

Mental health legislation in Sri Lanka: the time for change is now

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Summary

Despite a history of being subjected to mental health legislation for over a hundred years, Sri Lanka relies on these archaic laws to implement its present day services when most other countries in the region which have enacted recent reforms. This has resulted in discrepancies in service delivery and a less than

optimum level of care. With the expansion of the country's mental health services and other social changes, the need for immediate reforms, drafted a decade ago but not yet legislated, is convincing.

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Mental health laws in the South Asian region have been continuously evolving over the past few decades, in keeping with improved delivery of care, societal changes and the demand for enhanced accountability from a population that is becoming increasingly aware of their rights and privileges.

Several countries in the region-India, Pakistan, Afghanistan and Nepal-have redrafted their laws relating to mental health care in the last twenty five years.

India enacted its Mental Health Act in 1987 simplifying admission procedures, enabling separate treatment facilities for children and strengthening the human rights of the mentally ill(1). Afghanistan effected changes to its already existing Mental Health Act in 1997, focusing on least restrictive care, the rights of consumers and mechanisms to oversee involuntary procedures(2).

At the turn of the century, Pakistan's reforms through the Mental Health Ordinance of 2001 led to a reduction in the number of days allowed for involuntary treatment and created a central authority overseeing mental health services(3). Nepal enacted its Mental Health (Treatment and Protection) Act in 2006 to ensure the rights of the mentally ill and streamline involuntary treatment (4).

The other countries in the region apart from Sri Lanka -Bangladesh, the Maldives and Bhutan-do not possess specific mental health legislation. Bangladesh has formulated a mental policy and draft legislation, the latter awaiting implementation since 2002(5). The Maldives and Bhutan, the least populous among the South Asian nations, have no specific mental health related laws (6, 7).

In such a regional context Sri Lanka stands out: it has archaic legislation dating back to the Lunacy Ordinance of 1873 when the country was a British colony. These laws still operate with minor modifications, the last of these being over fifty years ago, in 1956(8).

The need for new regulations relating to mental health, incorporating the needs and demands of a new millennium has been unanimously acknowledged. They have indeed been on the drawing boards since 2000 but have remained a 'draft' for over a decade now. Despite many pronouncements to the contrary, there appears to be no haste in the attempts to formally enact this legislation.

While these 'draft' laws prolong their period of gestation, Sri Lanka continues to function on existing regulations which has drawbacks that have not been remedied. As a consequence, there are significant negative influences on the care of the mentally ill.

Among them are laws that sanction involuntary treatment only at the country's premier mental health facility, the National Institute of Mental Health (NIMH). This means that clients, if they are to be cared for in a manner that is in accordance with the letter of the law, will need to be transported from all corners of the island to the NIMH. In practice they are cared for in regional facilities more in the spirit of the law-and in breach of the Ordinance- invoking common law which has provisions to act in the best interests of the client, if necessary.

Also outdated are review procedures. Involuntary admissions, if they are to be challenged can be done only through civil courts. This is hardly possible for clients already handicapped by a lack of awareness, social stigma and financial constraints. A simpler, treatment centre based review procedure is a dire need.

Encouragingly, the draft Mental Health Act, now hibernating within the bureaucracy of the health authorities addresses these issues (9). That though is a small consolation when the new laws have been stagnant for over a decade.

In the interim, the country has moved on, recovering with resilience from the Tsunami disaster in 2004 and seeing the end of civil strife in 2009. Its mental health services continue to grow, with an increasing number of psychiatrists serving in in-patient units across the country and medical officers trained in Psychiatry manning less populous locations. Services are moving towards reasonable, if not comprehensive coverage of even remote regions.

The next leap forward would be the streamlined delivery of mental health care in the community; the first steps in this direction have been taken with the training of required personnel having begun.

With each of these developments having its impact on the delivery of services, it is imperative that the law keeps pace. It would be tragic for Sri Lanka if progress in mental health care was to be hindered because of a lack of supporting legislation.

In contrast, Sri Lanka introduced with alacrity new laws to prevent discrimination against disabled persons in 1996, over a decade before the United Nations ratified the Convention on the Rights of Persons with Disabilities in 2008 (10). Commendable indeed but this also suggests that while those lobbying for the rights of the mentally ill do not have sufficient clout, the political will to redress the balance is also lacking.

History supports the assertion that mental health laws evolved as a tool to improve service delivery, from the days when the Lunacy Act was introduced in Britain in 1845 (11). Nevertheless, some nations have turned the full circle: Britain, for example has reached a juncture where new legislation, the Mental Health Act of 2007, has been criticised for being against the interests of the mentally ill, because of a defensive tendency to focus on risk issues (12).

Again, Sri Lanka finds itself in a uniquely disadvantaged position: instead of its mental health laws providing the impetus for better care, available services are not functioning optimally because of the lacuna in the legislation.

The time has come for all stakeholders in mental health care to take note. Mental health care reforms, when delayed, amount to mental health care being denied. For a country that boasts of free health services for its people and impressive health care indices for its socio-economic standing, it is too high a price to pay. Therefore, the time to act is now.

Declaration of interest

None

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