HELPING THE HELPLESS: AN INSIGHT INTO THE REALM OF MENTAL HEALTH LEGISALTIONS

Dissertation submitted to the National Law School of India University in fulfilment of the requirements for the award of the degree of

MASTER OF LAWS

Submitted by

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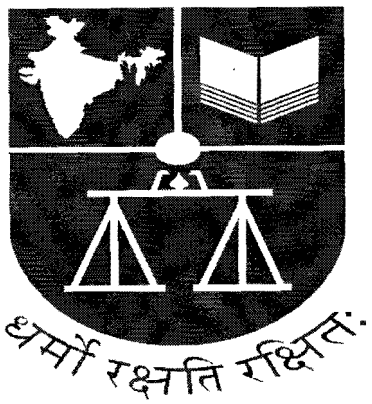

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CERTIFICATE

This is to certify that the dissertation titled "HELPING THE HELPLESS: AN INSIGHT INTO THE REALM OF MENTAL HEALTH LEGISALTIONS" submitted by Ms. Nayanika Barua is a record of bonafide work carried out by her under my supervision and no part of this dissertation has earlier been submitted for any degree or diploma or published elsewhere in any form.

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June 14, 2014

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DECLARATION

I, Nayanika Barua, do hereby declare that the dissertation titled "HELPING THE HELPLESS: AN INSIGHT INTO THE REALM OF MENTAL HEALTH LEGISALTIONS" submitted by me for the award of the degree of **Master of Laws** of National Law School of India University is my own work. The dissertation has not been submitted for any other degree of this university or any other university.

Nayanika Barua.

Nayanika Barua

ACKNOWLEDGMENT

Apart from the efforts of myself, the success of my dissertation depends largely on the encouragement and guidelines of many others. I take this opportunity to express my gratitude to the people who have been instrumental in the successful completion of this dissertation

I would like to show my deep sense of gratitude to my supervisor Prof.(Dr) Sarasu.E.Thomas for her immense guidance and supervision throughout my work in this subject matter. Without her encouragement and guidance this dissertation would not have materialized.

I would like to show my greatest appreciation to Prof.(Dr) T. Ramakrishna. I can't thank him enough for his tremendous support and for his motivatation for taking up this issue for my further research.

I would give my heartfelt thanks to my parents, my sisters and brother, my friends and my teachers without whom this task of my research would not have been completed. Their moral support and strength cannot be forgotten during my research I would also like to thank the National Law School of India University Library for the wealth of information therein and thank the Library Staff for their co-operation.

The guidance and support received from all the members who contributed was vital for the success of the dissertation. I am grateful for their constant support and help.

At last, I thank the Almighty for his immense blessing upon me to continue my work with success.

Nayanika Barua

CONTENTS

Abbreviations

UN United Nations

ICCPR International Covenant on Civil and Political rights

ICESCR International Covenant on Economic ,Social and Cultural Rights

UNCRPD United Nations Convention Of the Rights of Person with Disabilities

MHA Mental Health Act

PWD Person's with Disabilities Act

DMs Disability Movements

NMH National Mental Health

MHFW The Ministry of Health and Family Welfare

SMO Social Movement Organisatioin

NGO Non Profit Organization

List of cases

B.R. Kapoor V. Union of India

Chandan Kumar v. State of West Bengal

PUCL v. Union of India

R.C. Narayan v. State of Bihar

Robert Heijkamp and Anr. V. Bal Anand World Children Welfare Trust and Anr.

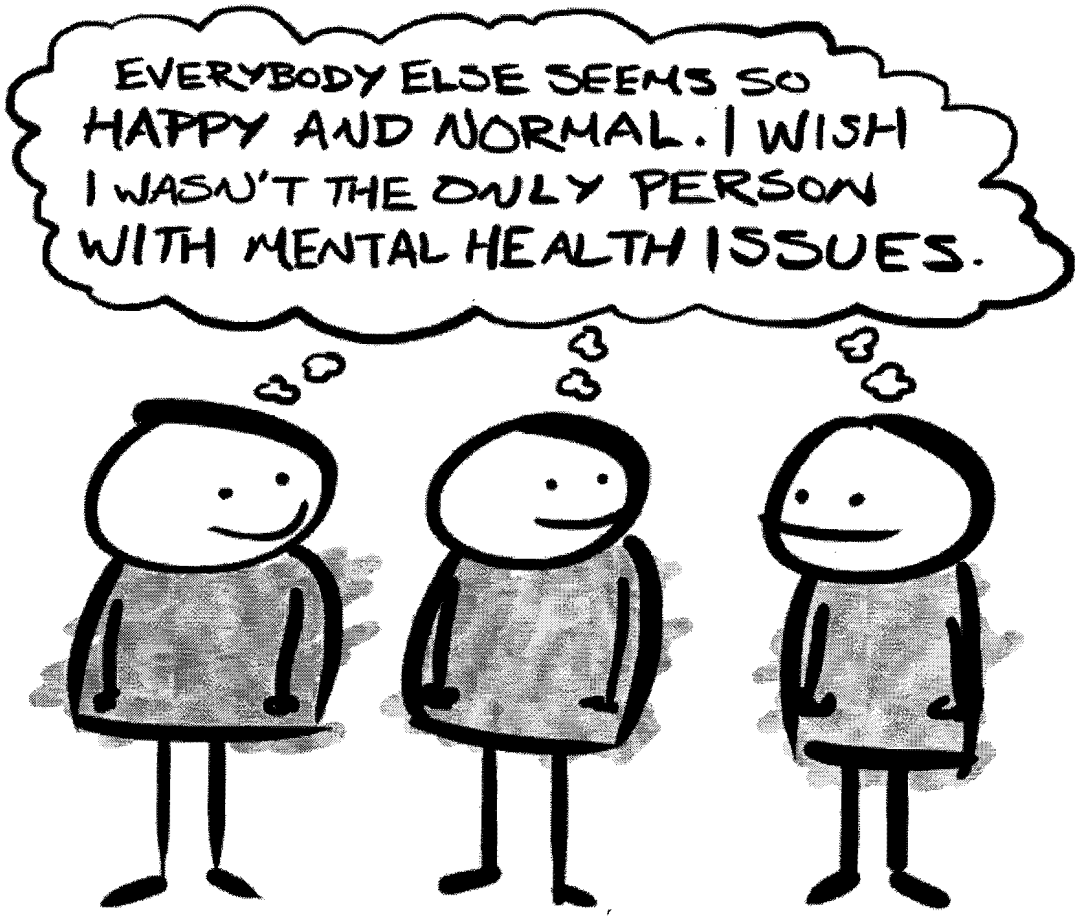
Suchita Srivastava v. Chandigarh Administration

S.P. Sathe v. State of Maharashtra

Sheela Barse v. Union of India

Supreme Court Legal Aid Committee v. State of MP

Veena Sethi v. State of Bihar



Dedicated to all the patients of

Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tezpur (Assam)

PROLOGUE;

More than six hundred million people, or about 10% of the world's population, have some type of disability.[1] Around 80% of disabled persons live in developing countries, where they experience material deprivation and social exclusion[2].

The response to this vulnerable sector is very pathetic and a sense of shame where we claim to bring equality, progressive growth and development. We are lost in the midst of social welfare and profit making mechanisms. We are tend with the materialistic growth and development rather than overall development of a country where there is no distinction,discrimination,social exclusion of any group of people in any manner for its ability, competency or its monetary capacity to equate itself with the normal racing group of profit making.

From a layman perspective the "mentally disabled group" is a curse to a society, for a family or to social gatherings, it has always been faced stereotype or prejudice attitude of being incurable or a curse to the humanity for its nature. It has always gathered a negative symptom or discrimination in every field or parameter it has approached i.e starting from education, family life, friends, health, employment etc. The instances of such social exclusion is not decreasing even in the agesis of equality, liberty and human dignity where every mandate of legislation pays highest importance for maintaining this principle and goals for highest attainment of development.

The stigmatization of mental illness has ever been prevalent in our society with no boundaries of difference. In actuality the "difference principle" is applied in a way of distinguishing one being normal and other being

[1] Gerard Quinn et al., Human Rights and Disability 1 (2002), available at http://www.nhri.net/pdf/disability.pdf.
[2] The Second Annual Report on the Implementation of US AID Disability Policy 1-2 (2000), http://pdf.dec.org/pdf_docs/PDABT610.pdf

"abnormal, mentally disabled", etc. who is discriminated more than being physically tortured. Life in reality is like a death for them. In true terms, the meaning of life is not available to this vulnerable category of people. The tendency of the maximum people's stringent behaviour have to be altered for the focused change in the recovery and enjoyment of all fundamental rights enshrined by each state's law of the land.

National and international concern for the mentally unsound seems to have grown over the years, particularly in the post- 1990 era, perhaps as an insignificant repercussion of the wave of globalisation and the uproar for the protection of human rights. The UN General Assembly Resolution on the 'Principle for the Protection of the Persons with Mental Illness and the Improvement of Mental Health Care 1991' proclaims that 'all persons with mental illness ... [need to be] treated with humanity and respect for the inherent dignity of the human person'.[3]

The right to the highest attainable standard of physical and mental health qualifies as one of the most indispensable rights of not just patients with physical disabilities, but also every person by virtue of their mere existence. Even the 'brooding omnipresence of the Right to Life under Art 21 of the Constitution would include within its sweep this aspect of human emancipation and recognition in the society.[4]

Additional examples of human rights violations of people with mental health disorders.Some people are isolated and locked in cage-like rooms or restrained to their beds for extended periods of time with little or no human contact. Others are subject to the misuse of psychotropic medications. In some institutions patients lack proper clothing, clean water, adequate food or

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[3] Kaushik Laik, SAGA OF THE 'MENTAL REVOLUTION' IN INDIA: A CRITICAL OVERVIEW OF THE INDIAN MENTAL HEALTH LAWS IN LIGHT OF THE INTERNATIONAL AND DOMESTIC SOCIETAL SCENARIOS, Citation: 31 Commw. L. Bull. 41, 44 (2005)

[4] Id , 2005

functioning toilet facilities. In many care situations, patients are not provided with a sense of purpose or community and are isolated from family, friends and opportunities for work, all of which are detrimental to improved mental health.[5] The major discrimination accounts in the following manner :-

Unjustified Institutionalization

A significant human rights violation facing many children and adults with mental disabilities across the world is that they are segregated in long-stay institutions such as psychiatric facilities, social care homes, and orphanages where residents are unable to exercise their most basic human rights. Conditions in such institutions are often unacceptably poor, and residents are too often at risk of abuse and neglect.

The unjustified segregation of people with mental disabilities in long-stay institutions is in itself a human rights abuse. It places severe restrictions on their rights and freedoms by barring them from access to education and employment and denying them the right to choose where and how they live and with whom they associate. Furthermore, institutionalization reinforces the stigma and prejudice towards people with mental disabilities and perpetuates the misconception that they are incapable or unworthy of participating in community life.[6]

Social Exclusion

The severe lack of community based alternative services in many countries means that even individuals who have not been placed in long-stay institutions face social exclusion because there is little or no support to facilitate their participation in community life. Ingrained societal prejudice also perpetuates social exclusion, as people with mental disabilities are often kept

[5] http://disabilityandhumanrights.com/2012/07/13/historic-hearing-in-us-senate-on-un-disability-treaty/

[6] http://www.who.int/mental_health/mindbank/en/

at home by their relatives, who may seek to protect them from potential abuse, or wish to avoid bringing shame on the family.[7]

Abuse of Guardianship

Both the United Nations 4 and the Council of Europe 5 have highlighted concerns about the serious human rights violations connected with guardianship. Guardianship is a system in which a court appoints a person the guardian to make decisions on behalf of someone who has been judged to be incapable of making decisions for him or herself the ward. In many countries, a guardian has wide-ranging power and control over many aspects of a wards life. For example, it is common for a ward to be unable to exercise basic civil rights such as the right to marry, vote, or work. Guardianship is also often abused to deprive a ward of his or her property or to place a ward involuntarily into an institution.[8]

Education and Employment

People with mental disabilities face major challenges in exercising their fundamental rights to education and employment. In Central and Eastern Europe and the former Soviet Union, thousands of children with mental disabilities are excluded from the educational system on the basis of their diagnoses alone, irrespective of their abilities. Those segregated in institutions often receive no form of education at all. This denial of education leads to lifelong dependency, poverty, and social exclusion.

Without access to adequate education, people with mental disabilities have little chance of securing employment or engaging in other meaningful activities that are crucial for every persons dignity, independence, and inclusion in community life. Another barrier to employment is the stigma

[7] http://www.who.int/mental_health/mindbank/en/
[8] Id

attached to mental disabilities. Employers are often unwilling either to employ people with mental disabilities or to provide necessary workplace accommodations.[9]

Statement of the problem:

The researcher is touched by the vulnerability of the situation faced by the mentally disabled person. It happened so that once during my childhood days I was in Tezpur Bus stand waiting to go somewhere and could see a group of young people who literally abused a mentally disabled old lady who was so helpless and was chasing the group for her defence. This scene always loitered me since my childhood. I had various thoughts and my questions were never answered .The myth that being contacted with the mentally disabled people we might also have the same conditions and behaviour persist until I came to know about the truth and reality of the nature of mental illness. Although there are Mental health laws which are prevalent and are for the protection and promotion of human rights did not seemingly showing any positive endeavour to their betterment.

This problem of the mentally disabled has never been addressed much like a matter of importance in the past decade but just as an allied issue which did not get significance until with the disability movements in various parts of the world . After the ratification of member states in the UNCRDP there is a change in the social behaviour of all class people from social or charity based to right based protection. The discrimination, stigmatization of the mental illness have ever been prevalent and the mental health laws are still like the outdated machines which are not conducive for practical regime. Under this impression the researcher finalised taking up the problem of knowing the actual mechanism and the mental health policies which are for their protection and promotion of human rights.

[9] http://www.who.int/mental_health/mindbank/en/

Aims and objectives:

This study intends to examine the factors associated with the mental disabilities, different areas of discrimination among the mentally disabled person and the mental health policies and laws prevalent. The study is descriptive, elaborative in nature to find the interplay of factors associated with discrimination. This study broadly seeks to examine the influence of social discrimination against mentally disabled in their life and under the umbrella of society, institutions and social policies. The following are the objectives of the study;

a) To know the influence of discrimination against mentally disabled person with respect family members, peer groups, community and society, to their poverty; as a social factor

b).To know about the ins and outs of the mental health policies and legislations prevalent in the international and national sphere;

c). To know about the disability right movements and social movement organisation who are working for the legal rights of the mentally disabled group

d). To know the nature of discrimination against mentally disabled in the field of the education, employment ,vocational training ,physical restoration etc by government and the political bureaucratic set up while legislating the policy for mentally disabled people.

Hypothesis:

For the present study the following specific hypothesis has been adopted to enumerate the problem taken up by the researcher:

> ***" Mental health legislations are not in adherence to the present day needs of the mentally disabled group which results in victimisation and lack of protection of their human rights."***

Research questions:

The researcher envisages the following questions while going into the study;

a. What are the perspective of equality and non discrimination in regard to the mentally disabled group?
b. Is there any change in the charity based approach attitude to rights based of the state in bringing modification to mental health laws?
c. What are the challenges faced by the judiciary in deciding matters of mentally disabled group?
d. How are the international obligations changing the attitude of the state parties in taking up the issue for protection of mentally disabled group?
e. What are the reformations made by the national legislations in regard to the mental health legislations in India?

Research methodology: Methodology

The study is analytical, descriptive and critical which pays reliance on secondary resources as books, reports, articles from various resources, working papers and pictures. The study pertains itself to the present conditions of the human rights violations of the mentally disabled group and

as such the study has been made through the extensive literature reviews and the reports given by the international organisations and the state held reports as and when it was available.

Literature review : The researcher has gone through the following contents of literature and the contemporary texts for gathering relevant data to find out the relevancy of the subject matter. The list is not exhaustive but taking into consideration of the relevancy of the subject matter discussed the following are stated and whenever any literature pertaining to the subject is found it has been used for furtherance of the research:

1. *Towards a no-force paradigm in mental health law , Malavika Prasad*: This article describes about a paradigm shift of mental health laws in India and in other countries of the world. This article focuses of the manner of forced intervention and institutionalisation of persons with mental illness who are denied rational agency to person with mental illnesses on an assessment of lack capacity. The legal institution of 'guardians' and other substituted decision-makers further aggravate the denial of capacity of persons with mental illness by providing for a denial of agency. Both positive and negative nature towards mental health aspect could be analysed.

2.*Mental Health services in India ,S. RAJKUMAR* : This article focuses the attention of the government policies and the development programs in the field of mental health care. This article had given the development of mental care facilities from its antiquity to the present time and have proposed some recommendations for the future outlay in the mental health care facilities.This article is an influential piece whereby I got the insight towards a development of the mental health care facilities.

3. *Saga of the 'Mental Revolution' in India: a Critical Overview of the Indian Mental Health laws in light of the international and domestic societal scenarios, Kaushik Laik:* This article focuses on the manner of discrimination, prejudice against the mentally disabled in India and other countries of the world. The article has briefly analysed the development and the scope of mental health as a matter of jurisprudential and social studies, the shift to a critical examination of the Indian paradigm reveals a mixed coffer of views. Lunacy and mental disorders have been known to Indian society from time immemorial, however the remedy to the problem is still to be unfolded which has been projected throughout the article.

4.*Assuming Responsibility: Disability Rights and the Preparation of Art Educators, Doug Blandy*: This article focuses about the Disability rights activists who have presented the public with a socially transformative orientation to people with disabilities. The Americans with Disabilities Act of 1990 aided this transformation through policy. This article argues in support of art educators joining with disability rights activists in promoting equity. The minimum levels of competence in the understanding and awareness of disability rights helps in promoting equality and development in the society.

5. *Learning Disabilities,G. Reid Lyon* : This article throws a positive light to the reader by broadening the parameter of difficulties in learning. The concept of learning disability focuses on the notion of a discrepancy between a child's academic achievement and his or her apparent capacity to learn and the discrimination faced during the period of learning and the sensitivity in the whole process affecting his learning period. This article throws an important insight to the reader and the general mass about the problem of learning and the manner of discrimination faced during its academic sessions of one's life.

6. *Work and Psychiatric Disability in Canadian Disability Policy: Lynn Cockburn, Terry Krupa, Jerome Bickenbach, Bonnie Kirsh, Rebecca Gewurtz,Philana Chan and Meridith McClenaghan;* This piece of article provides the impact of mental health issues on employment , how little attention has been directed to Canadian policy regarding psychiatric disabilities, and how these policies influence workplace practices. This articles projects out the various intricacies and the defects without a proper mental health policy with special reference to Canada.

7. *Mental Disabilities and the Human Right to the Highest Attainable Standard of Health, Paul Hunt & Judith Mesquita* : This article gives an analytical approach of health and its developmental programs. Despite progress in developing countries appropriate services, additional policy and legislative initiatives are a prerequisite for the realization of the right to health for persons with mental disabilities. A human rights approach, including participation, autonomy, dignity, inclusion, monitoring, and accountability, should guide all relevant actions for attaining highest standard of health.

8. *Mental Health Care And Human Rights , NIMHANS* : This book has a comprehensive set of articles and an analytical data regarding the various dimensions of mental health care and the human rights violations in regard to their disability. This book has some extensive case study in regard to the conditions, health care programs and the legislations in regard to the protection of human rights of the disabled.

Tentative Chapterization : The tentative chapterisation of the research are as follows:

Chapter 1 Introduction : This chapter gives an overview of the subject matter and its conceptual analysis and a reference of human rights violation in regard to the mentally disabled group.

Chapter 2 Equality : This chapter brings out some jurisprudential context of equality and its relevance with the subject matter and some socio –econmic conditions and their reactions to the matter of mental disability and equality.

Chapter 3 Functionality of International Instruments: This chapter gives an analytical, descriptive descriptions of the mental health laws in the international platform and its functionality.

Chapter 4 Transitional Development of Mental Health Legislations in India; this chapter deals with the descriptive and critical analysis of the mental health legislations from ancient period to modern period.

Chapter 5 Political Bureaucracy and mental health laws : this chapter deals with the analysis of the loopholes of the legislative functioning and the Ministries concerned for any development in regard to mental health laws.

Chapter 6 Challenges and reforms : This chapter brings out the present day challenges and the intricacies of mental health legislations while taking up matters with due importance.

Chapter 7 Concluding Observations : This chapter deals with the overall analysis done in the foregoing chapters and gives an idea about the subject matter.

Chapter 1

Introduction

1.1 General notion of Mental Health :

What is mental health?

Mental health is an indispensable part of health, and has been defined by WHO as "a state of well being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"[10]

Mental health and well-being are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. They directly underpin the core human and social values of independence of thought and action, happiness, friendship and solidarity. On this basis, the promotion, protection and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world.[11]

What is the value of mental health?

The importance of good mental health to individual functioning and well-being can be amply demonstrated by reference to values that are fundamental to the human condition. The most essential are as:

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[10]World Health Organization, *PROMOTING MENTAL HEALTH: CONCEPTS, EMERGING EVIDENCE, PRACTICE*, (2005).

[11] World Health Organization, *INVESTING IN MENTAL HEALTH: EVIDENCE FOR ACTION*,(2013).

Independent thought and action:

The capacity of individuals to manage their thoughts, feelings and behaviour, as well as their interactions with others, is a pivotal element of the human condition and helps to work effectively.[12]

Pleasure, happiness and life satisfaction:

There is a long standing and recently re-emphasized argument that happiness represents the ultimate goal in life and is the truest measure of well-being. Mentally abled and fit persons could bring more value to any work which they could take in hand.[13]

Family relations, friendship and social interaction:

Individuals' self-identity and capacity to flourish is deeply influenced by their social surroundings, including the opportunity to form relationships and engage with those around them (family members, friends, colleagues). Loneliness, social isolation and difficulties with communication all heighten the risk of developing or prolonging mental illness.[14]

Thus , Mental health is not just the absence of mental disorder. It is defined as a state of mental, including cognitive and physical well-being in which individuals have the ability to realize their potential, cope with the normal stresses of life, work productively and fruitfully, and are able to make contributions to their community.[15]

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[12] World Health Organization, *INVESTING IN MENTAL HEALTH: EVIDENCE FOR ACTION*,(2013).
[13] Helliwell J, Layard R, Sachs J, *WORLD HAPPINESS REPORT* , 2012.
[14] World Health Organization, *INVESTING IN MENTAL HEALTH: EVIDENCE FOR ACTION*,(2013).
[15] www.Mental Health in india.html

MENTAL ILLNESS

A mental illness refers to a range of health conditions and disorders that significantly affect how a person feels, thinks, behaves and interacts with other people. 'Mental illness' is a general term that refers to a group of illnesses of the mind, in the same way that heart disease refers to a group of illnesses and disorders affecting the heart.

According to the WHO, 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' Mental health is the foundation for individual well-being and effective functioning of a community.

Most people believe that mental disorders are rare and "happen to someone else." In fact, mental disorders are common and widespread. Most families are not prepared to cope when they learn that their loved one has a mental illness. It can be physically and emotionally trying, and can make us feel vulnerable to the opinions and judgments of others.

Globally, more than 450 million people suffer from mental disorders. Many more have mental problems that are not diagnosed. Prevalence of mental health problems ranges from 10 to 370 persons per 1,000 population in different parts of India. Nearly 1.5 million people suffer from severe mental disorders and 5.7 million persons suffer from various psychiatric disorders requiring immediate help at any given point of time. This includes a population that needs continuous treatment and regular follow-up attention.[16]

[16] World Health Organization, Ministry of Health and Family Welfare, Government of India,2003.

After having a brief note on mental health and mental illness now the researcher will deal about mental disability and the conceptualise analysis of the subject matter.

MENTAL DISABILITY:

Concept:

The concept of mental disability occurs due to insanity , which implies a degree of mental disturbance so menacing and so disabling that the person may be considered from the legal point of view to be immune from certain responsibilities and may disallow him certain privileges that may require a degree of competence.

Today mental disorders stand among the leading causes of the diseases and disability in the world, it has become necessary to generate awareness of mental health especially in counties where too many misconception are existing to deal it.

The concept of mental health in India encompasses only the treatment of seriously mentally ill person admitted in the mental hospital, otherwise it has no implications to them. Though the morbidity rate of mental disorder in surprisingly in high in India, it is a very recent change that few people have started acknowledging the relevance of general mental health.[17]

People with mental disorders experience disproportionately higher rates of disability and mortality. For example, persons with major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely than the general population, owing to physical health problems that are often left unattended [such as cancers, cardiovascular diseases, diabetes and HIV

[17] S.K Awasthi, *LAW OF DISABILITY*,23,(2nd edn., 2011).

infection) and suicide. Suicide is the second most common cause of death among young people worldwide.

Mental disorders often affect, and are affected by, other diseases such as cancer, cardiovascular disease and HIV infection/AIDS, and as such require common services and resource mobilization efforts. For example, there is evidence that depression predisposes people to myocardial infarction and diabetes, both of which conversely increase the likelihood of depression. Many risk factors such as low socioeconomic status, alcohol use and stress are common to both mental disorders and other non communicable diseases.[18]

While describing mental disability we have to take three more terms into consideration . They are as follows :

MENTAL RETARDATION:

Mental retardation (MR) is a condition diagnosed before age 18, usually in infancy or prior to birth, that includes below-average general intellectual function, and a lack of the skills necessary for daily living. When onset occurs at age 18 or after, it is called dementia, which can coexist with an MR diagnosis.[19]

INTELLECTUAL DIASBILITY:

Intellectual disability is a term used when a person has certain limitations in mental functioning and in skills such as communicating, taking care of him or herself, and social skills. These limitations will cause a child to learn and develop more slowly than a typical child.

[18] World Health Organisation, *MENTAL HEALTH PLAN 2013-2020*,(1st edn.,2013).
[19] http://www.psychologytoday.com/conditions/mental-retardation

Children with intellectual disabilities (sometimes called cogriitive disabilities or, previously, mental retardation) may take longer to learn to speak, walk, and take care of their personal needs such as dressing or eating. They are likely to have trouble learning in school. They will learn, but it will take them longer. There may be some things they cannot learn.[20]

MENTAL ILLNESS :

Under **section2(l) the Mental Health Act, 1987** mentally ill person means a person who is in need of treatment by reason of any mental disorder other than mental retardation.

Under **section(r) of Mental Health Care Bill,2013** "mental illness" means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence.

CLASSIFICATION OF MENTAL DISEASES:

The mental diseases can be classified as follows :

a). Organic Mental Disorder

b). Mental and behavioural disorders due to psychoactive substance use.

c). Schizophrenia

d).Mood disorder

e). Neurotic stress related and somatoform disorders

[20] http://nichcy.org/disability/specific/intellectual#def

f). Behavioural syndromes associated with psysiological disturbances and physical factors and personality disorders. Etc.

This list is not exhaustive as there are varied levels of disorder.

Legal definition of disability:

The legal definition of disability has been an issue of much debates and discussion yet a specific restrictive view is not yet born. Despite the efforts of the WHO, which resulted in the International classification of Functioning, Disability, and Health (ICF) , there is no international universal legal definition of disability.[21]

The 1981 Census of India was the first and the last twentieth century census to enumerate the disabled.In it they were classified as blind , dumb, and crippled.As result, only 1.1 million were identified as disabled in the data recorded by the 1981 Census.

The National Sample Survey Organisation(NSSO)also surveyed 'the disabled' in 1981 and subdivided them into four classes; visually handicapped, communication disability, locomotor disability and mentally handicapped. These classes were all less restrictively defined than in the Census, although only marginally so. The Census took no account of the mentally disabled and neither the Census nor the NSSO included those afflicted with leprosy.

The 2001 Census also categorised disabilities as 'in seeing' , 'in speech' , 'in hearing' , 'in movement' , and 'mental disability'. Therefore , finally in Census 2001 and the NSSO Survey 2002, mental illness was counted for under the category of disability.

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[21] World Health Organisation, *International classification of Functioning, Disability, and Health*, 2001.

1.2 HUMAN RIGHTS AND MENTAL DISABILITY

People with mental illness encountering human rights violations in meeting their basic needs are a reality to be found in every corner of the globe.[22]The Preamble to the Constitution of India assures equal treatment and equality of opportunity and status to all the citizens. Every person with a mental illness has the same basic rights as every other person, specifically including the rights set out in the International Covenant on Civil and Political Rights (ICCPR) and the rights recognized in the Declaration on the Rights of Disabled Persons; that discrimination on the basis of mental illness is not permitted and that people being treated for a mental illness must be accorded the right to recognition as a person before the law.[23]

Despite the adequate legislations, we often come across horrendous stories about the way people with mental illness are treated in community and various psychiatric institutions.[24] Further, World Health Organization (WHO) states that we are "facing a global human rights emergency in mental health" as many countries lack the basic legal framework to protect those with a disability.[25] A free India was not an exception, as evident by the National Human Rights Commission report[26] which highlighted the gross inadequacies and subhuman living conditions in mental hospitals. Furthermore, India's dismal record of rights violations of the mentally ill was glaringly exposed with the grotesque death of 25 patients at an "asylum" in

[22] Gostin LO, Human rights of persons with mental disabilities,The European convention of human rights. Int Law Psychiatry ,2000.
[23] www.Legal Service India.com
[24] Gadit AA, *ABUSE OF MENTALLY ILL PATIENTS: ARE WE IGNORING THE HUMAN RIGHTS PRINCIPLE?*, 2008
[25] www.who.int/mental_health/policy/legislation/en/index.html,
[26] http://nhrc.nic.in/Publications/Mental_Health_Care_and_Human_Rights.pdf

Tamil Nadu.[27]The lack of human rights or their violations, as seen in the Erwadi tragedy and similar cases, does not stem from a shortcoming in existing Indian or international law per se; but is the result of social stigma, prejudice, and other social and economic factors linked with mental illness.

Now after drawing the interface of human rights and mentally disabled protection we have to analyse the concept of mental health laws and mental health legislations for its effective working and its execution in the protection and promotion of human rights.

Human-rights-oriented mental health legislation is vital because of past and ongoing violations of these rights. Some members of the public, certain health authorities and even some health workers have, at different times and in different places, violated – and in some instances continue to violate – the rights of people with mental disorders in a blatant and extremely abusive manner.[28]

In many societies, the lives of people with mental disorders are extremely harsh. Economic marginalization is a partial explanation for this; however, discrimination and absence of legal protections against improper and abusive treatment are important contributors. People with mental disorders are often deprived of their liberty for prolonged periods of time without legal process (though sometimes also with unfair legal process, for example, where detention is allowed without strict time frames or periodic reports). They are often subjected to forced labour, neglected in harsh institutional environments and deprived of basic health care. They are also exposed to torture or other cruel, inhumane or degrading treatment, including sexual exploitation and physical abuse, often in psychiatric institutions.[29]

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[27] http://wwwcscsarchiveorg:8081/MediaArchive/libertynsf/(docid)/
[28] World Health Organization, *RESOURCE BOOK ON MENTAL HEALTH,* 2005
[29] Id,6

Mental health law represents an important means of re-enforcing the goals and objectives of policy. Mental health law or other legally prescribed mechanisms, such as regulations or declarations, can help to achieve these goals by providing a legal framework for implementation and enforcement.

It can establish a system of enforceable rights that protects persons with mental disorders from discrimination and other human rights violations by government and private entities, and guarantees fair and equal treatment in all areas of life. Legislation can set minimum qualifications and skills for accreditation of mental health professionals and minimum staffing standards for accreditation of mental health facilities.It can create affirmative obligations to improve access to mental health care, treatment and support. Legal protections may be extended through laws of general applicability or through specialized legislation specifically targeted at persons with mental disorders.[30]

Policy and legislation are two complementary approaches for improving mental health care and services; but unless there is also political will, adequate resources, appropriately functioning institutions, community support services and well trained personnel, the best policy and legislation will be of little significance. Mental health law can influence the development and implementation of policy, while the reverse is similarly true. Mental health policy relies on the legal framework to achieve its goals, and protect the rights and improve the lives of persons affected by mental disorders.[31]

Legislation is needed to prevent discrimination against persons with mental disorders. Commonly, discrimination takes many forms, affects several fundamental areas of life and (whether overt or inadvertent) is pervasive. Discrimination may impact on a person's access to adequate treatment and

[30] World Health Organization, *RESOURCE BOOK ON MENTAL HEALTH,7,(* 2005)
[31] Id,8

care as well as other areas of life, including employment, education and shelter. The inability to integrate properly into society as a consequence of these limitations can increase the isolation experienced by an individual, which can, in turn, aggravate the mental disorder. Policies that increase or ignore the stigma associated with mental disorder may exacerbate this discrimination. People with mental disorders are vulnerable to violations both inside and outside the institutional context.

The need to be legally fair to people who have committed an apparent crime because of a mental disorder, and to prevent the abuse of people with mental disorders who become involved in the criminal justice system, are further reasons why mental health legislation is essential. Most statutes acknowledge that people who did not have control of their actions due to a mental disorder at the time of the offence, or who are unable to understand and participate in court proceedings due to mental illness, require procedural safeguards at the time of trial and sentencing. But how these individuals are handled and treated is often not addressed in the legislation or, if it is, it is done poorly, leading to abuse of human rights.[32]

Legislation can ensure that appropriate care and treatment are provided by health services and other social welfare services, when and where necessary. It can help make mental health services more accessible, acceptable and of adequate quality, thus giving persons with mental disorders better opportunities to exercise their right to receive appropriate treatment.[33]

[32]World Health Organisation, *RESOURCE BOOK ON MENTAL HEALTH,10,(2005)*
[33] Id, 12

CHAPTER 2

Principle of equality: A faded terminology

2.1 General notion

'Equality' in essence is absent by listening to the tunes of disabled. It is followed by the phrases like discrimination, disadvantaged, incompetent, isolation, ignorance, etc to these vulnerable group.

The objective requirement of equality has ever since been faded and has not taken its grip to tackle the distortion gap which is entangled with the disabled group in a society. The prejudice attitude and the stereotype behaviour towards these vulnerable groups has been a negative step for their growth and development and is often leading to discrimination and lowering their human dignity. The basic responsibility of social welfare state to aspire its all citizens with all necessary security, education, employment etc. for their welfare is not matching its criteria with the disabled category population. The welfare state ideology is not in consonance while making any legislation, provisions, for the development of the disabled populace. The nature and manner of handling the sensitive issue of these class of population is in a very pitiable state of affairs.

The persons with mentally disabled in certain along with all other forms of disabled persons have been subjects for social welfare, charity, and protection. Unless the last twentieth century the issue of protecting or giving security was basically assistance providing rather than providing them with

rights. There is a change in the approach with the discourse of some special measures adopted by legislating bodies for protecting their rights and enhancing these vulnerable groups to walk along with all members of the society with equality although a little different.

The idea that disability is framing itself under civil rights protection is a relatively recent idea in human rights discourse. Disability has open its recognition as a subject of discrimination in a very recent past days. It has always been a matter of oppression, discrimination, or social structure practices or often as a myth in some cases. As such the right of equality which was faded in the past days should get its colour by our efforts to bring them into a new horizon land where although being different would not bother no one in fulfilling their rights.

The essence of rights of persons with disability is necessary to their struggle for equality and social participation. Adriene Asch states that "denied access to vote, education, employment, housing, transportation, marriage and parenthood, many people with motor, sensory, cognitive and emotional impairments, along with a group of legal advocates, have spent decades fighting for their legal safeguards to citizenship and social life.[34]

The absence of equality based approach to disability in India invites some fundamental questions. Does the concept of equality have any relation with the mentally disabled? Is our understanding of disability undergoing a change with the introduction of the concept of Equality?

Inorder to testify the aforesaid statements , the researcher would deal with the various laws prevalent in the country and taking into consideration various approaches of equality theory as proposed by various thinkers and schools in regard to it.

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[34] Jayna Kothari, THE FUTURE OF DISABILITY LAW IN INDIA, 2 (1st edn., 2012).

2.2 EQUALITY UNDER THE BANNER OF THE SUPREME LAW OF LAND

Equality is set out under the Indian constitution Articles 14,15,16. While Article 14 is the general guarantee of equality ,Articles 15 and 16 deal with non discrimination , equal opportunities , and non- discrimination in public employment respectively. Both these articles do not mention disability as a prohibited ground of discrimination.[35]

Equality is guaranteed to all citizens under article 14 of the Indian constitution as a fundamental right. The article guarantees that the state shall not deny to any person equality before the law or the equal protection of laws within the territory of India. While the Constitution does not specially proscribe discrimination on the ground of disability, it does not contain non discriminatory provisions that guarantee equality and equal opportunities for all citizens in Article 14.[36]

The fundamental right to life enshrined in the Indian Constitution provides the guarantee of life with liberty and dignity to all persons resident in India. The right of persons with disabilities to respect, dignity and freedom is part of this generic right to life. However, the recognition of disability as part of a larger terrain of human diversity is something that has not yet entered official discourse on disability rights. Article 21 of the Constitution of India protects the Right to Life and Personal Liberty, which are inclusive of the principles of inherent dignity and individual autonomy for all persons residing in India.[37]

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[35] Jayna Kothari, THE FUTURE OF DISABILITY LAW IN INDIA, 5 (1st edn., 2012).
[36] Id,5
[37] http://www.frontline.in/static/html/fl2921/stories/20121102292107700.htm(last visited on 27th april,2014)

DENIAL OF EQUALITY

A constitutional denial of the right to vote for persons with psychiatric and intellectual disabilities.[38] There is a clearly discernible disjuncture between the treatment of persons with disabilities other than mental disability on the one hand, where the focus is on affirmative action, and persons with mental disability on the other, where protections and special measures tend to take the form of custody and negation ranging from mild to severe methods. The denial of suffrage to persons with mental disabilities under Article 326 of the Constitution is one specific example that betrays a basic inequality between legal protections provided.[39]

Now an attempt has been made by the researcher to have an inclination towards the various equality theories in regard to the attitude towards the disabled category. The following are as stated :

2.3Theories of equality and their role in interpretation of equality

1. **Formal equality:** The first is the formal theory of equality or the equal treatment model. This concept of equality requires that likes be treated alike and presumes the impartial enforcement of legal and social rights. Neutrality in the application of the law and the absence of different treatment levels are presumed to result in equality.[40] Article 14 guarantees to all persons equal protection of the equal laws and equal protection means the right to equal treatment in similar circumstances. In the formal approach 'difference' justifies 'differential treatment' even if it is unequal in effect. In the case of disability, sticking strictly to such formal equality can lead to situations that are discriminatory and unjust. Many Laws do pass the test of formal

[38] Article 326 of Constitution of India

[39] http://drpi.research.yorku.ca/AsiaPacific/resources/IndiaLPPRep/Section01#note2(last visited on 22nd april,2014)

[40] J.C.McCrudden, THE CONCEPT OF EQUALITY,9 (2003)

equality but adversely affect people with disabilities. For example, legal denial in India of the right to vote by people confined to institutions.[41] In the case of disabled persons, different treatment is required in many respects in order to enable them to gain access to work and other opportunities. This approach is therefore not sufficient to address concerns of persons with disabilities , as they are not similarly situated when compared to able bodied persons and require different levels of treatment that accommodates their disabilities.[42]

2. **The Minority Group Right Model** : The history of the civil rights movement in the context of Race, caste, and gender based discrimination saw a move from the individualistic arguments of equality to the arguments for minority group rights. There are definitely parallels for disabled people in this minority group rights analysis because persons with disabilities have also been historically discriminated against. This analysis depends on viewing disability as a group- defining characteristic, although one of the biggest legislative stumbling blocks of the minority group approach has been the definition of disability itself. Not only the reactions to different forms of impairments very diverse , there is also a belief among the various disability groups that their needs are very different from other disability groups. The most marginalized categories even within the disabled have always been persons with mental and intellectual disabilities.[43]

3. **Sen's Capabilities Approach** : In his book , 'The idea of justice', Amartya Sen discusses the capabilities approach which could have a strong impact on conceptualising equality for persons with disability. According to this approach, 'in contrast to the utility based or resource

[41] Jayna Kothari, THE FUTURE OF DISABILITY LAW IN INDIA, 7(1st edn., 2012).
[42] Id,8
[43] Id,9

based lines of thinking ,individual advantage is judged by a person's capability to do things which she or he has reason to value ,and a person's advantage in terms of opportunities is judged to be lower than that of another if she has less capability or less real opportunity- to achieve those things that she has reason to value'.[44] For example , a person with severe disability cannot be judged to be more advantaged merely because she has a larger income or wealth than her abled–bodied neighbour. We have to look at the overall capabilities that they manage to enjoy.[45] Sen's idea of capability is linked with substantive freedom and gives a central role to a person's actual ability to do the different things that he/she values doing.

The following theories and school of thought have brought out the substance to the protection and promotion of the disabled in their own perspective. Each theory have examine the difficulty or the positivity of executing the provisions of equality and have admitted or denied the literal notion of the significance of equality in its own parameter. Therefore in actuality the matters of disability are often guided by such principle of thoughts and work according to the need of the time and circumstances which come up.

After analysing the theories we can now focus about substantive equality with regard to the disabled group and their significance.

2.4 SUBSTANTIVE EQUALITY

The limitation of the principle of formal or procedural equality and the limitations of the group rights or status based equality model lead us to the concept of ' substantive equality'. Substantive equality embraces

[44] Amartya Sen ,THE IDEA OF JUSTICE ,231 (2009).
[45] Id,253

a wide range of concepts such as equality of opportunity and equality of results.

Equality of Opportunity

The substantive equality theory incorporates both the ideals of equality of opportunity and special treatment or structural equality. It looks at the history of group discrimination and identifies traditional or classic forms of discrimination. Equality of opportunity addresses some of the limitations of formal equality by taking into account and redressing historical conditions of inequality .

Equality of opportunity means far more than an absence of direct and indirect discrimination: 'even if all forms of discrimination were completely eliminated ,gross inequalities of opportunity might persist , both as a result of the accumulation of disadvantage due to past discrimination and as a result of continuing differences in patterns of education and training and in inspirations among relevant sections of the community. With these new tune of substantive equality there arises the ambit of social inclusion of the group for its development.

SOCIAL INCLUSION

The theory of substantive equality also includes within its ambit the concept of social inclusion. This concept of equality incorporates the premise that all persons –inspite of their differences – are entitled to be considered and respected as equals ,and have the right to inclusion and to participate equally in the social and economic life of society.[46]

[46] Jayna Kothari, THE FUTURE OF DISABILITY LAW IN INDIA, 13 (1st edn., 2012).

Substantive equality also emphasizes the dignity, autonomy, and worth of every individual . Participation is an important means of overcoming marginalisation and social exclusion. The participation of affected groups such as persons with disabilities increases the likelihood that strategies will succeed as well as democratizing the very process of achieving equality.

As Lawson notes, ' a commitment to respect for human dignity requires a focus not as on sameness or identical treatment but on individual flourishing'. For this reason, respect for dignity will sometimes require treatment which is different rather than treatment which is identical.[47]

Substantive equality also requires a positive duty to promote equality , resulting in proactive structural change. Instead of being patronising and fostering dependence(difficulties often associated with social welfare), the duty to promote equality ,based on social rights ,use the force of legislations to encourage policy initiatives, which further the aims of the equality agenda.

The positive obligation to promote equality approach, public authorities is enshrined in the concept of substantive equality under article 14 of the constitution, which guarantees ' equality before the law' and 'equal protection of the laws'. Under the substantive equality approach, public authorities are placed under a duty to actively take steps to promote greater equality of opportunity for particular groups.

Inorder to ensure equality of opportunity , protective discrimination and affirmative action is provided for under the constitution to do away with the social disparities. This doctrine of protection to the

[47] Id, 14

minority groups can only be implemented when the boarder view of equality comes into play. The restrictive interpretation and the defence in regard to social and economic disparity if still persist would not show a positive growth of the doctrine of Equality in its authentic sense.

2.5 PICTURE IN REALITY IN REGARD TO MENATL DISABILITY LAWS AND THE EQUALITY DOCTRINE

Disability law in India prior to the 1990s was effectively only a sub category of social welfare law and protectionist legislations. Early laws dealing with people with disabilities consisted of legislations such as the Indian Lunacy Act, 1912 which categorized people with mental and intellectual disabilities as "lunatics" and provided for their guardianship and care. This was replaced with the Mental Health Act in 1987, but even this statute focused entirely on providing for the guardianship and institutionalisation of persons with mental and intellectual disabilities.

In other legislations relating to social welfare or public employment, some welfare provisions were made for persons with disabilities by reserving some categories of jobs for disabled person. Hence, disability laws in India had twin effects- there was a paternalistic denial of legal capacity for persons with mental and intellectual disabilities and on the other hand the only welfare measure provided was reservation in employment.

Mental disability and mental health care have been neglected in the discourse around health, human rights, and equality. This is perplexing as mental disabilities are pervasive, affecting approximately 8% of the world population. Furthermore, the experience of persons with mental disability is one characterized by multiple interlinked levels of inequality and

discrimination within society. Efforts directed toward achieving formal equality should not stand alone without similar efforts to achieve substantive equality for persons with mental disabilities. Structural factors such as poverty, inequality, homelessness, and discrimination contribute to risk for mental disability and impact negatively on the course and outcome of such disabilities.

A human rights approach to mental disability means affirming the full personhood of those with mental disabilities by respecting their inherent dignity, their individual autonomy and independence, and their freedom to make their own choices. A rights-based approach requires us to examine and transform the language, terminology, and models of mental disability that have previously prevailed especially within health discourse. Such an approach also requires us to examine the multiple ways in which inequality and discrimination characterize the lives of persons with mental disabilities and to formulate a response based on a human rights framework. [48]

After analysing the extent of theory and practicality, and the nature of protection which are availed to the disabled group we can trace some imprints of the theories of the equality which in essence is just a paper work of some school and not the action in work. The equality in essence is not yet fulfilled to its parameter in regard to the mentally disabled group.

[48] http://www.ncbi.nlm.nih.gov/pubmed/20845839

Chapter 3

Functionality of International Instruments

3.1 Introduction

We cannot despair of humanity, since we ourselves are human beings. *-Albert Einstein*

Mental health care needs to be an integral part of the general health services. According to a survey: Census 2001, stated 2.19 crore people in India are disabled. The WHO report states that around 10% population of world is disabled.

Health is one of the important indicators of economic development of any society. Health is defined in the preamble of the World Health Organisation (WHO) and in Article 25 of the Universal Declaration of Human Rights. This states that everyone has the right to medical care.

Mental health is an important component of the overall health of any individual.

"All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood"

United Nations Universal Declaration of Human Rights

Human rights are the "basic fundamental rights and freedoms to which all humans are entitled". This encompasses a broad range of rights related to

civil and political issues, such as the right to life and liberty, freedom of expression, right to equality before the law and social, cultural and economic rights, including the right to participate in culture, the right to food, the right to work, and the right to education.[49]

.3.2 INTERNATIONAL LEGISLATIONS IN MENTAL HEALTH CARE

"All people with mental disorders have the right to receive high quality treatment and care delivered through responsive health care services. They should be protected against any form of inhuman treatment and discrimination." **- World Health Organisation**

Mental health is an integral part of health and well-being, as reflected in the definition of health in the Constitution of the World Health Organization: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Mental health, like other aspects of health, can be affected by a range of socioeconomic factors [described below) that need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery in a whole-of-government approach.[50]

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[49] D Nagaraja & PratimaMurthy (ed),MENTAL HEALTH CARE AND HUMAN RIGHTS 37(1st edn.,2008).

[50] World Health Organization, *INVESTING IN MENTAL HEALTH: EVIDENCE FOR ACTION*,(2013).

3.3 Functionality of the international legislations :

Right to Health as a Basic Human Right and International Covenant:

The United Nations has defined human rights to mean generally as "those rights, which are inherent in our nature and without which we can not live as human beings. In 1948, the United Nations through its Declaration of Human Rights affirmed the basic principle that a mentally ill person should at all times be treated with humanity and respect for the inherent dignity of the person. Every person with a mental illness should have the right to exercise all civil, political, social and cultural rights. The Declaration of the Rights of the disable, which includes person with mental illness was adopted by the **United Nations in 1975.**

Article 12 of the International Covenant on Economic, Social and Cultural Rights, 1966 also provides "that the state parties to the present Covenant recognize the rights of everyone to the enjoyment of highest attainable standards of physical and mental health. As far as women mentally ill patients are concerned.

Article 12 of the Convention on the Elimination of all forms of discrimination against women provides that state parties shall take all appropriate measures to eliminate discrimination against women in the field of health.

In the area of providing access to free medical services to mentally ill patients **Article 19 of 1969 Declaration on Social progress and Development** could be relied upon, which calls for the provision of free health services of the whole population and of adequate preventive and curative facilities and welfare medical services accessible to all.

The 1971 Declaration on the Rights of Mentally Retarded Persons[51]

This Declaration was adopted by the General Assembly on 20th December 1971, keeping in view the necessity of providing help to mentally retarded persons in order to enable them to develop their abilities and promoting their integration in the normal life. The Declaration provides a framework within which national and international actions should be initiated for the advancement of rights set forth in regard to the mentally disabled group.[52]

International Year of Disabled Persons(1981)[53]

The General Assembly on 16th December 1978, decided to observe the Year 1981 as International Year for Disabled persons with certain objectives keeping in consideration with the increasing violation of these class of vulnerable group.[54]

In **1996, WHO developed the Mental Health Care Law: Ten Basic Principles** as a further interpretation of the MI Principles and as a guide to assist countries in developing mental health laws. The WHO also developed Guidelines for the Promotion of Human Rights of Persons with Mental Disorders, which is a tool to help understand and interpret the aforementioned UN principles 1991 (known as MI Principles) and evaluate human rights conditions in institutions[55].

The UN Convention on the Rights of the Persons with Disabilities (2006) was drafted and negotiated between 2002 – 2006 marks a "paradigm shift" in attitudes and approaches to persons with disabilities. . As of July 2010, 87 countries have ratified the Convention, 54 have ratified its Optional Protocol and 145 have signed the CRPD. It takes to a new height the movement from

[51] See, annexurel
[52] http://:www.legal Service India.com(last visited, 21/4/2014)
[53] See, Annexure II
[54]http://:www. legal Service India.com(last visited ,21/4/2014)
[55] http://bhrc.bih.nic.in/docs/mental-healthcare-and-human-rights.pdf(last visited ,22/4/2014)

viewing persons with disabilities as "objects" of charity, medical treatment and social protection towards viewing persons with disabilities as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free, and informed consent as well as being active members of society. It has proposed a comprehensive definition of persons with disabilities as 'all those who have long-term physical, mental, intellectual and sensory impairments.[56] The first human rights treaty of the 21st century, but it also represents the official recognition of disability as a human rights issue on the international stage.

The CRPD is the first globally binding human rights instrument to comprehensively address the civil, cultural, political, social and economic rights of persons with disabilities. The CRPD provides a clear legal, moral and political roadmap for change. It does not intend to create new rights. It merely seeks to clarify the applicability of existing human rights law in the specific context of disability. To this end, it tailors existing human rights law in the specific circumstances and obstacles faced by persons with disabilities

3.4 Approaches of International Instruments towards the role of Mental Disability Legislations :

The researcher while focusing the attention towards the international legislations could get a holistic approach towards its concern for the mentally disabled group. It has from its inception to the present moment had never left its concern towards disability paradigm.

A series of international human rights treaties and other instruments have been in place since 1945. The UN provided an ideal forum for the evolution and adoption of these instruments. The international human rights law today

[56] http://bhrc.bih.nic.in/docs/mental-healthcare-and-human-rights.pdf(last visited ,22/4/2014)

comprises treaties, declarations, guidelines and principles – more than 100 in number.

The member States of the UN have reposed and reaffirmed their abiding faith in fundamental human rights, in the dignity, integrity and worth of every human being as a person and in the matter of equal rights of women and men as also in certain special rights for children and even to these sensitive issue of mentally disabled group.[57]

Mental health legislation is necessary for protecting the rights of people with mental disorders, who represents vulnerable section of society. They face stigma, discrimination and marginalization in all societies, and this increases the likelihood that their human rights will be violated. Mental health legislation can provide a legal framework for addressing critical issues such as the community integration of persons with mental disorders, the provision of care of high quality, the improvement of access to care, the protection of civil rights and the protection and promotion of rights in other critical areas such as housing, education and employment. Legislation can also play an important role in promoting mental health and preventing mental disorders.[58]

There is no national mental health legislation in 25% of countries with nearly 31% of the world's population, although countries with a federal system of governance may have state mental health laws. Of the countries in which there is mental health legislation, half have national laws that were passed after 1990.[59]

Mental health legislation is essential because of the unique vulnerabilities of people with mental disorders. [60]The absence of mental health legislations

[57] http://bhrc.bih.nic.in/docs/mental-healthcare-and-human-rights.pdf, 17, 2008 (last visited ,22/4/2014)
[58]World Health Organisation, MENTAL HEALTH LEGISLATION &HUMAN RIGHTS,2003
[59] Id,2
[60] World Health Organisation, MENTAL HEALTH LEGISLATION &HUMAN RIGHTS,10,2003

with proper execution provisions have led to increase cases of mentally disabled persons and their violation of human rights. The international instruments basically can provide the following pathway:

- It can provide a new zone to the nation state to take care of these vulnerable group of people who are party to the international instrument through their legislations.
- It provides a wider platform to discuss, debate analyse the various issues which rise up in regard to the mental health laws and their solutions to be executed and planned.
- It provides an insight to the state about the significance of the issue in concern of mental disability and to take up new measures to eliminate discrimination and provide equity and justice.
- It takes into attention of the various nation state regarding the mental health legislations and policies to be taken up for the protection and promotion of human rights.
- It helps the policy makers to know about their pitfalls in the legislations and the amount of budgetary allocations to be invested in the mental health laws.
- It helps to know the nation states about the innovative steps to be taken by involving community health services, health programms, rehabilitation centres, care homes etc.
- It provides the insight to deal with the matter of mental disability both from medical model to social model and bring all necessary changes conducive for the protection and promotion of human rights.

- It enhances the wider ambit of public private partnership in regard to the mental health issue and its prospective works to its development.

Despite some progress in terms of legislation over the past decade, such violations of the human rights of persons with disabilities have not been systematically addressed in society. Most disability legislation and policies are based on the assumption that persons with disabilities simply are not able to exercise the same rights as non-disabled persons.

Consequently the situation of persons with disabilities often will be addressed in terms of rehabilitation and social services. A need exists for more comprehensive legislation to ensure the rights of disabled persons in all aspects - political, civil, economic, social and cultural rights - on an equal basis with persons without disabilities. Appropriate measures are required to address existing discrimination and to promote thereby opportunities for persons with disabilities to participate on the basis of equality in social life and development.[61]

3.5 Positive strength of international instruments

- **Those that are binding on States and create legal obligations to the States Parties.**

Under this heading, we can state that International human rights treaties are binding on States Parties that have ratified the instruments. Some universal instruments, such as the Universal Declaration of Human Rights, and some specific provisions, such as the principle of non-discrimination, have become part of customary international law and are considered binding on all States, even those that have not ratified a human rights treaty that embodies norms of customary law.

[61] http://www.un.org/esa/socdev/enable/disovlf.htm#overleg3 (last visited,6/5/2014)

Under the regime of The **International Covenant on Civil and Political Rights (ICCPR)**[62] **for the protection of disabled group the various provisions and procedures set forth adequate a defined set for protection and promotion of human rights**

The right to life constitutes the most fundamental of rights to the extent that it is the pre curser to all other human rights guarantees. **Article 6** of the ICCPR[63] is a paramount importance and irrespective of any class the protection would be endeavoured to the parties concerned.

Article 7[64] is also relevant to the protection of rights of disabled persons. This provision set forward a dignified meaning giving its essence to the need of the disabled group in enduring its development and giving their fundamental rights of which they are a capable party.

Article 9 is in relevance to persons with mental disabilities who may be susceptible to arbitrary arrest and detention. It also describes about the rights of the accused in consideration with the detention

Article 23 (2) recognises the right of men and women of marriageable age to marry and to found a family. It could be argued that this right is violated when mentally disabled persons are compulsorily sterilised and compulsory institutionalised.

Article 25 states that every individual has a right in public affairs without any unreasonable restrictions.

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[62] http://www.un.org/esa/socdev/enable/comp202.htm(last visited,12 /5/2014)

[63] states that the "...inherent right to life (...) shall be protected by law...", and that no one can be arbitrarily deprived of his / her life

[64] The article states: "...no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment." It further provides that "...no one shall be subjected without his or her free consent to medical or scientific experimentation."

Article 26 states about the customary principle of equality and non discrimination.

All these specific provisions of ICCPR takes into consideration of the disabled group and their importance and not alienating them from the mainstream of normal life in a society by providing them with all facilities and rights enshrined as a human being. For the execution of these provisions there is an effective mechanism for the protection of the disabled group.

Reporting procedures available under the Mechanism of ICCPR

Article 40 of the ICCPR obliges States Parties to submit an initial report within one year of the Covenant coming into force for the States concerned, and thereafter, every five years. The reports consists of the measures, execution and implementation procedures whereby each member states are obliged to do and to what extent they had been successful or failed in their process.The obligations of the States include undertakings by them not only to respect, but also to actively ensure all the rights mentioned in the Covenant to individuals within their territory.

After consideration of the reports, the Committee proceeds to draft and adopt its comments comprising a critique of the report, noting positive factors, drawing attention to matters of concern and making suggestions and recommendations.

Under the regime of The **International Covenant on Economic Social and Cultural Rights (ICESCR)**

The following provisions and the complaint mechanisms has been provided for the workability of the international instruments in regard to disability:

Article 12 (1)[65] states that in relation to disabled persons, this right may be violated when necessary measures are not taken to prevent malnutrition; when appropriate medical care and rehabilitation services are not provided for disabled persons; when immunisation campaigns to prevent diseases are not carried out; and when people live in overcrowded conditions no conducive to mental health then the basic principle underlying article 12 is violated.[66]

Article 13 (1)[67] can be interpreted to mean that disabled persons must have effective access to education, which is appropriate to their abilities.

Article 15 (1) (a)[68] recognises the cultural right . This right if violated, for example, when access to facilities in which cultural activities take place is inappropriate, like for cinemas, theatres, libraries, sports stadiums, museums etc. or when disabled persons are excluded from participating in cultural life on account of prejudices the state should take appropriate measures.

Reporting mechanism under the 1503 Procedure of the Economic and Social Council

The reporting procedure under the ICESCR is very similar to that of the ICCPR, but unlike the Human Rights Committee, the Committee on Economic, Social and Cultural Rights cannot receive complaints. States submit an initial report within two years of ratification and periodic reports every five years. NGOs can also submit reports on countries to be examined by the Committee. The Committee has taken the step also to examine the situations in countries that have not submitted reports to ensure their

[65] "...right of everyone to the enjoyment of the highest attainable standard of physical and mental health."
[66] http://www.un.org/esa/socdev/enable/comp203.htm(last visited,12/5/2014)
[67] "States Parties recognise the right of everyone to education."
[68] "...right of everyone to take part in cultural life."

accountability. The reason that no complaints procedure exists for this Covenant, is that the implementation of economic, social and cultural rights is progressive in nature, and therefore violations would be difficult to identify because of each country's different level of development.[69]

Therefore, equal attention should be given to the protection of these rights and their application to disabled persons. Thus, the provisions of both Conventions may be invoked for the protection of the rights of persons with disabilities.

3.6 Application of International Conventions, Standards and Norms to Domestic Law

(a) Application of International law.

Translation from an international convention, standard or norm to national law and then to local implementation is slow and complex but fundamental. States are primarily responsible for transforming legislative, administrative and judicial practices, to empower persons with disabilities to exercise their rights. States that have become Parties to an international convention are legally bound to implement the provisions contained in the convention in their domestic jurisdiction.[70]

International law leaves it to States to adopt such legislative and other measures, consistent with their constitutional processes, to give effect to the obligations which they undertake to implement and ensure that any person whose rights or freedoms are violated have an effective remedy justifiable before independent and impartial tribunals.[71]

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[69] http://www.un.org/esa/socdev/enable/disovlf.htm#overleg3 (last visited,16/5/2014)
[70] http://www.un.org/esa/socdev/enable/disovlf.htm#overleg3(last visited,16/5/2014)
[71] http://www.un.org/esa/socdev/enable/disovlf.htm#overleg3(last visited,16/5/2014)

Three main **methods** are available to implement international legal instruments in domestic law:

(1) Direct incorporation of rights recognised in the international instrument into what may be termed a "bill of rights" in the national legal order.[72]

(2) Enactment of different legislative measures in the civil, criminal and administrative laws to give effect to the rights recognised in international legal instruments.[73]

(3) Self-executing operation of international legal instruments in the national legal order.[74]

The course of the legislative process will differ according to the relevant domestic legal systems. For instance, incorporation of international human rights principles and norms in national constitutions - or similar documents - remains the most important way of bringing national laws in conformity with international standards. Signing of the UNCRPD by various nation states and executing and implementing in the domestic legislations.

3.7Role of domestic courts - incorporation of international norms and standards by domestic courts.

Direct application of international law by domestic courts also can play an important role in implementing international human rights norms applicable to persons with disabilities by means of compliance with relevant international standards and citing precedents in other jurisdictions. Due process of law has to be followed in matters of disability legislation.[75]

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[72] id
[73] http://www.un.org/esa/socdev/enable/disovlf.htm#overleg3(last visited,17/5/2014)
[74] id
[75] http://www.un.org/esa/socdev/enable/comp104.htm#4.5(last visited,12/5/2014)

Furthermore, judicial initiatives may propel executive and legislative branches of Governments to act with regard to drafting, enforcing and evaluating disability legislation. Courts also may encourage various interest groups to take up action on certain issues.

The greater the extent to which international norms on disability is widely known, the greater the possibility of domestic courts complying with these norms. This allows courts to play a major role in interpreting and developing international norms and standards, by applying international standards in domestic issues of disability.[76]

In relation to economic, social and cultural rights, implementation will differ from one country to another, depending on their level of development. Yet, all countries require major programme efforts. The obligation of States Parties in the international human rights instruments to promote progressive realization of the relevant rights to the maximum of their available resources clearly requires Governments to do much more than merely abstain from taking measures which might have a negative impact on persons with disabilities.

There are a number of 'general' conventions and recommendations that are applicable to the rights of persons with disabilities which have adopted under the auspices of various intergovernmental bodies and international agencies. The inclusion and the reaffirmation of the human rights of persons with disabilities in documents reflects the increasing recognition given to the human rights of persons with disabilities which is a growing need of the hour.

Reality or drawbacks in the execution of the international instruments

There were advantages and disadvantages in formulating new international instrument specifically addressing the human rights of persons with

[76] http://www.un.org/esa/socdev/enable/disovlf.htm#overleg3(last visited,18/5/2014)

disabilities. Prior efforts by the international community to address the rights of persons with disabilities have been inadequate or too limiting of rights. Some norms have had the effect of limiting the State's responsibility to integration 'within the limits of the State's capacity'; while others limit the responsibility of the State based on the 'capacity' of individuals to exercise their rights. Concern were expressed that a new instrument might have the unintended consequence of marginalising persons with disabilities, and that discrimination could be perpetuated by attention to the rights of persons with disabilities in a special instrument. The severe resource constraints, which already limited the efficiency and effectiveness of the United Nations human rights mechanisms, also needed to be borne in mind.[77]

On the other hand, many of the existing norms, principles, declarations, standards, and guidelines dealing with disability issues are dispersed through various instruments; some are not sufficiently specific, legally binding; others are not overall, they do not ensure widespread and effective legally operative freedom from discrimination on the basis of disability.[78] A new convention would afford the opportunity to revise or discard existing standards or statements of rights which were inconsistent with current thinking about the human rights of persons with disabilities or which were unsatisfactory in other respects. It was observed that group-specific instruments, for example, those guaranteeing the rights of children, women, minorities, and indigenous peoples, have focused attention on issues that would have remained much less visible under the general human rights instruments.

It was further observed that the diversity and dispersal of existing norms, principles and standards does not serve the needs of uniformity or universalization of rights or of a holistic approach to effective implementation of those norms and other standards. A comprehensive international

[77] http://www.independentliving.org/docs4/disberk0.html#anchor2-4(last visited,18/5/2014)
[78] Supra,29

instrument may also be a convenient format for promoting common standards, guiding domestic policy-makers through use of such common standards, legislators and others to make these standards legally obligatory and practically effective. In turn, the use of common international standards renders reporting and monitoring easier and more rational, providing minimum standards that will be applied in all countries while not precluding the adoption of higher national standards in some States. Thus in essence the reality of the international instruments remains just a paperwork and no proper execution is possible for better welfare of the disabled group.

However, a possible recommendation can be put forward wherein, in some countries there is a need for a treaty because other laws do not provide such minimum protections while persons with disabilities in such countries are in need of greater legal protection. In such jurisdictions, a treaty would impact positively on the development of domestic legislation for the promotion and protection of the rights of the persons with disabilities.

The UNCRPD effort for the protection and promotion of human rights is also reducing in actuality because of various provisions of reservations by the member states which brings the whole working of the convention as ineffective and not in consonance with the purpose and object for which it was brought into existence.

CHAPTER 4

TRANSITIONAL DEVELOPMENT OF MENTAL HEALTH LEGISLATIONS IN INDIA

4.1 ANCIENT TO MODERN PERIOD:

Backdrop of Mental Illness: An Understanding

From time antiquity mental illness has been facing serious stereotypes and prejudices in regard to its nature .It was predominated by the belief that sin and witchcraft were responsible for mental illness; mentally ill people were restricted to jails and asylums or should be secluded from the society so that it does not have its evil effect on other members of the society. This phase was very much prevalent until some specific theoretical schools explaining the pathogenesis of psychiatric disorders from their respective perspectives created an impact in psychiatry.[79]

The ambit of development and the jurisprudential scope of mental health as a matter of concern for social studies, reveals different views. Lunacy and mental disorders had its imprint to the Indian society from time immemorial, although the works and scholarly analyses on this subject were unveiled in recent times. While tracing back to the ancient Indian texts, it reveals the fact that not only was lunacy recognised in the societal pyramid, but also that patriarchal chauvinism existed even then.[80]

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[79] Id,38.

[80] Kaushik Laik, *SAGA OF THE 'MENTAL REVOLUTION' IN INDIA: A CRITICAL OVERVIEW OF THE INDIAN MENTAL HEALTH LAWS IN LIGHT OF THE*

Interestingly, the description of personality was considered in terms of sathvik, Rajasik and Tamsik representing the intellectual and moral, emotional and passionate, with Tamsik depicting more or less mental subnormality. This was perhaps the clue that guided Najabuddin Unhammad (1222 AD), an Indian physician, to describe seven types of mental disorder: Sauda-a-Tabee (schizophrenia), Muree Sauda (depression), Ishk (delusion of love), Nisyan (organic mental disorder), Haziyan (paranoid state) and Malikholia-a-maraki (delirium).[81] The period was 'victim blaming' and definitely societies were outcasting the people who were disabled as they considered them as curse of a family or of a society. They were discriminated and people had stereotype attitude towards this group of people.

Such was Indian society and special homes for the mentally ill were established during the glorious reign of Ashoka, which perhaps laid down the foundations for the present-day lunatic asylums.[82]

The present day system of Mental Health institutions and various laws which are being made, had its origin from its antiquity and can be considered as a significant role for the investigation of the conditions of human rights violations meted out to these vulnerable group from its inception of the society to the modern techno life.

The society although was seemingly revolving with varied issues and rights and welfare oriented public policies which were taken up nevertheless paid much heed to this group of people. The mentally ill people. have always been neglected or have been overwhelmed with some stereotype behaviour in most of the community. They have always been discriminated, treated

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INTERNATIONAL AND DOMESTIC SOCIETAL SCENARIOS, Citation: 31 Commw. L. Bull. 41, 44 (2005).

[81] http://www.lpgmonline.com/article.asp?issn=0022-3859. year=2001 ;volume=47;issue= 1 ;spage=73;epage=6;aulast=Parkar.htm, last visited on 28th april,2014

[82] *Id*

against their dignity or often have been alienated from the mainstream as being a cruse to the society for their evil deeds and should not accommodate themselves with the society members.

4.2 MODERN ARENA OF MENTAL HEALTH LEGISLATIONS

India enters the new millennium with many changes in the social, political, and economic fields with an urgent need for reorganization of policies and programmes. The mental health scene in India, in recent times, reflects the complexity of developing mental health policy in a developing country. The protection and promotion of human rights for the mentally disabled group can be grouped under following heads in India:

UNDER THE CONSTITUTION OF INDIA :

The researcher would try to bring into notice about the protection given to the mentally disabled group under supreme law of the land and there are no barriers or differences in regard to their capacity or competency for which they would be discriminated or alienated from the society. The various provisions in regard to the protection of these vulnerable group are:

Article 14. Equality before law.[83]

Under this regime every person residing in India is under the impression of getting equal protection and no any such discrimination or alienation.

Article 15. Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth.[84]

[83] See Annexure, III

[84] See annexure, III

Under this provision there is an explicit mention of the prohibition of the discrimination which protects the human rights of the mentally disabled person.

Article 16. Equality of opportunity in matters of public employment[85]

Under this provision the state does not bar any person not to seek employment opportunities dispensed by the government rather equality principle is maintained.

Article 3 and Article 41[86]**:**Under the regime of these two articles the social welfare model is seen whereby an equitable opportunity is given to all citizens of the country irrespective of any discrimination.

SEVENTH SCHEDULE [Article 246]

List I–Union List (Entry No. 13,List II–State List (Entry No. 9.)

List III–Concurrent List(Entry No. 16.)[87]

ELEVENTH SCHEDULE [Article 243G] (Entry No. 23.), (Entry No. 26)[88]

TWELFTH SCHEDULE [Article 243W] (Entry No. 6.)(Entry No. 9)[89]

Under the regime of the various schedules, the constitution of India has shown and able to prove about the social model approach in helping to eliminate disability in any form and provide a conducive atmosphere for the promotion and protection of human rights.

4.3SPECIFIC MENTAL HELATH LEGISLATIONS BY GOVERNMENT OF INDIA

[85] See Annexure,III
[86] See Annexure, III
[87] See Annexure, III
[88] See Annexure, III
[89] See Annexure, III

The National Health Policy (2002) clearly spells out the place of mental health in the overall planning of health care. These developments have occurred against the over 25 yr of efforts to integrate mental health care with primary health care (from 1975), replacement of the Indian Lunacy Act 1912 by the Mental Health Act 1987, and the enactment of The Persons with Disabilities Act 1995 focusing on the equal opportunities, protection of rights and full participation of disabled persons. The growth of voluntary action for mental health care in the areas of suicide prevention, disaster mental health care, setting up of community mental health care facilities, movement of family members (care givers) of mentally ill individuals, drug dependence, public interest litigation to address the human rights of the mentally ill; research in depression, schizophrenia and child psychiatric problems are other major developments.[90]

INDIAN Mental Health Act (1987): A BEGINNING

Prior to 1993, Indian Lunacy Act, 1912 was governing the mental health in India. In 1947 when we got independence and Indian Psychiatric society came into existence, ILA, 1912 was considered an inappropriate act for mentally ill. So IPS drafted a mental health bill and submitted it to govt. of India 1950 but it took another 28 years for govt. to present it in the Lok Sabha which was subsequently referred to JPC. Various committees established didn't consult IPS at any juncture though 10 psychiatrists were invited to give oral evidences. After a gap of another 8 years the bill was adopted as Mental Health Bill by Rajya Sabha in 1986 and the Lok Sabha in 1987. This bill received President's assent on May, 1987 but another 6 years were wasted before finally implementing the act in April 1993.The Objectives of the act enumerates specific provisions for the disabled.[91]

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[90] J.K.Tiwari, *MENTAL HEALTH ACT, SALIENT FEATURES,OBJECTIVES, CRITIQUE AND FUTURE DIRECTIONS, 2008*

[91] See Annexure,IV

The advantage of the Mental Health 1987 is that the act is conceptually definitely many steps ahead of ILA (Indian Lunacy Act), 1912, trying to keep pace with advances in psychopathology and psychopharmacology. The fact that even four decades after Indian received its independence, we were continuing with an outdated and anarchic law speaks volumes about the importance of this act.[92]

Various positive changes in the MHA, 1987

More humane approach to problems of mentally ill persons by changing the terminology e.g. lunatics and criminal lunatics have been replaced by the term mentally ill person and mentally ill prisoner etc. and new chapters on management of their property and protection of human rights have been included and for the better protection of the mentally disabled group.[93]

DIFFICULTIES WITH THE MENTAL HEALTH ACT,1987

The MHA 1987 has had a troubled life ever since it came into pragmatic being in 1993. There have been substantial critiques of the act, which has been labelled as being ;

i) overly legal in its scope, process and outcome, stressing upon custody with little regard for therapeutic aspects of psychiatric care,

ii) establishing similar legal controls upon both voluntary and non-voluntary classes of patients, and

iii) being discriminatory towards nongovernmental institutions of psychiatric care.

[92] J.K.Tiwari, *MENTAL HEALTH ACT, SALIENT FEATURES,OBJECTIVES, CRITIQUE AND FUTURE DIRECTIONS,13, 2008*

[93] See Annexure,V

Another reason for the act's unpopularity is its relative silence on the more practical aspects of patient care that psychiatrists face on a daily basis. It is also true that many patients in India are regularly admitted against their wishes by psychiatrists on the basis of proxy consent provided by friends and relatives and treated against their wishes without recourse to a legally justifiable means of doing so.[94]

Difficulties with procedural rules in Indian MHA '87

India has a long tradition of families carrying out many of the responsibilities and duties that in a developed country would properly be the role of the social services. The primacy of family (and indeed friends) has been recognized in the MHA '87 where except for patients who are detained by the police (Section 25) and prisoners who are diverted into the mental health system by court rulings (Sec 27, 29), most other applications for involuntary hospitalization become the responsibility of the family or friends of the patient.[95]

Despite the ready availability of the family to share the burden of caring for the mentally ill, the process of seeking and receiving treatment under the MHA '87 is exceedingly arduous, appears to be more penal and less therapeutic, and can lead not only to isolation of patients and professional alike, but also stigmatize them .Conversely, it is also not unknown for families/relatives to abandon patients in psychiatric institutions and never to take them back again.An MHA, by implicitly discouraging mentally ill patients' and their families from using it due to procedural difficulties that it poses for users, will lead to increasing stigma for the patients and their families,

[94] Jaydip Sarkar, *A New Mental Health Act for India: An Ethics based Approach*, Indian Journal of Psychiatry, 2004
[95] Id, 105

thereby encourage the pursuit of alternative and dubious forms of 'cures' and may lead to desertion of the patients by their families.[96]

4.4Human Rights and Mental Health Act, 1987

Chapter VIII of this Act contains a very novel and explicit provision of protection of human rights of mentally ill persons.[97]

The Mental Health Act also by its definition of mentally ill persons excludes from its regime the mentally retarded. It also does not differentiate between the various degrees of mental illness that requires specialized care and treatment. However, it permits the commitment to hospitals of the criminal mentally ill. It makes no special provision for their care, treatment and discharge. Beside the above, there is no provision for compensating those wrongfully incarcerated or negligently treated or victimized in any manner by misuse of powers under the Act. Another important shortcoming in this context is that there is no right to rehabilitation of those mentally ill discharged after being found fit.[98]

4.5 ROLE OF JUDICIARY

It is submitted that it is a matter of great regret that judiciary in India was given opportunities in number of public interests litigations filed and which were relating to inmates of mentally ill patients, but it did not dare to enumerate the human rights of mentally ill patients. On the aspect of judicial

[96] Trivedi, J. K. The Mental Health Legislation: An ongoing debate (editorial) Indian Journal of Psychiatry, 44(2),95-96(2002)
[97] See annexure,VI
[98] Mental Illness, Care, and the Bill A Simplistic Interpretation,Vandana Gopikumar, S Parasuraman

intervention, the Supreme Court concerning the management of mental hospitals decided the following cases-

1. In *B.R. Kapoor* V. *Union of India*[99] *and PUCL v. Union of India,*, both relating to functioning of the hospitals for mental diseases, Shahdara, Delhi.

2. *R.C. Narayan* v. *State of Bihar*[100] and the order dated 11.11.97 the case concerning the Ranchi Mental Asylum.

3. *Supreme Court Legal Aid Committee* v. *State of MP*[101], where the Supreme Court intervened to improve the working of the Gwalior Mental Asylum.

The subject of health falls under the concurrent list in the Indian Constitution empowering both the centre and states to introduce measures including the authority to legislate. The Mental Health Act 1987 is civil rights legislation with a focus on regulating standards in mental health institutions. There are serious questions over the effectiveness of this Act in ensuring protection to person's property and management of persons covered.

A perusal of the above referred cases clearly revel that until recently many mentally ill persons were consigned to jails and those living in mental health institutions were no better off, as the conditions both in prisons and in mental institutions were far below the stipulated standards. **Sheela Barse v. Union of India**[102] concerned the detention of non-criminal mentally ill persons in the jails of West Bengal. The appalling conditions in which they were held was noted by the Supreme Court which observed that admission of non-criminal mentally ill persons to jails is illegal and unconstitutional.

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[99] AIR 1990 SC 752, JT 1989 (2) SC 330, 1989 (1) SCALE 1571, (1989) 3 SCC 387, 1989 (2) UJ 119 SC

[100] W. P. No 339 of 1986.

[101] AIR 1995 SC 204, JT 1994 (6) SC 40, 1994 (3) SCALE 1042, 1994 Supp (3) SCC 489, 1994 (2) UJ 623 SC

[102] (1986) 3 Supreme Court Cases 632

Similarly in **Chandan Kumar v. State of West Bengal**[103], the Supreme Court heard of the inhuman conditions in which mentally ill persons were held in mental hospital at mankaundi in the District of Hooghli. The Court denounced this practice and ordered the cessation of the practice of tying up the patients who were unruly or not physically controllable with iron chains and ordered medical treatment for these patients.

The case of ***Veena Sethi*** v. ***State of Bihar***[104] also addressed the practice of keeping mentally ill persons in jail, where the Court declared that all mentally ill inmates must be examined every six months and released immediately if they are found to have no mental illness. In addition, it reaffirmed the principle that there should be an adequate number of institutions for persons with psychiatric disabilities, and that jail should not be considered an appropriate location for providing safe custody.

In the case of ***S.P. Sathe*** v. ***State of Maharashtra***[105] , the Bombay High Court regulated the administration of electroconvulsive therapy (ECT) to mentally ill persons after hearing of the conditions at the Institute of Psychiatry and Human Behavior in Panaji, Goa. Patients at the IPBH were reportedly given ECT without anaesthesia, a practice which could lead to general discomfort as well as bone fractures and dislocations. In addition, the IPHB neglected to obtain informed consent from the patients before administering the treatment.

RIGHT TO REPRODUCE

Suchita Srivastava versus Chandigarh Administration, 2009 (11) SCALE 813, an important judgment in regard to the practice and protection of the rights of the mentally disabled group. The analysis of the case has given a

[103] [(1995) Supp. 4 SCC 505]
[104] 1983 AIR(SC) 339
[105] Writ Petition No 1537 of 1984, Bombay

two folded dimension to the public and state whereby on one hand the reproductive right of the individual is in question and on the other hand the right of the unborn and the best interest which could be served to both child and the mother.

BRIEF FACTS OF THE CASE:

The Born in 1991, this woman was abandoned by her family in 1998, when she was just seven years old. After a few years with the Missionaries of Charity, she went to her new home: the state-run Nari Niketan in Chandigarh, India. Though she was 18 years old today, she said to have the IQ equivalent of a 9 year old. In this state-run institution, she was repeatedly raped by the staff, four of whom have been arrested. All this came to light only when she was shifted from there to another state-run institution Ashreya. She was unwell and was showing symptoms of illness which made the members of the Ashreya to take her to medical investigation.

The medical investigation revealed that the woman was pregnant, the Chandigarh Administration decided that it was in her best interests to abort the pregnancy. However the girl expressed an unambiguous and unequivocal desire to keep the child. Responding to the state's petition, the state High Court ordered an immediate termination of pregnancy.

This order was challenged by a Delhi based lawyer, filing a petition in the Supreme Court. After several days of intense debate in the media as well as the public, the Supreme Court refused to allow termination of pregnancy, and stayed the High Court order.

The rationale substantiated in the case provided a new dimension to the whole arena of stereotype behaviour towards the mentally disabled group and their inherent rights as provided by the law of the land.

The apex court examined the provisions of the **Medical Termination of Pregnancy (MTP) Act, 1971** and noted that consent is an essential condition for performing an abortion on a woman who has attained the age of majority and does not suffer from any 'mental illness'. The Court also examined the issue of the exercise of (I)**parens patriae**[106], i.e the state must make decisions in order to protect the interests of those persons who are unable to take care of themselves it was held that the Court should be guided by the 'best interests' of the victim/survivor and not of other stakeholders such as guardians or society in general.

The Court noted that a woman's right to make reproductive choices is a dimension of 'personal liberty', as understood under **Article 21** of the Constitution. Reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration was held to be a woman's right to privacy, dignity and bodily integrity. Thus, restrictions could not be placed on the exercise of reproductive choice such as a woman's right to refuse participation in sexual activity or, alternatively, on her insistence on the use of contraceptive methods. Women are free to choose birth control methods such as undergoing a sterilization procedure. It was observed that reproductive rights include a woman's entitlement to carry pregnancy to its full term, to give birth and to raise children.

In the aforesaid case the medical condition of the victim was described as 'mild mental retardation'. Under the MTP Act, the pregnancy of a woman above 18 years of age can be terminated with the consent of the guardian only if she is categorized as a 'mentally ill person'. As per Section 2(b) of the Act: "A 'mentally ill person' means a person who is in need of medical treatment by reason of any mental disorder other than mental retardation."

[106] http://indiankanoon.org/doc/1500783/ (last visited, 2/5/2014)

The Court observed that it was clear that the expression 'mentally ill person' is different from 'mental retardation'.[107]

That the victim's pregnancy cannot be terminated without her consent and proceeding with the same would not have served her 'best interests'.[108] The language of the MTP Act clearly respects the personal autonomy of mentally retarded persons who are above the age of majority. It is amply clear that one cannot permit a dilution of the requirement of consent for proceeding with a termination of pregnancy. Moreover proceeding with an abortion at a late stage (19-20 weeks of gestation period) poses significant risks to the physical health of the victim. The need to look beyond social prejudices in order to objectively decide that parental responsibilities can be taken by a mother of his child should be enlarged.[109]

In regard to the concerns have been expressed about the victim's mental capacity to cope with the demands of carrying the pregnancy to its full term, the act of delivering a child and subsequent childcare there should be the best medical facilities made available so as to ensure proper care and supervision during the period of pregnancy as well as for post-natal care.

Since there is an apprehension that the woman in question may find it difficult to cope with maternal responsibilities, the Chairperson of the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities (constituted under the similarly named 1999 Act) has stated in an affidavit that the said Trust is prepared to look after the interests of the woman in question which will include assistance with childcare.[110]

This case enumerates the transition of the attitude from charity based to rights based approach. This illuminating role played by judiciary is changing

[107] http://indiankanoon.org/doc/1500783/ (last visited ,2/5/2014)
[108] http://www.nirmauni.ac.in/law/ejournals/law/judgment2-v2i2.pdf (last visited,2/5/2014)
[109] Id
[110] http://indiankanoon.org/doc/1500783/ (last visited, 6/5/2014)

and we can see from the above stated analysis of the case. But however, this is not always the case but we should take positive and progressive steps towards its development and more approachable attitude of the judiciary towards this sensitive issue. Some other issues in due relation to mental disability and the interference of judiciary and its interplay:

RIGHT TO PROPERTY

Personal laws have a number of provisions which have a bearing on the rights of those with mental disabilities, impacting their right to legal capacity as well as their rights in a home /family. Personal laws do not generally make a distinction between mental illness and mental retardation and use archaic terms to describe mental disability, including insanity, unsoundness of mind, lunacy, idiocy etc.

Persons with mental illness may marry in many personal laws in India, as marriages are often entered into by agents or guardians rather than by marriages are often entered into by agents or guardians rather than by the individuals. Insanity is a ground in many personal laws in India for having a marriage annulled if the fact of such disability was not disclosed at the time of marriage. The issue of legal capacity is an important one to determine a person's autonomy in decisions relating to marriage. In many matrimonial laws/statutes, persons with mental disabilities are not allowed to marry on their own. While the lack of a right to marry applies to both sexes it has greater impact on women with its potential for forced pregnancy and ,also its potential for marital rape which is not considered an offence. In addition , while a person with mental disability may hold property ,such property cannot be disposed of by them. Such a person cannot enter into a valid contract or obtain probate for a will, or receive letters of administration to deal with properties of an intestate. While law does not impact the right of a woman

with mental disabilities from holding property , she is debarred from willing it away or gifting it.[111]

RIGHT TO ADOPTION

Family laws do discriminate against both women in general and against persons with mental disabilities in many ways. We can for instances, in adoptions of children among Hindus, the consent of a spouse need not be taken if the spouse is not of sound mind.[112]

The child can be given away by a spouse in adoption even against the wishes of a spouse of unsound mind.[113] This principle has been extended to instances of giving away children in adoption without the consent of their birth mothers. In ***Robert Heijkamp and Anr. V. Bal Anand World Children Welfare Trust and Anr.***[114] ,a case of adoption of the Juvenile Justice (Care and Protection of Children)Act, 2000,from Maharashtra, the Child Welfare Committee(cwc) had declared a person to be mentally unfit to take care of the child and declared a child legally free from adoption. Under the Juvenile Justice Act, the CWC has the power to declare the child legally free for adoption, but the question was whether the CWC had the authority to declare a person to be mentally ill and on the basis declare the child abandoned or in need of care and protection and thus free for adoption.

The Maharashtra High Court held that the CWC had no power to either consider or declare a person to be mentally ill. The determination of the mental health of a person is governed by the provisions of the Mental Health Act, 1987. Until the process is complied with, the child could not be declared free for adoption, even on the basis of doctor's certificates.

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[111] Sec 59, Indian succession act,1925 lays down the conditions for a valid will, and one of these conditions requires a person to be of sound mind.
[112] Sec 7&8 Hindu Adoptions and Maintenance Act,1956
[113] Sec 9 Id
[114] 2008(1) BomCR 719,MANU/MH/1288/2007

While it is not easy to bring about changes in personal laws and legal processes, they can be reinterpreted in the light of the Bill and the UNCRPD. There are some measures which can be put in place in order to ensure that, in matters relating to family law, women will not be discriminated against on the basis of mental health.[115] This includes challenging and changing interpretations of mental illness/ disability ,where the courts have taken a gendered approach without a higher degree of proof and with double standards on spousal duties and parenting responsibilities for men and women. Women with mental disabilities have to face greater discrimination within both public and private sphere and no legislations is helping to protect these vulnerable conditions.

4.6 NATIONAL MENTAL HEALTH PROGRAMME

India is one of the few countries that have a National Health Policy (NHP, 2002) that mentions mental health, as well as a National Mental Health Program (NMHP) and a dedicated Mental Health Act 1987 (MHA). By identifying PHCs as the epicentre for psychiatric treatment, NMHP (1982) attempted to integrate mental health into general health. It also proposed to deinstitutionalize to a community rather than hospital based model. However, by 2002, only 100 of 600 districts were brought under NMHP. This failure was due to poor funding, inadequate undergrad curriculum in psychiatry, manpower shortage, and poor evaluation, non-implementation of MHA and privatisation of mental health care.

The 11th Plan with a Rs1000 cr. allocation for mental health proposes to cover the remaining 500 districts by the end of the Plan period. However,

[115] Sarasu Esther Thomas et al,Social Exclusion and Persons With Disability,95 (1st Edn.,2013)

mental illness is a progressive disorder; for every 100 districts covered each year, there will be a backlog of districts without mental health services.[116]

The much wider scope of the restrategised National Mental Health Programme and the focus on public private partnerships, would provide more hope to these vulnerable group to work for some comprehensive mental health care.

Each State will have to carefully understand its mental health care needs, map its resources for mental health care delivery, and plan programmes aimed at improving mental health and ameliorating mental health problems among its constituents and provide all such facilities if taken into action.

4.7 RECENT DEVELOPMENTS IN THE AREA OF MENTAL HEALTH LEGISALTIONS

Analysis of Mental Health Care bill, 2013: Welcoming effort by the policy makers

Mental disorders are complex physiological infirmities of the nervous system. While they continue to be the toughest riddles in the field of medical research, they pose even more challenges in the socio-economic and legal contexts. In recent times the mental health laws across the world have undergone a significant change. India has also after much discussions , debates, social awareness has given a thought to amend the old Mental Health Act, 1987. An innovative step was started up with many draft bills and eventually the legislature was paying its eye on this sensitive issue of protection of human rights of mentally disabled group.

[116] *www.acmiindia.com (last visited, 22/4/2014)*

Eventually, a new mental healthcare paradigm has emerged which advocates that the mentally ill are not objects of charity or social protection but are subjects with rights and States and the International bodies are under an obligation to provide them with the means of enforcing these rights. The international consensus about the new paradigm was strongly conveyed by the near unanimous acceptance of the United 2006(commonly known as the Disability Convention') and Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (or simply the MI Principles).This consensus and the paradigm shift showed a new pathway to these vulnerable group is showing a new horizon of hope to get its appropriate protection of human rights and enjoy the basic fundamental rights as enshrined by the Law of the Land.

The researcher while analysing the international , national , civil society, NGOs,SMOs opinion could visualise the intent of urgency in making certain amendments to the existing acts and changing the attitude of charity to right based protection of the mentally disabled group. The researcher in this chapter is bringing out the effort taken by the legislature and other organs of the government in regard to the protection of the human rights of these group to ensure a healthy and a democratic life in India.

Now an attempt has been made in regard to the amendments made by the legislative policy makers in ensuring protection of human rights to the mentally disabled group. To fulfill its commitments under the Disability Convention, 2006 and MI principles of 1991, India needs a major overhaul of its disability laws and policies dealing with mental health care. The Ministry of Health and Family Welfare (MHFW) recently came out with the Mental Health Care Bill 2012 responding to this formidable legislative challenge.

The Mental Health Care Bill 2012: An Overview

After the ratification of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) by India which came into force in 2008, there was a clear need to amend the existing disability laws in India to bring them in compliance with the UNCRPD. It is in pursuance of this that the Mental Health Act 1987 ("MHA") is sought to be replaced the new Mental Health Care Bill 2012 ("2012 Bill").

The new Bill consist of 16 Chapters and 137 clauses and lengthy than the Mental Health Act,1987. Instead of going into the specific clauses of the Bill, we focus on the following broad themes which is of more significance:

I. **Definition of Mental Illness**:

One of the significant contributions of the 2012 Bill is the definition of 'mental illness' as "a disorder of mood, thought, perception, orientation and memory which causes significant distress to a person or impairs a person's behaviour, judgment and ability to recognize reality or impairs that person's ability to meet the demands of daily life and includes mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation". The definition of 'mental illness' is a major concern from the MHA which did not provide any guidance as to what would constitute mental illness except for stating that a person who was mentally ill and was in need of treatment and who did not come under the definition of mental retardation. This was clearly from a medical model of disability, while the 2012 Bill seeks to understand mental illness from a social model, giving a broad and inclusive definition as to what may constitute mental illness.

Further section 3 of the mental health bill,2012 also lays down other criteria for determination of mental illness.[117]

II. **Legal Capacity**:

The 2012 Bill provides every person has a right to make an advance directive, empowering him/her to decide how he/she should be or should not be cared and treated in mental illness. This provision enables every person's right and capacity to decide what treatment or care he/she must be subjected to. The Bill also states an elaborate procedure for registration and revocation of advance directives as well as situations in which such directives can be overridden.Another welcome provision in the Bill is the requirement that all treatments and medical research on mentally ill persons must be done only with their free and informed consent (by giving information about the risks, benefits, alternatives in an understandable language) or with the consent of the State authority, where the person is not capable of giving consent.[118]

III.**Protection of Rights of persons with mental illness**:

The Bill brings about a rights-based protection of mentally-ill persons. This was not the focus of the Mental Health Act 1987 and the 2012 Bill fills this requirement of the UNCRPD by guaranteeing to all persons the right to access to mental healthcare, and a range of services for persons with mental illness including shelter homes, supported accommodation, community based rehabilitation. The right to community living, the right to live with dignity, protection

[117] http://clpr.org.in/the-mental-health-care-bill-2012-an-overview/(Last visited, 16/3/2014)
[118] http://clpr.org.in/the-mental-health-care-bill-2012-an-overview/

against cruel, degrading and inhuman treatment, the right to equality and non-discrimination, the right to information, confidentiality and access to medical records; right to personal communication, legal aid and the right to make complaints about deficiencies in provision of services in addition to other similar legal remedies. It is for the first time that any law has guaranteed such rights to equality, non-discrimination and the positive rights for provision of basic services to persons with mental illness. In fact even the Persons With Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 ("PWD Act") does not guarantee such rights to persons with disabilities, and this Bill, if passed may lead to a positive change for the PWD Act as well.[119]

IV. **Duties of the Government**:

The burden of planning, designing, implementing programs for promotion of mental health and prevention of mental illness, creating awareness about mental illnesses, reducing stigma, sensitizing govt. officials including police officers, implementing public health programs to reduce suicides and other such programs has been placed on the appropriate government. Insufficient awareness, advocacy and sensitization about mental illness was a serious pitfall of the MHA and this is being remedied by the Bill.[120]

V. **Systemic changes in the mental healthcare system and new Fora for complaints:**

[119] MOVING TOWARDS AUTONOMY AND EQUALITY: AN ANALYSIS OF THE NEW MENTAL HEALTH CARE BILL 2012, centre for law and research

[120] MOVING TOWARDS AUTONOMY AND EQUALITY: AN ANALYSIS OF THE NEW MENTAL HEALTH CARE BILL 2012, centre for law and research

> The Bill seeks to create various new bodies and completely overhaul the existing mental healthcare system in the country. It provides for the establishment of the Central and State Mental Health Authorities, which would be responsible for the registration and oversight of mental health establishments by laying down minimum standards and a monitoring mechanism to ensure statutory compliance. The Bill also sets up the Mental Health Review Commission (MHRC) and state-wise Mental Health Review Boards (MHRB). The MHRC and MHRB are equipped with several administrative and adjudicatory functions and will form the first level of interaction of any person with mental illness or his/her representative with the mental healthcare system for violation of any of his or her rights. This is a whole new regime when compared to the MHA which gave an unbridled power to the Magistrate in the mental health system, which has now been reduced to only a few specific cases. With the introduction of these new bodies, for the first time, a person with mental illness can directly approach a forum for protection of his/her rights.[121]

Thus, the Mental Health Care Bill 2012 makes significant changes over the MHA bringing about protection and empowerment of persons with mental illness. The Ministry of Health and Family Welfare must consider having a National Mental Health Care Policy to solve various administrative bottlenecks that this Bill may create. Various countries which have a mental health legislation also have a mental health policy creating a comprehensive legal framework for their mental health system. The mental health policy is a necessary for an effective implementation of any policy or program and for smooth and effective functioning. This an effort making draft for the mentally

[121] MOVING TOWARDS AUTONOMY AND EQUALITY: AN ANALYSIS OF THE NEW MENTAL HEALTH CARE BILL 2012, centre for law and research

disabled people but the legislature did not paid much heed to the legislative amendment made to the Mental Health Act,1987. The reactions to this bill were mixed with some groups lauding provisions decriminalizing attempted suicide by a mentally ill person, ensuring the availability of insurance for treatment of mental illness at par with physical illness and prohibition of certain medical procedures like the Electro Convulsive Therapy (in case of minors), Sterilization and Chaining, while others opposing the bill on the ground that its provisions curtailed patient autonomy and liberalized the laws for involuntary admissions to mental institutions.

After the defects of the draft bill of Mental Health Bill,2012 the legislative policy makers wanted to reform the gaps which will fulfil the objects of a new amendment of mental health laws. So a draft bill was made i.e namely Mental Health Care Bill,2013. The new Bill guarantees several rights to the mentally ill from the right to privacy in mental health establishments to the right to dignity. The Mental Health Care Bill, 2012, primarily focused on preventing inhuman treatment of persons with mental illness and aims at treating them as persons with equal legal capacity as others. The Bill is said to have drawn inspiration from the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).The new Bill, pending before Parliament, is an improvement over the existing 1987 Act.

MENTAL HEALTH CARE BILL,2013

The long-awaited Mental Health Care Bill, after an extensive consultation process that lasted over two years, has finally entered the legislative process. It enshrines access to healthcare as a right and holds the government accountable for service delivery. This Bill strikes a neat balance between the

practical needs of users and care givers and international conventions and frameworks.

Drafting a new legislation that involves the expression of rights of people, in particular, people who are vulnerable, is a sensitive process. The development of this Bill was participatory and involved active engagement with representative voices of those whom it intends to serve including, people with mental health problems, activists, mental health professionals and administrators.[122]

The Union Cabinet cleared the Mental Health Care Bill, 2013 that makes access to mental health care a right of all persons. The Mental Health Care Bill, 2013 was introduced in the Rajya Sabha on August 19, 2013. The Bill repeals the Mental Health Act, 1987.

The new Bill guarantees several rights to the mentally ill - from the right to privacy in mental health establishments to the right to dignity. It bars inhuman practices such as electro convulsive therapy without anaesthesia, sterilisation as a treatment for illness, chaining and tonsuring of heads of the mentally ill. The Bill also provides stringent penalties for those found running unregistered mental health care establishments which would be fined with Rs. 50,000 to Rs. five lakh depending on the frequency of the offence.[123]

Objects and Reasons to the Bill

Indian government ratified the United Nations Convention on the Rights of Persons with Disabilities in 2007. The Convention requires the laws of the country to align with the Convention. The new Bill was introduced as the

[122] http://www.thehindu.com/news/cities/bangalore/a-new-version-of-mental-health-act-likely/article4415809.ece (last visited ,12/3/2014)
[123] http://zeenews.india.com/news/delhi/proposed-mental-health-legislation-can-be-misused-delhi-court_893076.html

existing Act does not adequately protect the rights of persons with mental illness nor promote their access to mental health care Rights of persons with mental illness: Every person shall have the right to access mental health care and treatment from services run or funded by the government. The right to access mental health care includes affordable, good quality of and easy access to services. Persons with mental illness also have the right to equality of treatment, protection from inhuman and degrading treatment, free legal services, access to their medical records, and complain regarding deficiencies in provision of mental health care. The broad themes of this new mental health care bill,2013 are provided.[124]

The present Bill seeks to isolate the purely healthcare-related aspects while not going into the questions of guardianship and civic and political rights. He pointed out that the number of psychiatrists in our country is very small; it is not more than 4,000. So in nutshell we can state the following focus points of the Mental Health Care Bill,2013

a).Advance Directive[125]:

A mentally-ill person shall have the right to make an advance directive that states how he wants to be treated for the illness during a mental health situation and who his nominated representative shall be. The advance directive has to be certified by a medical practitioner or registered with the Mental Health Board. If a mental health professional/ relative/care-giver does not wish to follow the directive while treating the person, he can make an application to the Mental Health Board to review/alter/cancel the advance directive.

b).Central and State Mental Health Authority:

[124] See Annexure,VIII

[125] **PRS Legislative Research, 2013**

These are administrative bodies are required to (a) register, supervise and maintain a register of all mental health establishments,(b) develop quality and service provision norms for such establishments, (c) maintain a register of mental health professionals, (d) train law enforcement officials and mental health professionals on the provisions of the Act, (e) receive complaints about deficiencies in provision of services, and (f) advise the government on matters relating to mental health.[126]

c).Mental Health Establishments:

Every mental health establishment has to be registered with the relevant Central or State Mental Health Authority. In order to be registered, the establishment has to fulfill various criteria prescribed in the Bill.

The Bill also specifies the process and procedure to be followed for admission, treatment and discharge of mentally ill individuals. A decision to be admitted in a mental health establishment shall, as far as possible, be made by the person with the mental illness except when he is unable to make an independent decision or conditions exist to make a supported admission unavoidable.

d).Mental Health Review Commission and Board:

The Mental Health Review Commission will be a quasi-judicial body that will periodically review the use of and the procedure for making advance directives and advise the government on protection of the rights of mentally ill persons. The Commission shall with the concurrence of the state governments, constitute Mental Health Review Boards in the districts of a state. The Board will have the power to (a) register, review/alter/cancel an advance directive, (b) appoint a nominated representative, (c) adjudicate complaints regarding deficiencies in care and services, (d) receive and

[126] **PRS Legislative Research**

decide application from a person with mental illness/his nominated representative/any other interested person against the decision of medical officer or psychiatrists in charge of a mental health establishment.[127]

e).Decriminalising suicide and prohibiting electro-convulsive therapy:

A person who attempts suicide shall be presumed to be suffering from mental illness at that time and will not be punished under the Indian Penal Code. Electro-convulsive therapy is allowed only with the use of muscle relaxants and anaesthesia. The therapy is prohibited for minors.

Despite the pain staking efforts taken by the policy makers but the effort is not in consonance with the protection to be sought to the mentally disabled group under the following grounds[128]. The researcher could bring into light the following facts which is very essential to bring the best interest of these vulnerable group but are not yet taken into considerations in the Bill:

Rejections

The Parliament if passes the Bill and it is assented by the President, it will replace the Mental Health Act of 1987. But however there were certain loopholes which needs the immediate attention.

Objections to the Electro Convulsive Therapy (ECT):

Even as the Mental Health Care Bill 2013 is scheduled to be taken up in the Parliament during the ongoing Winter Session, psychiatrists have voiced objections to the proposed ban on direct electro convulsive therapy (ECT) or

[127] **PRS Legislative Research**
[128] **PRS Legislative Research**

administration of shock to patients with serious mental illness. There was a need for a complete ban on modified ECT.[129]

While the legislation stresses on elimination of cruel methods of treatment like tonsuring and chaining patients, it also includes ban on ECT without anaesthesia. This has raised the heckles among mental health experts as they deem it a step that would deprive a major chunk of patients from cheap and very effective treatment.

Modified ECT entails procedures in presence of anaesthesiologists while including a whole routine from anaesthesia administration, muscle relaxants, blood and electrolyte monitoring, intubation as well as drugs for recovery. This not only increases the cost of treatment but also makes treatment inaccessible for a vast majority of people requiring the therapy as it restricts facilities to top health institutions.

Unmodified ECT is not what it appears to be. It is the safest and the most affordable treatment for conditions like schizophrenia, manic depression and psychotic patients that is available at sub-divisional hospitals and district mental health programme modules.

It is not cruel or barbaric as it is deemed to be. The shock is given at very low voltage and for short duration. The shocks induce anaesthetic effect on the patient instantaneously and he does not feel any pain even if the convulsions appear to be so, the psychiatrists have argued.[130]

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[129] Shri Amrit Kumar Bakshy, President, Schizophrenia Awareness Association, Maharashtra; during his deposition on 4th, October, 2013

[130] http://www.newindianexpress.com/states/odisha/Psychiatrists-Oppose-Mental-Health-Care-Bill/2013/12/15/article1946558.ece

CLAUSE 124 and Clause 114(2)

The said Bill gives no power to the affected person to seek exit from the institution if he was not satisfied with the treatment. The Bill is also silent on the right of the affected person to live independently and there was a need to bring an amendment to the proposed legislation in this regard. Further there was a need to relook at clause 124 which says that all persons who attempt to commit suicide are presumed to be suffering from mental illness unless proved otherwise. Further there was a need to relook at clause 114(2) of the Bill in which "proof of Mental Illness" obtained from a Board would suffice for obtaining 'divorce' which was not fair to convert a legal dispute into a medical dispute. Therefore, there was a need to delete this provision.[131]

EXIT PROVISION AND NON AVAILABILITY OF MENTAL INSTITUTIONS:

The Bill was silent on the procedure for exit of patients after availing treatment. The Bill was also silent on rehabilitation of the treated and recovered patients. He also raised the issues like criminals being sent to Mental Institutions without availability or otherwise of beds in such institutions; no proper definition of psychiatric nurse/psychiatric social worker; regressive provision for transportation of patient from one State to another which would not be in the interest of the patient.

The proposed Bill still continues its link with the correctional system. The **clause 101**, **chapter XII**, on ' leave from the hospital' requires a police officer to accost the person with mental illness to return to treatment facility. This further serves to stigmatise the person with mental illness. The section

[131] Ms. Amita Dhanda, Professor and Head, Centre for Disabilities Studies, NALSAR University of Law, Hyderabad submitted that she was of the view that the said Bill was not in harmony with the United Nations Convention on Rights of Persons with Disabilities (UNCRPD) in letter and spirit and was in infringement of Part III of the Constitution.

dealing with 'leave' should be repealed. It also contradicts with person's right to get discharged without any consent from officer in charge/psychiatrist.[132]

TRANSFER AND PRISON SETTING :

The Bill vests the right to transfer the person with mental illness from one mental health establishment to another, within and outside a state to the State Authority and this could go against the interest of the person and his right . This has the danger of abandonment and alienation of the person. A prison set-up coming to a hospital is not a very practical move. In Clause **109 under Chapter XIII , section 7** requires an FIR to be lodged for any mentally ill homeless person. The matter of using the police measures like lodging FIR further increases the stigma and the person could get lost in the system.[133]

NO REHABILITATION SCHEMES FOR MENTALLY DISABLED PERSON:

The Bill is silent on issues of rehabilitation aspects for chronic mental illness. There is no provision for protecting the rights of persons with mental illness who are abandoned/disowned by their family members/who refuse to accept the person back into the family. The Bill also could make a provision for addressing stigmatizing behaviours in family, community and workplace.[134]

QUALIFICATION OF PSYCHIATRIST

There were certain concerns which needed to be addressed viz. high level of qualification needed to qualify as a clinical psychiatrist would act as a

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[132] The views of Dr. S.K. Deuri, Director, Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tejpur, Assam on the Bill on the 16th December, 2013.
[133] The views of Dr. S.K. Deuri, Director, Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tejpur, Assam on the Bill on the 16th December, 2013.
[134] id

dampener as manpower needed to qualify for the post of clinical psychiatrists would be difficult to find in practice.[135]

After going through such pitfalls of the bill there were some suggestions and positive inclinations towards the bill which should not be overridden. They are as follows;

POSITIVE FLOW OF THE BILL:

The following points on the said Bill:

(i) the present Bill laid emphasis on the quality aspect and encouraged transparency in the field of Mental Health unlike previous Acts,

(ii) laid emphasis on ECT treatment not to be given to children;

(iii) the terms 'Advance Directive' and 'Nominated Representative' are in line with the United Nations Convention on Rights of Persons with Disabilities(UNCRPD).[136]

According to the experience of Institute of Human Behaviour &Allied Sciences (IHBAS), Delhi and technical office of State Mental Health Authority (SMHA), Delhi: it stated the following

(i) Differentiation of "treatment order" versus "ad mission order" in the Bill as mandatory admission for involuntary treatment is difficult to apply in the community setting and is also not in the spirit of the government policy of promoting and providing community based mental health services including rehabilitation.

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[135] Dr. Sudhir K. Khandelwal, Professor of Psychiatry, AIIMS, New Delhi during the course of his deposition before the Committee on the 4th, October, 2013

[136] The views of Dr. Shekhar Saxena, Director, Department of Mental Health and Substance Abuse, World Health Organization, Geneva, Switzerland on 11th October, 2013

(ii) Confidentiality of Psychiatric Case Records Related to Right to Information Act must be ensured. Thus the clause related to right to access to medical records must be fine tuned accordingly.

(iii). Provision of Mobile Mental Health Service needs to be introduced in the Bill and specially the provision of legal authorization for emergency medication in the field by Mobile Mental Health Unit team should be mentioned in the draft Bill.

(iv) There should be separate provision in the draft Bill regarding foreign nationals with clear clauses as problems in terms of admission/initiation of treatment/forced treatment/discharge are faced when foreign national is being brought by Police/Magistrate/Embassy.

(v) A provision for district wise Board of Visitors should be made in the Bill and Board of Visitors should be sectorised by making provision for district wise BOV.

(vi) Make it mandatory for all lincensed psychiatric hospitals/ nursing homes to provide emergency psychiatric services.

(vii) The provision of retired judge to be the Chairman of the proposed Mental Health Review Commission may be reviewed as it would be better if some person from user/carer/advocacy group can be given the charge of the Chairman of Mental Health Review Commission.

(viii) Government Hospital Psychiatry Units should be brought under ambit of SMHA in the Bill.[137]

[137] The views of the Delhi Government with the experience of Institute of Human Behaviour &Allied Sciences (IHBAS), Delhi and technical office of State Mental Health Authority (SMHA), Delhi

Positivity in the proposed Bill:

(i) Constitution of Mental Health Review Board in the districts under Section 80 of Chapter XI is a key step to safeguard the rights of persons with mental health conditions;

(ii) the Bill contains sufficient safeguards in regard to the provisions for 'Advance Directive' and 'Nominated Representative'

(iii) unlike previous legislation where the entire onus to protect the rights of the individual with mental condition was on the magistrate, the new Bill places this responsibility on a five member district board on which it would be mandatory to have a psychiatrist on board to review the clinical status of patient and the psychiatrist has major decision making powers in the functioning of the Board.

iv).The majority of Indians who suffer from a mental illness, and in particular those who live in poor and rural circumstances, the unavailability of appropriate, evidence based mental health care was a major impediment to their recovery. The quality of life of such persons and their caregivers was abysmal, often initiating a downward spiral into further poverty, hopelessness and even homelessness.

Social exclusion, violent victimization and human rights abuse were more prevalent in people with mental illness. The lack of access to evidence based treatment and care for mental illness has reached a critical point and a concerted national effort was needed to address this public health crisis.[138]

After considering all the positive and defects of the proposed bill, the hope of being coming out with the new horizon is still awaited by each member with a rising nature of significance in the society without any discrimination and

[138] Dr. Vikram Patel from the Public Health Foundation of India (PHFI) during his deposition before the Commitee on 11th October, 2013.

alienation from the society with the stereotype behaviour involved in the community.

From the above stated analysis we can draw out the inference of the transitional change that has been led in India in regard to the mental illness and the rights involved with the person of mentally disabled group. We could see a transition from victim oriented to medical oriented definitions and recently to rights based approach for the protection of persons with disabled group. The Draft PWD Bill,2012 ,while it demonstrates a huge improvement in terms of visioning and detailing , seems to follow a similar script in many respects – city centrism; continued focus on the formal sector ,employment, neglect of the rural areas, compartmentalised way of looking at skill development/ vocational training without addressing the entire gamut of issues that slf enterprise entail and far fetched social justice delivery mechanisms That are likely to remain out of bounds for the poor and the uneducated among the PWDs. An important facet of mental disability was totally outsighted and leading to the mental health bills which focused mainly on the rights, equality and liberty of the mentally disabled group. This transitional change is a welcoming effort of all persons who are involved for the promotion and protection of the human rights of the mentally disabled group.

Chapter 5

POLITICAL BUREAUCRACY AND MENTAL HEALTH LAWS

5.1General Notion:

The researcher while going through the legislations and other legal provisions was astonished to figure out one of the probable cause for the inadequacy of laws for the mentally ill people is the bureaucratic conflicts and the less bothered nature of the executive and legislature towards these vulnerable and neglected group. The principal reason for the inadequacies in the existing policies is the ambiguous approach of policy makers to disability. The policy makers are pondering with the approach with what they should act on for the purpose of protecting the human rights of the disabled group.

The bureaucratic formula to best suit themselves regarding the approaches to disability as:

Welfare based - people with disabilities are objects of state charity in need of medical treatment and social protection.

Rights based - people with disabilities are citizens with rights, equally capable of claiming these rights and making autonomous decisions based on their free and informed consent as well as being active members of society.

However such thoughts never come into action in reality and projects a differently set up screen for the common public which often displays a new horizon of hope and no action its eternity.

The Census 2001 states that there are 2.19 crore persons with disabilities in India, constituting 2.13 per cent of the total population. One WHO report states that ten per cent of the entire world's population live with disability (650

million) and that there are more people living with disability in India than in any other country. The picture gets its substance in the following manner:

No census, No statistics, and No problem.

The assumption carried out by the authorities in the mind : **no census, no statistics, and no problem**. The clear failure of the Census Commission to make any attempt to collect statistics on disability until 2001. And now with a 2.13 per cent estimate in the 2001 census, the contentious status of figures for disability raises a fundamental obstacle to framing and implementing effective policies throughout India.[139]

The principal reason for the inadequacies in existing policy can be attributed to the ambiguous approach of policy makers to disability. The existing law perceives a person with disability to have some sort of a 'deficit', in need of social compensations from the government: he/she is not a productive human resource on a par with other members of society.

Of all people living with disability, 35.9 per cent belong to the 0 to 19 years age group, which in absolute terms amounts to 7 million young people. Across the subcontinent 90 per cent of India's 36 million children with physical and mental disabilities aged between 4-16 years are out of school.

5.2 CONFLICT BETWEEN DEPARTMENTS:

Now, when we move to the technicality of the actions of the legislature there is an ongoing conflict which department should give its prime focus on the disability group.

The prime focus of the Union Ministry of Social Justice and Empowerment is rehabilitation, not education, and education is not part of its agenda

[139] CLRA Policy Brief for Parliamentarians, Indian Disability Laws - an obsolete picture, Policy brief series: No. 5; 2008 August

Currently, the education of disabled children does not fall within the purview of the Human Resource Development (Education) Ministry, but is instead the responsibility of the omnibus Ministry of Social Justice and Empowerment.. There is also no synchronisation between the ambitious dreams of Education for All - Sarva Siksha Abhiyan (SSA) - drawn up by the Ministry of Human Resource and Development, and the objective of integrated schooling outlined in the Persons with Disabilities Act, 1995.[140]

5.3 NEGLECT OF THE MENTALLY DIASBLED

One more interesting case of social injustice through disability laws concerns people living with mental illness. The mental illness category has been officially recognised by the PWD Act. The recognition given to mental illness is more by default rather than by intent. The very definition of mental illness in the PWD Act, is by elimination rather than explanations since 'mental illness' is defined as any mental disorder other than mental retardation.[141]

Yet, they are denied any employment quota: even free education is not accessible since mental illnesses are in most cases diagnosed after the age of 18, after which point free education is embargoed under PWDA. The definition of mental illness itself is loaded with concepts of illness and dysfunctionality more than functionality. The Mental Health Act, 1987, explicitly states that a "Mentally ill person" means "a person who is in need of treatment.

One of the most difficult aspect of the PWD Act is the way the definition of disability operates in relation to people with mental retardation and mental illness. The PWD Act shows very little understanding of the nature of mental disability and current developments in the field. Persons with mental disability

[140] CLRA Policy Brief for Parliamentarians, Indian Disability Laws - an obsolete picture, Policy brief series: No. 5; 2008 August

[141] Jayna Kothari, THE FUTURE OF DISABILITY LAW IN INDIA, 45 (1st edn., 2012).

are constantly under the threat of being excluded from the protection as there exists a long history of prejudice and stigma against them and the PWD Act does not affirmatively seek to protect their rights.[142]

5.4 CONVENTION AND THE UPCOMING LEGISLATIVE AWARENESS

United Nations Convention for Rights of Persons with Disabilities (UNCRPD) was adopted in 2006, which marks a paradigm shift in respect of disabilities (including disability due to mental illness) from a social welfare concern to a human right issue. The new paradigm is based on presumption of legal capacity, equality and dignity. Following ratification of the convention by India in 2008, it became obligatory to revise all the disability laws to bring them in harmony with the UNCRPD. Therefore, the Mental Health Act – 1987 and Persons with Disability Act – 1995 were under process of revision and draft bills have been prepared.[143]

The convention is intended to be a human rights instrument with an explicit social development dimension. It adopts a broad categorisation of persons with disabilities and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms. It clarifies how all categories of rights apply to persons with disabilities to effectively exercise their rights and highlights areas where their have been violated and where protection of rights must be reinforced.[144]

The general principles of the Convention are: recognition of inherent worth and dignity; individual autonomy and independence; non discrimination; full and equal participation; respect and acceptance of human diversity; equality of opportunity; accessibility; equality for men and women, and respect for evolving the capacity of children with disabilities and their right to preserve

[142] Jayna Kothari, THE FUTURE OF DISABILITY LAW IN INDIA, 43 (1st edn., 2012).
[143] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3705679/
[144] Nimushakavi Vasanthi& Sarasu Esther Thomas(Ed), SOCIAL EXCLUSION AND RIGHTS OF PERSONS WITH DISABILITY ,57 (1st edn.,2013)

their identities. Many of these principles appear in existing laws of disability, but the welfare based approach of the government presents major obstacles to all such concepts of empowerment.

Besides the existing rights mentioned in the Acts, there are certain rights under the major themes of life and liberty rights, equality of respect and opportunity, right to association and social participation, right to political participation, right to health and double discrimination in relation to children and women in disability referred to in the CRPD but not appropriately incorporated within Indian disability laws and provisions in other statutes. Interestingly a number of these rights are included in the fundamental rights of the citizen by the Constitution of India, but without mentioning reasonable accommodation for Persons with Disabilities.[145]

5.5 BACKDROP and the way of Mental Health Laws :

In India, disability is largely seen as a product of cultural impediments such as beliefs and stereotypes as well as structural impediments like poverty, lack of development, illiteracy, unemployment and caste, class and gender barriers. PWD are marginalised in education, employment, mobility and other significant life areas. The meaning of disability in India is embedded in this basic struggle for survival and cultural understanding. Prevention and rehabilitation models continue to be relevant in such circumstances.[146]

In independent India following the policy of welfare, the National Council for Handicapped Welfare was set up to frame policy guidelines for the entire country and to prioritise disability programmes. This council, comprising central and state ministers and rehabilitation experts, regulated the activities

[145] CLRA Policy Brief for Parliamentarians, Indian Disability Laws - an obsolete picture, Policy brief series: No. 5; 2008 August

[146] Economic and political weekly, february 5, 2011 vol xlvi no 6

of the central and state governments and of voluntary sectors.[147] Most of the rehabilitation services in India followed the biomedical model in which hospitals and primary health centres played a key role. Disability was viewed as a diseased state and the emphasis was on curing, correcting or attempting to ameliorate the problem so that PWD became as "normal" as possible.[148]Almost all the older organisations acted as service providers working with the idea of rehabilitation.

Phase 1980:

The 1980s saw a shift in the policy frame, from welfare to development and marked the phase where the disabled now figured not as recipients but as participants in the development process. The Decade of Disabled Persons (1983-92) marked another shift in the whole debate about the goals of rehabilitation. With enactment of the Persons with Disabilities Act, 1995 (19), by the Indian Parliament stage was set. This comprehensive law ensures equal opportunities, protection of rights and full participation of people with disabilities in all spheres of national life. With this, the government did away with charity and welfare based models of rehabilitation. The Act guarantees equal rights, with provision of imprisonment for those who indulge in discriminatory practices. This period witnessed the greater interest and participation of international NGOs and the emergence of local NGOs in partnership with government working at the community level.[149]

[147] Id

[148] Economic and political weekly, february 5, 2011 vol xlvi no 6

[149] Economic & Political Weekly, february 5, 2011 vol xlvi no 6 ,67

Phase :1980-90s

Several factors were involved in the rise of disability movements in the late 1980s and 1990s. Among these one might mention a much more accountable state policy, the strong presence of women's movements, the interest and push of international agencies, the presence of which created more conducive space for the political mobilisation of marginalised groups such as the disabled. The passing of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, in 1995 owes much more to international pressure than to lobbying and protests by disability rights groups.

A simple comparison with Disability Rights Movement(DRM) in the west indicates that they had to wage a much longer struggle and demonstrate a much stronger presence for passing of the amendments. In India, this phase saw groups being formed by disabled activists for claiming their political, legal and social goals by adopting rights-based approach. In the 1990s, globalisation further determined the course of DRM in the Indian context especially through larger international influences, stronger presence through local NGOs, and easy availability of funding, greater possibility of networking and faster and productive information flow through the web.[150]

5.6Social Movement organisations:

Disability rights groups, however, are diverse in nature as reflected in their definitions of disability and strategies of activism. To make sense of the diverse nature of organisations which loosely form movements, the concept of social movement organisations (SMO) is useful as it allows us to locate heterogeneities in terms of ideologies and practices of the groups which at

[150] Economic & Political Weekly, february 5, 2011 vol xlvi no 6 ,67

the same time adhere to the larger goal of the disabled. In studying inter-organisational dynamics of SMO, one could analysed how each of the major SMO of the civil rights movement shaped collective action by carving out its own spheres of organisational activity and producing the leaders, organisers, and tactics that provided the movement with its power and dynamism. At the DRM were essentially engaged in struggles for creating conditions for "independent living" for people with disabilities. More recently, post-structuralist disability scholars have pointed to the limitations of social models and have tried to bring back the impaired body to the discussions on disability. Postmodernist and postcolonial interpretations, on the other hand, expand the scope of the debate by urging us to note the diversities of social contexts and implications of colonial discourses on questions of health, disability and social-structural inequalities.

From 1990s to the present date ;

The DRM in India started only in the early 1990s. The launch of the Asian and Pacific Decade of Disabled Persons in 1993 gave a definite boost to the movement. In that year, the Indian government organised a national seminar in New Delhi to discuss the various issues concerning disabled citizens. The main need that emerged from the seminar was for a comprehensive legislation to protect the rights of PWD. However, it was only after intense lobbying of the Disabled Rights Group (DRG) that the crucial legislation was passed in 1995 .

Till the 1990s, only persons and groups with physical disabilities tended to constitute the disability rights groups and those with **mental and developmental disabilities** were largely left out as these impairments were considered to have their own special issues, which were largely medical in nature. In this case, many NGOs run by families or parents of those with intellectual disabilities emerged who pushed for the passing of regulation, the

National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 which deals with issues relating to persons with developmental disabilities.

The Persons with Disability (PWD) Act 1995 has been the most convenient tool for disability activists pushing their rights-based demands. The movement was further strengthened when the National Centre for Promotion of Employment for Disabled People (NCPEDP) launched Disability 2000, a national campaign in which it collaborated with disability rights organisations, advocacy groups and local governments and formed the National Disability Network. Disability organisations are actively engaged in defining and transforming disability policy and discourse at the local level and beyond.[151]

Much of the literature is either in the form of news, reviews, compilations of articles from across the globe, studies in the form of cases and literature produced by NGOs, or documentation of rehabilitation practices and reflections on policy issues without substantiated facts.

Persons with mental disabilities are constantly under the threat of being excluded from protection as there exists a long history of prejudice and stigma against them and the PWD Act does not affirmatively seek to protect their rights.

Under such failures and defects with the legislations ,the mentally disabled category have faced greater difficulties in regard to the protection and promotion of human rights. Disability itself is a sensitive issue , but inspite of its vulnerability the category of mentally disabled is not attained much of the attention which is the need of the hour. Although various NGOs and SMOs have been working towards the right based approach of the disability but the

[151] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2949925/pdf/IJPsy-46-104.pdf

need of the protection which should have been availed by the mentally disabled group is very minimum .

The Mental Health Act ,1987 although is in consonance with the mentally disabled group but its provisions is now a failure in the present arena where diverse issues and facts have come up and the provisions were very static to some affairs of the mentally disabled and the dignity of such group is not well protected which needs attention.

More than a decade has passed ,the mental health laws have not been revised and even the legislature has not paid any heed to such pain of these vulnerable group. Although the NGOs ,SMOs, have been constantly working and even the ratification of India in The UN Convention Of Rights Of Persons with Disabilities did not arose the legislature which is evident from the pending status of the Mental Health Care Bill, 2013

The Mental Health Care Bill, 2013 seeks to consolidate the legislations related to mental illness and improve the conditions in mental health facilities existing in the country while ensuring the process of appeal by a person admitted to a psychiatry institution, rehabilitation, reintegration with families and community in nonmedical settings. The Bill addresses the issues of mental illness and capacity to make mental health care and treatment decisions; advance directive; nominated representative; rights of persons with mental illness; duties of appropriate government; central and state mental health authorities; mental health establishments; mental health review commission; admission, treatment and discharge. The Bill also consolidates the law regarding the responsibilities of other agencies, restriction to discharge functions by professionals not covered by professional offences and penalties.[152]

[152] http://www.indianjpsychiatry.org/cpg/cpg2009/article7.pdf

The Mental Health Act, 1987 could not protect the rights of persons with mental illness and promote their access to mental health care in the country. In the light of above it was proposed to repeal the Mental Health Act (MHA), 1987 and bring in a new legislation. However the legislatures are still with the less bothered nature which could be seen from the status which still could not bring any new hope for the mentally disabled group. Although the Union cabinet passed its consent and even Rajya Sabha passed its consent over the Bill with the new amendments but the Lok sabha did not consented over the matter resulting in the Pending status of the Bill fading the hope for the mentally disabled group.

Therefore we could analyse that the political bureaucracy and the organs of the government has to arise from their cozy beds and work for these vulnerable group. The social movements, NGOs dedications or the civil society have worked their best to promote and protect the human rights violation of these groups. The need of the hour is the changing mindset of the political bureaucratic departments and the organs of the government to show deep and dedicated concern towards these group of people and show its keen obligatory nature which they had shown while signing the UNCRPD and work actively so that the paperwork comes into action and not a dead letter.

Chapter 6

Challenges to Mental Health Reforms

After analysing the various international and national legislations in regard to the mental health laws , the researcher could get the actual conditions which are revolving with regard to the mental health laws. Human well-being in a country cannot be ensured unless its citizens are physically and mentally fit. Mental health is prone to neglect because it is difficult to detect, difficult to cure and also difficult to explain to the people. The Mental Health Care Bill although taking into consideration various aspects regarding safeguarding their rights and all other allied sectors which are involved in the protection of human right of mentally disabled is still not having a upward progress. There are a huge number of pitfalls in legislative, administrative , manpower to tackle the mental health laws. The most basic challenges which needs immediate change to meet the urgency of protecting human rights of mentally disabled people are as :

6.1Few Mental Health Practitioners and Institutions in India

A recent statistic from the MHFW indicates that about 7 percent of the Indian Population suffers from some form of mental disorder. Another interesting statistic is that 90 percent of these disorders remain untreated. The leading cause behind this paradox is the acute shortage of mental health institutions and qualified mental health practitioners in India. Our large and populous country of 1.2 billion people has about 38 mental health institutions, 3,500 psychiatrists, 500 clinical psychologists, 300 psychiatric social workers and 1,000 psychiatric nurses to treat its mentally ill citizens.[153]

[153] http://jilsblognujs.wordpress.com/2012/12/23/mental-health-law-reform-challenges-ahead/

According to the National Family Health Survey, the private medical sector remains the primary source of health care for the majority of households in both urban areas (70 percent) and rural areas (63 percent) of India. While private players contribute immensely to the health care industry, it remains the case that they generally shy away from investing in mental health institutions. This is mainly due to low policy priority given to mental health sector, strict licensing requirements under the Mental Health Act 1987 and the lack of any special incentive for investing in this sector. Today in India, government health policies mainly focus on communicable diseases like HIV/AIDS, malaria and tuberculosis or on child malnutrition or on reproductive healthcare. Mental healthcare rarely finds mention in the policy. This underscores the importance of this sector and makes the investment environment in such services unattractive and discouraging.[154]

[154] http://jilsblognujs.wordpress.com/2012/12/23/mental-health-law-reform-challenges-ahead/

PSYCHIATRIC BEDS AND PROFESSIONALS

- Total psychiatric beds per 10 000 population 0.25
- Psychiatric beds in mental hospitals per 10 000 population 0.2
- Psychiatric beds in general hospitals per 10 000 population 0.05
- Psychiatric beds in other settings per 10 000 population 0.01

- Number of psychiatrists per 100 000 population 0.4
- Number of psychiatric nurses per 100 000 population 0.04
- Number of psychologists per 100 000 population 0.02
- Number of social workers per 100 000 population 0.02

- Number of Mental hospitals 43 with a bed capacity of 20,000

Source WHO Country Profiles: India 2001

II.Private Investment :

Another factor that reduces the likelihood of private investment in mental health care is the strict licensing regime set up by the Mental Health Act 1987; the legislation that currently governs the mental health sector. This Act lays down a complicated procedure of issuing a non-transferable and non-heritable license to a person who wishes to open a mental healthcare institution. The act further discriminates between government established institutions and privately maintained institutions by exempting the government institutions from the statutory requirement of obtaining a license. If private participation is to be encouraged, this system of licensing needs to be rationalized. The Mental Health Care Bill 2012 goes a long way in this regard. The bill replaces the stringent licensing system with a simpler system

of registration. The registration unlike a license is not linked to a particular person and is freely transferable for instance on the sale of the institution. It also allows the institution an appeal to the High Court if the grant of registration or renewal of registration or cancellation of registration is refused by the appropriate authority. While the bill seeks to relax the laws governing the setting up of mental health institutions it must ensure via its provisions that this does not in any way affect the quality of health care provided in these institutions.[155]

III.Rural health care

Most of the institutions and practitioners are located in urban areas. This creates a serious problem in a country like India where over 70 percent of the population lives in rural areas.

To ensure that rural areas also benefit from private investment, the incentives given to invest in rural areas could be greater than those given for investment in urban areas. Another way in which the presence of mental health facilities in rural areas can be increased is by proper implementation of the District Mental Health Program which was initiated by the Government of India in 1996. Currently, the program is under implementation in only 123 of the total 657 districts of the country. A proper implementation of the program would go a long way towards ensuring that rural areas have adequate mental care facilities in near vicinity.[156]

IV.Poor Quality of Mental Health Institutions

The unacceptable quality of medical care provided to the mentally ill in the existing mental health institutions in our country shows the level of protection given to the mentally disabled persons. It would not be an overstatement to

[155] http://jilsblognujs.wordpress.com/2012/12/23/mental-health-law-reform-challenges-ahead/

[156] http://jilsblognujs.wordpress.com/2012/12/23/mental-health-law-reform-challenges-ahead/

say that the patients who receive mental health treatment in India are treated in a most inappropriate and inhuman way in our mental institutions. The institutions usually resemble prisons where the mentally ill are debased and deprived of their dignity. They are made to live in unacceptable living conditions and are shackled down in chains for long hours.

They are fed unhygienic prepared unwholesome meals, are subjected to painful medical procedures without their consent, are regularly beaten and in some cases are also subjected to sexual assault. Sometimes they are sterilized on the basis of a medical myth that sterilization cures mental disability. In essence, the patients never receive adequate treatment. Rather the treatment aggravates their condition and makes them sick and infirm for life completely eliminating any hope of rehabilitation or a chance of leading a normal life. Any mental health care legislation must develop a structured mechanism for ensuring that our mental health institutions do not fall short of the internationally accepted standards of treatment and care.[157]

The Mental Health Act 1987 and the State Mental Health Rules 1990 provide detailed safeguards to ensure that the health institutions meet the statutory standard. While building upon this legacy, any new legislation must incorporate the minimum standards laid down in the Disability Convention of 2006 and the MI Principles of 1991. Further, steps must be taken to bring government maintained institutions under the purview of these regulatory procedures. It may be noted here that the Mental Health Act 1987 is quite inconsistent with the principles and safeguards laid down in the aforesaid international instruments and as government hospitals are deemed to be licensed institutions under the act, it is unclear whether the procedures laid down for revocation of license in cases of non-compliance are applicable against government facilities.[158]

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[157] http://jilsblognujs.wordpress.com/2012/12/23/mental-health-law-reform-challenges-ahead/

[158] *Id*

V. Consent of mentally ill patients

Another aspect that would have to be substantially addressed in mental health legislations is with respect to consent of the patient to receive treatment. It is a cardinal principle of medical science that no one may be subjected to any medical procedure without his/her express consent and such procedure may not continue after the person has withdrawn his consent. Mental Healthcare raises complex questions regarding consent. The Mental Health Care Bill 2013 provides innovative solutions to the problem of consent. The bill allows persons to register an 'advance directive' with the appropriate mental health board[159]. An 'advance directive' is a legal document containing details of the kind of treatment a person wishes to receive or does not wish to receive in the event of mental illness. It also contains the details of the person's nominated representatives who are entitled to give consent on the person's behalf when he is not in a position to give consent. The bill provides procedures for amendment or cancellation of advanced directives and also gives powers to the Central or State mental health board to review advance directives and to suspend or amend them in some special cases (for instance when the advance directive has been made under force, coercion, undue influence etc. or when it was made without proper knowledge). While many groups are touting advance directive as a foolproof solution to the problem of consent, it remains to be seen how this statutory tool would operate in real life. This provision has been opposed on the grounds that it would be susceptible to gross misuse especially in rural areas where the patients are illiterate and are not aware about their rights.[160]

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[159] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3777341/?report=classic

[160] http://jilsblognujs.wordpress.com/2012/12/23/mental-health-law-reform-challenges-ahead/

VI .Rehabilitation and Social Awareness

Another issue that the bill attempts to address is rehabilitation and social awareness. These concepts are inter-related. The extent to which a patient can be restored back in his life (family, community and occupation) depends on the social understanding of mental illness and the attitude of the society towards the mentally ill.[161]

A society which rejects the mentally ill or which despises them cannot possibly assist in rehabilitation of the patient. As societal attitudes are shaped to a large extent by education, an awareness program which aims towards creating social understanding about mental illness can directly assist in making the society more suitable for rehabilitation of the patient. Mental Health Act 1987does not contain any provisions regarding social education or patient rehabilitation.[162] The Mental Health Care Bill 2013 addresses this lacunae and creates an obligation on the Central and State governments to spread awareness about mental illness and its appropriate treatments. The Bill lays emphasis on lowering the stigma associated with mental illness so that a patient's rehabilitation in the society may be facilitated. It may be noted here that a proper implementation of the aforesaid provisions may go a long way in debunking the long standing myths about mental illness (like mental illness is caused due to demonic possession or that mental illness is incurable) and make the society a better place for the mentally ill.[163]

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[161] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)61620-7/fulltext

[162] http://www.ncbi.nlm.nih.gov/pubmed/21407970/

[163] http://jilsblognujs.wordpress.com/2012/12/23/mental-health-law-reform-challenges-ahead/

Analysis:

From the above facts and situations and the various figures which could be seen we can state that it is a very pathetic state of affairs whereby we have not taken any action with the need of the people . We are still with the banner of slogans , paper works and debates and discussion. We are far lagging behind to protect and promote the violations of human rights of these disabled group. The inadequate attention and the presupposition of the work of the old laws and its functioning is nowhere landing in any positive horizon of growth and progress but rather more pitiable sights of affairs.

The need of the hour is the execution of modification made in the old act and laws should be in consonance of the varied needs of the mentally disabled people. We should act rationally and logically keeping in view of the sensitive nature of the disabled group. It is the protection which they are expecting from the authorities not a share of property from which they will be earning profits .The expectation of these group is very minimum as compared to the abled persons who is enjoying almost all the basic amenities of life. We should now be little more compassion towards this group of people and pledge ourselves to work in their favour and leave aside all the political , selfish interest or profit making wishes and support them a little so that they could also get a little of what they are expecting as a human being and respect their human dignity to the most.

Although we are ratifying international documents and trying to act in their best interest to protect the human rights but in true essence we are not showing the much effort from all categories of people involved in it . The series or the circle of the persons involved in protecting their rights should come up and dedicatedly act towards their protection and use the most time in reformation and bring equity and justice to the people suffering from such disability and helping them to live a dignified life.

"A little act of ours will bring smiles to a lot of people."

Chapter 7:

Concluding Observations

In pursuance of the detailed and critical analysis of mental health laws and mental health legislations in the aforesaid chapters, the researcher had gone through various phases in dealing with the whole situation and circumstances of the mental disability . The sensitivity of the issue can never be felt unless one goes into the deep intricacies and the detailed analysis. Although there are various literature, views, opinions, discussions, debates etc. which are held all over the world but in essence a huge bundle of work is left to be accomplished.

The researcher in this last part of the research is in such a position that after going through all analysis and critical views in regard to the development and upcoming prospects of the mental health legislation, the researcher could see the actual ins and outs of the whole situation in regard to the mentally disabled group. There is a paradigm shift in the mentally disabled laws from the antiquity to the present era of globalisation. However , there are lots of issue which needs great attention and concern which are kept aside for later discussions and analysis.

The progress and prospects towards mental disability laws is moving upwards in the ladder of positive growth and development. The proper enactment of laws and execution will show a new horizon and hope to these

vulnerable group who needs the utmost attention which if not given will result in further victimisation in coming days.

Disability rights movement in India is still trying to register its presence in the public sphere. It has, however, undoubtedly touched the lives of masses of persons with disability and pushed for a more disabled friendly environment in the country.

Given the enormity of a country like India, dealing with heterogeneous communities and issues of stark underdevelopment, striking differences in the backdrops of western DRM and Indian DRM are visible. In India, the provision of accessible environment, disability support services, job reservation and rights issues have to be contexualised within the larger picture of deprivation and marginalisation. The State has played a very important role in taking the lead in formulating acts and policies, initiating disability prevention and rehabilitation programmes and promoting organisations affecting the lives of millions of disabled in the country. With the passing of the PWD Act and with the India ratifying the UN convention on the rights of the disabled, the ground was laid to demand rights to citizenship, respect and opportunities for persons with disabilities. To establish disability studies as a discipline too, state support is critical and positive responses have been coming from universities. Unlike the women's movement in India where changes in law and policies followed aggressive protests and lobbying by women's activists, in the case of the DRM, the shifts in the State's development policies itself triggered the background for disability rights activists to come together.

The role of transnational discourses on disability rights flowing from international funding organisations further helped to consolidate the disability rights group identities in the Indian context. With the beginning of the cross-disability movement, a political identity for the disabled was claimed and

asserted in the public sphere. From the beginning, gender has also been incorporated as a major aspect of disabled identity owing to the already existing fertile ground laid for it by disabled feminist scholars in the west.

Unlike the western countries, where state and international agencies are looked upon by DRGs as matter of rights, in developing countries with poor social security mechanisms, much is left to families and communities as they have traditionally been responsible for taking care of their disabled members. While acknowledging this fact and also pointing to shrinking community and family support mechanisms, the State is being reminded of its responsibility towards disabled citizens. Pointing to disabled unfriendly attitudes DRGs ask for the removal of social barriers too through legal interventions, disabled friendly policies and a supportive bureaucracy.

Though many rights groups are informed by the social model and have moved away from charity to self-advocacy approach, in practical strategies they adopt biosocial approaches where disability is seen both as a medical condition and a product of social oppression. CBR initiatives which always adopted a rehabilitation approach have also made room for rights-based perspectives. Groups have grown into organisations and are more professionalised and face routinisation.

The role of individual activists is very crucial as they have made DRGs visible and also helped to claim an identity of DRM by and for PWD. Their limitations are in terms of relying on western models and perspectives, narrow focus on jobs, reservations and concessions, little understanding of the grass roots and an inability to deal with diversity. They use slogans like "exclusion and discrimination" without much consideration of diverse contexts where inequalities of several kinds always exclude some people from some contexts. In fact their inability to consider the positive cultural resources like undocumented histories of the disabled, family and community support

mechanisms and also a much more responsive state creates a myopic vision.

In the Indian context, a general disabled friendly attitude is often construed as based on charity or pity approach, but family support is often taken for granted. However, in the west, relative lack of family or community support pushed disabled activists towards ideas of independent living. The fact of exclusion of the disabled from certain spheres of life in the Indian context is supported by surveys, but community support is relatively easier to come by. Except in cases of certain severe disabilities and illnesses like leprosy, TB or AIDS, social stigma is not very strong and PWD and their families find ways to deal with it .

A general suspicion on the part of disability rights activists working with government-funded organisations, or those run by "regular" persons and a belief that experience is essential to theory and practice may prove to be limiting in the long run. The heterogeneity across organisations, however, points to convergence and divergence required for working on diverse issues, with different understandings of disability to deal with the complex realities of the lives of the disabled in India.

The personal aspirations and co-option of many activists in committees in India and abroad is pointing towards depoliticisation. Political participation remains one of the most neglected issues in DRM. One of the major implications of the assertion of disability rights is its growing visibility in the public discourse in the Indian context. In the last one decade or so, disability issues are being raised in the media, in NGO documents and policy documents of the State.

The challenges before the DRMs are enormous. The recognition of diversities, historical, social structural arrangements, fast changing social, political and economic dynamics have posed new challenges. Building a strong movement requires a better and nuanced grasp of the complexity of socio-political contexts which the disabled inhabit. Lessons from the past and learning from other movements like the women's movement will go a long way in strengthening DRMs in the Indian context.

TESTING OF THE HYPOTHESIS: After the analysis of the whole subject matter and taking into consideration the following hypothesis :

> ***" Mental health legislations are not in adherence to the present day needs of the mentally disabled group which results in victimisation and lack of protection of their human rights."***

The researcher while going through the study of mental health legislations and the protection of human rights of the mentally disabled group have cross across varied dimensions of phases whereby from antiquity to the present arena the platform of changes has been occurring but its impact is not as compared to the initiatives taken up. The credit from charity based to the rights based could be seen very prominent in the coming days . However, the proper execution and implementation of the proposed laws is still a dream to come true.

During the course of the research the transition of changes that have occurred could testify the proposed hypothesis which is seemingly is proved with the enduring failures and the non implementation of laws .The bureaucratic set up and the differences in the approaches and the conflicting departments often deviates the track of the policy makers ending up with only proposed hopes and wishes but certain development of the judiciary cannot be outsighted as it has actively taken into consideration the intricacies of the

issues of the vulnerability and have tried in the protection and promotion of human rights.

Mental disability and mental health care have been neglected in the global debate on health, human rights, and equality. Within the mental health field itself, much of the debate has been at a theoretical level, with a focus on stigma concepts and attitudes rather than on acts of discrimination. A shift of focus from stigma to discrimination is needed, as this would place the mentally disabled in a position of parity with respect to anti-discrimination legislation and the human rights agenda. The development of mental health policy and legislation within countries that have not established formal equality for mental disability is indeed a priority, and there are a number of global institutions actively engaged in this task. While highly necessary and laudable, these efforts to achieve formal equality should not stand alone, without similar advocacy focused on the achievement of substantive equality for persons with mental disabilities. Real life factors such as poverty; illiteracy; homelessness; war and displacement; discrimination based on ethnicity, race, and gender; social exclusion; stigma; and abuse all impact the mentally ill individual's ability to access services and realize full personhood within their communities. These factors also play a role in enhancing individual risk for mental disabilities, and so, too, they act to hinder recovery and reintegration into social and occupational life.[164]

A rights-based approach to mental disability means domesticating treaties such as the United Nations Convention on the Rights of Persons with Disabilities. Using the framework of this convention and others like it, it is possible to formulate an active plan of response to the multiple inequalities and discrimination that exist in relation to mental disability within our communities. While health care professionals arguably have a role to play as

[164] Lance Gable & Lawrence O. Gostin, Supra Note 49.

advocates for non-discrimination, and justice, it is persons with mental disabilities themselves who have the right to exercise agency in their own lives and who, consequently, should be at the center of advocacy movements and the setting of the advocacy agenda. In support of this agenda, health care professionals need to become activists for the social and economic transformation of society into an environment in which those with mental disabilities, experience substantive equality.[165]

[165] *Id.*

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Annexures

Annexure I

The 1971 Declaration on the Rights of Mentally Retarded Persons:

The Declaration lays down following principles:

1. The mentally retarded persons has to the maximum degrees of feasibility the same rights as other human beings.

2. The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.

3. The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities.

4. The mentally retarded person, whenever possible should live with his own family, or with foster parents and participate in different forms of community life. The family with which he lives should be provided with assistance.

5. The mentally retarded person has a right to qualified guardian when this is required to protect his personal well being and interests.

6. Disabled persons are entitled to have their special need taken into consideration at all stage of economic and social planning.

7. Disabled persons have the right to live with their families or with foster parents an to participate in all social, creative or recreational activities.

8. Disabled persons shall be protected against all exploitation, and treatment of a discriminatory, abusive or degrading nature.

9. Disabled persons shall be able to avail themselves of qualified legal aid when such aid proves indispensable for the protection of their person and property. If judicial proceeding are instituted against them, the legal procedure applied shall take their physical and mental condition fully into account.

Annexure II

International Year of Disabled Persons(1981).

The objectives set forth by the General Assembly are :

1. Helping disabled persons in their physical and psychological adjustment to society.

2. Promoting all national and international efforts to provide disabled persons with proper assistance, training, care and guidance, to make available to them opportunities for suitable work and to ensure their full integration in society.

3. Encouraging study and research projects designed to facilitate the practical participation of disabled persons in daily life, for example, for improving their access to public buildings and transportation systems.

4. Educating and informing the public of the rights of disabled persons to participate in and contribute to various aspect of economic, social and political life.

5. Promoting effective measures for the prevention of disability for the rehabilitation of disabled persons.

ANNEXURE III

Article 14. Equality before law.–The State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India.

Article 15. Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth.–

(1) The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex, place of birth or any of them.

(2) No citizen shall, on grounds only of religion, race, caste, sex, place of birth or any of them, be subject to any disability, liability, restriction or condition with regard to–....."

Article 16. Equality of opportunity in matters of public employment.–

(1) There shall be equality of opportunity for all citizens in matters relating to employment or appointment to any office under the State.

(2) No citizen shall, on grounds only of religion, race, caste, sex, descent, place of birth, residence or any of them, be ineligible for, or discriminated against in respect of, any employment or office under the State....."

Article 38. State to secure a social order for the promotion of welfare of the people. and .Article 41. Right to work, to education and to public assistance in certain cases

SEVENTH SCHEDULE

[Article 246]

List I–Union List

Entry No. 13. Participation in international conference, associations and other bodies and implementing of decisions made thereat.

List II–State List

Entry No. 9. Relief of the disabled and unemployable.

List III–Concurrent List

Entry No. 16. Lunacy and mental deficiency, including places for the reception or treatment of lunatics and mental deficients.

ELEVENTH SCHEDULE

[Article 243G]

Entry No. 23. Health and sanitation, including hospitals, primary health centers and dispensaries.

Entry No. 26. Social welfare, including welfare of the handicapped and mentally retarded.

Article 243W]

Entry No. 6. Public health, sanitation conservancy and solid waste management.

Entry No. 9. Safeguarding the interests of weaker sections of society, including the handicapped and mentally retarded

Annexure IV

Mental Health Act,1987

Objectives of the act

1. To establish central and state authorities for licensing and supervising the psychiatric hospitals.

2. To establish such psychiatric hospitals and nursing homes.

3. To provide a check on working of these hospitals.

4. To provide for the custody of mentally ill persons who are unable to look after themselves and are dangerous for themselves and or, others.

5. To protect the society from dangerous manifestations of mentally ill.

6.To regulate procedure of admission and discharge of mentally ill persons to the psychiatric hospitals or nursing homes either on voluntary basis or on request.

7. To safeguard the rights of these detained individuals.

8. To protect citizens from being detained unnecessarily.

9. To provide for the maintenance charges of mentally ill persons undergoing treatment in such hospitals.

10. To provide legal aid to poor mentally ill criminals at state expenses

11. To change offensive terminologies of Indian Lunacy act to new soother ones

Annexure V

Positive strengths of the mental health Act

• Creation of Central and State Mental Health Authorities- a welcome step to safeguard the interests of the mentally ill person under one authority

• Procedure for admission and discharge of voluntary patients have been simplified and liberalized. In this act, no consent from two visitors is required as well as no written request is required

• Minor can be admitted with the consent of a guardian under this act. This provision is not there in the Indian Lunacy Act, 1912.

Separate provision for admission of involuntary patients under category "Admissions Under Special Circumstances"

• Special centres for special population like drug addicts, under 16 years, mentally ill prisoners etc.

• Establishment and maintenance of psychiatric hospitals and psychiatric nursing homes in private sector which was not in the earlier law

• Discharge procedure have been made easy and more simplified

• There are new different addition in this law like protection of human rights of mentally ill persons, penalties, cost of maintenance and management of properties of mentally ill persons

• Prohibition on any research on subjects without proper consent

Annexure VI

Human Rights and Mental Health Act, 1987

Section 81 provides that-

1. No mentally ill persons shall be subjected during treatment to any indignity whether physical or mental or cruelty.

2. No mentally ill person under treatment hall be used for the purpose or research unless (i) such research is of direct benefit to him for the purpose of diagnosis or treatment, or (ii) such person being a voluntary patient has given his consent in writing or where such person is incompetent by reason of minority or otherwise to give valid consent, on his behalf, has given his consent in writing, for such research.

3. Subject to any rules made in this behalf under Section 94 for the purpose of preventing vexatious or defamatory. Communication or Communications pre-judicial to the treatment of mentally ill persons, no letter or other communications sent by or to a mentally ill persons under treatment shall be intercepted, detained or destroyed. The doctrine of informed consent is partially recognized under the Mental Health Act 1987, when a patient voluntarily admits himself in the hospital or accepts treatment without any admission.

When a mentally ill patient detained as an inpatient and does not have property to bear the cost of treatment, in such cases his expenses shall be borne by the Government of the State. (Sec. 78) If a mentally ill patient owns a property and he is not in a position to manage his property, the Court may entrust the management of such property to the Court of wards, Section 54(1).

Under Section 97 of the Act when a mentally ill person is not represented by a legal practitioner in any proceedings under Mental Health Act 1987 before a District Court or a Magistrate and such a patient does not have sufficient mean to engage a legal practitioner then the District Court or Magistrate shall assign a legal practitioner to represent him at the expense of the State.

The Good faith clause (Section 92) dispenses with accountability of the government or its servants for any negligence in the care and treatment of inmates of asylums. The provision for legal aid to the mentally ill (Section 91) restricts the facility to proceedings before a District Court or a Magistrate. The Act is silent on the right to legal aid and counseling at all stages including the facility of approaching the High Court or the Supreme Court.

Annexure VII

Essential Features of the Mental Healthcare Bill 2013:

- The Central and State Mental Health Authorities will continue as regulatory agencies.
- Any person, with or without mental illness, can make an Advance Directive (AD) stating how he/she wishes to be treated for a future mental illness and also how he does not wish to be treated. Such an AD can also be challenged by families, professionals etc. This provision is included to meet the CRPD's requirement for protecting legal capacity of persons with mental illness.
- A person with mental illness can appoint a Nominated Representative to take decisions for him/her. This provision too is included to meet the CRPD's requirement for protecting legal capacity of persons with mental illness.
- A person with mental illness has the right to live in, be part of, and not segregated from society. Government has an obligation to provide for half way homes, community caring centres etc.
- The MHC Bill, 2013 makes a clear assertion that all persons have a right to access mental healthcare and treatment from mental health services run or funded by the Government. Such services should be affordable, of good quality and available without discrimination.
- A person with mental illness has the right to be protected from cruel, inhuman and degrading treatment. Some treatments currently being used will be prohibited, most importantly, Electro-convulsive Therapy given without anaesthesia and the practice of chaining patients to their beds.
- The Bill recognizes that the overwhelming majority of the mentally ill are in their homes. Caring for a mentally ill person is financially and

emotionally draining for any family. A significant portion of the wandering homeless have mental illness. The Bill therefore addresses the needs of families and caregivers and the needs of the homeless mentally ill.

- In some instances of advanced illness, when the person is not in a position to make decisions for himself/herself, it may be necessary in the best interest of the health and welfare of the person with mental illness to be admitted, to a treatment facility with the support of their nominated representative. The Bill sets out in some detail the measures established to ensure that all cases of supported admission are reviewed without loss of time. This is well within the provisions of Article 12 of the UNCRPD.
- All cases of such supported admissions will be reviewed by a Mental Health Review Commission which will function through District Boards. The essential task of the Commission/Boards is to ensure that admission of any person to a mental health facility is the least restrictive care option under the circumstances.
- The MHC Bill has provisions for Central and State Mental Health Authorities (CMHA & SMHA) and a Mental Health Review Commission (MHRC). This is the structure followed in all modern and progressive legislations. The CMHA and SMHA are largely administrative bodies concerned with regulating/setting standards for mental health facilities, maintaining registers of such facilities and of mental health professionals and carry out training functions. The composition of these bodies reflects these functions.
- The MHRC is a quasi-judicial body to provide an independent oversight to the functioning of mental health facilities and protect the rights of persons with mental illness in these facilities. It thus meets the need for an independent review mechanism as required under the

CRPD. The composition of the MHRC reflects in quasi-judicial function(headed by a retired High Court Judge and staffed with District Judges).

- The direction and thrust of the MHC Bill, 2013 is that the State assumes the responsibility for providing adequate health care, including support to caregiving facilities. At present the District Mental Health Programme (DMHP) operates in 123 districts in the country though it must be recognized that delivery of healthcare services is not optimal essentially for the reason that the DMHP requires every district to have a full complement of appropriately trained professionals. Though the National Mental Health Programme .(NMHP) offers financial support to state governments to increase the number of seats in medical colleges and nursing colleges in the appropriate disciplines, progress has not been fast. The 11th Plan outlay for NMHP including DMHP was Rs.623 crores. In a parallel exercise to the drafting of the MHC Bill 2013, the DMHP has been substantially reworked with a focus on community and home based care as required by the MHC Bill, 2013."[166]

[166] SEVENTY-FOURTH REPORT On THE MENTAL HEALTH CARE BILL, 2013 (Ministry of Health and Family Welfare)