Dr. Shanti Sheth, I would like to welcome you to this sitting of the Joint Committee. It is very kind of you to have responded to our call and come here to give evidence.

Attention of the witness was drawn to Direction 53 of the Directions by the Speaker.

We have received your memorandum. Would you like to say some thing before we ask you questions?

DR. SHETH: Madam, may I draw your attention to page 3 Section (M)—Definition.

MR. CHAIRMAN: Let me tell you in respect of definition not only you but other witnesses who have appeared before this Committee have raised objections. It has been suggested to us that mental sub-normality is not a treatable condition and should not be considered as mental illness. We would like to hear your views.

DR. SHETH: I entirely agree on this point deposed by my colleagues earlier. Mental sub-normality may not be treated as psychiatric condition unless there it is associated with psychosis. What happens is sometimes mental deficiency is a condition by itself means a person whose intelligence is much lower. Quite often this condition is associated with psychotic conditions. So, he must be treated as a mentally ill person because he will have to be restrained in an institute.

MR. CHAIRMAN: What is the definition you would like to keep?

DR. SHETH: If a person has to be compelled to undergo treatment by law, the following words have to be added to the definition of a mentally ill person: "who is considered a nuisance and dangerous to himself and others and for public safety".

SHRI SAKTI KUMAR SARKAR: Do you want to retain the words "such other condition of a like nature as may be prescribed" or do you want them to be deleted so that it may not be misinterpreted in future for ulterior motives?

DR. SHETH: These may be retained provided you add the words I have just mentioned to the definition. Otherwise, you will have to redraft the entire para.

MR. CHAIRMAN: In what way?

DR. SHETH: It will take some time. I will send it.

SHRIMATI USHI KHAN: You said 'nuisance' must be added to the definition. Would you be so good as to define what you mean by it?

DR. SHETH: I said, nuisance and dangerous. For example, he is making so much disturbance that it will be difficult for the neighbours to stay there. He may make noise or throw stones.

SHRIMATI USHI KHAN: But the law of tort as it stands will not cover all these. You need an amendment to that law to cover these.

DR. SHETH: I can only express my opinion. The legal aspects will have to be examined.

In page 3, in sub-clause (q) the words 'convalescent home' are mentioned. There is no convalescent home run by either the Central Government or State Governments. But there are a number of private sanatoria where a person who has recovered from mental illness can go for convalescene. If the Government is going to control the private sanatoria the philonthropic persons will not give shelter to such patients because it would be considered an interference. Therefore, the words 'convalescent home' may be removed.

MR. CHAIRMAN: There have been instances where these convalescent homes were dens of vice. Don't you think some sort of licensing of these institutions is necessary?

DR. SHETH: As far as licensing of hospitals and psychiatric nursing homes is concerned, I entirely agree. But I am referring to the number of private sanatoria in the country. Even a dharamsala is a sanatorium where persons who have been mentally ill, come and stay.

MR. CHAIRMAN: If it is not a special convalescent home for psychiatric cases, no licensing will be required. If a person wants to go to any other institution which is not a recognised institution for this purpose, nothing prevents him from doing so.

DR. SHETH: If a sanatorium is used by a patient who is convalescing from mental illness, the control will automatically come in. That is my fear.

About 'sub-clause (r), to my knowledge there are a number of post-graduate degrees and diplomas in psychiatry which are not recognised by the Medical Council of India at present.

MR. CHAIRMAN: All Indian degrees are recognised. We do not recognise the degrees of those countries who do not recognise our degrees.

DR. SHETH: I am certain that as far as the State of Maharashtra and Gujarat are concerned—there we have the institutes which have been imparting degrees on Psychiatry from the year 1954 onwards, but they are still not recognised by the Medical Council.

MR. CHAIRMAN: Which is this?

DR. SHANTI SHETH: Bombay University.

MR. CHAIRMAN: Without any hospital and patients.

DR. SHANTI SHETH: We have got a hospital. We have got a recognised Institute, but the degree or diploma is not recognised by the Medical Council of India.

MR. CHAIRMAN: I do not know. But there must be some lacuna because they have recognised so many other degrees.

DR. SHANTI SHETH: I am not going into that aspect. Here the word 'Psychiatrist' means a medical practitioner possessing the prescribed degree or diploma recognised by the Medical Council of India. I have already written to the Medical Council of India. I have already written to the Medical Council to give me a list of degrees or diplomas in psychiatry recognised in this country. I am not so sure about other degrees. But I can tell you this much that as far as Maharashtra and Gujarat are concerned, they are not recognised and so later on wherever the word 'Psychiatrist' is used...

MR. CHAIRMAN: If you see further, the definition of 'Psychiatrist', you will see that the State Government can designate anybody as a Psychiatrist keeping in view his knowledge and experience.

DR. SHANTI SHETH: There is no such reference in any State Mental Manual where the word 'Psychiatrist' is recognised.

MR. CHAIRMAN: This is for the first time that this Bill is introducing the word 'Psychiatrist' and you must

understand that so few of you are there in this country that all over the country probably for some years to come, we will not be able to get Psychiatrists.

DR. SHANTI SHETH: I have a suggestion. I think it will serve the purpose of the Bill if this is re-worded as, "Psychiatrist means a Medical person possessing a medical degree or diploma". That means, it may be MBBS or any other medical qualification recognised by the Medical Council of India and possessing a post-graduate degree or diploma. It is not necessary that the post-graduate degree or diploma should be recognised.

SHRI SHAKTI KUMAR SARKAR: Would you kindly say from your experience about the Clinical Psychologists being included here?

MR. CHAIRMAN: Let him finish his statement.

DR. SHANTI SHETHI: Madam, if you permit me, I will answer the question put by the hon. Member. I am one person who has great respect for Clinical Psychologists. I have always felt that they have a place along with the Psychiatrists. But there are a number of medical conditions. I will give an example. Insanity or Psychosis or Psychiatric conditions can result as a result of brain tumour. How will a clinical psychologist be able to determine that this so-called psychosis or insanity is due to the physical disorder. He has no means at his disposal to know that and if he is to certify, it will lead to some serious medical trouble.

SHRI SHAKTI KUMAR SARKAR: So, we can safely say that Clinical Psychologists should not be taken into consideration for treatment.

DR. SHANTI SHETH: I did not say, for treatment. I was referring to the Bill, to the extent of and in regard to certifying a patient.

SHRI SHAKTI KUMAR SARKAR: If they are allowed for treatment of insanity and other things, will they not come under the purview of this Act?

DR. SHANTI SHETH: In what manner?

SHRI SHAKTI KUMAR SARKAR: Their objection is that they have been excluded from the purview of this Act so that they are actually barred from practice. What is your suggestion?

DR. SHANTI SHETH: This Bill has relation to the mental disorder, it is primarily and basically concerned with the medical science and therefore those psychologists or the Clinical Psychologists play a very important role in the medical treatment, in the psychological treatment of a patient. But as far as this Bill is concerned, he has no place. I think it is sufficiently clear.

MR. CHAIRMAN: I might mention here one or two things. They said that they are running nursing homes on their own. They also said, "Now by this law, you will exclude us." You should instead of saying 'medical officer' say, 'an officer' which may be a Psychiatrist or a Clinical Psychologist or a Psychiatric social worker because they are all capable of looking after the patients.

DR. SHANTI SHETH: Looking after is one thing. But here whenever the word 'Psychiatrist' is referred to the question of certification comes in. There is the question of medical aspect.

MR. CHAIRMAN: For running the homes, you will put them in charge.

DR. SHANTI SHETH: Provided some Medical Officer is available to look after the medical aspect because the Clinical Psychologist has no means at his disposal to know without the aid of medical man that this illness is not due to any underlying medical condition. For example, how is a G. P. going to know about the vitamin deficiencies.

MR. CHAIRMAN: You have in your memorandum talked about Sec. 18(2).

DR. SHANTI SHETH: There are some minor points, which are very important from my point of view. On page 4 section 4, sub-section (2) I want to add the words "municipal corporation" because we have to cover the institutions run by the municipal corporations.

MR. CHAIRMAN: Do you think that all these should be excluded?

DR. SHANTI SHETH: I am not saying that. I am saying that the municipal corporation should be taken into account.

MR. CHAIRMAN: When a private person establishes an institution, surely he should observe certain standards which have been laid down before a licence is granted. Instead of adding the words "municipal corporation", I would have appreciated it if you have said that the exemption even in the case of Central and State Governments should be taken away.

Sub-clause (2) of clause 4 says:

"Nothing contained in sub-section (i) shall apply to a psychiatric hospital or psychiatric nursing home established or maintained by the Central Government or State Government."

I think this should be deleted.

LEGISLATIVE COUNSEL: If sub-clause (2) is deleted, then Government has to obtain a licence.

MR. CHAIRMAN: I think Government should set an example and not be chary of being inspected by the licensing authority. I think some of the Government mental institutions are in a very deplorable condition. So, I feel that sub-clause (2) should go. We should consider this.

DR. SHANTI SHETH: May I add that the special wards in the hospitals and the teaching institutions should be exempted. They need not have this licence. Otherwise, it would be very difficult to teach.

MR. CHAIRMAN: I agree. So far as service conditions are concerned, they should be common. So far as limitation about three months or six months are concerned, perhaps they should leave them out.

DR. SHANTI SHETH: In a general hospital we do not differentiate between a patient suffering from physical illness or mental illness. We cannot do that. The whole idea of this Bill is to remove the stigma so that a patient who is suffering from mental illness should be able to go to a general hospital easily for treatment. But if we are going to say that he should be sent to a ward which is licensed, it will create difficulties.

MR. CHAIRMAN: I agree.

DR. SHANTI SHETH: Then I come to clause 7 on page 5, which says:

"A licence shall not be transferable or heritable."

It is not always done. But sometimes, with the best of intentions, it is not possible for the Government to come forward with a building and other facilities for a nursing home. But there are reasonable chances that the private sector may come up sooner or later, as in other countries like America, where these institutions are maintained by the private sector. A philanthropist or charitable-minded person may build a nursing home. But if it is not transferable or heritable, how can he run the show? His son should have the right to inherite it.

MR. CHAIRMAN: Suppose a man dies; his wife inherits his property. But, in the case of an institution of this type the wife of the doctor has to apply for a licence.

DR. SHANTI SHETH: It is not she who runs it. Even when the owner dies, the doctors remain the same, the conditions under which the licence was granted remain the same.

REPRESENTATIVE OF HEALTH MINISTRY: Suppose A is running an institution and he dies and B takes it over. He may not have the necessary finance to run it. So, a fresh licence should be obtained.

MR. CHAIRMAN: Your point is well taken. Something should be done. Suppose Doctor A dies because of heart attack. What happens to the nursing home until a fresh licence is taken?

DR. SHANTI SHETH: Now, we come to page 8, clause 19. Here, any mentally ill person who does not or who is unable to express his willingness for admission as a voluntary patient, may be admitted." This is in reference to a patient who is taken as a voluntary boarder. It means, a relation of the patient makes an application on his behalf and he is taken in. The intentions of this clause are good, but my point here is that we have also to look after the interests and the protection of the patient because there are *mala fides* of the relations and there have been a number of cases in history where it is noticed that for certain reasons, patients have been pushed into the asylums and thereby deprived them of certain rights. Why we have a provision for a voluntary boarder is because we want to get him treated. Here we say: "An application made in that behalf by a relative of the mentally ill person if the Medical Officer in charge is satisfied that in the interests of the mentally ill person it is necessary to do so" (that is, admitting the patient). It can also happen that the medical officer or the psychiatrist can also connive with the relative of the patient if he is empowered to certify such a patient. If he certifies like that, the patient loses civil liberty. This is my apprehension. So, some protection has to be provided against the *mala fides* of the relatives.

MR. CHAIRMAN: The relative will have to bring two certificates, that of a doctor and that of a psychiatrist. As a matter of fact, the opposite has been suggested to us and that is, those who are poor people coming from the interior villages, if they come to a big place like Calcutta or Madras or Delhi, they have to go in search of the psychiatrist and when they have hardly any money to get to such cities, they are put to very great hardship if they are to go for these certificates and therefore, these two certificates may be given by the Institute where they are coming for admission of the patient. The Institute people may say after examination that the patient is not required and they may send him back.

DR. SHANTI SHETH: There are two ways of admitting a patient in a mental hospital.

MR. CHAIRMAN: One is voluntary. The second is extraordinary circumstances where relatives bring a patient.

MR. SHANTI SHETH: I am referring to extraordinary circumstances under which a relative brings the patient and makes an application that the patient should be kept in the hospital or nursing home.

MR. CHAIRMAN: The Medical Officer in charge of the hospital should certify that this patient needs or does not need to be in the hospital.

DR. SHANTI SHETH: I am not saying that. When a patient is admitted under extraordinary circumstances because a relation makes an application to the Superintendent of the hospital, here the *mala fide* of the relation comes in. He makes an application. Supposing he is brought under such conditions after administering *bhang*. If the Superintendent certifies, he is admitted as a voluntary boarder. Fair enough. But some times a situation does arise where an officer can have link with the relation. So, to protect against the *mala fides* we should say that

there should be some outside psychiatrist of a generale hospital who should also certify about the patient. This will protect the person against the *mala fides*. That is my suggestion.

MR. CHAIRMAN: What happens is this. The relative before making an application has to give with it two certificates.

DR. SHANTI SHETH: Not as a voluntary boarder.

MR. CHAIRMAN: Yes. In extraordinary circumstances it is required. It is highly unlikely that all of them are corrupt.

DR. SHANTI SHETH: I request you to read clause 19.

MR. CHIARMAN: Clauese 19 states as follows:-

> 19. (1) Any mentally ill person who does not, or is unable to express his willingness for admission as a voluntary patient, may be admitted and kept as an inpatient in a psychiatric hospital or psychiatric nursing home on an application made in that behalf by a relative of the mentally ill person if the medical officer in charge is satisfied that in the interests of the mentally ill person it is necessary so to do:
>
> Provided that no person so admitted as an inpatient shall be kept in the psychiatric hospital or psychiatric nursing home as an inpatient for a period exceeding 90 days except in accordance with the other provisions of this Act.
>
> (2) Every application under subsection (1) shall be in the prescribed form and be accompanied by two medical certificates, from two medical practitioners (including a psychiatrist) of whom one shall be a medical practitioner in the service of Government, to the effect that the condition of such mentally ill person is such that he should be kept under observation and treatment as an inpatient in a psychiatric hospital or psychiatric nursing home."

DR. SHANTI SHETH: It is in this context I want to say that usually the certificates are produced and signed by the officers of the Institute, say, the Superintendent or someone like that.

MR. CHAIRMAN: It is being suggested to us that we should allow the institution to do it.

DR. SHANTI SHETH: By all means. I do not say 'No'. But in the case of voluntary patients where the application is made by a relative, some outside agencies should also certify. This is to prevent the *mala fides*.

MR. CHAIRMAN: In India most cases are being brought by the relatives. Most cases are of poor people and if you say like that, they have to go in search of a private psychiatrist. It is stated here that among the two medical practitioners one should be a Government servant.

DR. SHANTI SHETH: The point is, the Superintendent is already in the service and the psychiatrist is also in the service.

MR. CHAIRMAN: It is stated that the "application shall be accompanied." This involves that he has to get it from outside. So, I think we should allow the institution to do it.

DR. SHANTI SHETH: There is nothing wrong in my suggestion.

MR. CHAIRMAN: Clause 19 further says:

> (3) Any mentally ill person admitted under sub-section (1) or his relative may apply to the Magistrate for his discharge and the Magistrate may, after giving notice to the person at whose instance he was admitted to the psychiatric hospital or psychiatric nursing home and after making such inquiry as he may deem fit, either allow or discuss the application.

(4) The provisions of the foregoing sub-sections shall be without prejudice to the powers exercisable by the Magistrate before whom the case of a mentally ill person is brought, whether under this section or under any other provision of this Act, to pass a temporory treatment order or a reception order, as the case may be, if he is satisfied that it is necessay so to do in accordance with the relevant provision of this Act."

The point is any relative or friend of the patient can apply to the magistrate and say that he has been wrongfully detained.

DR. SHANTI SHETHI: The two are different issues. A voluntary patient volunteers to get himself admitted and to get out of the hospital. We do not say to a patient who is suffering from a physical disorder, say paralysis, that he should go to the court. Why should a voluntary patient be asked to go to the court? He stands on the same footing.

MR. CHAIRMAN: A voluntary patient will be discharged the moment he wants to.

DR. SHANTI SHETH: Please see Clause 3.

MR. CHAIRMAN Anyway, I think this will need some examination. He will be discharged at his own request. If a relation has brought and got him admitted on the basis of some certificate, another relative can apply to the magistrate and say this is wrongfully done, and it is for the magistrate to as for such assistance as may be necessary.

DR. SHANTI SHETH: Page 9, line 45. The word "may' should be substituted by "must."

MR. CHAIRMAN: In legal parlance, we are told "may" and "shall" have the same significance.

DR. SHANTI SHETH: Page 12, Clause 24(2), it states:

"On receipt of the application, the magistrate shall consider the allegation ....."

The word "allegation" should be changed. When a doctor writes his clinical findings, they are not allegations.

MR. CHAIRMAN: It has been suggested to us that admission should be simplified, and we should only have voluntary, extraordinary circumstances and commitment by a magistrate. Temporary treatment order and emergency admission are unnecessary. Do you agree?

DR SHANTI SHETH: I agree it should be simplified.

Page 13, line 4. Sometimes what happens is this. A patient certified by a psychiatrist and medical officer is produced before the magistrate. The patient is not in an acute stage. By the time he is produced he has a lucid internal, he does not show any gross disorder and he talks very intelligently. The magistrate has no way of finding out whether he is an insane person or not.

MR. CHAIRMAN: I am afraid we cannot do anything about it. Otherwise, we will open the flood-gates for exploitation of the patients. Some of these problems will remain. They will have to exercise their judgement in each ease.

Thank you very much.

[*The Committee then adjourned*]

JOINT COMMITTEE ON MENTAL HEALTH BILL, 1978

RECORD OF EVIDENCE TENDERED BEFORE THE JOINT COMMITTEE ON THE MENTAL HEALTH BILL, 1978.

Friday, the 6th October, 1978 from 11.00 to 13.00 hours and again from 15.00 to 16.40 hours

PRESENT

Dr. Sushila Nayar—*Chairman*

MEMBERS

Lok Sabha

2. Shri Anant Dave
3. Shri Raj Krishna Dawn
4. Ch. Hari Ram Makhasar Codara
5. Shri Harikesh Bahadur
6. Shri S. Jaganathan
7. Shri Kacharulal Hemraj Jain
8. Shri Hukam Chand Kachwai
9. Dr. Bapu Kaldate
10. Shri Rajshekhar Kolur
11. Dr. Sarojini Mahishi
12. Shri Mallikarjun
13. Shri S. G. Murugaiyan
14. Shri Rudolph Rodrigues
15. Shri Sakti Kumar Sarkar
16. Shri Shrikrishna Singh
17. Shri H. L. P. Sinha
18. Shri N. Tombi Singh
19. Shri Jagdambi Prasad Yadav
20. Shri Yuvraj

Rajya Sabha

21. Shri G. C. Bhattacharya
22. Shri Krishna Nand Joshi
23. Shri Robin Kakati
24. Shri Ibrahim Kalaniya
25. Shri Khyomo Lotha
26. Shri Harekrushna Mallick
27. Shri Kalraj Mishra
28. Shri Bhagwati Charan Varma

SECRETARIAT

Shri Y. Sahai—*Chief Legislative Committee Officer*

LEGISLATIVE COUNSEL

1. Shrimati V. S. Rama Devi—*Joint Secretary and Legislative Counsel*
2. Shri Y. P. Sud—*Assistant Legislative Counsel*

REPRESENTATIVES OF THE MINISTRY OF HEALTH AND FAMILY WELFARE (DEPARTMENT OF HEALTH)

Shri Anand Prakash Atri—*Deputy Secretary.*
Shri P. V. Mazumdar—*Assistant Director General Health Services.*

WITNESSES EXAMINED

1. Dr. C. K. Parikh,
   Medico Legal Consultant,
   Corresponding Member (Forensic Pathology)
   American Academy of Forensic Sciences,
   Bombay.

2. Dr. K. C. Dube,
   Consulting Neuro-Psychiatrist,
   Sr. Medical Superintendent (Retd.),
   I|C Research Unit Mental Hospital, Agra.

3. Dr. S. S. Jayaram,
   Consultant Psychiatrist,
   Bangalore Nursing Home,
   Bangalore.

4. Dr. L. P. Varma,
   Ranchi.

सभापति महोदय : 18 से 23 के बीच में हमें फाइनेलाइज कर लेना है ताकि रिपोर्ट तैयार हो जाये । इसलिये माननीय सदस्य जो भी संशोधन पेश करना चाहते हैं वह कृपा करके साथ ही साथ भेजते जायें तो अच्छा होगा, क्योंकि तारीखों को बदलने की कोई गुंजाइश नहीं है । नवम्बर के पहले सप्ताह में आप ही लोगों ने तारीख दी थी । तो मैंने 5, 6, 7 तक दूसरी मीटिंग रखी हुई है और 8 से मीटिंग शुरू करते हैं तो रिपोर्ट तैयार करने के लिये समय नहीं रह जाता है । रिपोर्ट तैयार करके 15 नवम्बर को हम लोग उसको अडाप्ट करने के लिये आयेंगे, 4 नवम्बर की जगह । किसी को नोट आफ डिसेंट देना हो तो उसके लिये भी छपने का समय चाहिये ।

MR. CHAIRMAN: There will be no meeting on the 4th November because they say that they cannot get the report ready by the 4th. We can meet on 13th.

SHRI RUDOLPH RODRIGUES: Let us make it 15th.

सभापति महोदय : 13 को कर देंगे । या 11 को कर दीजिये । या शुक्रवार 10 तारीख कर दीजिये ताकि मेम्बर घर भी जा सकें । 11, 12 छुट्टी है । इसलिये रिपोर्ट अडाप्शन के लिये 10 नवम्बर फिक्स करते हैं । 4 नवम्बर तक रिपोर्ट तैयार नहीं हो पायेगी । इसलिये 10 नवम्बर ठीक है ।

15 तारीख तक संशोधन आप लोगों के आ जाने चाहियें ।

श्री हुकम चन्द कछवाय : सभापति जी, आपने यह भी तय किया था कि एक बार आगरा चलेंगे वहां का मेंटल अस्पताल देखने के लिये ।

सभापति महोदय : हमने मेम्बरों को कहा था कि तिहाड़ जेल का मेंटल वार्ड भी दिखा देंगे और आगरा भी ले जायेंगे । जब यहां पर 7 तारीख को 1 बजे मीटिंग खत्म हो जायेगी, दोपहर में तिहाड़ जेल का मेंटल वार्ड दिखा देंगे और उसके बाद 23 को हम लोग जब मिल रहे हैं तो लोग एक दिन पहले ही आते हैं इसलिये 22 तारीख को आगरा का प्रोग्राम सारी कमेटी का रख देंगे ।

एक माननीय सदस्य : क्लास थर्ड क्लास डिस्कशन के बाद विजिट रखिये ।

सभापति महोदय : 28 के बीच में आपको जो अमेंडमेंट देना है दे देंगे । इसलिये 22 को हम जायें ताकि जो देखें उसके आधार पर अपने संशोधनों में अगर कुछ परिवर्तन करना चाहें तो कर दें ।

आप लोग 17 को आ जाइये उस दिन दिखा देंगे । अगर बस से न जाना चाहें तो ताज ऐक्सप्रेस से चले जाइये, आगरा मेंटल अस्पताल वाले गाड़ियां स्टेशन पर ले आयेंगे ।

मेरी राय में 22 का इतवार है उस दिन का प्रोग्राम रख लीजिये आगरा जाने का ।

SHRI RUDOLPH RODRIGUES: If the hon. Members are willing, we can go on the 8th.

MR. CHAIRMAN: We have not informed them. We are having a Central Health Council meeting. Many of those people will also be here for the Council meeting. Let us have it on 22nd and I will also be with you.

Dr. C. K. Parikh

(The witness was called in and he took his seat)

MR. CHAIRMAN: Dr. Parikh: I would like to welcome you on behalf of this Committee. I would further like to go through this formality of informing you that your evidence shall be treatd as public and is liable to be published, unless you specifically desire that all or any part of it should be treated as confidential. Even if you do that, it is liable to be made available to the Members of Parlia-

ment. It cannot be kept confidential from them.

Dr. Parikh, we have received your memorandum. Before we start putting you questions, would you like to make a preliminary statement and say anything further about your memorandum?

DR. C. K. PARIKH: In chapter I, under the definition of Medical Officer, you have mentioned a gazetted medical officer insanity is a very specialized subject; and a general medical officer has very little idea about what is the psychiatric condition of a patient. So, he would not normally be justified in certifying a patient for admission to a mental hospital. So, any person who, after having graduated, has an experience of 5 years in psychiatry should be considered as sufficiently qualified to certify a patient. Secondly, there are not many persons in Government who are holding gazetted posts and who are psychiatrists.

MR. CHAIRMAN: Do you want us to put this in the Act? Normally speaking, people would naturally try to see that a person possesses the experience and knowledge required, before putting him as in charge of a psychiatric hospital. But there are only about 700 of you who are qualified psychiatrists in the country. There are areas in the country where there may be no psychiatrists at all. If you have to have some facilities for the patients there, what do you do?

Normally, if a qualified man is available, nobody wants a less qualified person to be in charge. Instead of 5 years, a person might have 4 or 3-1/2 years; and if you put the condition in the law, we will be debarring such a person from holding that post. The Bill has given the definition of a psychiatrist as anybody who, you think, has knowledge, experience and training in that field. Similarly, the medical officer may be a psychiatrist; or may not be one. He may have 5 years or more of experience, or a little less of it. But it is obvious that somebody who does not know anything about mental sickness would not be put in charge.

DR. PARIKH: Under the circumstances, anyone who is having some knowledge of psychiatry would be adequate.

MR. CHAIRMAN: You would like it to be put in the Act.

DR. PARIKH: For one reason, that certifying an insane patient is not like issuing an ordinary medical certificate. It is almost a medico-legal document. Unless a person has some training in psychiatry, I don't think he is justified in certifying a patient.

MR. CHAIRMAN. What is your view with regard to a clinical psychiatrist, or a psychiatric social worker being in charge?

DR. PARIKH: If she holds medical qualifications, yes.

MR. CHAIRMAN: Medical qualification is a must.

DR. PARIKH: Yes These are medical conditions and they are so intricate as far as the brain is concerned, that unless he has undergone training in that field, he would not be suitable to hold that post. The next point is this: under Section 13, sub-section (1) at page 6, I would suggest that there should be a definite proforma, because the records of different institutions will be kept in a different manner. Some records may not meet with the legal requirements. We have a proforma for injury report, as we have for cases brought in by the Police in respect of individual cases.

MR. CHAIRMAN: Or is it meant for the institution? This sub-section deals with the inspecting officer.

DR. PARIKH: There should be a general proforma which should have an indication as to how a particular patient was brought in, and is being

treated, so that if at any stage some problem arises, the responsibility can be pinpointed.

SHRI KRISHNA NAND JOSHI: It is not the responsibility of the inspecting officer. All the formalities are fulfilled when the patient is brought.

DR. PARIKH: The inspecting officer may see whether the proformae are kept or not.

MR. CHAIRMAN: You say that the proforma should be kept according to a standard method, so that the inspecting officer can check it.

SHRI MALLIKARJUN. Once a patient is admitted, a case sheet can be there.

MR. CHAIRMAN: The witness says it should be kept in a prescribed manner.

SHRI MALLIKARJUN: The question of an additional proforma does not arise, because there is already a prescribed proforma for case-sheets.

MR. CHAIRMAN: There should be some uniform proforma.

SHRI MALLIKARJUN: How is it going to help?

MR. CHAIRMAN: This can be done under the rules. You may please see clause 10 on page 5. We shall certainly bear in mind what you have said with regard to prescribing a proforma with regard to an individual patient.

DR. PARIKH: You see page 15, section 28 and sub-section 2. I think in an emergency even any registered medical practitioner should be entitled to get a patient admitted even in a non-registered nursing home or any nursing home where a patient can be treated on an emergency basis. It should not necessarily be a registered psychiatrist nursing home only for emergency purposes.

SHRI HARAKRUSHNA MALLICK: It cannot be for an indefinite period. Soon after tht emergency, the case should be referred to the nearby hospital.

SHRI KRISHNA NAND JOSHI: The doctor who is not a psychiatrist may show ignorance and he may be in collusion with other persons.

SHRI RUDOLPH RODRIGUES: It is covered by the wording itself.

MR. CHAIRMAN: It has been suggested to us that there should be only three types of admissions: voluntary admission, admission under extraordinary circumstances, where the relatives or friends or anybody else can bring the patient and admission through the Magisterial order. Emergency admission and other admissions can be covered under those three types of admissions. Then this chapter can be deleted. You have also said in your memorandum that the process should be simplified. Then you have mentioned four categories for admission in your memorandum and the admission should be made as easy possible. So far as number fourth is concerned, it is primarily of a voluntary nature. But with regard to others, the Magisterial order can come in. Will you agree that there should be some special provision under this? The emergency admission can be covered under extraordinary circumstances. The relatives can bring the patient to a hospital.

DR. PARIKH: That is my impression. One can resort to any of these nursing homes.

MR. CHAIRMAN: So far as the Magisterial order is concerned, it should be for the mental hospital or the nursing home, etc, as the case may be. But so far as the emergency admission is concerned, it should be covered under extraordinary circumstances. Some relative should bring the patient. It should not be necessary to go through all the complicated magisterial procedure. They should be able to bring the patients to all these places.

DR. PARIKH: That is most desirable. I would like the procedure to be simplified. In society, there is a certain amount of stigma attached to mental disease and all people would not like to go to general hospitals, if this is not simplified or if permission is not granted for treatment. Some of the persons would not like to get treatment even in some of the registered private nursing homes in such manner as would be dangerous to the society. There are several institutions which are existing. There is a certain amount of stigma attached to this with the result that people still resort to some vague places. I think the admission must be made too easy; and if a person wants to take his patient to a private nursing home for treatment, he should be allowed to do so.

MR. CHAIRMAN: This is not being denied. But all these places, nursing homes, hospitals, etc., which claim to treat these mentally sick people should have adequate facilities: and they should be liable to inspection.

DR. PARIKH: This is perfectly sound proposal. Then page 20, section 42 and sub-section 2. Normally, when a person is going to visit, I think everything is kept upto date. As soon as the visit is over, then again the things are as were before. So, if this period is made more frequent, then the people can follow up. It should be made at least three and preferably four once in every three months and once in every four months.

SHRI KRISHNA NAND JOSHI: In the last para of your note you have mentioned four categories. Keeping in view all this, don't you think that the definition should be so changed so that all cases may not go to the magistrate and only hostile cases will go to him? Otherwise, it will be difficult for the magistrate. Ultimately, the magistrate has to send him to some general hospital if the mental hospital is not there, or he will be sent to the jail. Don't you think that some such provision should be made? What is the idea behind this categorisation?

DR. PARIKH: Recently I had an occasion to go to Hyderabad in connection with the post-graduate examination. I found there was a medical student who was admitted in the mental hospital. He has been there for almost 13 years now and he has been suffering from schizophrenia, of which he should have been cured long back. Since proper facilities are not available, he is mixing with all other type of people with the result that his disease is aggravated. Separate facilities should be available for separate requirements. Again, take a person who makes an attempt to commit suicide by taking poision. He should be sent to a psychiatrist, because it shows there is some mental conflict. It is not good treating him for poisoning and then allowing him to go home without seeing a psychiatrist. At the same time, he should not be allowed to mix with schizophrenics, because this requires a different type of environment and treatment.

SHRI KRISHNA NAND JOSHI: Do you suggest a simpler definition of "mental illness" so that you may not involve him in legal complications?

MR. CHAIRMAN: If you look at sub-clause (m), the definition of "mental illness" on page 3, is very complicated. Should there be a simpler definition? Yesterday somebody was saying that schizophrenia was being abused in divorce cases. So, something should be done here also so that it is not abused. Would you advise a simpler definition?

DR. PARIKH: In such cases where admission is a problem on account of classification, it must be seen by qualified psychiatrists.

MR. CHAIRMAN: Should we change the definition in the Act?

DR. PARIKH: The definition is, I think, broad-based. Probably, it need not be changed.

SHRI MALLIKARJUN: Just now you have expressed your apprehension about the admission of patients and a psychosis patient going to a psychiatrist. The moment he knows that he is going to a psychiatrist, there will be further degeneration. In such cases, what is the alternative?

DR. PARIKH: If he is sufficiently dangerous, his relatives can apply to the court for having a court-appointed psychiatrist certify him so that he may be placed in charge of a particular psychiatrist or institution.

MR. CHAIRMAN: But, under extraordinary circumstances, the relatives can go straightway to the institution for admission. Would you object to that?

DR. PARIKH: I would not object to that.

MR. CHAIRMAN: In order to get control over the property of a person, somebody may do it.

DR. PARIKH: This will be only of a temporary nature.

MR. CHAIRMAN: What is your definition of "temporary"?

DR. PARIKH: From three days to fourteen days.

DR. SAROJINI MAHISHI: Besides being a medico legal consultant, are you attached to any hospital?

DR. PARIKH: I am attached to G. S. Medical College and K. M. Hospital. I teach forensic medicine in an honorary capacity. I am an examiner for both MBBS and MD. Being honorary, I am allowed private practice.

SHRI HAREKRUSHNA MALLICK: What is your opinion about obligatory sterilisation of those patients whose illness can be genetically transmitted?

DR. PARIKH: I think the suggestion is quite sound, and this is being practised in some countries.

MR. CHAIRMAN: All mentally sick people?

DR. PARIKH: Those who are suffering from serious genetically transmittable diseases, like degeneration of the retina.

MR. CHAIRMAN: I know of a case of degeneration of retina, which was cured later on.

SHRI HAREKRUSHNA MALLICK: In India, there are people who go in for consanguine marriages by tradition. It has been known that consanguine marriage leads to dropping of genes and loss of genetic propertries. That is why we find mental deficiency, colour blindness and so many other diseases. In order to reduce mental illness, should we not give advice to the society, to the people, that consanguine marriages may be avoided? It should be both legal as well as medical advice. What is your view about it?

DR. PARIKH: There are age-old traditions in certain communities and consanguine marriages will remain prevalent among them because they do not want property to go to any other community or family.

SHRI HAREKRUSHNA MALLICK: Science cannot be compromised on any ground. The people are doing that without knowing it. How to stop it?

MR. CHAIRMAN: Mr. Mallick, you ask questions relating to the Bill before the Committee. If you want to discuss these matters with him, you can do it privately.

I think, there are no more questions to ask. I thank you very much for giving evidence before the Committee. I would like you to have tea with us.

We now adjourn for tea break.

(The witness then withdrew).

II—DR. K. C. Dube

(The witness was called in, and he took his seat)

MR. CHAIRMAN: I would like to welcome you on behalf of the Committee and also on my own behalf and I would like to inform you that the evidence to be given by you shall be treated as public and is liable to be published unless you specifically desire that all or any part of it should be treated as confidential.

I may further explain that even though you may desire that your evidence partly or fully be kept confidential, it is liable to be made available to the Members of Parliament. It cannot be kept confidential from them.

With this I would now request you to please make any preliminary remarks that you might like to make at this stage.

We have received your statement—which is No. 15 among the papers circulated to hon. Members—and I would request you to highlight any points of your statement to refresh the Members' mind about them or added anything done to it, and then the hon. Members would like to ask you a few questions.

DR. DUBE: I thank you very much. I would like to apologise for being late because the train was late.

I would like to make a few preliminary comments in the first place.

When I wrote the previous comment sometime ago, I was in a hurry and I could not go into great detail about the same because I was leaving in a couple of days for Geneva. I want to apologise for making a statement in the first paragraph there because I thought that in the Objects of the Bill, that thing is very obnoxious and I would like that that objective should be deleted because when we trace the history of psychiatry, it was not that the society has to be protected from mental patients but it is the mental patients who have to be protected from the society. In fact, mental patients are no more dangerous than anybody else in the society, rather the people in the society are more dangerous than the mental patients. Therefore, with all apologies and with humility, I would like to say that that portion should be deleted in the Objectives. Before coming to the other parts of the Bill that is my suggestion.

I would like to add in the Statement two points:—(1) a clause which would introduce measures to protect the mentally ill from being neglected and harmed by others and to prevent him from harming himself and others, and (2) another clause to provide care and treatment to the mentally ill in the best possible manner.

In fact in this country although we have various mental hospitals and various places of treatment, I think there is much left to be desired to be done for the care of the mentally ill. I think these are the most neglected in the fields of medicine. In fact that requires a great deal.

MR. CHAIRMAN: Mentally sick patients who are violent or who have a mania to kill—there are such cases. Does not the society need to be protected from them?

DR. DUBE: But they can be handled in other ways. They can be given injections. They can be treated in other ways. They can, of course, be kept with the Mental Hospital for whom it is meant but to say that 'to protect the society from them . . .'—that portion is not correct.

MR. CHAIRMAN: Would you say 'to protect the society from such people'?

DR. DUBE: 'To protect the mentally ill from being neglected and prevent him from harming himself and others.'

MR. CHAIRMAN: This is not going to appear in the Act when it is published.

DR. DUBE: If it is going to be circulated to Members, I thought...

MR. CHAIRMAN: It has already been circulated.

DR. DUBE: I have gone through the clauses, I have made comments about the Bill.

My first reaction to the Bill is that it is most complicated and very difficult to implement. In fact it has placed a lot of responsibility on various people, especially, the person in charge of psychiatric hospitals and Superintendents. He has just to keep on moving, going to the Magistrate, getting a certificate etc. to certify that it is a fit case for admission, etc.

MR. CHAIRMAN: Please see page 3. What have you to say about definition (m)?

DR. DUBE: If you permit me, may I hand over a copy to you from which I shall read?

MR. CHAIRMAN: The memorandum.

DR. DUBE: This is a fresh one which I have prepared.

MR CHAIRMAN: Now, I would like you to enlighten us whether you think that the definition (m) 'mentally ill person' is satisfactory.

DR. DUBE: I think in general it covers all.

MR. CHAIRMAN: It has been told to us that this is liable to result in great mischief when you include psychoneuroses, psychosomatic disorder or mental sub-normality etc, etc. etc.

It was explained to us that in the Divorce Act the use of the term 'psychoses' has been greatly abused. Similarly anybody with a peptic ulser or high blood pressure which has psychosomatic element may land in a mental hospital because of the mischief of certain people who may be interested in getting the patient out of the way. Similarly psychoneuroses, psychosomatic disorder etc. it is extremely difficult to find out. We are simplifying this definition. Perhaps it was not scientific but it was used earlier namely 'a person of unsound mind' which, at any rate, includes psychoses and leave all the rest your mental subnormalities, it is suggested that there should be a separate Act altogether. They are not treatable and they cannot be improved by putting them in an institution for the mentally sick unless they have some super-imposed behaviourial problems or psychopathic condition. Would you like to comment on the ideas that have been given to us?

DR. DUBE: The definition here is alright. But the application in the subsequent act has to be specific. In fact, I have mentioned somewhere in this that you have to define in what conditions they should be admitted.

MR. CHAIRMAN: How will you do that? Is it possible to do that at every stage to define the psychosomatic disorder? There is an element of psychosomatic or psychoneuroses in all of us at some time or other in our life to a greater or smaller extent.

DR. DUBE: Well, certainly, it can be misused.

MR. CHAIRMAN: It should be corrected.

DR. DUBE: It should be corrected in the light of the subsequent clause of the Act.

MR. CHAIRMAN: Okay. Now you proceed.

DR. DUBE: Take Chapter I, Section 2(a)(i).

MR. CHAIRMAN: That is regarding the cost of lodging, boarding, clothing, medicine or any other amenity provided to such person in any psychiatric hospital or psychiatric nursing home and the expenditure for his treatment and care therein.

DR. DUBE: 'Service' should be added after the word 'amenity'.

MR. CHAIRMAN: There is somewhere something mentioned—I forget that where it is, you may tell me later—where they have said that whatever be the cost of patient maintenance of record etc, should be taken from him. A lot of objections were raised to this. We are now looking into it.

DR. DUBE: I think the 'amenity' should be the physical comforts and other facilities but it may not include 'service' as such.

MR CHAIRMAN: Okay.

DR. DUBE: I think 'service' should be included. Coming to clause 2(f), I want the following to be added:

> 'psychoneuroses of a general hospital or other hospital where psychiatric patients are liable to be kept' should be added.

MR. CHAIRMAN: You want to license even the psychiatric ward of a General Hospital.

DR. DUBE: They will of course admit psychiatric patients.

MR. CHAIRMAN: But the general feeling that was expressed before us was there is a stigma for those going to mental hospitals. If you make the general psychiatric ward of the General Hospital to come under licensing then the problem will increase. It should be left where there is absolutely no problem of application of this law. Anyway, the patients go mostly as voluntary cases; they go and can come back. They get such treatment as may be necessary. Today no law applies to the psychiatric ward of a General Hospital. So, we were strongly advised to please keep the psychiatric ward of the General Hospital out of the mischief of this Act by very eminent psychiatrists.

DR. DUBE: Suppose in a district place there is a General Hospital where would the Magistrates keep the patients? Would he keep them in jail to which I would strongly object?

MR. CHAIRMAN: This thing came up very prominently and some of the specialists objected to the magisterial order cases being kept in psychiatric ward of General Hospitals at all. We explained that there would be a great problem if they are kept in jail also. It was agreed that they should be provided with treatment and some rooms should be provided for the temporary detention of such cases till they can be removed to the proper phychiatric hospital.

DR. DUBE: May I ask you a question with your permission? You think that these general hospitals where neurotic wings are there they are free or they are not locked or restrictions are not placed on the patients.

MR. CHAIRMAN: In many of these wings, no restrictions are placed except in the case of occasionally disturbed patients who might have to be put under sedation or something like that. Take for instance, the All-India Institute of Medical Sciences. You go and see the psychiatric ward there or even in the Safdarjung or Willingdon Hospitals. They are mainly out-door patients. Sometimes they can run away. They are voluntary cases and they are of a particular type. They are not kept under lock and key. Therefore, let us not make the General Hospitals into the certified or certifying institutions. The treatment of Mentally sick patients has been revolutionised. A major part of the burden is on the out-patient services. A few patients may have to be kept temporarily for five days, three days or seven days in the hospital in a crisis. Most of the treatment should be at the O.P.D. And if you bring them under this Act, we are advised, that it is likely to do more harm than good.

DR. HAREKRUSHNA MALLICK: How will the licensing help?

MR. CHAIRMAN: Let him answer.

DR. DUBE: It means only the inspection of the facilities. It does not mean any restriction or anything. If there is licensing, people may go and inspect how the patients are treated.

DR. HAREKRUSHNA MALLICK: Whom do you recommend to inspect these wards?

MR. CHAIRMAN: Let him proceed in his own way, Dr. Mallick. He is answering one after another. We are coming to inspection. That is coming later.

DR. HAREKRUSHNA MALLICK: The point was already raised.

DR. DUBE: There is a point in that. When you are bringing the general hospitals into the ambit, it does not mean that it has any restriction; they can admit the patients under the voluntary admission clause. The only thing is that these hospitals will be liable for inspection. That is all. They may admit only ordinary cases or voluntary cases, but still they may need inspection so that ordinary and voluntary cases are dealt with in a humane manner.

DR. HAREKRUSHNA MALLICK: I think every Member has been feeling that the legacy of British era should be over after the Bill is passed. All of us feel that the word 'lunacy' or 'lunatic' should be changed. In view of this may I know whether while considering all other aspects, we can do away with the use of these words?

DR. DUBE: The word 'lunacy' has not been used since long. We are not using this word from 1925, that is the time when lunatic asylum was changed for all time. Then coming to Section 2(k), I would say that it is a very sensitive point but I would like only the practitioners registered in a State Medical Register should be allowed to practice. The portion "or a person whose name has been entered in a State Medcial Register in accordance with the provisions of that Act or a person whose name has been registered in a State Medical Register in accordance with the provisions of any other law relating to the registration of medical practitioners for the time being in force" should be deleted.

SHRI JAGDAMBI PRASAD YADAV: What is your objection to this?

DR. DUBE: Because they have not received adequate training. Many of them are untrained and they have registered their names.

MR. CHAIRMAN: There are people who were practising as compounders for the last 10 years who have been registered in U.P. this is the situation. Therefore Dr. Dubey feels it is necessary to delete this last portion.

DR. DUBE: Then in Section 2(m), the word 'addition' is mis-spelt and it should be 'addition'. There in section 2(g), it may read as psychiatric hospital or phychiatric nursing home or a psychiatric wing of the general hospital, etc. as the case may be. Then Chapter-II Sectoin 4(1). The word 'asylum' in this section in para 2 seems out of place as the word has been given up long ago and carries severe stigma. No asylums exist in India now.

MR. CHAIRMAN: We agree with you. We will call it an 'institution'. But at present our institutions are called as asylums and they are licenced. In future these may not be called asylum. We have to take cognisance of what exists today.

DR. DUBE: Then, Section 3.1 may be established or maintained for:

1. acute ill psychiatric cases

2. chronic cases needing custodial care

3. those who have been convicted for any offence

4. psychiatric hospitals for children under the age of 15.

5. those belonging to other class categories such as alcoholics, drug addicts, epileptics, psychopath, etc.

I have mentioned that the age of 18 years as provided for at present in the Bill, should be reduced to 15 years.

MR. CHAIRMAN: Why?

DR. DUBE: Because mixing of people over the age of 15 years is not good. There should be separate institutions, because mixing up acute with chronic patients or other kinds of patient is not good.

MR. CHAIRMAN: Instead of these two categories, you have suggested 5 categories.

DR. DUBE: Now Section 6(a). How can the licensing authority spell out the needs of the area? There are different categories of mental patients. They might reject an application just for trivial reasons. One mental institution might exist there. It will not be proper to give this power to the licensing authority.

MR. CHAIRMAN: You say that the phrase "having regard to the needs of the area" should be removed.

DR. DUBE: Yes. Moreover, I have done the largest investigations of mental morbidity in this country. The active rate prevalent is 18 per thousand. It was 13 million to 15 million people. In the present population of India, it should be much more. The licensing authority will not be in a position to decide how many mental patients there are. In fact, in Western countries more than 50 per cent of the beds are occupied by mental patients.

MR. CHAIRMAN: Please go through Section 6 in full. There are people who are in a position to start such institutions, and they say that they should be given licences.

SHRI MALLIKARJUN: We are all aware of the fact that the areas are identified. There may be innumerable types of mental illnesses. So, there should not be any objection to this.

DR. DUBE: The function of the licensing authority, to my mind, would be to see that at the established institutions, proper facilities for the treatment and care of the sick are provided.

SHRI MALLIKARJUN: Unless the minimum requirements are fulfilled, no licensing authority is going to grant the licence.

DR. DUBE: The licensing authority may say: "Here is a mental institution. You cannot build another institution next door."

MR. CHAIRMAN: The witness says that it is dangerous to give this power to the licensing authority.

DR. DUBE: To my mind, section 13(1) is a very objectionable one. The inspecting officer should have no access to any confidential record, unless the inspection is done by a team of psychiatrists who will maintain strict confidentiality. The inspecting officer will only report on the general treatment; but he will make no comment on the type of therapy, as it may vary according to different schools of thought.

Again, under Section 13(2) it is said:

"(2) The Inspecting Officer may interview in private any patient receiving treatment and care therein—

(a) for the purpose of inquiring into any complaint..." i.e. to see how far that complaint is true.

MR. CHAIRMAN: There are complaints that there is bad treatment and maltreatment. Should he not see the records? The patient or his relative may make a complaint. Without seeing the records, how can you deal with the complaint?

DR. DUBE: My suggestion was that it should be seen by a psychiatrist.

MR. CHAIRMAN: Psychiatrists can differ from one another.

DR. DUBE: But that is the best thing which you can do. Many times, delusional complaint is not often realized by a lay man. I say: this because I have a lot of experience in this field. People have made delusional complaints.

MR. CHAIRMAN: You say that other general complaints can be looked into by the licensing officer. But so far as examining the records is concerned, it should be done only by a psychiatrist.

DR. DUBE: Yes. I also object to section 13(2)(b).

SHRI KRISHNANAND JOSHI: What is the total number of psychiatrists in the country?

DR. DUBE: We are about 800 members of the Indian Psychiatric Society; and there are many other psychiatrists who are not its members.

SHRI KRISHNA NAND JOSHI: Other experts have said that there are 600 or 700 psychiatrists in the country. They are now needed in every hospital. Possibly, in district hospitals also. If we impose the restriction that only psychiatrists should do the inspection of the records, where will we get the people from? This will create a lot of difficulty.

DR. DUBE: I think it will not be difficult to get one inspecting psychiatrist team, in every State.

MR. CHAIRMAN: You say that for specific complaints, it may be done by a specialised psychiatrist, and not by a general practitioner—who will be a general medical man.

DR. DUBE: In fact, this point is made more clear in section 13.2(b). This clause is also objected to because this inspecting officer may be incompetent to pass an opinion on therapy while therapist may think in terms of psychotherapy treatment alone while the inspecting officer may have other views like organic and physical therapy. In my view the inspection should only be limited to maltreatment, neglect and corruption. There are people with different schools of thoughts giving different therapy. It is not necessary that you must follow a particular kind of therapy. The inspecting officer may have one view about therapy while the incharge of the patient may have a different view on the therapy.

MR. CHAIRMAN: How would you judge a patient without seeing the record?

DR. DUBE: There is no treatment at all for a chronic patient.

MR. CHAIRMAN: So many things are being done in the mental hospitals. Patients are being illtreated, exploited and dropped. How do we guard against this type of thing? If the Officer In-charge says: "This patient need no treatment." We accept it.

DR. DUBE: The inspection should be very very strict. Unless the inspection is strict, these patients are going to be maltreated.

Section 13.3: Where the inspecting officer is satisfied that the patient in a hospital or the nursing home is not receiving proper treatment and yet he has to report the matter to the licensing authority, the licensing authority may not merely issue instructions on the opinion of the inspecting officers alone but should invite the person incharge of the institution to reply or to give somethnig in his defence, to explain his conduct.

MR. CHAIRMAN: This cannot be done without giving him a chance to reply. The licensing authority will not issue instructions on the opinion of the inspecting officers alone but should invite the person incharge of the institution to reply in his defence. This is your suggestion I think this is all right. It should be included.

DR. DUBE: *Chapter III: Part I Section* 15—2 *and* 3: This is very important. I am quoting from the World Health Bulletin. Prior to recommending this section, I would like to quote the rights of the mentally retarded "The declaration on the Rights of Mentally retarded persons was adopted (by the General Assembly of the United Nations) in 1971. It reaffirms, as a just principle, that "The mentally retarded person has, to the maximum degree of feasibility the same rights as other human beings." It enumerates aspects of care, security, and protection to which the mentally retarded person is entitled and provides for very strong legal safeguards whenever any restriction or denial of these rights is found to be necessary. Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This Procedure must be based on an evaluation of the social capacity of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities." When an adult is admitted as a voluntary patient he is supposed to have an insight into his condition and to decide on his own the need of the treatment to qualify himself for voluntary treatment under section 15.1. In the case of a minor when the guardian decides so it may be at times for other intentions than good and many times the mentally retarded could be admitted with impunity as a voluntary patient under this clause. Since a voluntary patient exercises his free will he will have to get admitted under other provisions of the Mental Health Act or else the minor's interest will be misused. Therefore, it would be very essential that no mentally retarded or chronically ill person is admitted as a voluntary patient under section 15.1.

MR. CHAIRMAN: It has been suggested to us that if we are seriously considering to take out the mentally retarded person from the purview of this Act, then this objection will be removed. The parents will have to bring the patients to the hospital.

DR. DUBE: There are other methods that can be used.

MR. CHAIRMAN: We went to Srinagar. We saw some ten persons bringing a patient from 50 miles away with great difficulty. Now in order to get the patient admitted into the hospital, if they were asked to get the medical certificate and go through all the formalities, then it will be impossible for them to do go, as things stand today in respect of the Act. You must understand the problems keeping in mind the conditions of our country and what is available to the people. You must understand how they bring the case to the hospital.

DR. DUBE: I entirely agree with you, but there are provisions of the Act—Emergency Treatment Act.

MR. CHAIRMAN: We want to do away with too many types of admissions. We want to keep only three forms of admissions.

MR. CHAIRMAN: Let us simplify the Act as much as possible.

DR. DUBE: Section 15(2)—Under this clause, admission should be limited to a period of not exceeding three months and under no case should it be extended or as an easy way out his admission made permanent under any other clause.

Section 18(1)—The procedure described under sub-section 3 of section 20 is an easy way to first admit a patient as a voluntary boarder and then admit him under temporary treatment order and then ultimately permanently admitted under different sections. My suggestion to voluntary admission is that a person must be

under a condition to decide that he needs treatment and the moment such discrimination is expected to be lost, he should be discharged under the powers and then a relative or friend should be informed to take action under temporary treatment clause. Only neurotics, incippient psychotics, alcoholics and deviants should be admitted under voluntary admissions.

MR. CHAIRMAN: I would like that 90 per cent or more should be voluntary admissions. You are being very reactionary when you say that only alcoholics etc. should come as voluntary cases and not others. We want to do away with all other forms of admission except the three I mentioned.

DR. DUBE: I have included psychotics also. But they must be able to decide whether they want treatment.

MR. CHAIRMAN: They will come as voluntary cases or they will be brought by friends and relatives under extraordinary circumstances, which is an extension of the voluntary clause. Only in exceptional cases magisterial order will be necessary. You may provide the safeguard that if some other friend or relative complains to the magistrate that the patient has been wrongfully brought by that frined or relative, then a magisterial order may be necessary. Let them come voluntarily or with the help of some friend or relative. Only in cases where there is nobody or a policeman picks up somebody or somebody is violent or is a criminal —only in such cases they may bring him to a magistrate and a magisterial order will be necessary.

DR. DUBE: My submission is, once voluntary patients are brought, they can be easily admitted under some other clause.

MR. CHAIRMAN: We are doing away with some of the other clauses.

DR. DUBE: Section 18(1)—In no case should voluntary admission cases be given period of leave of absence beyond 36 hours.

MR. CHAIRMAN: Why? A voluntary patient has come. His mother is sick and he wants to be by her side. He can go for a week and come back.

DR. DUBE: It is said here that leave of absence up to 180 days may be given. It will lock up a bed in the hospital. Secondly, it will show that he did not really need hospitalisation.

MR. CHAIRMAN: We have said, it should not be more than 30 days. We want to remove the words "not exceeding 180 days in the aggregate". If he wants to be absent for more than a month, let him be discharged and re-admitted if necessary. Do you agree with this?

DR. DUBE: Yes. Then, Part II—Admission under special circumstances—This seems to me to be flawful and unnecessary.

MR. CHAIRMAN: What has been suggested to us is that 90 days is perhaps too long and this should also be reduced. The majority of the admissions today are under this provision. Relatives and friends bring the patients. We want to do away with subsequent things like temporary treatment order, emergency, etc. We want to bring them all within the purview of admission under special circumstances.

DR. DUBE: When a person is admitted on the strength of two medical certificates, why should he be discharged by the Magistrate? He can be discharged by the Medical Officer within a specified period of three months.

MR. CHAIRMAN: Further, it has been suggested to us that these two certificates may be provided by the officers of the institution itself because those people who come from outside, will find it extremely difficult to run round and get two certificates. These

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doctors will fleece them. Therefore, what is necessary in voluntary cases is that they should be discharged by the Medical Officers whenever necessary.

DR. DUBE: The idea behind this to is to make the treatment simple.

MR. CHAIRMAN: We want the whole thing to be made very simple. In extraordinary cases may be included all other we want to do away with the emergency and temporary treatment orders.

DR. DUBE: The Magistrate in the temporary treatment orders should visit the hospital within 36 hours. If the patient is paraded before the Magistrate by the Medical Officer, it will be a difficult business and it will create stigma.

MR. CHAIRMAN: When we have simplified it, there is no question of the Magistrate coming into most cases.

MR. CHAIRMAN: Will you have any objection to simplyfying the procedure if cases are brought by friends and relatives, there is no need to refer to the Magistrate and they are treated as voluntary cases unless and until somebody complains that there is some *mala fide* intention.

DR. DUBE: It would be a welcome step if he is kept without the Magistrate's orders up to 3 months as a temporary treatment case. It will remove all stigma.

About the Magistrate's visit, I think it is the duty of the Magistrate to visit the hospital at least once in a week.

MR. CHAIRMAN: You have got Inspectors and those Inspectors are the hospital visitors. You may ask the Visitors to go and visit more frequently than is provided here. To ask the Magistrate to visit the Mental Hospital every week is something which we cannot really appreciate.

DR. DUBE: In places where psychiatric hospitals or psychiatric nursing homes do not exist, the patient is usually detained in a jail. I think, this is most humiliating and most inhuman aspect of the whole thing specially when women are concerned. I think the patients should be admitted or detained in a general hospital.

SHRI KRISHNA NAND JOSHI: Dr. Jain made a study and according to his study, 18.31 per thousand population suffer from mental diseases. Here in this case, they have suggested that every district hospital should have a psychiatric clinic with a minimum of five beds. If such a provision is made, will it not solve your problem?

DR. DUBE: For the last two or three plans, they were planning to have 800 psychiatric clinic and hospitals but not a single came into existence.

SHRI KRISHNA NAND JOSHI: If such a provision is to be made without any facility, how will they treat them?

DR. DUBE: Facilities do exist in general hospitals. To keep a mental patient there for ten days is very easy.

Coming to part IV(C) Section 28, sub-sections 3 and 4, I consider that to saddle the medical officer with the charge of producing a patient before the magistrate is a cumbersome and an impractical steps. In the first place as little confrontation should be made with the magistrate in the court for the obvious reason that it gives an impression as if a criminal is being produced. In the second place it would be very inconvenient for the medical officer to take the patient back and forth from hospital to court; thirdly it is not conducive to enhance self-esteem of the patient, thus paraded with an escort in the public, neither the confidentiality will be assured. I suggest that magistrate should visit the hospital in each case.

About Section 24(7), I wonder whether it would be practical for the magistrate to examine the patient in camera although this rule has always existed.

MR. CHAIRMAN: This rule is already there.

DR. DUBEY: But this is never done. About 27(1). I would like to add 'citizen' along with the officer of a police station.

MR. CHAIRMAN: Section 28(C), we are thinking of taking it out. Now Section 29. For instance, a person having delusions when he comes before the Magistrate, he talks absolutely normally. If he is kept under observation for a day or two, then he may display some of this and other traits.

DR. DUBE: I do not think a good Psychaitrist will be in a position not to do it in a day.

MR. CHAIRMAN: 30 and 31 have been dealt with. Now, 11(B) of Indian Lunacy Act.

DR. DUBE: This needs to be incorporated somewhere in the new Act in a modified form for foreign nationals in which case the ambassador or one of his functionaries should be deemed to be the magistrate to order admission to such psychiatric hospitals or nursing homes which the Government will decide to receive the patient.

MR. CHAIRMAN: We will look into it.

Chapter IV—Part II—Discharge.

DR. DUBE: In my long experience I have found that the visitors do not often make a quorum of three with the result that the patient who has been waiting and hoping for discharge for a long time is unnecessarily kept back and gets frustrated. I would suggest that either this section be done away with and all powers be given to the incharge of the hospital or there should be two visitors who may approve discharge. The persons incharge of the hospital should be quite competent.

MR. CHAIRMAN: I am inclined to agree with you.

DR. DUBE: Section 48(3). The leave of absence should not be more than 30 days at a time to the maximum of 60 days. Long leave of absence locks up a bed besides if a person can remain out for 180 days he can probably remain out all the time or in case he is to be admitted the formality should be gone through again after he is discharged after 60 days.

Section 49. I do not think that Magistrate should interfere with the grant of leave when refused by the hospital authority because it might interfere with therapy.

Chapter VI, Section 88. There is no provision how the recovery of cost of maintenance will be made and by whom when the relatives liable to pay the cost fair to pay. Responsibility for recovery is the Magistrate's who orders the fixation of maintenance charges but usually the psychiatric nursing home or the hospital suffers if this payment is not made and is usually held responsible for non-recovery.

MR. CHAIRMAN: It has been suggested that the recovery should be made from the personal possesions of the patient like ring etc. I think, this is very unfair. We went to Srinagar and saw there that a patient was keeping her silk clothes bundle etc. under her arms. She would not part with that. So, the recovery should be made either from the relatives or the State should bear the expenses.

DR. DUBE: But the Government is all the time pressurising the Superintendent of the Hospital to recover the amount. That is why, I say that recovery should be made by a summary trial by the magistrate.

SHRI KRISHNA NAND JOSHI: From whom?

DR. DUBE: From the patient's relatives who have filled up the agreement form to pay the dues.

MR. CHAIRMAN: We will examine this.

SHRI HAREKRUSHNA MALLICK: You have rightly said that this could be completely done away with.

MR. CHAIRMAN: We will discuss it afterwards.

DR. DUBE: My last point is: No penalty has been prescribed for a wrong certification and no immunity has been provided if act done in good faith even though there may be an error of judgment.

MR. CHAIRMAN: Dr. Dube, we are coming to Agra on the 22nd and if after sending your Memorandum which we are circulating, any of our hon. Members have any further questions to ask you, I hope you will be willing to answer them here and also you will tell the authorities of your institution to make the necessary arrangements for our visit. Of course, the Ministry will be informing them, but we are also telling you.

(The Committee then adjourned)

III. Dr. S. S. Jayaram.

(The witness was called in, and he took his seat)

MR. CHAIRMAN: I would like to welcome you to this sitting of the Committee. It is very kind of you to have spared time to appear before us.

(Direction 58 was read out)

Now you have sent your detailed Memorandum, which has been circulated to all the Members. Would you like to make a preliminary statement, you are welcome to do so. After that our Members may ask you some questions.

DR. JAYARAM: Thank you, Madam for the permission so that I can give you some introduction about this. This is a body from both the Houses which has taken pains to visit the patients all over India many big and small institutions and psychiatric departments and because of this extensive information and data collection that you have made, I think, you should not stop simply with this Bill, which has got an idea about the admission, stay and discharge, but should be able to incorporate and recommend on all issues of law which relate to Mental health. There are many aspects which require the consideration of an august body like this, especially things like privileged communication and confidentiality and regarding the testifying capacity and competency. I want you to give some more attention to the rights of the patients inside as well as of the Psychiatrists. I would like to use all the knowledge that you have got on improving the present mental health facilities all over India and also to formulate if possible a future mental health plan for our country. Now I would like to make a request on behalf of the Indian Psychiatric Society. We have been requesting you to get this Bill passed for the last 25 years. I remember, Madam, when you came over to Bangalore in 1964 you addressed our Indian Psychiatric Society Conference and you promised to take it up and see that it is done.

MR. CHAIRMAN: It was finalised, the Bill was prepared, but they could not give time to introduce it and to pass it in the Lok Sabha. So, the Act has not materialised. Now, I hope that this time...

DR. JAYARAM: I want that this time this Bill must be passed without any postponement.

MR. CHAIRMAN: You have made some general observations in your Memorandum. Would you like to go on to the suggestions for alterations which you have given in your Memorandum?

DR. JAYARAM: On Page 3 (m), regarding the definition of 'mentally ill person', I would like to say that the definition is perfectly alright. But mental deficiency is entirely different from mental disorder.

MR. CHAIRMAN: I may tell you, it has been presented to us by several people that we should delete mental deficiency and mental subnormality from this Bill. It has also been told to us that we should not keeps this definition include Psychoneurosis and Psycho-somatic disorders. We should simplify this definition. Some people suggested that the simplest form would be what was used a long-time ago viz., "persons of unsound mind". I do not know whether that is satisfactory. But if you have something to give us now, you may do so. Otherwise, you may go back and send it to us within the next three or four days, not later than that.

DR. JAYARAM: I shall send it from Bangalore.

MR. CHAIRMAN: The next one is 'q'.

DR. JAYARAM: The meaning of 'convalescence' is recovery and it is only a recovered person who is a convalescent. For that the Mental Health Act should not come in. For example, in Bangalore, I have got half-way Home, into which I have taken nine men and nine women and these people have been discharged from the Hospital:

MR. CHAIRMAN: You would like us to delete:

> "and includes a convalescent home established or maintained by the Government or any other person for such mentally ill persons;"

DR. JAYARAM: Yes.

MR. CHAIRMAN: You have also stated somewhere else that Psychiatric words of General Hospitals and psychiatric clinics in General Hospitals should not come under the purview of this Act.

DR. JAYARAM: This is a very important point and there are conflicting views on this.

MR. CHAIRMAN: I just wanted to ask you one thing. The idea of licensing is that there should be adequate facilities and there should not be exploitation of the patient. Do you think it is unreasonable to ask all these Government people also to have certain minimum facilities?

There is a clause which says, this law will not apply to governmental institutions. It has been told to us that governmental institutions must also be licensed and must be subjected to inspection so that the Government itself does not neglect mental Hospitals etc. and does what should be done.

DR. S. S. JAYARAM: It must apply both to governmental and private institutions which are entirely meant for the mentally sick patients. At present, all over India, the psychiatric units of general hospitals are treating about a thousand patients per day. If these units have to take a licence, undergo inspections and apply for licence one year before it lapses, if these people have to undergo all these troubles, I do not think it is proper. There are also general nursing homes where there is a psychiatrist in attendance or a psychiatrist comes from outside to treat the patient. It is not necessary and proper to bring them under licensing. These people would have to send a report to the court and to various other people regarding the mentally ill persons.

MR. CHAIRMAN: If there is a nursing home or a hospital which is entirely for the care of the mentally ill persons, you would like that to be licensed.

DR. S. S. JAYARAM: Yes; if it is purely meant for the mentally sick patients, whether it is a nursing home

[Dr. S. S. Jayaram]

or a hospital. But not for a general nursing home or a general hospital.

MR. CHAIRMAN: You have stated that some psychiatrists are still non-gazetted.

DR. S. S. JAYARAM: I made further enquiries and found that most of the psychiatrists are also gazetted. Supposing there is a psychiatrist who is not a non-gazetted officer, he should be allowed to give a certificate.

SHRI S. K. SARKAR: As regards the licensing authority, do you suggest that it should be done from the Centre or from the States, as the case may be or do you suggest one single licensing authority at the Centre

DR. S. S. JAYARAM: For those hospitals which come under the Centre, the licensing authority could be given to the Central Government and for those hospitals which come under the geographical area of the States, it should be given to the States.

SHRI S. K. SARKAR: This is a Central legislation. Don't you think that there should be one licensing authority at the Centre?

DR. S. S. JAYARAM: I suppose this will be subsequently adopted by the various State Governments with certain modifications.

MR. CHAIRMAN: In any case, by a notification, they will apply it in their territories. The implementation has to be done by the States, not by the Central Government. In this Bill, there is a provision that the States can make the rules. It has been suggested to us that the rules should be uniform and that the rules should be Centrally made. What is your opinion?

DR. S. S. JAYARAM: The rules should be uniform and they should be Centrally made.

SHRI S. K. SARKAR: There are also clinical psychologist who treat patients. But they are not termed as medical officers. Do you think that they should be given a chance to treat the patients

DR. S. S. JAYARAM: No, Sir. The clinical psychologist carries out only the tests and helps the psychiatrist. He is a para-psychiatrist personnel. He has not got the medical qualifications. He cannot give drugs and ECT. Only a medically qualified person can give the treatment.

Then, I come to p. 5, line 34, Chapter II, 10. We have not given sufficient attention in the Mental Health Bill to the looking after the patients who are kept in the psychiatrist hospital. I want to add, "He shall not use physical punishment, mechanical restraint or solitary confinement unless they are absolutely necessary. Such means of restraint must be kept under lock and key and should be issued only by the Superintendent."

Otherwise, there will be a tendency to use these methods, the binding of the hands, securing the patient to the bed and such forcible restraints. It is to prevent that I want to suggest this.

MR. CHAIRMAN: I know of a case in the All India Institute of Medical Sciences, a case of a young engineer who became so violent that he had to be tied down. Nobody wants to tie down the patient unless it is absolutely necessary. Why put it in law? If necessary, you can put something in the rules as to who should keep these things, etc. We shall bear in mind your suggestion.

DR. S. S. JAYARAM: That is all right.

MR. CHAIRMAN: As regards p. 7, Chapter II—13(b), it has been suggested to us to delete this. You are also of the same opinion.

DR. S. S. JAYARAM: Yes.

I think, this is something different. Clause 13(2)(b) read:—

"(b) in any case, there the Inspecting Officer has reason to believe that any in patient is not receiving proper treatment and care, and where the Inspecting Officer is a medical practitioner, he may also examine the patient in private and may require the production of any medical records relating to the treatment and care of the patient in the psychiatric hospital or psychiatric nursing home and inspect the same."

Do you want to add something here?

DR. JAYARAM: I want the following to be added, namely:

"The Inspecting Officer cannot enforce the psychiatrist to divulge professionally confidential matter."

There is a professional confidence between the doctor and the patient, and this assumes extraordinary proportions particularly in a psychiatric patient. The psychiatrist has to promise the patient that he will not divulge all these matters. Otherwise, the patient will never open his mouth. The doctor notes down these matters and puts them in the confidential record. Except with the consent of the patient, this confidential matter, especially regarding his family affairs, sexual affairs, etc., should not be divulged to the inspecting officer.

MR. CHAIRMAN: Please see page 20 of the Bill, Clause 41, lines 14, 15 and 16; there is a proviso there:

"Provided that the Visitors shall not be entitled to inspect any personal records of an inpatient which in the opinion of the medical officer in charge are confidential in nature".

This is for the visitors. But so far as the inspecting officer is concerned, if he has reason to believe that a patient is not receiving proper treatment and care and he also is a medical practitioner—if you like, we may say here, a medical practitioner specialised in psychiatry or a psychiatrist—would you still object to his inspecting the records? Suppose the relatives complain that the patient is not getting proper treatment, and the inspecting officer comes to check whether it is true or not. How can he check unless he looks into the records?

DR. JAYARAM: The inspecting officer can inspect only things such as food, clothing, etc. The attending psychiatrist is the person who knows what is confidential. You can leave it to the discretion of the attending psychiatrist what information to give and what not to give.

MR. CHAIRMAN: Suppose the patient has complained that he is not getting proper treatment.

DR. JAYARAM: It is not necessary to go through his confidential record for that.

MR. CHAIRMAN: The record will have to be made available to the inspecting officer. Otherwise, how is he to determine whether things are being done properly or not?

DR. JAYARAM. In the rules—though not in the Bill—we can so that each person can have a general case sheet and a confidential case sheet; the confidential case sheet shall not be divulged to anybody except with the consent of the patient.

MR. CHAIRMAN: Now we come to page 7, part I—admission on voluntary basis, Clause 15.

DR. JAYARAM: There is something here which I have not put in writing. If you permit, I will say that now. All mentally ill patients should be treated on the same lines as the physically ill patients. There should be no difference at all in the

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dignity that we give, in the treatment that we give and in the way we look after them—between physical and mental patients. If a person suffers from fever or cough, he just goes to the hospital and gets himself admitted; he just indicates his desire to become an inpatient. Why should the mental patient sign a form for this? I cannot understand this. There is no necessity for any voluntary patient to sign a form. He can just indicate his desire to be admitted. If he has to sign a form, then it smacks of something legal or binding; he will be afraid that, if he signs, he will have difficulty in getting discharged. If a person is admitted on a voluntary basis, for discharge also he may just indicate his desire and get discharged. He does not have to sign again. Of course, if the medical officer finds that he requires hospitalisation, then there are various other laws for hospitalisation.

MR. CHAIRMAN: "Any person (not being a minor), who considers himself to be a mentally ill person and desires to be admitted to any psychiatric hospital or psychiatric nursing home..."

Here, after 'psychiatric nursing home', you want to add:

"or a psychiatric unit of a general hospital or a general nursing home with psychiatric facilities and a psychiatrist in attendance."

Here, when he comes to a licensed institution, he should apply in writing. Otherwise, later on, he might turn round and say, 'I never wanted to be admitted', And the doctor may be in difficulties. So I think you better leave it as it is. If he wants to go to a psychistric hospital or nursing home, let him take an application that 'I want to go'. In psychiatric ward of a general hospital he is going even today without an application .

DR. JAYARAM: That will be all right.

MR. CHAIRMAN: Page 8, Chapter III, Part II(1), line 42.

This is regarding 90 days. 'Not exceeding 90 days'—what do you wish to say? A voluntary case can always ask for release and he can go. He comes voluntarily and he goes voluntarily. It has been stated somewhere discharge is to be allowed by visitors or—Magistrates and all that. He wants to take all what away. The doctor there decides, 'Let him go'. The doctor admits and he discharges the patient. We do not want any difficulties for these voluntary cases.

DR. JAYARAM: Cl. 19 is admission under special circumstances it is not voluntary.

MR. CHAIRMAN: Cl. 19 is with regard to admission under special circumstances. There the relatives or friends bring the patients and they say please admit. They should have two certificates from doctors. It has been suggested that they may come from the interior. Five or six or seven of them come and with great difficulty they bring the patient to the town for admission. If we then tell them that they should go and bring two certificates, there will be difficulty and may be very kindly exploited. They do not know where to go. They do not know any practitioner in that area. In all such cases, all the formalities should be done by the doctors of the Mental Hospital themselves another than their going here and there in search of certificates. Are you agreeable?

DR. JAYARAM: It is quite permissible.

MR. CHAIRMAN: You think this is what should be done? The language—We can take care of.

Then page 13, Chapter III part IV. 25(1)—every officer in charge of a

police station may assist etc. Here, it has been suggested to us that short term treatment, emergency treatment etc. makes it very complicated and that these should be only three forms of admission—voluntary admission, admission in special circumstances which can take care of short-term cases and emergency admissions and commitment by the Magistrate. You agree with that?

DR. JAYARAM: Yes, voluntary, (short-term) and special circumstances and commitment.

MR. CHAIRMAN: So you do not have anything to say with regard to this.

Then with record to clauses 13 and 26(1) and also 26(2)(a)—if the Medical officer certifies that a person is a mentally ill person, here you want to add 'Medical Officer or a Psychiatrist'.

DR. JAYARAM: A Psychiatrist will be in a better position because he is more in the know of the mental diseases then a Medical Officer.

MR. CHAIRMAN: Will there be so many psychiatrists available? After that you go to page 15, clause 28(1)—line 6.

DR. JAYARAM: It is the same thing.

MR. CHAIRMAN: More, the important thing is that we are willing to have psychiatrists everywhere. But there is the dearth of psychiatrists. If they want all these psychiatrists will there be psychiatrists available?

DR. JAYARAM: I doubt it. At present they are there only in some States. It is not possible.

MR. CHAIRMAN: Let us put 'A psychiatrist or a medical officer' so that preference will be for a psychiatrist.

DR. JAYARAM: That will solve my problem.

MR. CHAIRMAN: Then page 15, clause 26(5) line 45—Now we were told very specifically as far as possible Magistrates should not to commit cases to the jail.

We asked the question: if there is no mental hospital, and if you do not want to send him to jail, where are such patients to be sent? The suggestion was that there may be one or two special rooms provided for such cases in the General Hospital. Will you agree with that?

DR. JAYARAM: The whole idea was that the stigma should not attach. 'Psychiatric ward of the General Hospital'.

DR. JAYARAM: That is all right. Many of these people who require admission as an emergency will be in acute psychiatric reactions where these people can be cured very quickly within 4 or 5 days of treatment and with heavy tranquillisers they will become better. If you admit them into the mental hospital, the stigma may come. So, as long as the stigma is not there and, if there is no psychiatric unit with a separate room, that may be all right. I agree.

MR. CHAIRMAN: I think we should leave it at that. Let them make necessary arrangements.

Now, we go to page 16, 32 line 42. Here again you want the same thing. After the 'psychiatric nursing home' you want 'psychiatric ward of a general hospital'. I suppose in the case of mental hospital the magistrate will order admission. Do we need to add here the 'general ward' or 'psychiatric ward of a general hospital' when the trend is to keep it out of the purview of the Act?

DR. JAYARAM: What I had in mind is that it may be determined in such place as they may deem proper. I do understand the removal of such a person to a hospital. What actually happens is that some of the

people are kept away in lock up or they are sent away to the jail.

MR. CHAIRMAN: What you are wanting is that pending removal to mental hospital, they may be kept in a general hospital or psychiatric ward of a general hospital and not in jail?

DR. JAYARAM: Not in a judicial jail or police lock up. Then I will be satisfied with that.

MR. CHAIRMAN: Okay. Then, on page 19, 39 line 32, you have said that a mentally ill person is entitled to send or receive letters and have visitors according to the rules of the hospital. Is it necessary that all powers and functions of magistrate may be exercised or discharged by the Commissioner of Police and by the officers incharge of the police station under this Act. Such functions may be discharged by any police officer not below the rank of an Inspector.

DR. JAYARAM: I think this should be done.

MR. CHAIRMAN: In fact someone said that this was too much for the Police inspector. We should remove this restriction. Any police officer should do. Otherwise it will become very difficult. Inspectors are not found everywhere. What do you say to this?

DR. JAYARAM: I thiuk the police people should be kept out of it.

MR. CHAIRMAN: How can we keep them out of this? If you bring in the magistrate, you have to bring in the police because you cannot bring in the magistrate without the police. If the man is found to be wandering in a village, and there is no body to take care of him, the policeman catches hold of him and brings him to a Magistrate. If a citizen does not do it, then the police will have to do that.

DR. JAYARAM: The police are entitled to take wandering men especially if they are dangerous. I have seen in some countries where there are what you call Mental Welfare Officers and they are not police people and I think that is in U.K. and in some other country too. The mental health welfare officers can be deputed; they can do that. We have not got such officers. We have no such officers in our country as yet.

MR. CHAIRMAN: Under the circumstances what do you say?

DR. JAYARAM: Only when the relative of the psychiatrist requests for the help of the police for admission of these people they can come in.

MR. CHAIRMAN: Anyway let us proceed further. Where do you want to provide this? That is about sending or receiving letters.

DR. JAYARAM: I think this is misplaced. Somehow or other I find that under the Mental Health Act, we should have got someone for looking after the person. We have done about admission as also about various legal things. There is no provision for the care of the patients. How to protect this legal right of the patient? He needs the legal rights of the protection that if a patient is not adjudged incompetent, then he can certainly receive letters and he can communicate with anyone. He can have the right to do anything he likes.

MR. CHAIRMAN: Let this be taken care of in this Bill. Page 23, Chapter IV, Part IV—Removal 50(1), line 33. The Bill provides:

"50(1) Any mentally ill person other than a voluntary patient referred to in section 15 may, subject to any general or special order of the State Government, be removed from any psychiatric hospital or psychiatric nursing home to any other psychiatric hospital or psychiatric nursing home within the State, or to any other State with the consent

of the Government of that other State."

"Provided that no mentally ill person admitted to a psychiatric hospital of psychiatric nursing home under an order made in pursuance of an application made under this Act shall be so removed unless intimation thereof has been given to the applicant."

Here what is the problem?

DR. JAYARAM: We had received some complaints from various other countries. So far, it is not in India—that the Government interferes and just transfers one patient from one psychiatric hospital to another and from there to another and then he was taken away. So as to prevent such a thing, if there is a transfer of the patient from one psychiatric hospital to another, it must be done only for psychiatric reason and not for any other reason.

MR. CHAIRMAN: How can it be? After all in Bangalore a lot of patients come from Tamilnadu and your hospital is always full. You do not have place for your patients. The State Government says they should be taken away to Tamilnadu from that State.

DR. JAYARAM: That is perfectly all right. There should be third party to decide about that.

MR. CHAIRMAN: You say about the transfer from one hospital to another or from one State to another wthout the consent and without the intimation to be given to the patient. That is not all right.

DR. JAYARAM: That can be done.

MR. CHAIRMAN: Page 31, Chapter VII—Penalties and Procedure—Here again look at sub-section (1).

"Whoever, after conviction under sub-section (1), continues to maintain a psychiatric hospital or psychiatric nursing home in contravention of the provisions of Chapter II, shall, on conviction, be punishable with fine which may extend to one hundred rupees for every day after the first day during which the contravention is continued."

DR. JAYARAM: Under 85(1) the provision is for a fine and 85(2) is only a continuation of this provision. Under 85(1) on conviction a psychiatric is punishable with imprisonment for a term which may extend to three months, or with fine which may extend to two hundred rupees or with both, and in the case of a second or subsequent offence, with imprisonment for a term which may extend to six months, or with fine which may extend to one thousand rupees, or with both. I only want that if psychiatric unit of a general hospital or general nursing home with psychiatric facilities are permitted to treat their voluntary patients, they are not to be liable to penalities if they take them and treat them.

MR. CHAIRMAN: You were asking us earlier not to bring psychiatric wards of general Hospitals within the purview of this Act. Why do you want to mention them in this act at all? It the psychiatric ward of the general hospitals is to be kept outside the purview of this Act, why do you want to mention that in the Act at all?

DR. JAYARAM: I just want to make sure about it.

MR. CHAIRMAN: I thought you said earlier that they should be kept outside.

DR. JAYARAM: Yes.

MR. CHAIRMAN: So, that is all.

DR JAYARAM: No. There is one more thing on page 33 Chapter VIII. The mentally ill persons who has been admitted has a right to vote, hold property and has other rights of a citizen of India unless he is separately adjudicated as incompetent.

MR. CHAIRMAN: I might tell you that we are protecting his property rights. Your point is well taken and

we shall see if it has not been provided for else where it will be provided for.

Thank you.

(*The witness then withdrew*)

IV—Dr. L. P. Varma.

The witness was called in, and he took his seat).

MR. CHAIRMAN: Dr. Varma we welcome you, on beheaif of the Committee, for having taken the trouble to come here and give us the benefit of your evidence.

I would like to make it clear to you that the evidence that you give is liable to be published and made available to Members of Parliament even though you may desire all or any part of the evidence to be treated as confidential. This is the stipulation in our Lok Sabha rules which I wanted to point out to you. Your Memorandum has been circulated to hon. Members already. If you want, you may make some general comments now and later on, members may ask you certain questions.

DR. VARMA: Thank you, Mr. Chairman and Members of the Committee, for having invited me before you for giving my views on this Bill.

First of all I would like to say that on the whole the Bill is very progressive and we like it and we welcome it too.

MR. CHAIRMAN: On page 2 Section 2A(2) regarding the expenditure to be incurred for having such persons to the hospital and from hospital, you have stated that this adds unnecessary burden for the Institution.

DR. L. P. VARMA: Yes, this is an unnecessary burden on the hospital. That is why I have said that the expenditure should be borne by his relatives.

MR. CHAIRMAN: Therefore you suggest that we should delete (1) and (2) part of this Chapter . . .

DR. L. P. VARMA: Yes, Madam.

MR. CHAIRMAN: After that you have stated an page 2 Clause 2(j) you want a clarification here regarding the medical officer. Your doubt is that if there is a separate Wing for these patients, then you want it to be separate or a part thereof so that there may be separate. Wings for various people like chronic cases or acute cases and so on.

DR. L. P. VARMA: Or there may be a psychiatric wing as in general hospital.

MR. CHAIRMAN: We have been advised that this should not be brought under the purview because of the stigma attached to admissions to a mental Hospital.

DR. L. P. VARMA: I do not now know why this Wing should be removed from the hospital. My idea is to have a smaller number of patients, say about 300 or so, so that in future the State Government may create mental hospital in different districts.

MR. CHAIRMAN: Then coming to page 4, Clause 4, it is suggested that the word "asylum" should be replaced by words "mental hospital". Why this word "asylum" has been kept here it has been explained to us is because there are certain institutions today called asylums.

DR. L. P. VARMA: Madam, in 1922 there was a lot of discussions on this point and the word "asylum" was removed and it was replaced by words "mental hospital".

MR. CHAIRMAN: Will the secretariat please examine why there was a lot of discussion on this point and whether the word "asylum" has been removed. Instead of the word "asylum" it may also be examined whether the word "institution" can be used. Now, page 34, clause 52. Here he wants that even if the guardian does not come, the patient should be removed to the place of his residence. So, we have to add here a word "not", that is, it will read as "if the guardian

does not come to take charge of him...".

DR. L. P. VARMA: Yes, Madam, that is what I wanted. You may examine it, because to-day in a large number of cases, nobody comes to take them away. At page 7 of the Bill, i.e. Chapter III section 18 it is said:

"....every voluntary patient, who is admitted to any licensed psychiatric hospital or licensed psychiatric nursing home, shall be liable to pay the cost of maintenance to the licensee of the hospital or nursing home; and, in the case of a voluntary patient, who is a minor, such cost shall be paid by his guardian.

(2) The State Government may, having regard to the nature of any licensed psychiatric hospital established or maintained by that Government and the means of the voluntary patients, provide, by notification, that any class or category of voluntary patients admitted to any such licensed psychiatric hospital or class of such hospitals, shall not be liable to pay...".

Why do we want to have this clause at all? If, for general conditions, the patients can be treated free—when they are brought by magisterial order they are treated and kept free—in the case of a patient who seeks treatment voluntarily why should we say something different?

DR. VARMA: Thank you, Madam, That is what I wanted.

MR. CHAIRMAN: Your next point is on clause 18. If a patient had voluntarily sought admission, and if he says he will not pay, he will not pay. At the time of admission you can decide whether he will pay. It depends upon the status of the patient. There are general wards and paying wards in general Hospitals. We can ask the State Governments to formulate the rules. They can say that certain income groups should pay, and certain other income groups need not pay. It should be just like the position obtaining in General Hospitals. Clause 18 says:

"(1) The medical officer in charge of a psychiatric hospital or psychiatric nursing home shall, on an application made in that behalf by any voluntary patient, and, in the case of a minor voluntary patient, by the guardian of the patient, grant (unless such medical officer initiates action under sub-section (3) of section 20), within twenty-four hours of the receipt of such application, leave of absence to the patient for a period not exceeding thirty days at a time and not exceeding one hundred and eighty days in the aggregate or discharge the patient from the psychiatric hospital or psychiatric nursing home."

Dr. Varma says, "Why do you want to give leave of absence? A voluntary patient can come and go at his will." What happens if he goes—and if you don't provide for leave for 1 or 2 days—and he comes back and there is no room? We have been advised that we should delete the portion "after 30 days."

DR. VARMA: To keep the hospital bed vacant for 30 days, will deprive other patients of such beds.

MR. CHAIRMAN: Do you want to reduce the period? You say that due to wedding in the family, sickness of mother etc. or his wishing to see his relations, he may like to go away for short periods, and that the provision of leave upto 30 days is necessary—but not upto 6 months.

DR. VARMA: Yes, Madam, It will be all right then.

MR. CHAIRMAN: Thank you very much. Dr Varma.

DR. VARMA: Thank you.

(The Committee then adjourned.)

RECORD OF EVIDENCE TENDERED BEFORE THE JOINT COMMITTEE ON THE MENTAL HEALTH BILL, 1978.

Friday, the 6th October, 1978 from 11.00 to 13.00 hours and again from 15.00 to 16.40 hours

PRESENT

Dr. Sushila Nayar—*Chairman*

MEMBERS

Lok Sabha

2. Shri Anant Dave
3. Shri Raj Krishna Dawn
4. Ch. Hari Ram Makkasar Godara
5. Shri Harikesh Bahadur
6. Shri S. Jaganathan
7. Shri Kacharulal Hemraj Jain
8. Shri Hukam Chand Kachwai
9. Shri Rajshekhar Kolur
10. Dr. Sarojini Mahishi
11. Shri Mallikarjun
12. Shri S. G. Murugaiyan
13 Shri K. Ramamurthy
14. Shri Rudolph Rodrigues
15. Shri Sakti Kumar Sarkar
16. Shri Shrikrishna Singh
17. Shri H. L. P. Sinha
18. Shri Yuvraj

Rajya Sabha

19. Shri R. D. Jagtap Avergoankar
20. Shri Krishna Nand Joshi
21. Shri Robin Kakati
22. Shri Maqsood Ali Khan

23. Shri Khyomo Lotha

24. Shrimati Noorejehan Razack

25. Shri Bhagwati Charan Varma

SECRETARIAT

Shri Y. Sahai—*Chief Legislative Committee Officer.*

LEGISLATIVE COUNSEL

1. Shri V. S. Rama Devi—*Joint Secretary and Legislative Counsel.*

2. Shri Y. P. Sud—*Assistant Legislative Counsel.*

REPRESENTATIVES OF THE MINISTRY OF HEALTH AND FAMILY WELFARE (DEPARTMENT OF HEALTH)

Shri Anand Prakash Atri—*Deputy Secretary.*

Shri P. V. Mazumdar—*Assistant Director-General Health Services.*

WITNESSES EXAMINED

1. Colonel (Dr.) Kirpal Singh,
National Professor Psychiatry,
Consultant Psychiatrist,
New Delhi.

2. Dr. G. G. Prabhu,
Assistant Professor of Clinical Psychology,
Deptt. of Psychiatry,
All India Institute of Medical Sciences,
New Delhi.

3. Dr. S. Dutta Ray,
Hony. Psychiatrist,
Holy Family Hospital,
Tirath Ram Shah Hospital and St. Stephens Hospital,
New Delhi.

4. Dr. R. L. Kapur,
Professor and Head of Department of Psychiatry,
National Institute of Mental Health and Neuro-Sciences,
Bangalore.

Colonel (Dr.) Kirpal Singh

(The witness was called in, and he took his seat)

MR. CHAIRMAN: Col. Kirpal Sigh, I welcome you to this sitting of the Joint Committee. (Read out Direction 58) First of all, you have stated about two types of hospitals. Now, in the Bill you will notice that there are five types of admissions—voluntary admission, admission under extraordinary circumstances, magisterial commitment, emergency admission and short-term treatment. It has been suggested to this Committee that we may omit these last two admissions emergency and short term and only such cases where the patient is violent and is considered a danger to himself or to others he may be taken to the Magistrate and they may be committed. What is your opinion?

COL. KIRPAL SINGH: About admission under extra-ordinary circumstances or under special circumstances, I would say that most of our population lives in villages and it is sometimes extremely difficult to get two medical certificates. I suggest that the Committee might please consider that the relatives can bring a patient direct to the hospital and as is done in State of Victoria, Australia,. The hospital should have a panel of doctors one of whom could examine the patient and certify.

MR. CHAIRMAN: This is a good suggestion. We want to accept the suggestion to delete the temporary treatment provision, what is your view.

COL. KIRPAL SINGH: When a patient is in a general nospital and he becomes uncontrollable, he has to be transferred to the Mental Hospital or a Psychiatric Hospital. But the process involved is the same i.e. commitment by a magistrate such a transfer from a General hospital to a Psychiatric hospital should be simplified.

MR. CHAIRMAN: Your point is well taken. When you need a certificate, why it is stated that one of them should be a Government servant; is a safeguard. Supposing there is a collusion between the doctors and the relatives to send the patient to a mental hospital or take away for property, land etc. of the person concerned, and they produce two certificates and put the patient behind the bar in a mental hospital. Then, if one of them is a Government servant who knows that disciplinary action can be taken against him, that will act a safeguard. If certificates are necessary, then one of them should be from a Government servant. That is the feeling of the Government and the Committee seems to agree to that. Would you agree with this salutary provision?

COL. KRIPAL SINGH: In the State of Victoria Australia, first the patient may be brought to the hospital by the relatives. The law there insists that the certificates should be from the private doctors and not from Government doctors who are already serving in the hospital so that they can be independent of the hospital. They have a panel of private doctors who would be called from time to time to examine and certify these patients who have been brought to the hospital.

SHRI MAQSOOD ALI KHAN: For how long have you been practising, in which branch of medicine, in private or in a Government institution?

DR. KIRPAL SINGH: I have been a psychiatrist for 34 years. I was in the Army for 28 years and after that I went to Australia and served there for 3½ years. I am a Fellow of the Royal College of Psychiatrists, and at the moment I am also the National Professor of Psychiatry for the IMA College of General Practitioners. I retired from the Army in 1968 in the rank of full colonel.

SHRI MAQSOOD ALI KHAN: You offer consultancy to patients in your private capacity?

DR. KRIPAL SINGH: I do.

SHRI MAQSOOD ALI KHAN: Please see page 3, definition (m). Objection has been taken to the mention of the words psycho neurosis, mental subnormality and psycho-somatic disorder. Would you like these to be deleted from the definition?

DR. KRIPAL SINGH: I would prefer that psycho-somatic disorder and mental subnormality be deleted from the definition, and a separate clause be put in for that. Mental subnormality in most cases is congenital, it is not an illness acquired after birth.

SHRI MAQSOOD ALI KHAN: In the British Act, they have made it severe mental subnormality. Would you prefer that?

DR. KIRPAL SINGH: I would suggest that "mental subnormality of a severe degree" might be included, but not mental subnormality as such.

MR. CHAIRMAN: Why do you want mental subnormality, which you cannot treat and set right, to be covered by this Bill at all? It has been suggested to us that for the mentally retarded and mentally subnormal there should be a separate law and institutions and we should take them out of this Bill completely.

Similarly, if we keep psycho-somatic disorders with definition somebody, out of some ulterior motive, may have a person with hyper tension or peptic ulcer, put into a mental hospital, which will be a very serious matter. So, it has been suggested that we should remove this category from the definition.

About psycho-neurosis too each one of us has had some neurotic episode or other in our lives. So, if you put psychonovosis in the definition of mental illness we are all liable to be admitted to a mental hospital under certain circumstances.

DR. KIRPAL SINGH: As far as mental subnormality is concerned, I entirely agree with you that there should be a separate law and institutions for looking after them. As regards psychoneurosis, if a voluntary patient wants to be treated in a psychiatric hospital...

MR. CHAIRMAN: Why do you want them to be covered by the law? Who prevents them from taking treatment? Today they are not covered by the law and yet they are being treated wherever they want. In fact, it has been suggested to us that the psychiatric wards of the general hospitals should be kept outside the purview of this Bill, so that no stigma attached to committed cases attaches to them, people can freely come and ask for advice here.

DR. KIRPAL SINGH: I agree with you.

SHRI SAKTI KUMAR SARKAR: Please see definition (q). Do you want that the convalescent home should be maintained by Government alone?

MR. CHAIRMAN: What applies to the psychiatric wards of mental hospitals applies with even greater force to convalescent homes. Patients have been treated and sent to the convalescent home pending integration with society. Why bring them within the purview of this Bill?

DR. KRIPAL SINGH: I do not think it is necessary to bring them within the purview of this Bill.

SHRI SAKTI KUMAR SARKAR: You do not want to have the magistrate in the picture?

DR. KIRPAL SINGH: Except in the cases which I have mentioned at page 2 para 2(c) of my memorandum, it should be a medical procedure, and not a judicial process.

SHRI SAKTI KUMAR SARKAR: It has been suggested that, regarding the licensing authority, the rules should be framed by the Government for the sake of uniformity, and the implementation may be left to the State Governments. Do you agree?

DR. KIRPAL SINGH: I entirely agree with you.

SHRI RUDOLPH RODRIGUES: You find the term "mentally ill offender" in the definition. If a person is mentally ill, can he be described as an offender?

MR. CHAIRMAN: Take the case of Ranga and Billa, there is a suggestion that only a mentally deranged person could commit such heinous crimes, so that there are offenders who are mentally ill.

SHRI RUDOLPH RODRIGUES: My point is that people who have no control over themselves commit crimes and they are described as mentally ill offenders. Would it not be better to call them mentally ill detenus, to remove the stigma?

MR. CHAIRMAN: If they commit a murder, what is wrong in calling them offenders? Offence may be serious, it may not be so serious. Any way, we can discuss it among ourselves.

DR. KIRPAL SINGH: On classification of psychiatric diseases, I think it has been mentioned now as 'mentally ill person'.

MR. CHAIRMAN: We have been told that we should remove this also because it will lead to very great complication. We will be grateful if you could suggest what will be a suitable definition.

DR. KIRPAL SINGH: I was trying to refer to this class of people who are called psychopaths. When they commit an offence, and they are liable to commit offences very frequently, they are considered responsible for their action because they are not suffering from what we, psychiatrists, call the psychosis or a severe degree of mental subnormality. So, if they are responsible for their actions, naturally they should be called offenders. There is no harm in calling them offenders.

SHRI RAJSHEKHAR KOLUR: Sometimes what happens is, the real and crooked brains remain behind the screen and innocent people are generally caught and punished. For these persons naturally the people try to give some different colour saying that these are mentally ill persons. In some cases, they use instigated or they are offered a huge sum.

DR. KIRPAL SINGH: I don't understand your point very well.

SHRI RAJSHEKHAR KOLUR: As our Chairman said, now the present controversy is going on. Some people are saying, they are mentally ill and all that. According to me and according, to some other persons it may be possible that the real culprits may remain behind the scene, they may not come into the picture at all. They commit some offences for which it is possible that they may escape.

MR. CHAIRMAN: What he is trying to say is that somebody else is the real criminal who plots and uses a mentally ill person to perform the crime. So, who is responsible for that crime?

SHRI RAJSHEKHAR KOLUR: Not only that. Such persons will be called as mentally ill.

MR. CHAIRMAN: But that is for the doctors to decide.

SHRI RAJSHEKHAR KOLUR: If such persons are there, they can commit offences wherever such persons are available.

MR. CHAIRMAN: It is something for the lawyers, magistrates and the doctors to consider. What is the reply to this question?

DR. KIRPAL SINGH: I am not competent to answer that question.

SHRI RAJSHEKHAR KOLUR: In Karnataka one person committed 11 murders within a short spell of one hour. That man was sitting in the Hanuman temple. At that time one lady went to the temple to offer her prayers and she asked him for a match box for lighting. He started

saying: 'Who is that nonsence fellow doing something?' and so on. And then that man started altercations against her and she reported the matter to her husband. The husband got wild and came to him. This fellow first thrashed the wife and killed her and then the husband. Then he entered the village. On the way he finished nearly 9 persons and the last person, the village chowkidar, was also done to death. Looking at this condition, the Head Constable asked the sentry to fire at him and he was fired.

DR. KIRPAL SINGH: Obviously this man was mentally ill. There is no doubt about it from the story you have narrated.

SHRI RAJSHEKHAR KOLUR: Earlier he was all right.

DR. KIRPAL SINGH: He must be suffering from delusions.

MR. CHAIRMAN: The very fact that the man committed 11 murders shows that he was a mentally unhinged person.

Regarding transfer from a general hospital to a psychiatric hospital, we have agreed with you that it should be done by the medical people.

श्री हुकम चन्द कछवाय : पागलों के बारे में आप ने अपने बयान में कहा कि डाक्टरों के पैनेल बनने चाहिए, वह निश्चित करें कि यह पागल है या नहीं, तो क्या इसमें प्राइवेट डाक्टर को भी लेना चाहिए सलाह के लिए या सरकारी डाक्टर ही तय करें या इस क्षेत्र में जो विशेषज्ञ हैं वह तय करें ?

डा० कृपाल सिंह : मेडिकल सर्टिफिकेट के लिए आप कह रहे हैं कि किसका होना चाहिए ?

श्री हुकम चन्द कछवाय : यह व्यक्ति मानसिक रोग से पीड़ित है इसकी घोषणा कौन करेगा ?

सभापति महोदय : सर्टिफिकेट की बात ही पूछ रहे हैं।

डा० कृपाल सिंह : मैंने यह सजेस्ट किया है कि अगर एक साइकियाट्रिस्ट सर्टिफाइ कर दे तो वह काफी होना चाहिए। अगर साइकियाट्रिस्ट नहीं है वहां तो दो मेडिकल ग्रेज्युएट जिनका एक्सपीरिएंस कम से कम पांच साल का होना चाहिए वह कर दें।

श्री हुकम चन्द कछवाय : कहींकहीं देहातों के अंदर डाक्टर अनुभव वाले मिलते ही नहीं हैं।

डा० कृपाल सिंह : तो मेरे ख्याल से उनको अस्पतालों में लाना चाहिए। अस्पताल का जो पैनल है उसमें से किसी को बुला कर दिखा दिया जाये ।

SHRI RUDOLPH RODRIGUES: Dr. Singh, you have stated that there should be an easy provision for transfer from a general hospital to a psychiatric hospital where a patient cannot be managed in a general ward. There is a possibility which I would ask you to consider. There are patients who come to a general ward and who are left there. At some point of time the general hospital to get rid of them can use this clause to transfer them to psychiatric hospital.

DR. KRIPAL SINGH: This remote possibility would remain , but I don't think it is likely to be misused.

SHRI RUDOLPH RODRIGUES: It can be misused.

DR. KRIPAL SINGH: I don not know what is the alternative. If the patient who has beeh referred or sent to a general hospital, say, for a minor injury or for malaria or for pneumonia, later on becomes psychiatric, that means he suffers from psychosis, and they canot manage him in a general ward, I do not know what

the alternative would be, but they would like him to go to a psychiatric hospital where they can manage him well.

SHRI RUDOLPH RODRIGUES: I am only just saying that there is a danger.

MR. CHAIRMAN: It is hardly likely that the general ward patients who are not mentally sick will be dumped in the mental asylum. It is hardly possible. In fact, it is the other way. It is more likely that they may send him from the psychiatric to the general hospital.

SHRI RUDOLPH RODRIGUES: One of the problems is that the patients are left in general hospital and no one will take them.

MR. CHAIRMAN: Yes, but then some other way was to be found. But we cannot stop transfer of mentally sick people from a General Hospital to a Psychiatric Hospital.

SHRI RUDOLPH RODRIGUES: I agree with you. But I am saying about the precautions.

DR. KIRPAL SINGH: I still feel that this provision of easy transfer from a General Hospital to Psychiatric Hospital should be there.

MR. CHAIRMAN: Then you have stated:

"All recommended (or certified) patients must be examined by a qualified Psychiatrist of the Hospital concerned within 72 hours of his admission and those found not suffering from a psychiatric illness should be discharged immediately. In cases where it is considered that the patient could continue to be under treatment as a voluntary patient and not a recommended patient it should be within the purview of the Medical Officer in charge of the Hospital to do so."

Now what is the difference between a voluntary and a recommended patient. A voluntary patient is somebody who comes himself and a recommended patient is one who is brought by his relatives or friends. Is that right?

DR. KIRPAL SINGH: Yes. A voluntary patient can give a notice of 24 hours and leave while a recommended patient will have to be seen by the Visitors and Superintendent and certified that he is fit for discharge. That is the difference between the two.

MR. CHAIRMAN: The next point is:

"Application for admission of a patient under Sections 19, 20 and 22: Besides the relatives of the patients it should be made possible for application for admission to be made by a friend, a social worker or a person in charge of an Institution where the patient may be resident."

It is a good suggestion.

The next one is:

"Visitors: Visitors should include at least two Mediceal practitioners one of whom should be a Psychiatrist. These two medical practitioners should be in addition to any Government Medical Officer who may be appointed as a Visitor."

This is your suggestion. This may be considered by the Committee.

श्री हुकम चन्द कछवाय : यह जो अधिक मात्रा में प्राइवेट अस्पताल खुले हैं मानसिक चिकित्सा के इससे आप सहमत हैं या सरकारी अस्पताल में मानसिक बीमारी का इलाज हो इससे सहमत हैं ?

डा० कृपाल सिंह : मरीज को तो अच्छा ट्रीटमेंट चाहिए। वह अफोर्ड कर सकता है प्राइवेट ट्रीटमेंट तो उसको क्यों मना किया जाये कि वह प्राइवेट नर्सिंग होम में न जाये ?

श्री हुकम चन्द कछवाय : आप चाहते हैं कि प्राइवेट लोग भी इलाज कर सकें और उनके पास मरीज जा सकें ?

डा० कृपाल सिंह : जी हां। मैं ऐसा चाहता हूं। उसकी वजह यह है कि हमारे यहां इतने बड़े मुल्क में सिर्फ 20 हजार बेड्स मेंटल हास्पिटल्स में हैं लेकिन पेशेंट्स शायद 13 मिलियन होंगे या कुछ लोगों का कहना है शायद 10 मिलियन होंगे, तो उनको इनमें कैसे दाखिला मिल सकता है ? अगर आप और भी हास्पिटल जल्दी से जल्दी बनायेंगे तो कितना कुछ बना लेंगे। इस वास्ते प्राइवेट की तो बहुत जरूरत है।

श्री हुकम चन्द कछवाय : जेलों के अंदर बहुत बड़ी मात्रा में जो लोग बन्दी हैं उनमें जो मानसिक बीमारी से पीड़ित हैं उनका इलाज वहां ठीक प्रकार से नहीं होता है जिससे वे अधिक बीमार वहां रह कर होते हैं और उनको देख कर और भी लोग इसके बीमार होते हैं, क्या यह बात सही है ?

डा० कृपाल सिंह : देखने से तो यह बीमारी नहीं जाती है, और यह जो आपका कहना है कि जेल में इलाज ठीक होना चाहिए, इसके साथ तो कोई डिफरेंस आफ ओपिनियन नहीं हो सकता। वह जेल में हो या कहीं हो, जो मानसिक बीमारी का मरीज है उसका इलाज तो होना ही चाहिए और आप अगर ऐसा प्राविजन इसमें कर सकते हों तो कर दें कि जो ऐसे मरीज प्रिजन्स में भी हों, उनको साइकियाट्रिस्ट देखे और उनका इलाज ठीक तरह से कराया जाये, चाहे प्रिजन में कराया जाये, चाहे साइकियाट्रिस्ट हास्पिटल में कराया जाये, उनका इलाज तो ठीक होना ही चाहिए।

श्री हुकम चन्द कछवाय : आप मेरा प्रश्न समझे नहीं। जो जेलों के अन्दर मरीज हैं मानसिक बीमारी के उनका इलाज ठीक तरह से वहां नहीं होता, वे दिन पर दिन वहां और अधिक बीमार होते जाते हैं, क्या यह बात सही है ? क्या आप इस बात को मानते हैं ?

सभापति महोदया : वह यह नहीं कह सकते हैं कि वह और भी बीमार होते हैं या नहीं। उन्होंने कहा कि जो मानसिक रोग से पीड़ित हैं चाहे वह क्रिमिनल हो या आफैंडर हो या कोई भी हों, उसके इलाज की व्यवस्था होनी चाहिए। लेकिन यह कहना कि नहीं है इसलिए वह और बीमार होते जाते हैं यह वह नहीं कह सकते हैं, इसके बारे में उन्हें अनुभव नहीं है।

डा० कृष्णानन्द जोशी : आपने अभी बताया कि सारे कन्ट्री में 20 हजार बेड्स हैं। 1968 में जो ए० पी० जैन कमेटी की रिपोर्ट छपी थी स्टडी आफ हास्पिटल, उसके मुताबिक 17445 कुल बैड्स थे कंट्री में। अब पिछले सालों में ढाई हजार की वृद्धि हुई होगी। उसमें बैटर पोजीशन इन स्टेट्स की है, महाराष्ट्र में 5712 बैड्स हैं, मैसूर में 1050, बिहार में 1883 और मद्रास में 1859 बैड्स हैं। कुल मिला कर चार स्टेट्स में करीब करीब दो तिहाई बैडस का प्राविजन है। इससे पैथेटिक कंडीशन का अंदाजा आप लगा सकते हैं कि कितनी पासिटी आफ बैड्स है। आपने सजेश्चन दिया कि जनरल हास्पिटल से साइकियाट्रिस्ट हास्पिटल में या मेंटल हास्पिटल में रिमूव करने का प्राविजन किया जाय। लेकिन छः या सात स्टेट्स में एक भी मेंटल हास्पिटल नहीं है। इस बीच में कहीं कोई होगया हो तो वह दूसरी बात है, तो जो आपने कहा वह कैसे संभव हो सकता है? इस कमेटी ने यह सजेस्ट किया था कि हर जनरल हास्पिटल में साइकियाट्रिस्ट विंग होना चाहिए और उसमें कम से कम चार बैड होना चाहिए जहां मेंटल डिजीज के पेशेंट्स रखने चाहिए। आपने कहा कि कोई वायलेंट हो गया, उसको सर्टिफिकेट मिल गया, वह मेंटल डिजीज का

पेशेंट डिक्लेयर हो गया, उसको कहां भेजेंगे ? इसलिए क्या आपकी राय में वहां जनरल हास्पिटल में तीन चार मेंटल केसेज के बैड्स होने चाहिए ?

दूसरा सजेश्चन इस कमेटी का यह भी है कि जब तक सारे देश में यूनिफार्म वे में नहीं हो जाता तब तक रीजनल मेंटल हास्पिटल का प्रावधान होना चाहिए, चार पांच छः स्टेट्स का या कुछ डिस्ट्रिक्टस का टुगेदर मिला कर ऐसा रीजनल हास्पिटल होना चाहिए । इसके बारे में आपकों क्या राय है और आपकी राय में कैसे यूनिफार्मिटी हो सकती है ? आज ला तो हम कोई भी बना सकते हैं लेकिन उसको प्रैक्टिस में कैसे लाएं यह सवाल पैदा होता है ।

डा० गोपाल सिंह : आपके सवाल के दो पार्टस हैं । आपने कहा है कि जनरल हास्पिटल्स में साइकियट्रिस्ट बैड्स होने चाहिए । यह तो बहुत जरूरी है और बड़े बड़े जनरल हास्पिटल में सबमें सहाइकियाट्रिस्ट बैड्स हैं । टीचिंग हास्पिटल्स में तो हैं, बाकी हास्पिटल्स में भी जरूर होने चाहिएं ।

श्री कृष्णानन्द जोशी : जनरल का मतलब डिस्ट्रिक्ट हास्पिटल आप समझ लीजिए । आप देखिए कि रिमोट डिस्ट्रिक्टस में जहां आर्डिनरी पेशेंटस का भी ट्रीटमेंट होना मुश्किल होता है वहां साईकियास्ट्रिस्ट बैड्स कहां से हो सकते हैं ? बड़े बड़े शहरी, चंडीगढ़ या दिल्ली जैसे शहरों की बात छोड़ दीजिए, साधारण डिस्ट्रिक्ट हास्पिटल्स की बात मैं कर रहा हूं जहां साइकियाट्रिस्ट ट्रीटमेंट की बात तो छोड़िए, आर्डिनरी डिजीजेज की भी दवा नहीं मिलती है और उसके ट्रीटमेंट का भी इंतजाम नहीं है ।

डा० गोपाल सिंह : जैसा आपने फर्माया है, साइकियाट्रिस्ट डिजीज जो है वह डिस्ट्रिक्टस में भी कामन है, रूरल एरियाज में भी कामन है । हर एक आदमी को तो शहर में लाया नहीं जा सकता । इसलिए यह जरूरी है कि जनरल अस्पताल में इसके लिए बेडस हों और इण्डियन साइकेटिक सोसाइटी ने बहुत पहले वह रकमेंडशन दी थी कि हर एक डिस्ट्रिक्ट अस्पताल में एक साइकेटिस्ट होना चाहिए और जब ऐसा हो जाएगा तो जो साइकेटिक पेशेंटस हैं उनका इलाज हो सकेगा और बहुत काफी लोग इस में कवर हो जाएंगे । जो पेशेंट्स कन्ट्रोलेबल नहीं हैं उनके लिए मैंने पहले ही कहा है कि उनको मेंटल होस्पीटल में जाना चाहिए या उन्हें साइकेटिक सेन्टर में भेज देना चाहिए । ऐसे केसेज तो रेयर होंगे ।

श्री कृष्णानन्द जोशी : क्या हर एक डिस्ट्रिक्ट होस्पीटल में ऐसे लोगों के बेड्स सेपरेट होने चाहिए ? इस बारे में आपका क्या कहना है ।

डा० गोपाल सिंह : जरूर होने चाहिए क्योंकि अब हमारे देश में साइकेट्रिस्टस काफी हो गये हैं ।

श्री कृष्णानन्द जोशी : कितने हैं ?

डा० गोपाल सिंह : 600 हैं ।

श्री कृष्णानन्द जोशी : वे तो काफी नहीं हैं ।

डा० गोपाल सिंह : और ट्रेनिंग स्कूल्स खुल सकते हैं ।

श्री कृष्णानन्द जोशी : महाराष्ट्र में 500 बैड्स हैं, तो वहीं पर बहुत ज्यादा साइकेटिस्टस होंगे और वहीं वे फंस गये हैं । मुल्क में दूसरी जगहों पर वे कहां मिलेंगे ।

डा० कृपाल सिंह : जो नये पोस्ट-ग्रेजुएट्स डिग्री लेकर निकलगे, उनके लिए एम्प्लायमेंट आपेरचिनीटीज और बढ़ जाएंगी ।

सभापति महोदय : बहुत बहुत धन्यवाद ।

(The witness then withdrew)

II—Shri G. G. Prabhu.

(The witness was called in, and he took his seat).

MR. CHAIRMAN: Dr. Prabhu, I would like to welcome you on behalf of this committee and would like to explain to you that the evidence that you give is liable to be published and treated as public unless you specifically desire that any portion or the whole of it should be kept confidential. Even if you so wish, it is liable to be made available to the Members of Parliament.

With that, I would like to say that you have complained that the Bill was not sent to you. It is not the fault of the Lok Sabha Secretariat. We sent the Bill to those people whose list was supplied to the Secretariat by the Ministry. The Bill must have gone to your Institute in any case. It is not sent to each individual in an Institute and we expect all of you can have a look at it when it is in your Institute and say what you wish to. It was sent to you later in the month of June.

DR. PRABHU: That is right.

MR. CHAIRMAN: Be that as it may, we have noted your views—what you have said in your Memorandum. You have said that specific suggestions on the different clauses of the Bill you would make when you come here.

Now I would very much like you to please enlighten us and let us have your suggestions with regard to the specific clause by clause of Chapter by Chapter wherever you would like to make suggestions. You must have made a note of it. If you wish to make any general comments before that, you are welcome.

DR. PRABHU: Before I go over the specific issues and the consequences, first I would like to make a submission. I did not make a complaint that I did not receive the Bill. In fact I just made a statement because I knew that an attempt is being made to elicit public opinion on this particular Bill and I just pointed it out so that it may be possible to elicit it from all sections of the society.

MR. CHAIRMAN: You might know that a large number of clinical psychologists have appeared before us.

DR. PRABHU: Before I go section by section, the two aspects I would like to say because I am making them specifically with reference to the available figures about mental illness that is being covered by this Bill as it exists in this country. In the written memorandum that I submitted, I have said that the Bill can at times become restrictive in the sense that all the people who are in need of help may not be in a position to receive it because, as things stand, from the scientific angle, we estimate that the prevalence of mental illness is 18 to 20 per thousand in this country which obviously means that there are 12 to 13 million people in this country who are mentally ill. These are very conservative figures not on the higher side because when it comes to the question of saying who is a mentally ill person, it may so happen that even a person who finds difficulty to go to bed or a patient of insomnia may be branded as a mentally ill person other than those who are perceived by others as needing health

care and the fact that the number of people who are receiving mental health care is only 125,000 meant that we are providing for less than 1 per cent of those who are acutely in need of mental health facilities. Even if we go by the fact that the facilities are mainly in the urban areas and even if we go by the fact of how many people are in need of mental health care in urban areas, it works out in urban areas to 2 to 3 million and even if we consider that all these people who are being given assistance are from urban areas which is definitely not correct because rural people also need it, we are providing mental health care to only 3 per cent of the people who are in need of care and under these circumstances, obviously, any authority which comes into being has to cater to a large number of people who are in need of it. It is in this background that when I go through the section—obviously the section that comes to mind is the section of definition, (m) where the mentally ill person has been given a very broad sort of definition. On the basis of the present day sort of scientific feeling about it I personally think that only clinical condition known as psychosis probably can come under this Bill especially because of the fact that later it has become more or less mandatory according to section 4(1), 6(c) and 9 (iii) that any body who is found mentally ill according to this particular Bill has to be in a nursing home which is being headed by a psychiatrist.

The question arises: How exactly mental abnormalities and psychosis, psychoneuroses, psychopathic state, mental sub-normalities or psychosomatic disorder cases fit in here and if included, will they get the best care which is required by them? Then there is one aspect that is not included in this definition but because of the progressive legislation to which we are contributing and which is likely to come into our focus is the question of the individuals who attempt to commit suicide. For example, it is estimated that nearly 14 per 10 lakhs commit suicide in this country which means nearly 91,000 people. According to the CBI report this year the number of people who attempted suicide is 3 times the number which makes it that the number of individuals who attempted suicide is about 3 lakhs and with the progressive legislation which is going on internationally and if we forget this Bill for the next 20 or 25 years and if this thing i.e. attempted suicide, is not made an offence, obviously we will have to take care of them who, I would say, are mentally ill cases. That is what is exactly being provided at present in a country like U.K.

Then the question comes up: are we in a position to provide this care at present?

I personally would submit this..

MR. CHAIRMAN: We have accepted your statement. You may proceed to the other points.

DR. PRABHU: My second point is this. This is about the question of the medical officer. You have got this in page 2, (i) (j), (k), read with Section 26(1)(b) and 2(a). The Medical officer has to have an MBBS degree. He should be a competent medical practitioner. Please see 26(1)(b) and 26(2)(a). The medical officer has to certify such person to be a mentally ill person. With regard to medical education in this country, the amount of psychiatric training given to them is not more 15 hours in the whole course of 5 1/2 years. You can well-imagine how far that advice can be taken as sufficient.

MR. CHAIRMAN: In the later scheme of things the Committee has been advised that the primary method

of admission. It is likely to be voluntary and under extraordinary circumstances in which the friends or relatives bring the patient to the hospital. Only a very small proportion is likely to come through the magistrate. Certificates to be given will not be of such a large number in any case.

DR. PRABHU: If that is the view of the Committee, I submit to its view. But what I want to emphasise is only this. When there are a number of people who are there, that is to say, 13 million or so, a small segment of that would be quite sizeable.

Now I come to Clause 40(1). It says:—

"The State Govt. shall appoint for every psychiatric hospital and every psychiatric nursing home in the State, not less than five Visitors, of whom at least one shall be a medical officer, preferably a psychiatrist."

This word 'preferably' may be substituted by the word 'shall'. It has to be stated that he shall be a psychiatrist. One person should be fully qualified. Of course Clause 97 provides that these rules with reference to inspection and so on can be changed. The word preferably may lead to some loopholes in the system and so the word 'shall be' may be put in there.

MR. CHAIRMAN: You suggest that one visitor shall be psychiatrist. In the light of the experience the Government can designate persons as psychiatrists. That can be done. Government can designate 'X' or 'Y' as a psychiatrist. So, that should not cause any difficulty.

DR. SAROJINI MAHISHI: He says that instead of medical officer, let it be put as psychiatrist.

MR. CHAIRMAN: He says that there are many mental hospitals in the country. They should be able to find a person who is a good psychiatrist who has worked in the area, who has got sufficient experience appoint him as a vistor.

DR. PRABHU: As I have said, it has to be mentally ill persons excluding the mentally sub-normal. Then, of course this difficuty will not come up. Otherwise we will immediately be faced with a serious difficulty. We have near about 150 institutions for the mentally retarded of which nearly 60 per cent provide residential care. They are not headed by a psychiatrist. The psychiatrist's interest is naturally limited. The conditions are not curable but are mainly trainable and so on As it is, if the definition is not changed, it will create difficulty.

MR. CHAIRMAN: This is likely to be changed.

Now I want to ask you a question. There is shortage of the institutions in the country for the mentally-retarded. You may come across in any part of India severally sub-normal persons with behavioral problems and conditions which would need institutional care and so on. If we remove them from the purview of this Bill it can be stated that the beds served in these hospitals can then be utilised by the others who need to be taken care of in a mental hospital. But tomorrow if the mentally ill are to be excluded, there will be place to take care of them, till such time that the new Bill for the care of mentally retarded comes in. So, would you like

to comment on this aspect of it? Can you suggest any solution?

DR. PRABHU: The types of severe subnormality is estimated at 7 per thousand of population whereas mild subnormality is estimated at 2.5 per cent of the population or 25 per thousand. Even now the number of those who are taken care of in the mental hospitals of the country is not substanital.

MR. CHAIRMAN: So, you would like mentally retarded to be excluded.

DR. PRABHU: Yes, Madam.

MR. CHAIRMAN: Would you like to say anything else?

DR. PRABHU: Section 93—page 34.

MR. CHAIRMAN: This has been suggested to us that rules should be framed by the Central Government and the execution may be done by the State governments. Then the rules would be uniform. Would you like to say anything else?

DR. PRABHU: The three sections under (ii) (a)—e, g & k on page 35 should not be under this particular section where there can be possibility of variation brought in.

MR. CHAIRMAN: If the rule making is uniform then your objection will disappear.

DR. PRABHU: Yes, Madam.

MR. CHAIRMAN: What next

DR. PRABHU: That is all that I would like to submit before the Committee.

AN HON'BLE MEMBER: The evidence that we have on record goes to show that these mentally ill patients have been very much ignored in our country and the stress is more on physical health and even when they are admitted to these hospitals where physical patients are looked after these mentally ill patients are being ignored. On account of that may I suggest to you. Should we not have in our country a Mental Health Board as such which should be able to take care of these mentally ill persons on separate basis altogether so that interests of these mentally ill people should not be ignored at any level.

DR. PRABHU: On this there can be only matter of opinion and I would submit this was virtually discussed and the one country in the developing world that is doing this is Indonesia. They have a separate directorate of mental health. As we do not have it, it looks it is done in an entire set-up. Probably we can give better care but as the experts from Indonesia tell us the minute it was separated from the general health care of the country a tendency starts growing what is to be provided to these individuals under the special circumstances. That itself gets neglected. So, Indonesia are now regretting as to why they separated because they think everything can be done within the General Health Department of the country but at the moment as the things stand there is stigma attached to the mental health.

SHRI KRISHNA NAND JOSHI: Now, the country will not be in a position to guide the manpower in the next hundred years or so. Supposing the suggestions that you have made have been taken, do you think that all the problems will be solved or how much time will it take?

DR. PRABHU: As far as the mental health manpower potential is concerned, our capacity at present is roughly 40 psychiatrists every year and about 20 clinical psychologists every year. This potential cannot be increased. If we start having teaching institutions, we would obviously require manpower. So our capacity is limited. With the tremendous short-fall we have as far as the manpower potential is concerned, if the number of psychiatrists in this country is about 700 as it is at present, it would be definitely not possible to solve the problem of manpower re-

quirements. In fact no country in the world has solved this problem. But definitely, if we make use of nearly 400 clinical psychologists who are about 600 and the services of about 200 social workers are utilised, we will immediately double the number of manpower potential which, I think when there is an acute shortage of manpower in this field, will help a great deal.

MR. CHAIRMAN: Even with the Clinical Psychologists, Social workers etc. the problem is not going to be anywhere near solution. You have to find out new ways.

DR. PRABHU: In fact when I touched upon the aspect of Medical Officer, that was one aspect which I was keeping in mind. I am sure when I say that if the total amount of teaching of mental health care in this country is not more than 15 hours during the 5½ years of study and training, how would you expect a person with 15 hours training to handle this problem. In fact when the community workers started getting training a few weeks, a question was raised as to how this few weeks' training would help in tackling the problem. If a person who has got 15 hours of teaching of mental health during the 5½ year period of training, cann't such persons who have undergone training for a few week be capable of tackling the problem of mental illness?

MR. CHAIRMAN: If you can think of some orientation, some training for the medically qualified people then those with the short training will be in a position to understand and get further experience under the supervision of these trained medical people. Further the parameds may be given training in the administration of selected drugs.

DR. PRABHU: In fact repeated representations have been given to the Indian Medical Council to increase from 15 hours of teaching to 75 hours. In the Seminar of W.H.O. held in this country in 1971, it was suggested that a minimum of 75 hours psychiatric teaching is necessary.

MR. CHAIRMAN: Dr. Prabhu, thank you very much for having come and given your valuable suggestions.

(The Committee then adjourned)

III—Dr. S. Dutta Ray.

(The witness was called in, and he took his seat).

MR. CHAIRMAN: We welcome you. I would like to make it clear to you that the evidence that you tender shall be treated as public and is liable to be published unless you specifically desire that all or any part of it may be treated as confidential. Even then it is liable to be made available to Members of Parliament.

We have just received a copy of your memorandum, and naturally it has not been circulated. So, I would request you to kindly give the highlights of what you wish to see before we ask you questions.

First of all, you have said that this definition of the mentally ill person should be changed. You have suggested that we should remove mental sub-normally, psycho-somatic disorders and psycho-neurosis from the list, and only psychosis be left.

Then, at page 2, para 4, I have not quite followed what you want. Will you please explain? We have been advised that the psychiatric units of the general hospitals should not be brought within the purview of this Bill for two reasons. One is, the treatment in these units is free, it requires no formality, mental illness should be treated as any other illness. Just as patients of other diseases can go to any hospital and get treatment today and that we should not do anything to create any difficulties for the mentally ill to go to a general hospital for treatment. Secondly a certain amount of stigma is always there for going for treatment to mental hospitals and as such it will be better that wards psychiatric in gene-

ral hospitals are left primarily for voluntary cases and they are not brought under the purview of this Act. Now we would like to hear from you as to why you want these wards to be brought within the purview of this Act.

DR. DUTTA RAY: Firstly, we have elaborate rules which guide the management of even private psychiatric nursing homes. They have to be licensed. A certain quality of care has to be provided to the patients. Secondly there are private nursing homes as well who treat all sort of patients and even psychiatric patients are admitted there. Now if we take a stand that all kinds of psychiatric patients can be treated in all kinds of medical institutions and no formalities are necessary, then it is alright. But if we have to have laws which legally guard the civic rights of the patients who are admitted against their wishes, then this should be done.

MR. CHAIRMAN: But how about the voluntary cases? These psychiatric wards of General Hospitals are not meant for those who are admitted against their wishes.

DR. DUTTA RAY: But many of them are severely ill that they are not in a position to understand the implications of their admission.

MR. CHAIRMAN: That is what I am saying. But they are not admitted against their will. They are being admitted either voluntarily or they are being brought either by their relative or friend. They are not being committed by a Magistrate. What you are worried about is that the quality of care should be adequate.

DR. DUTTA RAY: Yes. Many severelly ill patients are being treated in the psychiatric wards of General Hospitals. By no stretch of imagination they can be imagined to be voluntary patients because they are not in a position to exercise their judgement and so there should be a provision to keep them with the relatives. Otherwise, we are liable to some legal complications. For instance, if there is a General nursing home and they admit a very severely disturbed psychiatric patient and if the rules do not permit the relatives staying with him, then this can be construed as forcible incarceration of a patient in a hospital.

MR. CHAIRMAN: The point is, the law cannot say that the relatives should stay or should not stay. It will be for the doctor incharge of the Institution to have the relatives with them or not.

DR. DUTTA RAY: Apart from the administrative problems, the officers who are taking charge of the patients must have some legal safeguards.

MR. CHAIRMAN: For voluntary cases or for those that are being brought by the relatives, there is no legal problem.

DR. DUTTA RAY: Supposing a patient is admitted and treated against his wishes, because the relatives forced him to take treatment.

MR. CHAIRMAN: You just now said that he is not in a fit condition to exercise judgement. You can say this *viz.*, if a patient in the hospital wishes to make a representation against his admission, then the matter can be referred to the Board of Visitors or the Magistrate. You would like this suggestion to be made that if a patient is not a voluntary patient, but admitted under extra-ordinary circumstances, *i.e.*, being brought by a relative or friend, if such a patient, after coming to the hospital, makes a complaint that he has been brought there against his wishes, then the matter shall go before the Board of Visitors or the Magistrate within 72 hours.

DR. DUTTA RAY: Yes. We have a special provision, emergency provision.

MR. CHAIRMAN: We want to delete the emergency provision. It

has been suggested that there should be only three types of admission, *viz.*, voluntary admission, admission under special circumstances, i.e., those which are brought by friends or relatives or head of an institution and the third. committed by a Magistrate. It has been suggested that the commitment by the Magistrates should be there only for certain special type of cases. They are: those found to be suffering from mental illness while under trial for a criminal offence, convicted persons showing evidence of mental illness, where management of property is the issue, where a person is believed to be suffering from mental disorder and is at large and is considered to be dangerous to himself and others, where a person suffering from mental illness is alleged to have been neglected or ill-treated by relatives. These are the five categories of cases in which commitment by the Magistrate should be there. Otherwise, it should be voluntary or under special circumstances. It is conceivable that the relatives and friends may be interested in robbing off the ill person by putting him in a mental hospital and if this man is capable of making a complaint or anybody else on his behalf makes a complaint then that should go before the Board of Visitors or the Magistrate within 72 hours. Is that acceptable?

DR. DUTTA RAY: Yes.

MR. CHAIRMAN: Then in sub-clause (k) of Clause 2, you want the following portion to be deleted:

> "..or a person whose name has been registered in a State Medical Register in accordance with the provisions of any other law relating to the registration of medical practitioners for the time being in force."

DR. DUTTA RAY: Yes.

MR. CHAIRMAN: The next one is 'admission under Special circumstances'.

DR. DUTTA RAY: Now that you have clarified, I had suggested that this admission under Special circumstances should be deleted. This is because we already have a form of admission under temporary admission. Under temporary admission we have stated that the validity would be for six months and under special circumstances it would be for three months

MR. CHAIRMAN: That is alright. If necessary, it can be extended.

DR. DUTTA RAY: I would suggest that we keep temporary admission and delete 'admission under special circumstances'. The only difference I find is that the patients who are admitted under special circumstances can continue in the hospital for a period of three months whereas under temporary admission, they can continue for six months. Looking at the turnover of the Mental Hospitals, I feel that six months would be a reasonable period for most of them to go out.

MR. CHAIRMAN: This is a matter which may be examined whether we should keep admission under special circumstances or we should keep temporary admission whichever is a better provision. We should not have too many types.

DR. DUTTA RAY: Yes.

The second clause was the prescribed medical certificate form. If we are going to have special types of admission, then we should have special types of medical certificate form. The problem which I foresee is, who will decide under what type of admission the patient is being committed.

MR. CHAIRMAN: We are simplyfying it. In the case of voluntary admission if the patient so desires the doctor will have to discharge him within 24 hours. The man who comes under 'special circumstances' or temporary admission, unless some other person makes a representation, he stays there till he gets better, for three months or four months or five months it is upto six months, I think.

DR. DUTTA RAY: When we have too many admissions, I foresee...

MR. CHAIRMAN: We are proposing not to have too many types. The patient comes voluntarily or the patient is brought voluntarily by his family or friends or he is committed by the magistrate. These are the only three forms of admission the committee is thinking of keeping.

DR. DUTTA RAY: If we have only three forms of admission, then even the present medical certificate from would do. This comment was made because I was thinking that there were more than three types of admission.

MR. CHAIRMAN: Relatives may bring the patient from the villages. They are asked to bring two medical certificates. They are liable to be harassed and exploited by the practitioners in the town. With great difficulty they bring the patient to the town. It will be extremely difficult for them to go and search for doctors to get the certificates because they are simple people, they do not know anybody in the towns. So, it is suggested that the hospital may keep a panel of doctors who may be telephoned by the hospital to certify.

DR. DUTTA RAY: Under the present provisions, not only are two medical certificates required but one of them should be from a psychiatrist and the other from a government servant. What is happening now is, most of the relatives who are having very disturbed patients to be admitted to mental hospitals cannot take them to government hospitals; they only bring two certificates from two medical practitioners, present them to the Magistrate and the Magistrate is kind enough to accept them.

MR. CHAIRMAN: We have seen with our own eyes that relatives tied up the patients and brought him to the mental hospital. We saw that in Srinagar. They did not go to the Magistrate, they came to the hospital. If they come with the Magistarte's orders, then there is no problem, but if they do not come with Magistrate's orders and if they do not have two medical certificates, what does the doctor in charge of the institution do?

DR. DUTTA RAY: If they have to go and fetch a certificate from a government medical officer, that will make it more combersome and difficult.

MR. CHAIRMAN: Your point is that it should be simplified and the difficulties removed.

DR. DUTTA RAY: Yes.

MR. CHAIRMAN: You have said: if the mentally ill person is unable to express his willingness for admission and emergency admission is desired, then the relatives can always take recourse to the provisions under Clause 28C— Admission in Emergencies, page 15. What are your suggestions here?

DR. DUTTA RAY: This is a part of the argument why we should not have admission under special circumstances and retain only admission under temporary admission clause.

MR. CHAIRMAN: You have said: the pre-requisites of 'Reception Order' on application mentions about two medical certificates from two medical practitioners... What is the difficulty here?

DR. DUTTA RAY: The Clause mentions that one certificate shall be from the medical practitioner in the service of Government. It will cause great difficulty. Here we are already suggesting that one of the certificates should be from a psychiatrist. That means, we are already taking the safeguard that some expert has seen and opined that the patient should be admitted in a special institution.

MR. CHAIRMAN: You are suggesting that the patients who are very disturbed and refuse to be taken to government hospital should be seen at home, but most government medical

officers have no obligation to visit the house of the mentally-ill person and issue certificates; the practice in most cases even under the present laws according to you is to obtain and secure two medical certificates from two private medical practitioners and not government medical officers; and this practice should be regularised; the legal safeguards to patient's civic rights are already protected under other sections of this Act; the sanctity attached to certificates from government medical officers should go. Here, I must explain that the idea was that the relatives may, in collusion with a private practitioner, have the patient admitted—just to put him away from the scene. This provision is a safeguard against that. The government servant will be more under the control of the Government and may not indulge in wrong practice. But you say that it will cause difficulty and, therefore, you are suggesting that we should do away with the certificate from the government medical officer. Is that your point?

DR. DUTTA RAY: Yes.

MR. CHAIRMAN: The Committee will consider your suggestion.

Then you have said that the rules pertaining to discharge of patients—Clause 43—by the visitors do not take cognizance of not an uncommon situation obtaining in mental hospitals namely that despite the recommendation of the medical officer in charge of the patient for discharge by the visitors, the latter often choose not visit the hospital to comply with such recommendations. The emotional repercussions and inconvenience thus caused to the patients and his expectant relatives can easily be imagined. In fact, most frustrated medical officers in charge get such patients discharged later on through the committing magistrates with the help of application from the relatives and their own recommenadtions to the Magistrate for discharge. Do you mean to say that Visitors do not agree with the medical officers?

DR. DUTTA RAY: Yes.

MR. CHAIRMAN: Do you think that the discharge should be at the discretion of the doctor and not through the Visitors?

DR. DUTTA RAY: No. The Board of Visitors have a very useful role, but it is very unlikely that they could judge the quality of the recovery of a patient better than the doctor who is treating.

MR. CHAIRMAN: Therefore, it should be the doctor's opinion which should count..

DR. DUTTA RAY: Yes. That should be more important. What is happening is, if patient is produced before the Board of Visitors and they do not agree to discharge, the doctor is put in a very awkward situation. And it does happen.

MR. CHAIRMAN: Please make a note of this. We will have to discuss this.

Then with regard to the period of validity of the receptions order, as in case of medical certificate. Within how many days after the issue of the reception order the patient should be admitted—that should also be specified. I think this is a very valid point.

Any of the Members would like to ask him any question?

SHRI MAQSOOD ALI KHAN: So far as the psychiatric clinics or hospitals are concerned, in view of the fact that there is paucity of beds available in the country, would you like that admission should be only restricted to those mentally ill persons who are either offenders or danger to society or nuisance to society?

DR. DUTTA RAY: I think the intention of this Bill is to define and regulate the admission of some special categories of mentally ill cases. Otherwise, there are diverse types of mental patients who are being treated by

private doctors, doctors having private nursing homes, phychiatric wards of General Hospitals, etc. In fact this should be encouraged. I am in full agreement with the view that a mental patient should be afforded all proper treatment and medical care and also with the plea made here that there are going to be more mental patients in the district hospital levels. When the Bill should also foresee that the quality of care of the mental patients is taken care of. Right now we have taken extra-ordinary care of license special hospitals etc. and we have a system of inspection of these places. We have given the facilities of visitors for the patients. But when it comes to the general wards of say district hospitals, a patient being kept there, he has no access to any other forum whether he can ventilate his problem and there is nobody who can inspect the quality of the care he receives. That is why I thought that even the psychiatric wards of General Hospitals should come within the purview of this will somewhere in some form.

SHRI MAQSOOD ALI KHAN: As there is a paucity of accommodation available in the psychiatric wards of the hospitals, should the government give any subsidy to those nursing homes which are run by private psychiatrists? Do you think that we should encourage them that way or there is no need?

DR. DUTTA RAY: I do not think there is any need for subsidy unless the government foresee that there is no scope of maintaining general wards which the poor patients can use. The licensing system itself adds to the stature of that particular nursing home, its reputation, etc. and the person in charge should benefit from it.

SHRI MAQSOOD ALI KHAN: Having gone through the Bill as such and just you were mentioning or rather hinting at it that it is more or less a procedural law that we are making and there is nothing said in the Bill for the amelioration of the conditions of the psychiatric hospitals and clinics and a sort of control over them which could have been to the detriment of the patients as such. Do you think that any provisions are necessary to be added so as to speak of the treatment that is going to be given and other things?

DR. DUTTA RAY: I think that would imply that we have to fix a percentage of our total national but at for health services and also have a special law which says that so much percentage should be ear-marked for patients needing mental health. That would perhaps go along way towards helping these hospitals which are run on very poor economic conditions.

SHRI MAQSOOD ALI KHAN: I have done.

MR. CHAIRMAN: This morning another witness told us that in Indonesia they tried to separate mental health from other types of health care so that they may get more facilities but now they are very sorry for having done it.

So this is something nobody can say how it will turn out. Anyway the scope of this Bill does not cover this. It is only to regulate the admission and to safeguard the rights of the mentally sick people with regard to property, etc.

Thank you very much.

(The witness then withdrew)

IV. Dr. R. L. Kapur

(The witness was called in, and he took his seat).

MR. CHAIRMAN: Dr. Kapur, I would like to extend welcome to you on behalf of the committee and also on my own behalf and I would also like to express my thanks that you could find time and take the trouble of coming over here and appear before the committee...

DR. R. L. KAPUR: Very kind of you.

MR. CHAIRMAN: May I explain to you that your evidence shall be treated as public and is liable to be published unless a specific request is made by you to treat all or any part of it as confidential. But even in that case, it shall be liable to be made available to the Members of Parliament.

With this preliminary remark, I would like you to make such remarks as you would like to make before you go on to clause by clause consideration if you so wish or if you wish to come straightaway to clause by clause you can do so.

DR. KAPUR: I just wanted to say that when the committee visited Bangalore, we had given a draft memorandum at that time. But after we had the discussion with the committee, I had the occasion to reconsider some of the points we made there and I would like to introduce some changes there.

Having said that, I would like to move from clause to clause.

SHRI MAQSOOD ALI KHAN: This is in adidtion to what you have addressed?

DR. KAPUR: In a addition and some changes also. Slight alterations.

MR. CHAIRMAN: You may just mention briefly what you have stated in your memorandum as preliminary remarks. You are adding to them whatever you would like to add in the light of our discussion with you.

DR. KAPUR: I will read out the preliminary remarks.

MR. CHAIRMAN: Add what you wish to add as you go along.

DR. KAPUR: I would read as follows:

"The concept of mental illness has considerably changed recently. It is considered as illness just like any other illness. With the advent of new drugs and new approach on treatment, even the highly excited mentally-ill patient can be controlled within twenty-four hours so that he would not be dangerous either to himsef or to others. Further, if the treatment is initiated as soon as the illness appears many patients can be rapidly improved and could go back into the society. Therefore, the aim of the new Mental Health Bill should be to provide early treatment facilities to all the mentally ill persons and, at the same time, it should help to eliminate the stigma and the fear among the public by making the psychiatric hospitals and psychiatric nursing homes easily accessible to the public as that of a general hospital or nursing home.

"(1) Mental illness and mental retardation are two different conditions. They should not be clubbed together. Preferably, a separate Bill or Chapter for mentally retarded persons should be provided in the Mental Health Act".

MR. CHAIRMAN: I may add here that it has been suggested that not only mental retardation and mental subnormalities should be taken out but conditions like psychosomatic disease and psychoneouroses should also be removed from the definition of mental illness. They are capable of great mischief if they are left there. Even the mention of schizophrenia is being opposed as it has been abused by us to divorce act.

DR. KAPUR: I do accept that. I was making very general remarks here. The particular point about psychosomatic illness to which you made a mention I was coming to that. There is no provision in the present Mental Health Bill for the treatment of mentally ill persons in a general hos-

pital. But, at present, with the assistance of the Governent of India, psychatric units have been started in teaching district hospitals in almost all the States. Therefore, all the provisions of the Mental Health Act should be extended to the psychiatric units of the general hospitals.

MR. CHAIRMAN: We would like to be guided here.

Dr. Wig from Chandigarh made a very strong plea that we should keep the psychiatric wards of a general hospital out of the purview of the Act for two reasons, firstly they are primarily for the voluntary cases and there should not be any difficulty placed in the way of voluntary admissions. As you yourself have said mentally sick should be treated, like any other patients who can go to the hospital or nursing home when they wish the same facility, also be accessible to these mentally sick patients; secondly, the general Hospitals today are free from stigma. Once you bring them within the Act, the stigma will come. However ignorant, it might be, it is still there with regard to the admission in the mental hospitals. Otherwise, the mentally sick people can be exploited. That is why he made a very strong plea that he did not want any magisterially committed cases in psychiatric wards of general hospitals and he did not want these psychiatric wards to come under the purview of this Act. In fact there may be a difficulty in a district where there is no other place for the mentally sick in case a patient is considered to be dangerous to himself or to a community as to where they should take him: or else he will be sent to jail. Dr. Wig said the patient should not be sent to jail. If there is no mental hospital and the patient is not to be sent to the psychiatric ward in a general hospital where is he to go? That was pointed out to him. I would like you to enlighten us as to what should be done in these two extremes. Dr. Wig wanted us to keep off our hands completely so far as this is concerned. Would you enlighten on this?

DR. KAPUR: It is a difficult situation. I was wanting the general hospitals to come within the purview of the Bill and, to the extent possible, facilities for the psychiatric patients should be provided for.

MR. CHAIRMAN: You mean proper standards of service should be provided.

DR. KAPUR: What I am going to say later is this. In a suitable place, I would like to introduce a clause for the informal admission as prevalent in all the other countries.

MR. CHAIRMAN: Do you consinder the voluntary admission is equivalent to that?

DR. KAPUR: Informal admission is not equivalent to that. If you read my reply, the first clause in the Bill provides for the voluntary admission of a patient. When admission is sought for a voluntary patient, he has to give 72 hours notice. Similarly for discharge 72 hours notice has to be given.

MR. CHAIRMAN: We are making it 24 hours.

DR. KAPUR: I would suggest that the informal admission is taken just like any other patient. He can leave at any time he wants. He is allowed to leave at any time he likes. That is what I would suggest in the case of an informal admission.

MR. CHAIRMAN: Not even 24 hours notice. He should be allowed at any time he wants to leave.

DR. KAPUR: If the doctors think that this person is now suitable for the informal admission, there should be change-over to some other way of

admission. A person who is given the informal admission should be able to leave the place.

MR. CHAIRMAN: He comes voluntarily and so he goes voluntarily.

DR. KAPUR: This is different from the voluntary admission. Now I want to go to the introduction. The admission procedures are cumbersome as pointed out in the Mental Health Bill. I would like to take them up when I come to clause by clause consideration.

MR. CHAIRMAN: May I mention what has been suggested? It has been suggested to us that there should be three types of admissions—voluntary admission—this may be made completely voluntary for admission and discharge the second is what we call admission under special circumstances include what we call temporary treatment order' under D.M.O's advice. But the provision of these two clauses may be combined; the third is the admission of the committed magisterial order in certain special types of cases and no other type of admission.

DR. KAPUR: I would like to elaborate on this as I go over to the clauses. If you permit me I will find it easier as I go through the Bill.

MR. CHAIRMAN: We now proceed with the clauses. You start with sub clause. You have said that 'Mental subnormality and psychosomatic disorder' should be deleted from the definition. What about psychoneuroses?

DR. KAPUR: I think that mentally-sick under neurotic condition is a mental illness.

MR. CHAIRMAN: True. But who does not suffer from some kind of neuroses some time or the other. If you keep it, then it becomes one of the clauses to be exploited for putting a person behind the bar for ulterior motives.

DR. KAPUR: I do not think this can be exploited that way because the condition under which a person is put under 'reception order', is specific That is the person is dangerous to himself or to the society. So, the psychosomatic or psychoneuroses is certainly a mental illness. I do not think this can be mischievously used because the treatments under which a patient ultimately gets admitted to a psychiatric hospital is for a long-term. These are very much specific and the terms are very much specific. The patient is either dangerous to himself or to the society and so longterm admission is sought.

MR. CHAIRMAN: True. If a girl gets married and she suddenly develops hysterical fits she may be admitted to the hospital, and evil divorce may be sought.

DR. KAPUR: That is where the question of service comes in. A medical officer has to certify whether the person has to be admitted under special circumstances or under detention order or not. I do not think that they will use that condition to admit the patient for a longterm. We should not. The only thing is that for the psychonuroses, the kind of facilities that is given for a longterm treatment of the patient may be missed.

MR. CHAIRMAN: Who denies them the facilities for treatment we are trying to make the treatment facilities separately available on a voluntary basis. Why do you want to bring in the psychoneuroses within the purview of this Act. Psychosis 'Yes'. There may be cases which must be admitted in their own interests but psycho-neurosis can come as out-patient cases.

DR. KAPUR: Mental sub-normality has to be treated by people educated in special knowledge. I am trying to keep these people out for that particular reason.

SHRI MAQSOOD ALI KHAN: Our aim is to make the phrase 'mentally

ill person' most understandable. How can we improve on this definition?

DR. KAPUR: I want to remove mental deficiency. I will read out:

> "A person who is in need of psychatric treatment for reason of mental dis-order and includes. . ."

MR. CHAIRMAN: Let us stop at the word 'dis-order' and remove the rest.

DR. KAPUR: At the moment what happens is that many of the mentally retarded are put in the mental hospitals. If we have a separate Act for the mentally retarded then it will be taken care of.

MR. CHAIRMAN: Let us proceed further.

DR. KAPUR: We had earlier suggested that the definition of a psychiatrist should include medical practitioners possessing post-graduate degree. Since then I have reviewed my position and I have thought that there are so few trained psychiatrists in the country. So, I drop my suggestion. I now come to Chapter II. Let us see 3(1). It says:—

> 'The Central Govt. may, in any part of India, or the State Govt. may, within the limits of its jurisdiction . . .'

I suggest that we may say 'will' in both the places in place of 'may'.

MR. CHAIRMAN: Lawyers say; I am told, that both may and shall have the same meaning.

SHRI KRISHNA NAND JOSHI: In the Rajya Sabha in a recent discussion, the Central Government pointed out the 'may' will be treated as recommendation.

DR. KAPUR: There are various parts of India where for miles around there are no hospitals at all. State and Central Governments have to take responsibility.

MR. CHAIRMAN: 'May' is all right.

AN HON. MEMBER. 'Shall' is mandatory.

MR. CHAIRMAN: It has been stated that rules have to be evolved to protect the mentally-retarded persons. As things stand, we cannot force the State and Central Government. That is what has been said.

DR. KAPUR: You find in the streets several mentally-retarded persons; their number is more than those who go to hospitals. They certainly need help and protection. You can't have mental hospitals like a honeycomb. If you can think of some other procedure, we are most willing to accept it.

MR. CHAIRMAN: You have said something about convalescent cases. You said that children of 15 years or so should be treated separately instead of mixing them with adults.

DR. KAPUR: If this can be worked and maintained well and good.

MR. CHAIRMAN: It has been stated that age of 18 may be reduced to 15 years for this purpose.

DR. KAPUR: 15 is acceptable. There are certain special kinds of pediatric illness which is appearing commonly among children of 15 years age-group: They need special treatment. This is different from those of adults. Below 15 you have this special category.

DR. SAROJINI MAHISHI: They need special protection under Cr. P.C.

MR. CHAIRMAN: They are tried for juvenile offences.

We are still on Chapter II.

DR. KAPUR: I am thinking of Clause 6 now, having regard to the nature of the area.

MR. CHAIRMAN: We have been adviced to delete that.

DR. KAPUR: Then I will go to the next point. Minimum facilities should

be the same all over the country. This is not spelt out. This is left to this States.

MR. CHAIRMAN: You say, rule should be made Centrally; all States should implement them. There should not be different rule in different States.

DR. KAPUR: Since you have deleted 6(a), 9 also will go.

MR. CHAIRMAN: That is consequential. Regarding 13(2) it is said that inspection officer's power to see all records is contrary to the requirement of confidentiality. What do you say?

DR. KAPUR: It is for that reason I have mentioned this. I am in double mind, so to say, on this issue. Patients may be held up against their will and so on. Some kind of inspection facility will have to be available. I am not however making comment about it.

MR. CHAIRMAN: Inspection officer has to have access to record. That is one thing if it is felt that he cannot function without them. May be, you can have two types of records—one, very confidential, not to be shown to anybody without the paient's permission—and the other a more general one—that may be about the patient, about treatmet given and so on and so forth.

DR. KAPUR: I could have radily agreed if certain things are there. We know the way things are done and the way records are kept under pressure and I do not think the people will be able to make such distinctions very easily. This is not strictly enforceable.

MR. CHAIRMAN: This record has to be made available to inspecting people; confidentiality should not come in the way. Is it your opinion?

DR. KAPUR: He has taken the hippocratic oath; he cannot disclose outside.

MR. CHAIRMAN: Has the Inspector to be a psychiatrist before he sees medical records.

DR. KAPUR: Yes.

MR. CHAIRMAN: He should inspect the record; he should be a psychiatrist; he should take an oath to keep them confidential.

DR. KAPUR: He is under an oath. He is a medical man. He can't divulge. If he reveals, he can be taken to task for that.

AN HON. MEMBER: You said about pressure. What do you mean by it?

DR. R. L. KAPUR: The possibility of pressure exists. Whenever a person has his freedom curtailed, as a mentally ill person has his freedom curtailed, it is likely to be misused. It has been misused in various parts of the world. To keep the patient against his wishes, what I am saying is that an Inspecting Officer, if he is able to see the file, if necessary, can examine the particular patient and see whether the person needs to be there or not, whether he has to be kept against his wishes or not. A person may be kept in the hospital against his wish but such a condition should not be prevalent. While we should make it easy for the doctors to look after the patients, we should not make it a sort of pressurization in certain cases.

Then coming to Chapter-III, para-I, I may make some general comments. I would like to change the categories of admission and the categories I am suggesting now are these:

"Informal admission"

"Voluntary admission"

"A reception order", and

"Emergency admission",

I had in my earlier memory omitted "Emergency admission". But I am bringing it back, the reason being that I re-read the clause and we were hoping that "Emergency admission" could be included "admission under special circumstances. But that needs two certificates. I suggest that "emergency admission" should be

possible on a certificate of one doctor only. It should be any general medical practitioner for a very short time because emergency is emergency. We cannot go on looking for a doctor. There may be a paranoid patient or a patient under alcoholic hallucination.

MR. CHAIRMAN: Another suggestion is that a patient who is brought to the psychiatric institution may be admitted without any certificate by the doctors of that institution or the doctors may keep a panel, as they are doing in Australia, for this purpose. And then one of the panel of doctors may be asked to see the patient and give a certificate but the relatives should not be asked to go from pillar to post for obtaining the certificate.

DR. R. L. KAPUR: I am absolutely in agreement if there is a panel of doctors available. We could prescribe that every institution should have a panel of doctors who can be sent for. But the patient must be admitted immediately.

MR. CHAIRMAN: Why do you want "informal admission"? What about "voluntary admission".

DR. R. L. KAPUR: If we can change the word "voluntary" to mean that the moment he wishes to be discharged, he should be allowed.

MR. CHAIRMAN: I would like you to spend a little time with the officials of the Law Ministry and the Ministry and you can give some suggestions regarding the Chapters 3 and 4. Now, we will leave the "admission procedure" because we are in general agreement. Then we go to Chapter IV Part-I. Let us go to page 20, Clause 41, Chapter IV—Inspection by visitors.

DR. R. L. KAPUR: I think it is a very unrealistic view to inspect every individual. There are hospitals having about 1200 patients. A committee of three persons inspecting every individual is not at all possible.

MR. CHAIRMAN: It has been suggested that instead of 3, it should be 5 and one should be a psychiatrist and one should be a medical officer, who are not the Government employees of any kind. They should be from outside. The second thing is that I would agree we should leave the visitors to go into those cases where a complaint was made to them. The third thing is that it has been sug gested to us that the decision of the doctor with regard to the discharge should not be subject to visitor's approval.

DR. R. L. KAPUR: That is what I was bringing in that if the doctor says that the patient can be discharged we shoud not wait till the end of the month for the discharge.

MR. CHAIRMAN: Now, with regard to leave of a person, you have said that it should not be more than 15 days.

MR. CHAIRMAN: Again, if you discharge the patients and they come back, but the beds are filled in the meantime, what happens? Moreover, because there is a wedding in the house or the patient wants to be with his relations, discharging him might become necessary. If you discharge him, but if it is necessary to re-admit him and no vacancy of bed is there, what will you do?

DR. KAPUR: By keeping the bed vacant, we probably serve the cause less. The condition in the new hospitals is not such that we cannot take in a few more persons. If the person is really in a position to stay away for more than 15 days, he should be really discharged.

SHRI MAQSOOD ALI KHAN: There are two important facts of law. In the Indian Lunacy Act of 1912, we have defined the word 'lunatic' which says: "Lunatic means an idiot or a person of unsound mind". You must have noticed that in different cases, persons of unsound mind have been deprived of very many rights; and there are cases where these persons are admitted to mental hospitals. The other relatives are interested parties.

They try to prove that the person concerned is of unsound mind. He is thus deprived of either succession or right to property or is absolved of the gravity of a crime. From 'lunatic', we have now switched over to a new definition, *viz.* 'mentally ill'. Don't you think that it is necessary for us to add a new definition in our new Bill, saying that treating any person as a mentally ill person does not necessarily mean that he has been of unsound mind? We may have another definition.

MR. CHAIRMAN: How can you do it? A man who has been mentally sick, has been of unsound mind.

SHRI MAQSOOD ALI KHAN: Here we have to see what was the gravity of the mental illness for which he was being admitted. You will admit that an idiot is not the person who has been defined in the present Bill. Idiocy is of a more grave nature; and even the lunation or a man of sound mind is not the man who comes to the doctors for psychiatric treatment for, say, psychoneurosis. He is not a man of unsound mind. In these cases, how would you distinguish it, so that he is not called a man of unsound mind—in respect of certain cases *e.g.* where he is going to be deprived of his property?

MR. CHAIRMAN: It seems to me that we are trying to make up for our ignorance this way. Instead of educating ourselves, we want the law to do it.

DR. KAPUR: It is not really relevant any more. The terms 'unsound mind' and 'idiot' were used at that time. Your fears, at the moment, are the hang-overs of that past.

SHRI MAQSOOD ALI KHAN: In the Lunacy Act it was there. There, 'idiot' and 'unsound mind' were written. And it was defined as such. That is why in all other criminal and civil Acts this phrase is used. We have changed them. There is a new phraseology altogether. Are we going to make all the changes in all other Acts, or to leave it as it is, so that lawyers and doctors are in a state of confusion?

DR. KAPUR: I think you will have to make the necessary changes in the other Act to go along with this.

MR. CHAIRMAN: The only definition used was 'mental disorder' and not 'unsound mind'.

SHRI KRISHNA NAND JOSHI: Once we leave out 'idiot' and other words, consequential amendments have to be made, wherever necessary.

MR. CHAIRMAN: It is not for us to consider it, it is for the Law Ministry. Let us now see page 33, section 92. It says there:

> "The medical officer in charge of psychiatric hospital or psychiatric nursing home wherein any mentally ill person is detained, under the provisions of this Act, shall, once in every six months, make a special report regarding the mental and physical condition of every such person to the authority under whose orders the person is so detained."

It has been suggested to us that this should be deleted.

DR. KAPUR: I agree.

MR. CHAIRMAN: Why Don't you think that it is the correct thing to do? Only in the case of committed patients that once in six months a report should be made. Majority will be voluntary or special circumstance cases.

DR. KAPUR: Committed cases are being reviewed every month, and not once in six months. Moreover, the Board of Visitors comes once a month. Automatically all these committed cases are going to be reviewed at that time.

MR. CHAIRMAN: They cannot do it. It is the medical officer who can. The Board may not give a detailed report on them. Once in six months, let the medical officer in charge put up a report before the Visitors, or the magistrate.

DR. KAPUR: The magistrate is a member of the visiting board. It seems unnecessary, because we are doing it once a month.

MR. CHAIRMAN: In some places, it is not done. In some places, it is not done even once a year.

DR. KAPUR: This Bill makes it obligatory.

SHRI KRISHNA NAND JOSHI: Suppose a patient is there under a reception order. As soon as the case goes from the magistrate, he becomes a guardian of the patient. He is expected to know what is happening to that case.

MR. KAPUR: He knows it.

MR. CHAIRMAN: As a visitor, he goes in a different capacity. But here he has ordered that the patient should be hospitalized. What harm is there if the report goes to him?

DR. KAPUR: It is a question of simplification of procedures. The magistrate has come and seen him once a month—or he is expected to do it.

SHRI KRISHNA NAND JOSHI: He may not get time. It is not necessary that he should come with the Board. He may be in the panel.

SHRI KRISHNA NAND JOSHI: But what is the official report? The regular record is maintained there.

DR. KAPUR: But if you are not satisfied with that, I accept that we have difficulty in enforcing it.

SHRI RAJSHEKHAR KOLUR: Supposing the patient wants to go out and he informs the doctor about it. But the doctor feels that he needs more medical treatment and care and he should not be allowed to go out without proper care and protection. We had decided about it in 1972 and now you are suggesting that we should not specify the time. When he got admitted, he was all right.

DR. KAPUR: I wanted formal admission and the voluntary admission to remain separately.

SHRI RAJSHEKHAR KOLUR: When he got admitted, at that time, he was all right. When he wants to go out, at that time, his condition is not that much all right.

DR. KAPUR: We can change over to the admission under special circumstances. We have that clause.

MR. CHAIRMAN: I thank you very much for taking the trouble of coming over here and assisting the Committee on the subject. I would like you to join us a cup of tea and there the Members may talk to you informally. Tomorrow, we are meeting at 11 A.M. Then we will be going to Tihar Jail at 2 P.M.

(The Committee then adjourned)

JOINT COMMITTEE ON MENTAL HEALTH BILL, 1978

RECORD OF EVIDENCE TENDERED BEFORE THE JOINT COMMITTEE ON THE MENTAL HEALTH BILL, 1978.

Saturday, the 7th October, 1978 from 11.30 to 12.15 hours

PRESENT

Dr. Sushila Nayar—*Chairman*

MEMBERS

Lok Sabha

2. Shri Anant Dave
3. Shri Harikesh Bahadur
4. Shri Kacharulal Hemraj Jain
5. Shri Hukam Chand Kachwai
6. Dr. Bapu Kaldate
7. Shri Rajshekhar Kolur
8. Dr. Sarojini Mahishi
9. Shri Mallikarjun
10. Shri S. G. Murugaiyan
11. Shri K. Ramamurthy
12. Shri Rudolph Rodrigues
13. Shri Sakti Kumar Sarkar
14. Shri Shrikrishna Singh
15. Shri H. L. P. Sinha
16. Shri Yuvraj

Rajya Sabha

17. Shri R. D. Jagtap Avergoankar
18. Shri Swami Dinesh Chandra
19. Shri Krishna Nand Joshi
20. Shri Ibrahim Kalaniya
21. Shri Maqsood Ali Khan
22. Shri Kalraj Mishra
23. Shrimati Ushi Khan
24. Shri Bhagwati Charan Varma

SECRETARIAT

Shri Y. Sahai—*Chief Legislative Committee Officer.*

LEGISLATIVE COUNSEL

1. Shrimati V. S. Rama Devi—*Joint Secretary and Legislative Counsel.*
2. Shri Y. P. Sud—*Assistant Legislative Counsel.*

REPRESENTATIVES OF THE MINISTRY OF HEALTH AND FAMILY WELFARE (DEPARTMENT OF HEALTH)

Shri Anand Prakash Atri—*Deputy Secretary.*

Shri P. B. Mazumdar—*Assistant Director General, Health Services.*

WITNESS EXAMINED

Dr. (Brig.) S. S. Syalee—*Consulting Psychiatrist and Neuro-physician, New Delhi.*

Dr. (Brig.) S. S. Syalee

(*The witness was called in, and he took his seat*).

MR. CHAIRMAN: Dr. Syalee, I welcome you to the Committee.

(*Direction 58 read out*)

We have received your Memorandum. Would you like to say something about your memorandum first?

DR. S. S. SYALEE: Thank you very much. I have only three observations to make.

Firstly, as regards Section 20, sub-section 2, p. 9, it is felt that a medical certificate from a qualified psychiatrist as defined under Chapter I, para 2(r), is far more reliable than certificates from two medical practitioners. This sub-section should be amended suitably. I suggest that every application under sub-section (1) of this Act shall be accompanied by either two medical practitioners' certificates of whom one shall be a medical practitioner in the service of Government or a qualified psychiatrist.

You may not be aware of the various complexities of the mentally ill people. Therefore, this sub-section should be amended as I have suggested. I feel one qualified psychiatrist's certificate is much more valid and adequate enough rather than having two certificates from the general medical practitioners.

MR. CHAIRMAN: The problem is that the number of psychiatrists in the country is so small that it will be extremely difficult for the people coming from the rural areas, from the villages, to arrange for the certificate. In fact, it has been suggested to us that we should not insist on their bringing a certificate. With great difficulty, they bring a patient from the interior areas. They go to the institution and the institution may admit them straightway. The officer of the institution should be competent enough to see whether the patient needs psychiatrist treatment or not. There may be a panel of doctors kept by the institution one or two of whom can be called to review whether the admission has been right or wrong. Otherwise, if we ask them to go in search of a psychiatrist, they will be either fleeced or put to great harassment. We want to make it very simple.

आज जब कोई मरीज जनरल अस्पताल में जाता है वह कहां से सर्टिफिकेट लाता है। जो सुविधा जनरल मरीज को है वही फेसिलिटी यहां देना चाहते हैं कि या तो मरीज सीधा वौलेंटेरिली चला जाये, या उसके रिश्तेदार ले आये इंस्टीट्यूशन दाखिल कर ले और 72 घंटे के अन्दर उसको देख लिया जाये कि ठीक एडमिट किया गया है कि नहीं।

Thirdly, the admission should be on the commital of the magistrate in special type of cases. These are the only types of admissions. We should not insist upon either a certificate from the psychiatrist or the general medical practitioner.

DR. S. S. SYALEE: I entirely agree with you. If that is your view and

the consensus of the Committee, I would certainly support it. I would suggest that this sub-section should be completely deleted. If the Bill is going to be passed as it is, then amendment is submitted.

MR. CHAIRMAN: We take note of your suggestion. The Chapters relating to admissions are being re-cast in the light of the evidence that has been given by you and others who have appeared before the Committee.

DR. S. S. SYALEE: I would certainly support your view that these cumbersome procedures are the main hurdle in the adequate treatment of the mentally ill persons. They should be removed. That is a very progressive idea.

DR. SYALEE: The same clause 22(6) pertains to the same subject matter. So it is decided to forgo the whole procedural and cumbersome demands according to this Bill. This may be completely removed.

Then in clause 40, sub-clause (3)— it is felt that some guidelines should be laid down by way of general directions that the visitors should be men of public eminence such as educationists, lawyers, social workers, doctors, etc. In the past difficulties have been experienced in dealing with some visitors having absolutely no educational qualifications at all. In the present Bill no guidelines have been given as to the qualifications of the visitors. I suggest that the visitors should have some background before they are made official visitors according to this Act. They should be educated people who should be able to understand and discuss with the Superintendent of the Mental Hospital as to what is exactly the correct position, at the time when he visits.

श्री अनन्त डवे : आपने जो कहा है कि ऐजुकेटेड आदमी विजिटर होना चाहिये, तो आपके विचार से विजिटर के लिये कौन सी क्वालिफिकेशन रखनी चाहिये ।

DR. SYALEE: They should be Graduates.

SHRI ANANT DAVE: At least.

SHRI MAQSOOD ALI KHAN: Brigadier, please pardon me for being bit inquisitive about certain things. But I want it should go on record.

I want to know what is your standing in the field, your experience and what your qualifications are.

DR. SYALEE: I am a Graduate of General Medicine and Surgery. I am DPM from London. I am an FRCP and also FRCS.

SHRI MAQSOOD ALI KHAN: How long have you been practising?

DR. SYALEE: 34 years.

SHRI MAQSOOD ALI KHAN: Are you attached to any private clinic at present.

DR. SYALEE: I am attached to a private clinic called East-West Medical Centre, 38, Golf Course Road and also Nandi Nursing Home.

SHRI MAQSOOD ALI KHAN: During the period of your practice did you find any hurdles created by the Indian Lunacy Act of 1912? Did you come across any so far as that Act was concerned?

DR. SYALEE: During the last one year I have got four cases which need immediate hospitalisation and treatment but they are not willing to be treated and the family and the relatives of the patients and the children are under great stresses and strains. Just the patients refuse to be admitted.

MR. CHAIRMAN: But if the patients refuse to be admitted, the old Act empowers the relatives to go to the Magistrate and get an order.

DR. SYALEE: Quite often his wife or the brother or the father move in the matter. But they feel so reluctant and the family feel so ashamed of dragging the case to the Magistrate and get order to take him to the mental hospital. So they do not adopt this attitude. In spite of my best efforts

to persuade them to adopt this attitude, they are not doing it. The cases are there for the last 6 months or a year. They are in a deplorable condition.

श्री आर० डी० जगताप (अवरांगाबाद) : भर्ती करने के बारे में आपका क्या सुझाव है?

श्री हुकम चन्द कछवाय : उन्होंने बताया कि योग्यता प्राप्त लोगों का प्रमाण-पत्र होना चाहिये ।

DR. BAPU KALDATE: Does the present Bill solve your difficulty to any extent and if not, what are your suggestions.

DR. SYALEE: It is the sentimental grounds that are the main stumbling block. Nobody wants to take the lead and even a psychiatrist of my standing in the field cannot persuade the relatives concerned to adopt the correct procedure in the interests of the patient and the entire family. The remedy seems to be only this that any social worker in the area should be authorised on behalf of the family to obtain the services of a psychiatrist or a doctor to deal with the matter. This is a social matter in which social agencies must come to the rescue of the patient and the social agencies should undertake this responsibility in the interests of the people concerned. If the doctor takes the case, he may be misconstrued that he is interested in making money. The relatives do not take the initiative, they just keep quiet and wait for some miracle to happen. They adopt all sorts of attitude taking the patients to various agencies which cannot do anything in these matters and the right treatment which is available is not provided. I feel that social agencies must be given this power and that should be included in the Act that whenever a qualified doctor or psychiatric or any friend or relative comes and tells them the real position, they should take the initiative.

MR. CHAIRMAN: For what?

DR. SYALEE: To take the patient to the hospital for treatment.

MR. CHAIRMAN: Social agencies should take, but not relatives?

DR. SYALEE: Relatives, of course, but, they are not taking an active part.

MR. CHAIRMAN: Do you expect the social agencies to take an active part instead of the family and the relative?

DR. SYALEE: I know in England they have mental health authorities and in each country there is one person who is authorised to have this privilege and where he is informed that Mr. so and so is mentally ill in such and such house, he takes up the entire responsibility of getting the legalities and formalities completed. There is no provision here in our country. It should be somebody whose bona fides should be above doubt and he should not be suspect.

MR. CHAIRMAN: Shri Kachwai.

श्री हुकम चन्द कछवाय : आपने कहा कि योग्यता प्राप्त व्यक्ति लिख दे कि यह व्यक्ति मानसिक रोग से पीड़ित है तो उसे मानना चाहिये । दो व्यक्ति लिखे उसकी कोई आवश्यकता नहीं है । तो योग्यता प्राप्त व्यक्ति से आपका मतलब पढ़े लिखे से है या जो मनोविज्ञान का विशेषज्ञ है उससे है ?

डा० स्यालो : जो मनोविज्ञान का पढ़ा लिखा है ।

श्री हुकम चन्द कछवाय : लेकिन कई स्थानों पर ऐसे लोग नहीं मिलते हैं, तो वहां क्या करना चाहिये ? वहां कौन व्यक्ति तय करेगा कि यह व्यक्ति मानसिक रोग से पीड़ित है और इसको भर्ती कराना जरूरी है ?

डा० स्यालो : गांव के मुखिया कर सकते हैं ।

श्री हुकम चन्द कछवाय : वह तो योग्यता प्राप्त है नहीं ।

SHRIMATI USHI KHAN: Mr. Kachwai asked and you have said in para (4) that there should be educationists, lawyers, social workers and others. I feel they should cover the ground except that in the villages at the district level you know there are doctors who can certify. So I do not know why we should have this general thing because sometimes in the villages there is a lot of confusion so far as land is concerned and people try to make others believe that so and so is insane and he is not capable of dealing with his own possessions, whether it is land or anything else. I feel that if you are going to have visitors of the category of the doctors etc., that would be better rather than bringing in someone else. What is your view?

DR. SYALEE: Those visitors only are authorised who are in the psychiatric hospital or psychiatric Nursing home. If somebody is to vouchsafe and testify that so and so needs the psychiatric treatment, any person who has some social standing whose bona fides are not in doubt should be there. He has the special knowledge. And no one would have such influence. What exactly is the condition of the patient if you were to approach against any individual? You may make him fit. It is open to him to vouch. This has been a subjective science in which anybody who is not trained and qualified will definitely be liable to make a mistake.

But, my point is that initially when the patient needs treatment and if he is not getting it or he is not getting the benefits of treatment, some social agency or somebody who is authorised to recommend should have the power. And ultimately it is the psychiarist and others who are concerned with this subject should be able to certify whether he needs treatment or not.

श्री हुकम चन्द कछवाय : जो मानसिक रूप से बीमार हैं उनको आम अस्पताल में रखना उचित होगा या इनको अलग अस्पताल में रखा जाय ? आप किस बात से सहमत हैं क्योंकि सभी जिलों में मानसिक अस्पताल नहीं होते ।

डा० सयाली : आजकल मेंटल इलनैस और दूसरी बीमारियों में कोई भेदभाव रखना उचित नहीं है । यह ट्रीटमेंट भी उसी अस्पताल में होना चाहिये जहां दूसरे मरीजों का इलाज हो रहा है । सिर्फ उसमें एक सेक्शन अलग होना चाहिये । मेंटल अस्पताल उन्हीं लोगों के लिये हो जिन्हें सिर्फ कस्टडी के लिये रखना होता है और उनका कोई इलाज नहीं हो सकता है ।

श्री हुकम चन्द कछवाय : प्राइवेट लोगों को लाइसेंस न दिया जाये इलाज करने के लिये, आप इस बात से सहमत हैं ?

डा० सयाली : इसमें तो लिखा है कि इलाज होना चाहिये । अगर मैं कोई नर्सिंग होम खोलना चाहता हूं और सरकार से लाइसेंस चाहता हूं : तो उसमें क्या हर्ज है । कोई भी स्पेशलिस्ट ट्रिटमेंट सेन्टर खोलना चाहता है और सरकार से इजाजत चाहता है तो उसको इजाजत मिल जानी चाहिये ।

श्री हुकम चन्द कछवाय : उसका मिसयूज नहीं हो सकता, ऐसा आप मानते हैं

डा० सयाली : मिसयूज तो हर हालत में हो सकता है ।

श्री हुकम चन्द कछवाय : आप चाहते हैं कि प्राइवेट मानसिक अस्पताल ज्यादा खुलने चाहियें ?

डा० सयाली : जी हां ।

SHRI RUDOLPH RODRIQUES: You have rightly sought clarifications to Section 40, sub-section (3). You

look at sub-section (2), page 19 of this bill. What does it say? It says:

> "Inspector General of Prisons and the Head of the Medical Service of the State shall be ex-Officio Visitors of all the Psychiatric Hospitals and Psychiatric Nursing Homes in the State".

I have nothing to say as far as first part is concerned. If an Inspector General of Prisons is put in, don't you think that this is an undesirable provision? Don't you think that the stigma is being attached here unnecessarily?

DR. SYALEE: I am sure that the gentleman who has drafted this Bill must have got the provision from the previous Lunacy Act or something like that. Previously the Inspector Generals were given wide powers. That is why probably it has come. Now the problem may arise if the Inspector General of Police has some information and, if he wants to satisfy himself, whether anybody is not being ill-treated or badly treated. If he has sufficient reasons to believe, then he can certainly walk into the mental hospital so as to satisfy himself.

SHRI RUDOLPH RODRIGUES: He does not need visitor.

DR. SYALEE: He can go and ask for the papers and ask questions from the head of the Hospital as to why he is being detained? He can satisfy himself.

SHRI RUDOLPH RODRIGUES: He can ask anyone in the hospital. Should he be necessarily a visitor?

MR. CHAIRMAN: You feel that the Inspector General of Prisons will be too busy a person to go every month to the Mental Hospitals and therefore we should not make him an ex-officio visitor. I think this is the duty which he has to do. Mental cases were kept in prisons as is being done in the capitals of India even to-day. We visited Tihar Jail where mental cases are kept. So that is the case with Delhi. This is a hangover from the past. What Mr. Rodrigues has asked is: Visitors must not be able to visit every now and then. He will visit every month as things stand. We have been told by institutions that visitors do not even come once in six months. Would you like to comment on this?

DR. SYALEE: I do not know whether the privileges which are granted to the Inspector General of Prisons is enjoyed by him or not. But, certainly, I have no objection if he has the privileges.

MR. CHAIRMAN: That is one thing. He can go there at any time. There is another thing. That is there is a visitor's group with three in number or whatever be the number. He is appointed under the law. Certain responsibilities have been cast on those visitors and so they are expected to go and help the doctors in various ways. Do you think that one such person should be the Inspector General of Prisons? That is a question. You yourself said that the visitors should be knowledgeable persons. The question is: Should they also be people who have some time to spare or not?

DR. SYALEE: The Inspector General of Prisons is supposed to have spare time. After all this is one of his legitimate responsibilities and duties.

MR. CHAIRMAN: What is the qualification?

DR. SYALEE: If the Inspector General of Prisons has all the requisite qualifications, he can certainly go and inspect.

MR. CHAIRMAN: What is the requisite qualification that he should have? I.G. Prisons will certainly be

a graduate. What other qualifications do you want for him? Let me get the clarification from the witness.

DR. SYALEE: If he is an IPS Officer he is surely competent to become a visitor in a mental hospital. But, it may not be the basic qualifications. At least the appointment which he is holding qualifies him.

MR. CHAIRMAN: He is not a Police Inspector. He is only an Inspector General of Prisons—not Inspector General of Police.

DR. SYALEE: He may be a medical officer—either a surgeon or anyone else.

MR. CHAIRMAN: He may be anybody from the administrative cadre risen to the post of an Inspector General of Prisons.

DR. SYALEE: He is a person who has got vast experience.

SHRI RUDOLPH RODRIGUES: We are giving this task to a person by virtue of his position as I.G. of Prisons and so on. You can't treat hospital or nursing home as something like a prison. It is going to be a stigma.

DR. BAPU KALDATE: We will discuss details when we come to the clauses.

MR. CHAIRMAN: Clause 42 says this:

"Notwithstanding anything contained in section 41, where any person is detained under the provisions of section 144 of the Air Force Act, 1950, or section 145 of the Army Act, 1950, or section 143 or section 144 of the Navy Act, 1957, or section 330 or section 335 of the Code of Criminal Procedure, 1973,—

(i) the Inspector General of Prisons, where such person is detained in a jail; or

(ii) the Inspector-General of Prisons and all or any three of the Visitors appointed under sub-section (1) of section 40, where such person is detained in a psychiatric hospital or psychiatric nursing home,

shall, once in every six months, visit such person at the place where he is detained..." etc.

SHRI RUDOLPH RODRIGUES: Section 42 does not require Section 40, sub-section (2).

DR. BAPU KALDATE: As I said, we need not go into detailed discussion on clauses at this stage.

MR. CHAIRMAN: Our witness does not think there is any harm in keeping it as it is.

श्री अनन्त बने : जो आपने कहा है कि विजिटर्स को ऐडूकेटेड होना चाहिये, लेकिन कई विटनेसेज ने यहां आ कर कहा है कि जब पेशेन्ट की हिस्ट्री लो जायेगी तो वह विजिटर्स को नहीं दिखानी चाहिये, बल्कि कानफीडेंशियल रहनी चाहिये। इस बारे में आप की क्या राय है ?

MR. CHAIRMAN: The position is this: According to this Act, the Inspector can ask for the record of the patient; he can look into it. He can go into it if there is any complaint that proper treatment is not given to the patient. Some people have said, this contravenes the confidentiality clause. What is your view?

DR. SYALEE: Whatever the patient has confided to the doctor is strictly personal and confidential. It is a privileged information and no authority can restrain him in getting such information. Nobody can force him to bring out this confidential information. Now, the question is not about this. The question is, a patient is detained in an institution. This information can be passed on to the Visitor who should be able to see and satisfy himself that the patient is not detained without sufficient reason.

SHRI MALLIKARJUN: You have said that the patient is detained in an institution. So the information can be revealed. There are various patients in various nursing homes and hospitals and so on. Maybe in one or two cases such things can happen. After all, many such persons are admitted in the private nursing homes and hospitals and what is the role of the Visitor in this behalf?

DR. SYALEE: The purpose of the Visitor going there is to satisfy himself that in respect of the patient detained in the psychiatric or mental hospital his detention is justified. That is the point.

MR. CHAIRMAN: Sometimes you get letters from relatives or friends saying that such and such person has not been treated well in an institution. He is neglected, and so on and so forth. Visitor can look into it. He can see whether this is correct or not correct.

DR. SYALEE: That is there. He should be satisfied. Otherwise he is free to take any action.

AN HON. MEMBER: Educationist, social worker or a competent person should be the visitor.

MR. CHAIRMAN: The power is not given to the visitor but it is given to the inspector. The inspector has to be a psychiatrist.

DR. SAROJINI MAHISHI: Please look at the definition given in subclause (m) of page 3. Is it all right?

DR. SYALEE: It is quite exhaustive. It covers practically every facet.

DR. SAROJINI MAHISHI: No addition or no substraction.

DR. SYALEE: I think it is exhaustive.

DR. BAPU KALDATE: Is 'mentally subnormal' put correctly? Should it be categorised in this definition?

DR. SYALEE: It is quite possible that mentally subnormal is better than mentally retarded.

MR. CHAIRMAN: Mental sub-normality is not a disease. It is not something which can't be improved by treatment. They can't be made to get over this subnormality by keeping them in an institution. This is what has been said by certain others. They say, these things should be treated separately. Separate Act should be provided for that.

DR. SYALEE: Separate Act should be provided for that. I agree. It should not be included in this.

MR. CHAIRMAN: You have psychosomatic cases. It is generally stated that the definition is very wide. A person having peptic ulcer may find himself or herself in a mental hospital. Some relatives or others interested person may put him away and that may happen.

DR. SAYALEE: It may happen. Some of these psychosomatic disturbances may persist for many years. Ultimately the patients may likely to suffer from a sort of advanced personality disorder. In most of the psychosomatic disorder, it is the personality disorder along with some personal ailments which is currently taking place.

MR. CHAIRMAN: Generally with every disorder, a man gets depressed. Then if you take him to mental hospital for emotional manifestations, that may lead him to suffer from physical disease. Supposing there is a case of chronic psychosomatic patient who gets depression and while in depression, he needs hospitalisation. In such a situation, he may be sent to psychiatric department of a General Hospital rather than a mental hospital, because he needs general treatment.

DR. SYALEE: It is much rarer for the psyhiatrist to treat the patient when he is suffering from psychosomatic disorder but at the same time he can treat the psychiatric patient much better than the patient suffering from psychosomatic disease.

श्री हुकम चन्द कछवाय : अनेक देशों में मानसिक बीमारी की परिभाषा अलग अलग ढंग से की गई है। उस तुलना में इस विधेयक में जो परिभाषा की गई है क्या उसे आप अच्छा समझते हैं ? या उसकी तुलना में ठीक नहीं है ?

डा० सयाली : जो हमारा पहले का लूनेसी ऐक्ट है उससे तो बहुत अच्छा है यह बिल और परिभाषा लेकिन यह नहीं कह सकता कि दूसरे ऐडवान्स्ड कन्ट्रीज के ख्याल के मुताबिक है या पीछे है। अभी हमारी सोसायटी इस मामले में इतनी जानकारी नहीं रखती है। इसलिये बहुत ज्यादा डेफ़ीनीशन करना भी ठीक नहीं है। जब हमारी सोसायटी मेंटल इलनैस को दूसरी बीमारियों के समान समझने लगेगी तो इसमें परिवर्तन किया जा सकता है।

श्री हुकम चन्द कछवाय : हमारे देश की आबादी के अनुसार कितने प्रतिशत लोग इस बीमारी से पीड़ित हैं ?

डा० सयाली : कम से कम 15 प्रतिशत आदमी इस बीमारी से पीड़ित हैं।

(The Committee then adjourned

JOINT COMMITTEE ON THE MENTAL HEALTH BILL 1978

RECORD OF EVIDENCE TENDERED BEFORE THE JOINT COMMITTEE ON THE MENTAL HEALTH BILL 1978.

Wednesday, the 8th November, 1978 from 14.00 to 15.00 hours

PRESENT

Dr. Sushila Nayar—*Chairman*

MEMBERS

Lok Sabha

2. Shri Harikesh Bahadur
3. Shri S. Jaganathan
4. Shri Kacharulal Hemraj Jain
5. Dr. Bapu Kaldate
6. Dr. Sarojini Mahishi
7. Shri Mallikarjun
8. Shri K. Raamurthy
9. Shri Rudolph Rodrigues
10. Shri Sakti Kumar Sarkar
11. Shri H. L. P. Sinha
12. Shri N. Tombi Singh
13. Shri Jagdambi Prasad Yadav
14. Shri Yuvraj

Rajya Sabha

15. Shri R. D. Jagtap Avergoankar
16. Shri Swami Dinesh Chandra
17. Shri Krishna Nand Joshi
18. Shri Ibrahim Kalaniya
19. Shri Maqsood Ali Khan
20. Shrimati Ushi Khan
21. Shri Bhagwati Charan Varma

SECRETARIAT

Shri Y. Sahai—*Chief Legislative Committee Officer.*

LEGISLATIVE COUNSEL

1. Shrimati V. S. Rama Devi—*Joint Secretary and Legislative Counsel.*
2. Shri Y. P. Sud—*Assistant Legislative Counsel.*

REPRESENTATIVES OF THE MINISTRY OF HEALTH AND FAMILY WELFARE (DEPARTMENT OF HEALTH)

1. Shri K. P. Singh, *Additional Secretary.*
2. Shri R. K. Singhal, *Joint Secretary.*
3. Dr. I. L. Bajaj, *Additional Director-General of Health Services.*
4. Shri Anand Prakash Atri, *Deputy Secretary.*
5. Shri J. S. Neki, *Director, Post Graduate Institute of Medical Education and Research, Chandigarh.*

WITNESS EXAMINED

Dr. A. B. Dutt, Superintendent, Bangiya Unmad Asram, Calcutta.

Dr. A. B. Dutt

(The witness was called in, and he took his seat)

MR. CHAIRMAN: Dr. Dutt, we are grateful to you for your coming here for the second time to give evidence before this Committee.

I wish to make it clear to you that your evidence shall be treated as public and is liable to be published unless you specifically desire that all or any part of pour evidence is to be treated as confidential.

I would further explain that even if you want it to be confidential, it is liable to be made available to Members of Parliament. You may now proceed. We have received your memorandum and have circulated that. If you wish to say anything or if you want to add or if you want to say in summary or highlight anything on that, you are free to do so.

DR. DUTT: Madam, Chairman, I have explained everything in detail in original as well as in my supplementary memorandum. I have also made some suggestions or amendments to the Bill. In view of the suggestions made in the memorandum I would be pleased to answer if any specific question is asked from me about the amendments that I have proposed.

DR. SAROJINI MAHISHI: From the memorandum that we have received it seems that you want the definition in Section 2 to be substituted for the one already in the Bill.

DR. DUTT: Madam, have suggested certain modifications as this is a Mental Health Act and not merely a Mental Hospital Act or Mental Nursing Home Act. So, the words 'Mental Hospital' and 'Psychiatric Nursing Home' be amended as 'Psychiatric facility'.

Section 2(f) should be read as:—

"licensed psychiatric facility' means a psychiatric hospital, psychiatric nursing home, psychiatric unit of a general hospital or psychiatric day hospital, as the case may be, licensed or deemed to be licensed, under this Act."

MR. CHAIRMAN: I would suggest to the Members that they may look at the paper in which Dr. Dutt has made suggestions for amendments.

DR. SAROJINI MAHISHI: After looking into his paper only I have asked him the question. Dr. Dutt's suggestion is with regard to the definition—Section 2 of the Bill—section to be substituted by what he has mentioned. Under Prolonged Care and Treatment Order, he wants it to mean an order made under the provisions of this Act for admission etc. etc. He wants the whole of it is to be specified by the definition clause.

DR. DUTT: That is correct.

MR. CHAIRMAN: Do you wish to add anything to the existing one?

DR. DUTT: I have suggested that certain terms should be modified. I have suggested under Sec. 2(f) for the existing term 'licensed phychiatric facility' should be substituted. I have also suggested that the word 'Magistrate' should be replaced by the words 'Justice of Peace'. Also I have suggested that 'Justice of Peace' means 'Ex-Officio Justice of Peace'.

MR. CHAIRMAN: Dr. Dutt don't you realise that Justice of Peace is not everywhere but Magistrates are everywhere. Perhaps Justice of Peace may be only in a very few places. You are thinking of Calcutta. And so you are talking in that fashion..

DR. DUTT: Madam, I have suggested that the 'Justice of Peace' means 'Ex-officio Justice of Peace'.

(a) in relation to a State or Union Territories the Chief Mental Welfare Officer.

(b) in relation to a metropolitan area or district.

(i) District Mental Welfare Officer.

(ii) Chief Medical Officer of Health.

(iii) Sub-divisional Medical Officer.

Instead of 'Sub-Divisional Magistrate', I have suggested the words 'Sub-Divisional Medical Officer'. Also I have suggested that the Chief Medical Officer should take over the role of doing the things of the District Magistrate under this Act. He has to have some judicial powers or executive powers. And so they should be ex-officio Justice of Peace as is being done in Trinidad and Tobago so that there is no additional expenditure for this. Gradually we can have district Mental Welfare Officers who will take over the functions of the sub-divisional medical officer or chief medical officer who are at present not psychiatrists. We have got to appoint one Chief Mental Health Welfare officer for the whole State. I have not suggested anything which will involve any expenditure either to the States or to the Centre as these people are available everywhere.

I have also suggested that Justice of Peace appointed by the State Government in relation to the entire State or Union Territory should be a Psychiatrist with at least ten years of experience after obtaining post-graduate qualifications. Psychiatrists are also available in plenty in this country who can also do this thing along with others.

MR. CHAIRMAN: You want the magisterial powers to be given to the medical people. You want the whole thing to be processed through the medical officers and not through the magistrates. This I can understand.

Any further question on this side?

SHRI SHKTI KUMAR SARKAR: Dr. Dutt do you think that the mental illness as defined in the Act is sufficient to cover all the problems relating to the mental illness?

DR. DUTT: I think so.

SHRI SAKTI KUMAR SARKAR: Do you feel that there should be any other change made to the Bill as suggested by other witnesses?

DR. DUTT: I do not know what has been suggested by the other witnesses. In U.K. the mental illness has been defined but not in our case.

SHRI SAKTI KUMAR SARKAR: Kindly give your valued opinion to each and every clause.

DR. A. B. DUTT: Since this proposed Act says that "'mentally ill person" means a person who is in need of psychiatric treatment by reason of mental disorder or mental deficiency or of any disturbance in his behaviour or mental state and includes a person

who has all or any of the clinical conditions known as psychoses, phycnoneuroses, psychopathic state, addition mental sub-normality or psychosomatic disorder of such other condition of the like nature as may be prescribed;"

SHRI SAKTI KUMAR SARKAR: Mental defficiency does not mean mental disorder.

DR. A. B. DUTT: It may be mental disorder, it may not be mental illness. In the U.K. under this Mental Act of 1959, everything has come under the term mental disorder. Mental illness means psychopathic state, addition, mental sub-normality or psychosomatic disorder, etc. So, everything comes under this. I think these are a good working condition.

SHRI KRISHNA NAND JOSHI: On page 21 of your note, you have said that the Bill should be amended in such a manner to encourage the families and family physician and not the gazetted Medical Officers in getting actively involved in the treatment of psychiatric patients and on the other side you have said that 90 per cent of the people are poor. Do you think that family physicians are available to each and every patient?

DR. A. B. DUTT: I wanted to get the general practitioners involved. The General Practitioners are plenty in every corner of the country. But the General Practitioners on psychiatric treatment side are not available. Just to have a certificate for getting admission to a Mental hospital, there is no need to spend a huge amount on psychiatrist or the Gazetted Medical Officers who may not know anything about mental illness.

That is why I suggested the General Practitioners and family physicians should be involved. We talk about the para-medical doctors and even we talk about the bare-foot doctors. Here we have excluded the person who will ultimately take care of the patients. That is the general practitioner and family physician. It is very easy to get a prescription from the doctor but it is very difficult to get a certificate from a psychiatrist. Equally gazetted Medical Officers are not in plenty. This is the problem. That is why I suggested like that.

CHAIRMAN: There are two main things in your suggestion. You do not want Magistrates to be brought into it. Now, you want the Institution of Mental Health Tribunal. Will you please elaborate the complete mental health tribunals?

DR. A. B. DUTT: Kindly look at the page 2 of my Supplementary Amendments which I have submitted yesterday. I will read it out.

"1. There shall be a Mental Health Tribunal in each State or Union Territory of India.

2. Each of the Mental Health Tribunals shall consist of—

(a) a number of persons (here matter referred to as "the legal members") appointed by the State Government on the advice of the Chief Justice of the High Court and having such legal experience as the State Government considers suitable;

(b) a number of persons (hereinafter referred to as "the specialist members") being psychiatrists as defined under section 2(r) of this Act appointed by the State Government;

(c) a number of suitably qualified and/or experienced medical practitioners, other than employees of the State or Central Government appointed by the State Government on the advice of the State or Territorial Branch of the Indian Medical Association.

3. The members of Mental Health Tribunals shall held and vacate office under the terms of the instrument under which they are appointed, but

may resign office by notice in writing to the State Government and any such member who ceases to hold office shall be eligible for re-appointment.

MR. CHAIRMAN: A man who resigns should not be reappointed. Why do you want to reappoint him?

DR. A. B. DUTT: Anybody may resign. But for those people who are appointed for three years, after they cease to hold office, they may be appointed. Now, coming to the Mental Health Tribunals I will read out the rest of the portion.

"4. One of the legal members of each Mental Health Tribunal shall be appointed by the State Government as Chairman of the Tribunal.

5. Subject to rules made by the State Government under this Act, the members who are to constitute a Mental Health Tribunal for the purposes of any proceedings or class or group of proceedings under this Act shall be appointed by the Chairman of that Tribunal or, if for any reason he is unable to act, by another member of that Tribunal—appointed for the purpose by the Chairman; and of the members so appointed—

(a) one or more shall be appointed from the legal members;

(b) one or more shall be appointed from the specialist members, and

(c) one or more shall be appointed from the members recommended by the Indian Medical Association.

6. Where the Chairman of the Tribunal is included among the persons appointed under paragraph 4 of this Scheduule, he shall be president of the Tribunal; and in any other case the President of the Tribunal shall be such one of the members so appointed (being one of the legal members) as the Chairman may nominate.

Powers and proceedings of Mental Health Tribunals

(1) Where, under any provision of this Act, an application to a Mental Health Tribunal is authorised to be made by or in respect of a patient, the application shall be made by notice in writing addressed to the tribunal for the State in which the psychiatric facility in which the patient is detained is situated or in which the patient is residing under guardianship, as the case may be.

(2) Except in such cases and at such times as are expressly provided by this Act, no application shall be made to a Mental Health Tribunal by or in respect of a patient; and where under any provision of this Act, any person is authorised to make an application to such a tribunal within a specified period, not more than one such application shall be made by that person within that period.

(3) Where application is made to a Mental Health Tribunal by or in respect of a patient who is liable to be detained under this Act, the tribunal may in any case direct that the patient be discharged, and shall so direct if they are satisfied—

(a) that he is not then a mentally ill person as defined under section 2(m) of this Act; or

(b) that iit is not necessary in the interest of the patient's health or safety or for the protection of other persons that the patient should continue to be liable to be detained; or

(c) that the patient, if released, would not be likely to act in a manner dangerous to other persons or to himself.

(4) Where application is made to a Mental Health Tribunal by or in respect of a patient who is subject to guardianship under this Act, the tribunal may in any case direct that the

patient be discharged and shall so direct if they are satisfied.

(a) that he is not then a mentally ill person as defined under section 2(r) of this Act, or

(b) that it is not necessary in the interest of the patient, or, for the protection of other persons, that the patient should remain under such guardianship.

The State Government may make rules with respect to the making of applications to mental health tribunals, and with respect to the proceedings of such tribunals and matters incidental to or consequential on such proceedings."

There are four countries where this sort of Mental Health Tribunal is in operation. Please see pages 8 and 9 of the notes which I have prepared for your committee. You will find this. This provision exists in the Mental Health Act, 1959 of England and Wales. It is there in the Mental Health Law, 1963 of Lesothe. It is there in the Mental Health Decree No. 30, 1972 of Ghana. It is there in the Mental Health Act, 1975, of Trinidad and Tobago. After this 1959 enactment in England some countries have made provisions for Mental Health Tribunals in their new Mental Health Acts. I have given the details in my note which I have already submitted to your Committee.

MR. CHAIRMAN: Instead of Magistrate deciding the application, it should be decided by Mental Health Tribunal.

Dr. A. B. DUTT: Yes.

SHRI SAKTI KUMAR SARKAR: Have you got experience yourself, of these countries? You have mentioned several countries in this note. Why is it that you say that this Act should be made applicable here also? Why do you say that this Act should be introduced here? What is it which has provoked you to suggest this thing to the Committee?

DR. A. B. DUTT: I was in U.K. from 1960 to 1963 myself and I have experience in this regard. This Act was enacted in 1959. It came into operation in 1960. This Act was working all right there. I have seen the report of the WHO which says this that not more than 2.5 per cent of the patients who are detained in the Mental Hospitals in U.K. apply to the Tribunal. You may please see the examples which I have given in my note. You will see that it is mostly the paranoid patients who complain about the doctors and their relatives. I have given the examples in page 14 re: R. Vs. Mc Naughton. This case follows the Mc Naughton rules. I have explained this there in my note.

SHRRI SAKTI KUMAR SARKAR: You want to prevent the misuse of the Act.

DR. A. B. DUTT: Instead of writing to the magistrate, let them write to the tribunal first. Doctors will not be harassed. A patient was under my care. He wrote as many as 40 letters against me, and 13 letters against his own family. He was in West Germany where he was arrested by the Police and was treated in the mental hospital. The embassy sent him to India and he was admitted into my hospital. He recovered and worked well with his brothers, for a few years and then he caught a relapse and was admitted for a second time in my hospital. Before he got admission to my hospital, he fled away to Bombay and from there to Delhi. He sent a telegram to his brother for money. He was missing again and he was ultimately traced and brought back to Calcutta. He was writing letters in his own name, in the name of other patients, in the name of my driver, in the name of nurses, and so on. There were enquiries from all the departments and one of the departments started proceedings against me. Ultimately his

complaint proved to be completely false. These proceedings last for two years. These things show what a paranoid patient can do. You all know about the case of Sumitra Desai. We have got to make this provision. I have got two judgments of the Calcutta High Court. A patient was wandering about for the last 6 years because of the court proceedings and no treatment can be done by his relatives only because of these proceedings. She received psychiatric treatment for many years at home. She was taken away from the custody of her next of kins by some people. A complaint was lodged with the magistrate. She was recovered by the police 28 days after the incident. She was released from the court by the magistrate without the knowledge of her next of kins. She immediately fell into the clutches of the accused of the case once again. The subdivisional magistrate, the only magistrate of this court, ordered for recording her statement under Section 164 of the Cr. P.C. and for having an immediate psychiatric examination by a board of psychiatrists.

Now the point is this: The magistrate passes orders. Courts are not executing them.

MR. CHAIRMAN: Magistrate is a powerful person.

DR. A. B. DUTT: Magistrate simply passes the order. Now, it is the duty of the subordinate staff to execute that order. It is brought up before the magistrate. When magistrate passes an order, it simply remains there. She was not produced before the Board of psychiatrists even after the magistrate's order. When it was found later on that the order of the magistrate was not executed, another magistrate wrote to the government to fix another date giving at least six weeks' time. It took 8½ months to arrange for her medical examination after the order was passed by the magistrate. I have given you a lot of information in the note which I have given to your Committee. It is an instance of the s divisional Magistrate complain against his own magistrate to court of the sessions. Both patient and the de-facto complain applied before the Additional Sessio Judge to be added as parties but t Sessions Judge refused. But lookir at the patient who was not even party, they just thought, as she w very well dresses, that the questi of lunacy was disputed. He not or rejected the petition but also m disparaging remarks against Police.

SHRI RUDOLPH RODRIGUES: would like to ask one or two clarifications. Do you think that there is any need, legal or otherwise to make a distinction which was done in the definitions between different types of orders? Can we not delete this part altogether?

DR. A. B. DUTT: There is only one alternative, that is, not to have any Mental Health Act at all. There are one or two countries in which the treatment of mental patients are done under the general public health Act. And here we must have some provisions for different types of problems which we face. Why have I mentioned these different types of orders? One thing which was in my mind and it is well in my mind, is that it may be very difficult to do a radical change unless the people are conscious about the mental illness and probably we will have to move step by step. That is why keeping the structure of Bill I had to modify it. That is why I just mentioned in my Supplementary Definitions regarding "prolonged care and treatment order". I have enclosed a copy of this with my letter to the Committee.

SHRI RUDOLPH RODRIGUES: Instead of giving three definitions, if the Act is suitably amended in the definitions itself, we can just say "an order made in the provisions of the Act covers all the definitions". There is no need to have such a provision. The second thing is this. He has sug-

an addition to Section 95. I as just wondering that this Section 1 as it is drafted is almost exclusive. What is the need for further proso?

DR. A. B. DUTT: Here the patient or any of his relative can go straight to any Magistrate and the Magistrate can issue a summon to the Doctor or any Medical staff or any staff of the hospital. If you kindly look at the Mental Health Bill, you will find such provision that nobody can go to a lower court without taking prior permission from the High Court and the High Court will hear the matter in camera and if the High Court is satisfied that there is a *prima facie*, they will leave the patient or his party but sue the doctors or the staff. Otherwise, the doctor and the medical staff under this Act will always be secure specially of the paranoid patients.

MR. CHAIRMAN: You are more concerned to protect the doctors and the patients. Surely we must not make it difficult for the patient who is expected to go and seek redress.

DR. A. B. DUTT: I will quote Section 141 sub-section 2 of the Mental Health Act of 1949 of England and Wales. It is not my personal opinion.

> "No person shall be liable whether on the ground of want of jurisdiction or on any other ground to any civil or criminal proceedings to which he would have been liable apart from this Section in respect of any Act purporting to be done in pursuance of this Act or any regulations or rules thereunder or in pursuance of anything done in the discharge of functions conferred by any other enactment on the authority having jurisdiction in part 8 of this Act unless the act was done in a bad faith or without reasonable care.
>
> "No civil or criminal proceedings shall be brought against any person in any court in respect of any such act without the leave of the High Court and the High Court shall not give leave under this Section unless satisfied that there is substantial ground for the contention that the person to be proceeded against has acted in bad faith or without reasonable care.
>
> This section does not apply to proceedings for an offence under this Act being proceedings which under any provision of this Act can be instituted only by or with the consent of the Director of Public Prosecution."

I have got this idea from this Mental Health Act.

SHRI RUDOLPH RODRIGUES: In his amendment to Section 28, he had added reference to two medical certificates. Would it not be advisable to specify that these two medical certificates should not be from a medical practitioner who is a relative of the person concerned?

DR. DUTT: I agree with the hon. Member.

DR. SAROJINI MAHISHI: On page 8 of the summary of the UK Act given by you, you have mentioned the age of 25; the patient should not be released before the age of 25. What is the significance of this age?

DR. DUTT: That is the provision in the Mental Health Act, UK that after the age of 25, the patient should be discharged unless in the opinion of the medical officer incharge, there is need for his further detention in the hospital.

MR. CHAIRMAN: What is the significance? Is there any special right conferred at the age of 25, or is there any developmental cut-off point at this age?

DR. DUTT: I should rather express my inability to say with what idea that provision was there.

MR. CHAIRM[redacted]ou are one of the top psychiatrists; unless you are convinced, why should you say?

DR. DUTT: Probably they have thought that they should not spend their life in the hospital because they are psychopaths, and the patients should be discharged at the age of 25.

DR. M. SAROJINI MAHISHI: There is no particular significa attached to the age of 25.

MR. CHAIRMAN: I thank you, Dr. Dutt, for having prepared such elaborate and informative notes for us and for having taken the trouble to come twice.

(*The witness then withdrew*)

GMGIPND—LS I—3108 LS—1125.