The Mental Healthcare Act, 2017 – An Analysis

A Dissertation submitted to the National University of Advanced Legal Studies, Kochi, in partial fulfilment of the requirements for the award of LL.M Degree in Constitutional and Administrative Law

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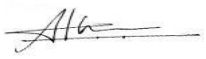
CERTIFICATE

This is to certify that **Ms. Elwin Wilson P, Reg. no. LM0120008** has submitted her dissertation titled, '**THE MENTAL HEALTHCARE ACT, 2017 – AN ANALYSIS**', in partial fulfilment of the requirement for the award of Degree of Master of Laws in Constitutional and Administrative Law to the National University of Advanced Legal Studies, Kochi under my guidance and supervision. It is also affirmed that the dissertation submitted by her is original, bona fide and genuine.



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I declare that this dissertation titled, '**THE MENTAL HEALTHCARE ACT, 2017 – AN ANALYSIS'**, which I have researched and submitted to The National University of Advanced Legal Studies in partial fulfilment of the requirement for the award of Degree of Master of Laws in Constitutional and Administrative Law, under the guidance and supervision of **Dr. Athira P.S**, is an original, bona fide and legitimate work. It has been pursued in academic interest. This work or any type thereof has not been submitted by me or anyone else for the award of another degree of either this University or any other University

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LIST OF ABBREVIATIONS

CPA	Care Program Approach
CPT	European Committee for Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CRPD	The United Nations Convention on Rights of Persons with Disabilities
CTO	Community Treatment Order
DMHP	District Mental Health Programme
ECT	Electroconvulsive Therapy
ECHR	European Court of Human Rights
EU	European Union
ICCPR	International Covenant on Civil and Political Rights, 1966
ICESCR	International Covenant on Economic, Social and Cultural Rights, 1966
IMCA	Independent Mental Capacity Advocate
IPC	Indian Penal Code
IPS	Indian Psychiatric Society
LPA	Lasting Power of Attorney
MI Principles	The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991)
NMHP	National Mental Health Programme
NHRC	National Human Rights Commission
NHS	National Health Services
NSF	The National Service Framework for Mental Health
OAS	Organisation of American States
PAHO	Pan American Health Organisation
The Standard Rules	The Standard Rules for the Equalisation of Opportunities for Persons with Disabilities (1993)
UDHR	Universal Declaration of Human Rights,1948
WHO	World Health Organisation
WMA	World Medical Association
WPA	World Psychiatric Association

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CHAPTER 1

INTRODUCTION

1.1. MENTAL HEALTHCARE: APPROACHES TO MENTAL DISABILITY AND CHALLENGES TO MENTAL HEALTHCARE

The study analyses the current legislative framework adopted towards care of and protection of rights of persons with mental disability in India.[1] This chapter outlines certain fundamental concepts relevant to understanding the legislative approaches adopted towards persons with mental disabilities in mental health legislation before discussing the scope of the study.

1.1.1. WHO DEFINITION OF MENTAL HEALTH

The WHO defines mental health as "a state of well-being in which every individual realises his or her own potential, can cope with the stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community." However, there need not be any correlation between good mental health and the absence of mental disorder. People with mental disabilities can achieve "good levels of well-being," living a meaningful and satisfying life, "within the constraints of painful, distressing or debilitating symptoms of mental disabilities."[2]

1.1.2. MENTAL ILLNESS

The WHO defines Mental illness as a diagnosable disorder with a set of symptoms, including abnormal thoughts, emotions, behaviour, and relationships. (WHO 2011a.) A mental illness can significantly affect a person's daily life, mental, emotional, and social abilities.[3]

1.1.3. MENTAL DISABILITY

The term "mental disability" includes persons with mental illnesses or disorders and persons with intellectual disabilities. The term "psychosocial disability" is preferred by many people advocating for disability rights as it shifts away from the medical model of disability and lies

[1] The subject under study, the Mental Healthcare Act, 2017, is aimed towards the "protection of persons with mental illnesses". However, the international legal instruments and comparative legislative framework that comes within the scope of this study makes references to the broader term "mental disability" as opposed to "mental illnesses". This Chapter may thus interchangeably make references to "mental illness" and "mental disability" to address the same subject, despite the literal differences in the meaning and scope of use of the two terminologies.

[2] WHO, *Social Determinants of Mental Health* 12 (2014), https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf?sequence=1 (last visited Feb 27, 2021).

[3] Abraham P. Francis & Beth Tinning, *Introduction in* SOCIAL WORK IN MENTAL HEALTH - CONTEXTS AND THEORIES FOR PRACTICE xxiii (2014).

within the social model of disability. Further, it focuses on the interaction between the psychological and social components of disability.[4]

1.1.4. MODELS OF DISABILITY

The models of disability underlie the legislative approach towards persons with mental disabilities in mental health legislation. The models are reflective of the evolving common perceptions towards persons with mental disabilities. A discussion on the different models of disability would help trace how the view towards persons with mental disabilities and their rights have evolved.

1.1.4.1. Medical Model of Disability

Under the traditional view towards disability called the medical model[5] or the public health approach, mental disability was viewed solely as a health issue that required "a health services response" or a "medical solution". It defines disability as the restriction in an individual's "ability to perform tasks." Further, it defines handicap as "the social disadvantage that could be associated with either impairment or disability."[6] The legislative approach under this model focused on providing special monetary benefits or infrastructural provision to persons with disabilities. It did not consider making any attitudinal or structural environmental changes for their welfare.[7] Due to the perceived incapability to perform social functions, persons with disabilities had limited social participation and were systemically excluded from social opportunities such as social welfare benefits.[8]

1.1.4.2. Social Model of Disability

In contrast to this approach lies the social model of disability as theorised by Michael Oliver, a disability activist and scholar.[9] He viewed disability as something imposed upon persons, over and above their impairment, by "an oppressive and discriminating social and institutional

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[4] Felicity Callard et al., *Chapter 1: Introduction*, *in* MENTAL ILLNESS, DISCRIMINATION AND THE LAW - FIGHTING FOR SOCIAL JUSTICE 14 (First ed. 2012).

[5] Medical model of mental disability. This model of disability is focused on the disability experienced by the individual, based on diagnostic criteria without consideration of the social context. Legislative approach was not aimed at establishing the legal rights of persons with disabilities. Instead, persons with disabilities were perceived to be "objects of welfare, health and charity programs" (Degener and Quinn G, 2000). See also, Theresia Degener & Gerard Quinn, *A Survey of International, Comparative and Regional Disability Law Reform*, *in* DISABILITY RIGHTS LAW AND POLICY INTERNATIONAL AND NATIONAL PERSPECTIVES (Mary Lou Breslin & Silvia Yee eds., 2002), https://dredf.org/news/publications/disability-rights-law-and-policy/a-survey-of-international-comparative-and-regional-disability-law-reform/ (last visited Aug 20, 2021).

[6] Jonathan Kenneth Burns, *Mental Health and Inequity: A Human Rights Approach to Inequality, Discrimination and Mental Disability*, Vol.11 HEALTH AND HUMAN RIGHTS 21 (2009).

[7] Felicity Callard et al., *Chapter 2: Principles and Concepts*, *in* MENTAL ILLNESS, DISCRIMINATION AND THE LAW - FIGHTING FOR SOCIAL JUSTICE 42 (2012 ed.).

[8] Michael Ashley Stein, *Disability Human Rights*, 95 CALIFORNIA LAW REVIEW 85–86 (2007).

[9] MICHAEL OLIVER, UNDERSTANDING DISABILITY FROM THEORY TO PRACTICE (1996 ed.).

structure."[10] The social model of disability recognised that "disability is a social construct and that health and illness are socially determined."[11] The ability of the individual to function is determined by factors external to the limitations faced by persons with disabilities.[12] The social model of disability accentuates that the reason for disability encountered by persons with disability is the failure of society to respond appropriately to the disability by providing "the means to promote their social inclusion."[13] Under this model, "a medical or psychiatric diagnosis becomes a disability when the individual experiences discrimination on account of that diagnosis." The exclusion and segregation experienced by people with mental disabilities represent socio-cultural responses to their disability. The current understanding of discrimination, substantive equality, and reasonable accommodation under the United Nations Convention on Rights of Persons with Disabilities (hereinafter referred to as CRPD) is explicitly based on this model of disability.[14] This model focuses on how the failures and barriers in the social environment could be addressed by suitable national legislative measures focused on the empowerment of persons with disabilities.[15]

1.1.4.3. Socio-Medical Model of Disability

Another model called the socio-medical model of disability is propounded by a British medical sociologist named Michael Bury.[16] He "reaffirms the reality of impairment in contributing to disability."[17]

1.1.4.4. Rights-Based Approach Towards Disability

Mental health legislation is rapidly evolving from being instruments for the protection of society from persons with mental disabilities[18] to devices for protection and promotion of the

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[10] Burns, *supra* note 6.
[11] Penelope Weller, *3. Lost in Translation: Human Rights and Mental Health Law*, *in* RETHINKING RIGHTS-BASED MENTAL HEALTH LAWS 68 (2010 ed.).
[12] Stein, *supra* note 8.
[13] Philip Fennell, *2. Institutionalizing the Community: The Codification of Clinical Authority and the Limits of Rights-Based Approaches*, *in* RETHINKING RIGHTS-BASED MENTAL HEALTH LAWS 13–14 (2010 ed.).
[14] The shift in approach from the medical model to the social model of disability gradually began in the 1970s as reflected in the international human rights standards adopted at that time (Declaration on the Rights of Mentally Retarded Persons 1971 and Declaration on the Rights of Disabled Persons 1975) which recognised the "equality of disabled persons." Yet these instruments also showed traces of the medical model in their assumption of the "special medical problems" of disabled persons requiring "segregated social services and institutions as remedies." The subsequent instruments adopted gradually incorporated the move towards the social model of disability. The Standard Rules represented the full adoption of the social model through its emphasis on equality of persons with disabilities and its definition of disability as resulting from social construction. The focus on equal opportunity and removal of social barriers to promote full social participation was also observed in the Vienna Declaration and Program of Action enacted in 1993. See, Stein, *supra* note 8, at 85-90.
[15] Callard et al., *supra* note 7, at 41-42.
[16] Michael Bury, *12. On Chronic Illness and Disability*, *in* HANDBOOK OF MEDICAL SOCIOLOGY 173–179 (Chloe E. Bird, Peter Conrad, & Allen M. Fremont eds., 5th ed. 2000).
[17] Burns, *supra* note 6, at 21-22.
[18] Persons with mental disabilities were historically deemed to pose a danger to society.

human rights of persons with mental disabilities.[19]

The model adopted by the CRPD is a human-rights-based approach to protect the rights of persons with disabilities.

The key features of the rights-based model resonate with the 'ideology of entitlement' adopted by Larry Gostin.[20] The ideology of entitlement includes emphasis on "access to appropriate mental health services, freedom from unwarranted detention (liberty), freedom from inappropriate medical intervention (dignity)," and the promotion of equality and non-discrimination.[21]

The effectiveness of a human-rights-based approach to achieve social inclusion and human rights protection is dependent on the social context.[22] The rights-based approach recognises the disability experienced by persons with impairments stemming from social, economic, and political forces. It ensures participation and leadership by persons with disabilities in actively advocating for substantive equality. The rights-based approach to mental health, as adopted by the CRPD, marks a shift away from the public health approach.[23] The human rights approach focuses on aspects beyond the quality of care and welfare entitlements. It regards people with disabilities as subjects of law and not objects, as was the legislative approach under the medical model of disability.

The human-rights approach to disability seeks to ensure, through legislation, the social participation of persons with disabilities in a respectful manner, accommodative of their differences. The rights-based approach to mental disability also involves adopting the framework and principles of the CRPD into the national framework. While adopted in response to treaty obligations under the CRPD, such national legislation should consider the "regional morals" that shape societal attitudes."[24] It is also important to note that expressed rights need to be accompanied by political and social advocacy to be of meaningful existence.[25]

Legal reform can be implemented through comprehensive mental health policies and national disability plans/strategies to tackle discrimination and strengthen the protection of the rights of

[19] Callard et al., *supra* note 7, at 19.
[20] Larry Gostin, *Contemporary Social Historical Perspectives on Mental Health Reform*, 10 JOURNAL OF LAW AND SOCIETY 49–50 (1983). See also, L. Gostin, *The Ideology of Entitlement: The Application of Contemporary Legal Approaches in Psychiatry*, *in* MENTAL ILLNESS: CHANGES AND TRENDS 27–54 (Philip Bean ed., Chichester, Wiley ed. 1983).
[21] Penelope Weller, *supra* note 11, at 54.
[22] Philip Fennell, *supra* note 13.
[23] Burns, *supra* note 6.
[24] Callard et al., *supra* note 7, at 49-50.
[25] Peter Bartlett, *17. Thinking about the Rest of the World: Mental Health and Rights outside the "First World"*, *in* RETHINKING RIGHTS-BASED MENTAL HEALTH LAWS 417–418 (2010 ed.).

persons with mental disabilities.[26] Further, a strategic plan needs to be formulated to address the deep-seated structural inequalities in the social, political, and economic spheres and social discrimination concerning mental disabilities within the communities. Implementing and monitoring a national disability strategy would require the meaningful engagement, active participation of the healthcare professionals, the persons with mental disabilities/illnesses, and state actors. In addition to using their clinical expertise, healthcare professionals should partner with persons with mental disabilities to advocate for society's social and economic transformation to create an environment conducive for persons with mental disabilities to experience substantive equality.[27] There should be a mechanism to independently monitor and review the national disability strategies to ensure transparency and accountability in reporting the progress made to its implementation. Indicators to measure effectiveness should be developed, and data should be periodically collected to evaluate the effectiveness of the national disability strategy.[28]

1.1.4.5. Recovery Approach to Mental Disability

The Recovery approach is a paradigm shift from diagnosis and medication-based mental health care towards a more holistic approach that addresses all the social determinants that affect persons' mental health. Such an approach should allow individuals to define their subjective meaning of recovery and recover based on their personal preferences. The recovery approach is not solely dependent on the mental health services. However, adopting the recovery approach within the mental health services settings would help ensure personalised care and support in the context of the persons seeking the services' living situation and experiences. Such services would not be focused on 'cure' but on providing support to identify the subjective meaning of recovery of the persons with mental illnesses and appropriately facilitate them to regain control of their identity and life and live a meaningful life. The WHO recommends that recovery-oriented services focus on five dimensions - connectedness through social inclusion, inculcation of hope and optimism, strengthening the sense of identity and self-worth, facilitating the persons to regain a sense of purpose and meaning in their lives based on their personal choices and preferences and empowerment.[29]

1.1.4.6. Therapeutic Jurisprudence Model

[26] Felicity Callard et al., *Chapter 12: Implementation and Enforcement*, *in* MENTAL ILLNESS, DISCRIMINATION AND THE LAW - FIGHTING FOR SOCIAL JUSTICE 162–163 (2012 ed.).
[27] Burns, *supra* note 6, at 20, 27.
[28] Callard et al., *supra* note 26.
[29] WHO, *1. Overview: Person-Centred, Recovery and Rights-based Approaches in Mental Health*, *in* GUIDANCE ON COMMUNITY MENTAL HEALTH SERVICES - PROMOTING PERSON-CENTRED AND RIGHTS-BASED APPROACHES 5, 10–11 (2021).

According to Winick, Mental health law has progressed from the medical model[30] to the legal rights-based and therapeutic jurisprudence models.[31] He linked the convergence of therapeutic jurisprudence and human rights values "in civil commitment procedures such as liberty, due process, the right to treatment and to refuse treatment and the exercise of decision making."[32] Some of the critical components of therapeutic jurisprudence are the right to counsel, mental health legislation, humane conditions in institutions for committal of persons with mental disabilities, and availability of community treatment.[33] Therapeutic Jurisprudence has emphasised the necessity of fair and evidence-based decision-making in civil commitment hearings of persons with mental disabilities.[34] While evaluating the capacity of persons with mental disabilities to provide consent to treatment, objective "consideration should be given to any debilitating symptoms[35] of mental illness."[36]

1.1.5. CAPACITY TO CONSENT

The mental disability of persons may impact the person's capacity to consent to medical treatment. However, it is not right to assume that all persons with mental illnesses have the incapacity to consent. Mental incapacity to consent need not be permanent and may be subject-specific, connected to the issue in question. Mental health legislation may contain specific provisions to address the course to be adopted in the event of such mental incapacity to consent. The intervention of the State or other persons as specified under the relevant mental health legislation is permissible in the best interest of a person with mental disabilities at the time of mental incapacity or where they are unable to make rational decisions regarding their best interest.[37] Where the legal provisions under the relevant mental health legislation lack clarity

[30] The medical model presumes integration to only be possible after treatment or cure of the person with mental disabilities. It ignores the aspect of changes required in society to make it easier for social integration of persons with mental disabilities.

[31] B.J. Winick, *Therapeutic Jurisprudence and the treatment of people with mental illness in Eastern Europe: Construing international human rights law*, 21 NEW YORK LAW SCHOOL JOURNAL OF INTERNATIONAL AND COMPARATIVE LAW 537–572 (2002).

[32] Michael L. Perlin, *10. Therapeutic Jurisprudence*, *in* INTERNATIONAL HUMAN RIGHTS AND MENTAL DISABILITY LAW: WHEN THE SILENCES ARE HEARD 210–211 (2012 ed.).

[33] Michael L. Perlin, *supra* note 32, 212–216.

[34] Ian Freckelton, *9. Extra-Legislative Factors in Involuntary Status Decision-Making*, *in* RETHINKING RIGHTS-BASED MENTAL HEALTH LAWS 205 (2010 ed.).

[35] Debilitating symptoms of mental illness refer to those symptoms which adversely affects the patient's ability to understand the nature and symptoms of illness and to rationally or reasonably assess his or her need for treatment and treatment options.

[36] Ian Freckelton, *supra* note 34, at 230.

[37] This represents a significant departure from the older view with respect to capacity to consent in cases of involuntary treatment. As per the older view, persons with mental illnesses were incompetent per se, "enabling society to commit and treat them, even over their objection, in order to further their best interests". The real question in the older approach is not whether "the paternalistic intervention is in the best interest" of the person with mental illness, but "whether the state or society has the right to decide that question for" the person with mental illness. This ethical dilemma has brought about the pre-requisite of proving mental incapacity to make

regarding the criteria to establish mental incapacity to consent, ethical and practical difficulties could arise while making such a judgement.[38] Art. 5 of the CRPD clarifies that the deprivation of legal capacity cannot be sufficiently justified by the existence of mental disability per se. It should be substantiated with evidence showing the individual's incapacity to make the specific decision in question. Guardianship statutes provide for procedures that allow the person to decide the course of action in advance in the event of such incapacity. Examples of such techniques are 'lasting power of attorney,'[39] 'living wills,' and 'advance directives.'[40] The use of psychiatric advance directives was expected to effectuate the autonomy rights of persons with mental illnesses by allowing them to "retain control over their medical treatment during periods of anticipated incapacity." However, this interferes with the medical decision-making authority of the treating clinicians.[41]

There is some dispute about whether the guardianship legislation or the mental health legislation takes precedence in cases where both legislations are applicable. However, generally, it is not considered desirable to prioritise mental health legislation (allowing for deprivation of liberty through detention) over guardianship legislation (capacity-based).[42]

1.1.6. CHALLENGES IN MENTAL HEALTH CARE

The WHO has observed that the care of persons with mental illnesses overlooks the social determinants affecting mental health[43] and mainly focuses on the diagnosis, medication, and symptom reduction in many countries. Such an approach has led to "an over-diagnosis of human distress and over-reliance on psychotropic drugs," especially in high-income countries. As a result, mental health is primarily addressed through the health systems, and there is insufficient development of the social services and structures to address the social factors. Such an unbalanced approach to the care of persons with mental disabilities further perpetuates the

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decisions regarding treatment before allowing any paternalistic intervention in this area. See, David B. Wexler, *2. Therapeutic Justice: An Overview And A Discussion Of Civil Commitment Standards and Procedure*, *in* MENTAL HEALTH LAW: MAJOR ISSUES 40 (1981). "Paternalism" in this context encompasses measures aimed at protecting the best interests or well-being of persons, even against their actual preferences or wishes. See, Peter Lack, Nikola Biller-Andorno & Susanne Brauer, *Chapter 1. Historical Review of Advanced Directives*, *in* ADVANCED DIRECTIVES 14 (2014).

[38] Callard et al., *supra* note 7, at 45-47.

[39] This instrument allows the signatory to appoint another person on his behalf (referred to as attorney), to make decisions, if the signatory loses mental capacity. The extent of power to direct specific instructions to the attorney may be controlled by the statute authorising the creation of such an instrument.

[40] While living will allows individuals to refuse a specific treatment in advance, advance directives enables the person to express their wishes regarding how they should be cared for. These instruments provide guidance to the decision-makers in the event of the author of the instruments' incapacity.

[41] Penelope Weller, *supra* note 11, at 63.

[42] Felicity Callard et al., *Chapter 4: Legal Capacity, Decision-making and Discriminatory Statutes*, *in* MENTAL ILLNESS, DISCRIMINATION AND THE LAW - FIGHTING FOR SOCIAL JUSTICE 73–77 (2012 ed.).

[43] The social determinants affecting mental health include: discrimination, poverty, unemployment, violence, abuse, social exclusion, lack of access to housing, education, social security and health services.

stigmatising attitudes in society among the general population and policymakers concerning mental health illnesses and disabilities. The prejudice against persons with mental disabilities also results in over-dependence on psychiatric institutions to care for persons with disabilities and general acceptance of coercive practices such as involuntary admission and treatment and use of restraints.

Stigma is a significant impediment to the "recovery, social integration and quality of life" of persons with mental disabilities and the provision of appropriate mental health services.[44] Due to the stigma against them, persons with mental health disabilities face social exclusion from the community and face disability-based discrimination in employment, education, housing, and civic participation in society.

There have been reports of instances of human rights violations and discrimination within the mental health care settings in high, middle- and low-income countries. Persons with mental illnesses, in many cases, are exposed to poor living conditions, abuse, and neglect, which is further aggravated by the power imbalance between healthcare staff and the users of the services.[45] Their subjection to coercive practices in psychiatric institutions causes them to feel traumatised, distressed, dehumanised, disempowered, disrespected, and disengaged from decisions on issues affecting them. The use of coercive practices also undermines the confidence and trust of the persons with mental disabilities in the mental health care staff, causing them to avoid the care and support needed.[46]

1.1.7. RIGHTS AND LAW REFORM

In 2017, the WHO published a report titled, "Advancing the Right to Health: The Vital Role of Law acknowledged the historical injustices to persons with mental disabilities perpetrated using the instrument of law. It observed thus, "Historically, the law has been used to structure the response to mental illness but not always consistent with human rights. People with mental illnesses, like persons with physical illness, require a full range of medical and social services. Instead, the law has sometimes been used to incarcerate mentally ill people in sterile institutions and without the protection required under the rule of law."[47]

A majority of psychiatric treatments involve a mix of both outpatient care and voluntary inpatient care. In addition, involuntary admission and treatment concurrently exist for mental

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[44] Beate Schulze, *6. Evaluating Programmatic Needs Concerning the Stigma of Mental Illness*, *in* UNDERSTANDING THE STIGMA OF MENTAL ILLNESS 85 (2008).
[45] WHO, *supra* note 29, at 2–3.
[46] *Id.* at 8.
[47] WHO, *Advancing The Right To Health: The Vital Role Of Law* xiv (2017), https://apps.who.int/iris/bitstream/handle/10665/252815/9789241511384-eng.pdf?sequence=1&isAllowed=y (last visited Jul 4, 2021).

healthcare, requiring stringent legal regulation and oversight.[48] However, with the increasing awareness of human rights, advances in the treatment of mental illness, and concomitant changes in politics and society, countries have acknowledged the need for legal reform to protect the human rights of persons with mental illness and disabilities and safeguard them against abuse and ill-treatment.

Mental health legislation provides the legal framework to address the unique vulnerabilities[49] and issues[50] faced by persons with mental disabilities, balance the human rights of the persons with mental disabilities with the needs and rights of their families and caregivers, promote access to care through providing mental health services, address competence and capacity of persons with mental disabilities and provide procedural safeguards to govern all aspects concerning admission, treatment, and discharge from mental health facilities.[51]

1.2. STATEMENT OF THE PROBLEM

India had ratified the United Nations Convention on the Rights of Persons with Disabilities in October 2007. Being a State Party to the Convention, India needed to harmonise and align its existing laws with the Convention's provisions. This mandate was sought to be achieved through the repeal of the Mental Health Act, 1987 and the enactment of the Mental Healthcare Act, 2017 (Act), and the Rules thereunder. As the new Act represents a recent change in approach towards mental health care, there is a need to understand and carefully evaluate:

a) Whether the Act has fully complied with the mandate under the Convention
b) Whether the Act realises the purpose of its enactment, i.e., protection and promotion of the rights of persons with mental illnesses
c) The implications of the Act on its key stakeholders
d) Areas for improvement in the current mental healthcare legal framework to meaningfully protect the rights of persons with mental illnesses and facilitate their full social inclusion and participation.

1.3. SCOPE OF THE STUDY

Law and mental health are inextricably linked to each other. The study seeks to evaluate whether the new Act realises the purpose of its enactment. It further tries to understand the

[48] Richard M. Duffy & Brendan D. Kelly, *Introduction*, *in* INDIA'S MENTAL HEALTHCARE ACT, 2017: BUILDING LAWS, PROTECTING RIGHTS 11 (2020).
[49] The vulnerabilities include stigma, discrimination and marginalisation faced in society.
[50] Mental health issues to be addressed by the legal framework include: access to care, involuntary admission and treatment, rehabilitation, community integration of persons with mental disabilities and promotion of mental health in society.
[51] WHO, *Improving Health Systems And Services For Mental Health* 12–14 (2009), https://apps.who.int/iris/bitstream/handle/10665/44219/9789241598774_eng.pdf?sequence=1&isAllowed=y (last visited Feb 27, 2021).

shortcomings of the Act. The internationally established human rights instruments and standards and the legislation in specific other jurisdictions are also analysed to assess the Act compared to comparative legislation and the international human rights standards.

1.4. RESEARCH OBJECTIVES

1.4.1. To trace the evolution of the mental healthcare laws in India

1.4.2. To evaluate the compliance of the Mental Healthcare Act, 2017 with the standards prescribed by the International Human Rights Instruments, with special reference to the CRPD.

1.4.3. To determine the Act's implications on its key stakeholders, especially the persons with mental illnesses, their families and caregivers in India.

1.4.4. To determine the shortcomings and areas of improvement under the Mental Healthcare Act, 2017 and Rules.

1.5. RESEARCH PROBLEMS

1.5.1. How have the mental health laws evolved in India?

1.5.2. Is there a significant change in approach towards mental healthcare under the new legislation?

1.5.3. Does the Mental Healthcare Act, 2017 comply with the International Human Rights Instruments and Standards, with special reference to the CRPD?

1.5.4. What is the impact of the Mental Healthcare Act, 2017 on its key stakeholders, especially the persons with mental illness, their family members and caregivers in India?

1.5.5. Are there any shortcomings in the Act and Rules which need to be addressed?

1.6. HYPOTHESIS

1.6.1. The Mental Healthcare Act, 2017 is not adequately beneficial to persons with mental illness.

1.6.2. It does not appropriately recognise the role of the family members and caregivers of persons with mental illness.

1.7. RESEARCH METHODOLOGY

The research methodology adopted is primarily doctrinal research through primary and secondary sources on mental health (with specific application to persons with mental disabilities).

The primary sources used comprise mental health legislation in India, the specific countries under the study, and the International Human Rights instruments and standards. The secondary

sources include books, research papers, recognised reports, and journal articles in the chosen field.

1.8. SCHEME OF CHAPTERS

1.8.1. Chapter 1: Introduction

The first chapter generally introduces the subject of the dissertation. This chapter includes the scope of the study, research objectives, research problems, hypothesis, and the limitations of the study. The change in the mental health legislation in India has created a necessity to critically analyse the new legislation to assess the effectiveness of its approach and shortcomings, if any, concerning its key stakeholders.

1.8.2. Chapter 2: International and Regional Human Rights Instruments and Standards for the Protection of Persons with Mental Illnesses

The second chapter traces the evolution of disability rights and the international human rights regime governing the field of mental disability. The international human rights framework analysis includes both "hard" and "soft" international law sources.

1.8.3. Chapter 3: Evolution of Mental Health Legislation In India

The third chapter analyses the history and evolution of mental health legislation in India. The chapter further critically assesses the Mental Healthcare Act, 2017 to:

a) outline the changes brought about by the legislation and
b) evaluate its impact on persons with mental illness, their families and caregivers, and mental healthcare professionals.

The analysis includes an appraisal of the available legal protection of the rights of persons with mental illnesses.

1.8.4. Chapter 4: Comparative Analysis: The United Kingdom (England And Wales), New Zealand and Sri Lanka

The fourth chapter deals with a comparative analysis of mental health legislation in three select countries[52] to evaluate how the rights of persons with mental disabilities are protected in these jurisdictions. The role of caregivers as recognised under the respective legislative frameworks is also analysed. The mental health legislation of the UK (England and Wales) is analysed to trace the similarity of development of the mental health law in India and the UK, having a common basis of legislation till India's independence in 1947. Sri Lanka and New Zealand were chosen for the study as they also share common law traditions with India as they were

[52] Countries from the Commonwealth, with a unified national legislative framework were chosen due to expected similarities in the system.

also a part of the British Empire. Both these countries, similar to India, have a single mental health legislation applicable to persons with mental illness.

1.8.5. Chapter 5: Research Findings, Conclusions, And Suggestions

The fifth chapter summarises the findings of the study. Further, suggestions and recommendations are discussed on the potential areas where legislative and policy reforms may be needed.

1.9. LIMITATIONS OF THE STUDY

1.9.1. The Act's impact on the other allied stakeholders – police officers, NGOs working in mental health, prison officers, and government institutions who may be involved in some part of the Act's implementation will not come under the scope of the study.

1.9.2. The study only includes the challenges faced in care delivery by the allopathic healthcare system. It excludes the challenges faced in alternative care delivery by Ayurveda, Homeopathy, Unani, Nafasiyatt, or Siddha systems.

1.9.3. The study does not make an in-depth coverage of the mental health "soft laws," i.e., the mental health policies and programmes that may have been adopted at the Centre and State levels in India.

1.9.4. The study will not comprehensively address the challenges faced by the caregiver families and persons with mental illnesses in detail, as empirical data from these stakeholders is not planned for this analysis.

1.9.5. The study does not include extrapolating the Rights of Persons with Disability Act, 2016 and any other applicable extension that may have benefited this study.

1.9.6. The comparative legislative analysis is restricted to mental health legislation of three countries. It does not involve a comprehensive comparative perspective due to the time constraint for the study. The legislative framework assessed in the UK includes only the mental health legislation for England and Wales only.

1.9.7. A parallel framework of political and ideologically driven legislation incidentally and indirectly impacts persons with mental illnesses. These legislations could include matrimonial laws, criminal law concerning mentally ill offenders, contract and property laws, suicide legislation, and laws establishing conditions for military recruitment. The impact of these laws may not be assessed as part of this study.

CHAPTER 2

INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS AND STANDARDS FOR THE PROTECTION OF PEOPLE WITH MENTAL DISABILITY

2.1 INTRODUCTION

This chapter briefly outlines the International and Regional instruments which establish the human rights of persons with mental disabilities. The analysis of these instruments would be helpful to:

a) Trace the development of human rights of persons with mental disabilities through the international and regional human rights instruments
b) Evaluate the established international standards in the field of mental healthcare and mental disability
c) Determine the rights of persons with mental illnesses or disabilities[53]
d) Identify the international standards against which comparison and assessment of national mental health legislation are possible.

2.2 EVOLUTION OF DISABILITY RIGHTS

The persons with mental illnesses form a section of society vulnerable to human rights violations and abuse both within the healthcare institutions during treatment and in the community. Institutional human rights violations may be due to inadequate care or the use of harmful care and treatment methods. The human rights violations of persons with mental illnesses in the immediate family and the community may be due to stigma, prejudice, and misconceptions associated with mental illness, which significantly impacts their ability to access appropriate care and reintegrate into the community.[54] As their ability to look after their self-interest may be impaired, persons with mental illness are often economically marginalised, subject to discrimination, neglect, social isolation, vulnerable to physical and sexual abuse, denied personal liberty, access to education, work, or public service benefits. There may also be improper discrimination faced by people with no disability either when they are erroneously

[53] The international human rights instruments and standards apply to the field of "mental disability". However, as the subject under study, that is the Mental Healthcare Act, 2017 addresses the "protection of persons with mental illnesses" as opposed to "mental disability", this Chapter may interchangeably make references to "mental illness" and "mental disability".
[54] Carla A. Arena Ventura, *International Law, Mental Health and Human Rights* 1 (2014).

presumed to have a mental disorder or had earlier experienced a mental illness in life.[55] Persons with mental disabilities face different forms of discrimination, including hostility, hatred, fear, pity, or patronisation.[56] Their vulnerability to abuse and neglect stems from their dependence on others and the nature of the disability. Their ability to seek assistance when victimised is also affected by their disabilities, which impact their physical health, mental competence, and strength to protect themselves.[57] Persons with mental illnesses often avoid seeking medical care due to fear of receiving a psychiatric diagnosis and societal stigma. Persons with mental illnesses also face more inferior health care for physical ailments than the general population due to either misattribution of their physical symptoms to their mental illness or possible biases in treatment decisions made by clinicians. According to therapeutic jurisprudence, the legal system is bound to honour the "three V's – voice, validation, and voluntariness" to protect the dignity of litigants[58]. However, persons with mental disabilities institutionalised in mental facilities with inadequate infrastructure are deprived of the "three V's."[59]

The State is bound to ensure physical, geographic, and economic accessibility to mental health care support, treatment and medication, without any discrimination to persons with disabilities. Persons with mental disabilities and the parents of children with mental disabilities are also entitled to access their health, diagnosis, and treatment information.[60] Mental health legislation and international standards seek to prevent human rights violations and protect the autonomy and liberty of persons with mental disabilities.[61]

Following World War II, the early global international human rights law developments did not adequately focus on persons with mental disabilities. It was considered an individual problem requiring medical attention, care, and treatment. [62] Until the early 1990s, there was no active

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[55] ERIC ROSENTHAL & CLARENCE J. SUNDRAM, *The Role of International Human Rights in National Mental Health Legislation* 2 (2004).

[56] Michael L. Perlin, *1. Introduction and Overview*, *in* INTERNATIONAL HUMAN RIGHTS AND MENTAL DISABILITY LAW: WHEN THE SILENCES ARE HEARD 18 (2012 ed.).

[57] ROSENTHAL & SUNDRAM, *supra* note 55, at 67–68.

[58] Therapeutic Jurisprudence focuses on the impact of law on people's lives and its influence on their emotional life and psychological well-being. See, Michael L. Perlin, *10. Therapeutic Jurisprudence*, *in* INTERNATIONAL HUMAN RIGHTS AND MENTAL DISABILITY LAW: WHEN THE SILENCES ARE HEARD 203–205 (2012 ed.).

[59] Perlin, *supra* note 56.

[60] Paul Hunt & Judith Mesquita, *Mental Disabilities and the Human Right to Highest Attainable Standard of Health*, Volume 28 HUMAN RIGHTS QUARTERLY 346–347 (2006).

[61] Melvyn Freeman et al., *Chapter 1: Context of mental health legislation*, *in* WHO RESOURCE BOOK ON MENTAL HEALTH, HUMAN RIGHTS AND LEGISLATION 4–5 (2005).

[62] The UN approach towards disability can be described as an evolution across 4 phases. In the first phase between 1945-1970, the UN policy did not separately provide for persons with disabilities. They were "invisible". In the second phase spanning 1970-1980, persons with disabilities attained recognition as "subjects of rehabilitation", influenced by the medical model of disability. In the third phase between 1980-2000, persons with disabilities were considered the objects of human rights. It was only after the dawn of the new millennium, during the 4th phase, that persons with disabilities became the subjects of human rights. See, Valentina Della Fina, Rachele Cera

dialogue on disability rights (primarily mental disability) as a social issue in a global public, political or legal debate.[63] As mental disability was not considered a separate human rights issue, the equality of all people irrespective of disabilities and the need for community and social integration without attitudinal and physical barriers was not given priority in the early human rights efforts. The formal recognition of the universal human rights' applicability to all humans to the specific sections of a vulnerable population (like persons with mental illness) is crucial for its enforcement.[64] Specialised conventions help recognise the marginalised population's particular concerns and bring attention to these needs, which the "mainstream human rights system may overlook".[65] It is only through international human rights conventions that governments' fundamental obligations are established, and regular reporting of the legislations and policies adopted to implement convention provisions is mandated.[66]

International human rights law is vital in the field of mental health due to two reasons:

a) It is the sole source that permits "international scrutiny of mental health policies and practices within a sovereign country".
b) The fundamental protections provided by the International human rights law "cannot be divested through ordinary political processes."[67]

2.3 FUNDAMENTAL RELATIONSHIP BETWEEN MENTAL HEALTH AND HUMAN RIGHTS

Mental health and human rights are inter-related in three aspects:

2.3.1 Relationship Between Mental Health Policy and Human Rights:

Exercise of governmental power by implementing mental health policies, programs, and practices can directly affect and violate certain human rights of persons with mental disabilities. These rights include citizenship, access to courts, economic and personal interests, personal autonomy, privacy, property rights, physical and psychological integrity and liberty. Therefore, the arbitrary and discriminatory exercise of such governmental power, without fair process, can be challenged through human rights claims.

2.3.2 Effect of Human Rights Violations on Mental Health:

& Giuseppe Palmisano, *From Invisible Citizens to Agents of Change: A Short History of the Struggle for the Recognition of Right of Persons with Disabilities at the United Nations*, *in* THE UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES: A COMMENTARY 2 (2017).

[63] Perlin, *supra* note 56, at 3.

[64] Perlin, *supra* note 56, at 11.

[65] ROSENTHAL & SUNDRAM, *supra* note 55, at 5.

[66] ROSENTHAL & SUNDRAM, *supra* note 55, at 8.

[67] Lawrence O. Gostin & Lance Gable, *The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health*, 63 MARYLAND LAW REVIEW 21 (2004).

Violation of human rights adversely affects mental health and may result in prolonged and acute mental agony to the victims.

2.3.3 Inextricable Linkages between Mental Health and Human Rights:

Positive efforts to improve mental health and human rights are mutually reinforcing as both are complementary approaches to the betterment and well-being of human beings. Mental health is essential for engaging in political and social life to exercise human rights. Human rights provide security and fundamental freedoms, which are crucial for mental well-being.[68]

2.4 COMPONENTS OF INTERNATIONAL HUMAN RIGHTS LAW

The International Human Rights Law consist of:

2.4.1. BINDING INSTRUMENTS:

Sources of "Hard" International Law include:

2.4.1.1. Customary International Law:

These include legal principles whose binding force is so widely accepted by the governments and legal scholars that they need not be written legal principles. In addition to this, certain principles have attained the force of binding, customary international law through adoption as an express instrument over time.[69]

2.4.1.2. International Human Rights Conventions / Treaties / Pacts / Charters:

These instruments create a binding obligation on the State Parties ratifying them to ensure conformance of government policies and state practices to the principles of the specific Convention signed and ratified. While customary law helps interpret human rights conventions, it is generally accepted that principles enshrined in them are more authoritative than customary law.[70]

2.4.2. NON-BINDING INSTRUMENTS:

Sources of "Soft" International Law include:

2.4.2.1. UN General Assembly Resolutions (also referred to as International Human Rights Standards):

The human rights standards represent the minimum standards necessary for protecting fundamental human rights, which could be examined against related human rights conventions and existing domestic law requirements. The human rights standards are a persuasive source of authority as to the requirement of international human rights law, where there is no specific

[68] *Id.* at 27–29.
[69] An example of such soft law principles attaining the force of hard customary international law is the Universal Declaration of Human Rights.
[70] ROSENTHAL & SUNDRAM, *supra* note 55, at 10–13.

domestic law on point or where the existing law provides fewer protections.[71] These resolutions further serve as "interpretive guides to international treaty obligations".[72] The MI Principles and the Standard Rules lay down the human rights standards and fair and decent treatment standards applicable to persons with mental disabilities.[73] The MI Principles and the Standard Rules respect the rights of persons with mental disabilities to self-determination.[74] Modification can be brought about in the established soft laws by passing a new resolution in the UN General Assembly. However, the limitation of the Human Rights Standards is that they offer fewer protections than existing human rights conventions. Further, the rights established in conventions or existing domestic laws of countries are superior to the standards.[75]

2.4.2.2. Technical and Professional Standards:

Various technical guidelines and policy statements have been adopted by UN agencies, world conferences and professional group meetings, in addition to the UN General Assembly Resolutions. Though helpful in interpreting international human rights conventions, these guidelines and policy statements are of lesser importance and authority in interpreting UN conventions than the UN General Assembly Resolutions.[76] One of the notable technical standards in mental health rights is the "Declaration of Caracas."

2.5 INTERNATIONAL HUMAN RIGHTS CONVENTIONS / TREATIES / PACTS / CHARTERS

2.5.1. International Bill of Human Rights

Though the "International Bill of Human Rights" did not specifically recognise and protect the right of persons with mental illness, these documents together laid the foundation for the recognition of human rights as well as civil, political, economic, social and cultural rights. Furthermore, the ICCPR and the ICESCR further developed the principles enshrined in the UDHR and represented the starting point for establishing legally binding international human rights instruments.[77] With increasing recognition of specific populations' vulnerability (children, women, persons with disabilities) to abuse, conventions were initiated, focusing on their rights and protection.[78]

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[71] ROSENTHAL & SUNDRAM, *supra* note 55, at 25.
[72] Gostin & Gable, *supra* note 67, at 43.
[73] *Id.*
[74] ROSENTHAL & SUNDRAM, *supra* note 55, at 18 (2004).
[75] ROSENTHAL & SUNDRAM, *supra* note 55, at 24.
[76] ROSENTHAL & SUNDRAM, *supra* note 55 at 15-16.
[77] Michael L. Perlin, *2. International Human Rights Law in Perspective: Legal Issues and Social Constructs*, *in* INTERNATIONAL HUMAN RIGHTS AND MENTAL DISABILITY LAW: WHEN THE SILENCES ARE HEARD 24, 27 (2012 ed.).
[78] Perlin, *supra* note 77, at 27.

2.5.2. Universal Declaration of Human Rights, 1948 (UDHR)[79]

The human rights of persons with mental illness found recognition for the first time in the Universal Declaration of Human Rights, 1948 indirectly, by recognising all humans' rights and dignity under Art.1. As humans possess rights by being born human, there is no need for persons with mental disabilities to prove they deserve these rights or be trusted with the socially and culturally acceptable exercise of their rights.[80] The UDHR provided under Art.2 that the rights and freedoms mentioned thereunder should be made available to all without distinction. In addition, the UDHR enshrines general legal principles and human rights norms recognised by customary international law.[81] Art.3 recognises the right to "life, liberty and security of the person". Art.5 prohibits "torture or cruel, inhuman or degrading treatment or punishment." While Art. 6 protects the right to "recognition everywhere as person before the law", Art.7 provides for equality before law and equal protection before law. Art. 9 prohibits arbitrary "arrest, detention or exile".[82] The express recognition of the right to liberty, prohibition of torture and equality before law had contemporary relevance to persons with mental illnesses as during the period of the adoption of the UDHR, the field of mental healthcare was witnessing the very early beginnings of a shift from institutional care to community-based care. India was one of the founding members of the UN and had signed the Charter on 26 June 1945 along with 50 other countries.[83]

2.5.3. International Covenant on Civil and Political Rights, 1966 (ICCPR)[84]

The International Covenant on Civil and Political Rights, 1966 has recognised the need to ensure availability of rights without discrimination[85], provide legislative measures for the enforcement of rights under the national legislative systems[86], ensure enforcement of remedies for violation of human rights and freedoms[87], protect the "right to life"[88], prohibit subjection to

[79] Universal Declaration of Human Rights, (1948), https://www.un.org/en/universal-declaration-human-rights/ (last visited Feb. 28, 2021). The UDHR was adopted on 10 December, 1948.
[80] Gostin & Gable, *supra* note 67, at 22.
[81] Michael Krennerich, *The Human Right to Health. Fundamentals of a Complex Right*, *in* HEALTHCARE AS A HUMAN RIGHTS ISSUE 25 (Sabine Klotz, Heiner Bielefeldt, & Andreas Frewer eds., 2017).
[82] Universal Declaration of Human Rights, *supra* note 79.
[83] United Nations in India, https://in.one.un.org/page/about-us/ (last visited Jun. 22, 2021).
[84] International Covenant on Civil and Political Rights, (1966), https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx (last visited Feb. 28, 2021). The ICCPR was adopted and opened for signature, ratification and accession by General Assembly Resolution 2200A (XXI) of 16 December 1966 and entered into force on 23 March 1976.
[85] ICCPR, Art.2(1).
[86] ICCPR, Art.2(2).
[87] ICCPR, Art.2(3).
[88] ICCPR, Art.6(1).

torture or cruel, inhuman or degrading treatment or punishment"[89], safeguard the "right to liberty and security of person[90]" and provide "right to recognition as a person before law."[91]

The UN Human Rights Committee protects, promotes and monitors the rights established in the ICCPR.[92] The Committee issued General Comment No. 18 regarding non-discrimination in 1989.[93] The First Optional Protocol to the ICCPR empowers the individuals to approach the Human Rights Committee through the communication procedure for Covenant violation, provided such individual is within the jurisdiction of a State Party to the First Optional Protocol.[94] India acceded to the ICCPR on 10 April 1979 but has not ratified the Optional Protocol to the ICCPR.

2.5.4. The International Covenant on Economic Social and Cultural Rights, 1966 (ICESCR) [95]

The International Convention on Economic, Social and Cultural Rights recognised "*the right of everyone to enjoy the highest standard of physical and mental health*" under Art.12(1). The various provisions of the ICESCR have been utilised by the persons with disabilities and their advocates "*to promote access to community treatment, develop a more effective and humane treatment for mental illness and increase the availability of educational and vocational training programs specifically for persons with mental disabilities*."[96] India acceded to the ICESCR on 10 April 1979.

General Comment No. 5 expressly recognised the obligation of all State Parties to eliminate disability-based discrimination, both de jure and de facto discrimination, against persons with

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[89] ICCPR, Art.7.

[90] ICCPR, Art.9(1). In 1982, the UN Human Rights Committee, the monitoring constituted under ICCPR, issued a General Comment (*CCPR General Comment No. 8: Article 9 (Right to Liberty and Security of Persons)* whereby it was clarified in sub-clause no. 1 that protection of Art. 9 of the ICCPR extends to persons with mental illnesses. See, UN Human Rights Committee, *CCPR General Comment No. 8: Article 9 (Right to Liberty and Security of Persons)* (1982), https://www.refworld.org/docid/4538840110.html (last visited Jul 13, 2021).

[91] ICCPR, Art.16.

[92] Human Rights Committee, https://www.ohchr.org/EN/HRBodies/CCPR/Pages/CCPRIndex.aspx (last visited Jun. 24, 2021).

[93] General Comment No. 18, The Human Rights Committee, (1989), https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCCPR%2fGEC%2f6622&Lang=en (last visited Jun. 22, 2021).

[94] First Optional Protocol to the ICCPR, https://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCCPR1.aspx (last visited Jun. 22, 2021). The First Optional Protocol was adopted and opened for signature, ratification and accession by General Assembly Resolution 2200A (XXI) of 16 December 1966 and entered into force on 23 March 1976.

[95] International Covenant on Economic, Social and Cultural Rights, (1966), https://www.ohchr.org/documents/professionalinterest/cescr.pdf (last visited Feb. 28, 2021). The ICESCR was adopted and opened for signature, ratification and accession by General Assembly Resolution 2200A (XXI) of 16 December 1966 and entered into force on 3 January 1976.

[96] Gostin & Gable, *supra* note 67, at 34.

disabilities.[97] General Comment No.5 emphasised a comprehensive legislative approach to tackle direct and indirect discrimination against persons with disabilities.[98] Such an approach would ensure persons with mental disabilities an equal opportunity[99] for full participation in civil society and provide legal remedies for human rights violations. Art. 2 of the UN Convention on the Rights of Persons with Disabilities also recognises this approach.[100]

2.5.5. The Convention on the Rights of the Child, 1989[101]

The Convention, for the first time, expressly recognised disability as a ground for discrimination. It recognised the rights of mentally or physically disabled children to "*a full and decent life*"[102], "*access to education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities to achieve the fullest possible social integration and individual development*"[103], "e*njoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation*"[104], "*periodic review of treatment and all other circumstances relevant to his or her placement where a child has been placed by competent authorities for care, protection or treatment of his or her mental health*"[105] and *"a standard of living adequate for the child's physical, mental, spiritual, moral and social development."*[106] India acceded to the treaty on 11 December 1992.

2.5.6. The Convention on the Rights of Persons with Disabilities, 2006 (CRPD)[107]

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[97] General Comment No. 5, The United Nations Committee on Economic, Social and Cultural Rights, (1994), https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCESCR%2fGEC%2f4760&Lang=en (last visited Jun. 22, 2021).

[98] The legislative structure to tackle disability-based discrimination could include a country's constitution, human rights legislation, anti-discrimination legislation (on the ground of disability), social services legislation, employment legislation, mental health legislation, national disabilities strategies and national mental health policies / plans. See, Callard et al., *supra* note 7, at 33-34.

[99] According to Degener and Quinn (2000), there are 3 kinds of anti-discrimination legislations depending on the model of equality adopted. (1) Formal /juridical equality approach treats all people equally without accounting for the differences between people, on the ground of non-discrimination. (2) The Equality of results approach focuses on achievement of equality in outcomes between persons with and without disability. An example of such an approach would be having the same proportion of employment of persons with and without disabilities. (3) Equal Opportunity / Structural Equality approach strives to "provide equal chances without ensuring equal results." This third approach is perceived to be the most effective to tackle disability-based discrimination. See, Callard et al., *supra* note 7, at 33-34.

[100] Callard et al., supra note 7, at 26.

[101] Convention on the Rights of the Child, (1989), https://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx (last visited Mar. 1, 2021). The Convention was adopted and opened for signature, ratification and accession by General Assembly Resolution 44/25 of 20 November 1989 and entered into force on 2 September 1990.

[102] The Convention on the Rights of the Child, 1989, Art.23(1).

[103] The Convention on the Rights of the Child, 1989, Art.23(3).

[104] The Convention on the Rights of the Child, 1989, Art.24 Para 1.

[105] The Convention on the Rights of the Child, 1989, Art.25.

[106] The Convention on the Rights of the Child, 1989, Art.27(1).

[107] Convention on the Rights of Persons with Disabilities, (2006), https://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx (last visited Mar. 4, 2021). The Convention was adopted on 13 December, 2006 and entered into force on 3 May 2008.

This Convention aimed to "*promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity*[108]."

Though persons with disabilities have always been entitled to rights, in theory, they had been denied them in law and practice.[109] This Convention acknowledged the need for legislative protection of the rights of persons with disabilities for the first time. The definition given for disabilities under the Convention includes mental illnesses. The Convention requires the promotion and protection of rights of persons with disabilities by the governments. It also requires private actors to provide reasonable accommodation to ensure full enjoyment of rights by persons with disabilities and enable social integration.[110] The Convention is founded on the twin principles of equality and non-discrimination.[111] With this Convention, there has been a shift in focus of mental disability law from rights concerning detention and involuntary treatment to newer areas – rights relating to housing, employment, education and community inclusion.[112]

The rights under the various international human rights conventions have been re-articulated in a manner meaningful to people with disabilities.[113] The Convention articulates disability not in terms of physical or mental impairment or limitations but from inadequate social responses to individuals' specific needs in society.[114] The Convention recognised the need for international cooperation and its promotion by international community actions to support national implementation efforts.[115]

The Convention compelled the State Parties to notice the conditions and issues faced by persons with mental disabilities arising from "neglect, lack of legal protection against abusive

[108] Art. 1, Convention on the Rights of Persons with Disabilities, 2006.
[109] Frédéric Mégret, *The Disabilities Convention: Human Rights of Persons with Disabilities or Disability Rights?*, 30 HUMAN RIGHTS QUARTERLY 500 (2008).
[110] Peter Bartlett, *The United Nations Convention on the Rights of Persons with Mental Disabilities and Mental Health Law*, Vol. 75 THE MODERN LAW REVIEW 757 (2012).
[111] Mégret, *supra* note 109.
[112] Bartlett, *supra* note 110, at 760.
[113] MARIANNE SCHULZE, *A Handbook on The Human Rights of Persons with Disabilities: Understanding the UN Convention on the Persons with Disabilities* 19 (2010), https://www.internationaldisabilityalliance.org/sites/default/files/documents/hi_crpd_manual2010.pdf (last visited Jul 13, 2021).
[114] Bartlett, *supra* note 110, at 752–778.
[115] Michael L. Perlin, *7. The UN Convention: The Impact Of The New UN Convention On The Rights Of Persons With Disabilities On International Mental Disability Law*, *in* INTERNATIONAL HUMAN RIGHTS AND MENTAL DISABILITY LAW: WHEN THE SILENCES ARE HEARD 145–146 (2012 ed.).

treatment", and prevailing social stigma.[116] Furthermore, the Convention saw the participation of persons with disabilities to recognise and protect their rights.[117]

The partial definition of "disability" provided in Article 1 recognises only "long-term physical, mental, intellectual or sensory impairments", which hinder the full and effective participation in society of persons with disability on an equal basis with others. Such a definition may exclude some mental conditions on account of the duration stipulated.[118]

The General Principles affirmed by the Convention under Art. 3 are *"respect for the inherent dignity, individual autonomy, including the freedom to make one's own choices, and independence of persons, non-discrimination, full and effective participation and inclusion in society, respect for difference and acceptance of persons with disabilities as part of human diversity and humanity, equality of opportunity, accessibility, equality between men and women* and *respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to prove their identities."*[119]

The CRPD emphasises discrimination as inclusive of all forms of discrimination, including 'denial of reasonable accommodation.' The obligation of State Parties under Art.4 include "adoption of all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the Convention, taking all appropriate steps, including legislation, modification or abolition of existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities, taking into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes and taking all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their financial affairs, to have

[116] Perlin, *supra* note 56, at 4–5.
[117] Perlin, *supra* note 56, at 14.
[118] Bartlett, *supra* note 110, at 758–759.
[119] In addition to the General Principles under Art.3 of the Convention, the State Parties undertook to recognise and promote the right of all persons to equality before the law and equal protection of the law, without any discrimination (Art.5), take adequate measures to ensure the full and equal enjoyment of all human rights and fundamental rights to women and children with disabilities (Art.6, 7), undertake the obligation to take effective and appropriate measures to raise awareness concerning rights, capabilities and contributions of persons with disabilities and combat harmful practices stigmatising them (Art.8), recognise the right to access to the physical environment (Art.9), independent living and community inclusion (Art.19), personal mobility (Art.20) and rehabilitation (Art.26), protect certain substantive rights, including right to life (Art.10), equal recognition before the law (Art.12), access to justice (Art.13), personal liberty and security (Art.14), freedom from torture or cruel, inhuman or degrading treatment (Art.15), freedom from exploitation, violence and abuse (Art.16), protection of physical and mental integrity of person on an equal basis with others (Art.17), freedom of movement (Art.18), privacy (Art.22), respect for home and family (Art.23), education (Art.24), health (Art.25), work and employment (Art.27), adequate standard of living (Art.28) and participation in political, public and social life (Art. 29 and 30). Art.9 refers to disability-specific provision for signage in Braille and other easy to read and understand forms, live assistance for accessibility to buildings. Art.14(1)(b) of the CRPD specifies that "the existence of a disability shall in no case justify a deprivation of liberty.

equal access to all forms of financial credit and additionally to ensure that persons with disabilities are not arbitrarily deprived of their property."

The CRPD has established two implementation mechanisms – the Committee on Rights of Persons with Disabilities, which monitors the implementation and the Conference of State Parties, which is authorised to consider matters regarding implementation.[120]

Though there was the active involvement of organisations for disabled people in the negotiation process of the CRPD, there was a notable lack of traditional stakeholders like the medical professionals in the process, which may have impacted the tenor of the negotiations. This non-representation of all critical stakeholders was evident in the drafting of Article 17, relating to the right to integrity. This fact also created difficulty in implementing the CRPD as the provisions may significantly alter the conditions of medical practice.[121] The CRPD is also silent on the issue of forced psychiatric treatment of persons with mental illnesses.[122] Art.25 expresses the principle of consent to treatment as a State obligation instead of an individual right. However, the word "consent" has not been defined and has been left open to interpretation concerning the functional capacity of persons with mental disabilities.[123] It is argued that "the CRPD also does not address the issue of the appropriate response when supportive social interventions do not in practice make rights real for the person with disabilities."[124]

The Art. 12 of the CRPD, which is further interpreted through General Comment No. 1 of the UN Committee on Rights of Persons with Disabilities to prevent involuntary interventions, has been criticised by some in the medical profession as "hurting the very people it purports to help."[125]

Sub-clause no. 7 of the said General Comment No. 1 observed that the practices which denied persons with disabilities of their legal capacity under substituted decision-making regimes such as guardianship, conservatorship, permitting involuntary treatment under mental health laws

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[120] Monitoring of Implementation of the Convention, https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/monitoring-of-the-implementation-of-the-convention.html (last visited Jun 11, 2021).

[121] Bartlett, *supra* note 110, at 756–757.

[122] Though this issue was not initially a part of the CRPD, it was later addressed. The UN Committee on Rights of Persons with Disabilities in its 11th Session from 31 March – 11 April 2014, issued General Comment No. 1 (2014) with respect to Art.12. In sub-clause no. 42 that "forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and is an infringement of the" rights under Art. 15-17. See, Committee on Rights of Persons with Disabilities, *General Comment No. 1 (2014)* (2014), https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement (last visited Jul 13, 2021).

[123] Oliver Lewis, *5. The Expressive, Educational and Proactive Role of Human Rights: An Analysis of the United Nations Convention on the Rights of Persons with Disabilities*, *in* RETHINKING RIGHTS-BASED MENTAL HEALTH LAWS 105 (2010 ed.).

[124] Bartlett, *supra* note 110, at 759.

[125] Paul Appelbaum, *Saving the UNCRPD - from itself*, 18 WORLD PSYCHIATRY 1–2 (2019).

should be abolished to ensure restoration of full legal capacity to persons with disabilities on an equal basis with others. This recognition of the full legal capacity of persons with mental disabilities on an absolute basis has been criticised. The initial legal presumption of capacity should be open to re-assessment where the decision-making capacity has been found to be impaired on psychiatric assessment. In such circumstances, adequate safeguards to protect the persons' rights and interests should be made. The exclusion of any exemption to the presumption of legal capacity, which may prohibit the consideration of the circumstances of persons with severe mental disabilities as exceptional, is viewed to violate their rights, especially in informed consent cases. The interpretation of the Committee may deny persons with mental illnesses the right to appropriate treatment and care to attain the highest standard of health as provided under Art.25 of the CRPD.

Further, the denial of involuntary treatment results in adverse consequences in the long term for persons with mental illnesses. Denial of such involuntary treatment can prevent intervention by family, community or clinicians to prevent the attempt to suicide by persons with mental disabilities, directly impacting the right to life under Art.10 of the CRPD. Such an interpretation is also believed to aggravate stigma and discrimination, increasing persons with mental disabilities being unable to get timely medical care and treatment.[126]

Though the CRPD marks a radical shift towards the social model of disability, there is a lack of an alternative model to guide the transformation to replace current practices and implement the human rights approach. The understanding of mental illness and disability is still heavily driven by the medical model of disability. Further, the approach of psychiatry targeting social order and control of persons with mental illnesses has remained unchanged.[127] India signed the CRPD on 30 May 2007 and ratified it on 1 October 2007.

2.5.7. Optional Protocol to the Convention on the Rights of Persons with Disabilities[128]

The Optional Protocol to the CRPD strengthens the implementation and monitoring of the CRPD by establishing complaints and inquiry procedures. The individual or groups can lodge complaints regarding violations under the CRPD (directly or on behalf of victims) with the

[126] Melvyn Colin Freeman et al., *Reversing hard won victories in the name of human rights: A critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities*, 2 LANCET PSYCHIATRY 845–847 (2015).

[127] Jasna Russo & Stephanie Wooley, *The Implementation of the Convention on the Rights of Persons with Disabilities*, 22 HEALTH AND HUMAN RIGHTS 151–162 (2020).

[128] Optional Protocol to the Convention on Rights of Persons with Disabilities, https://www.ohchr.org/en/hrbodies/crpd/pages/optionalprotocolrightspersonswithdisabilities.aspx (last visited Jun. 24, 2021).

CRPD Committee.[129] India has neither signed nor ratified the Optional Protocol to the Convention on the Rights of Persons with Disabilities.

2.6 UN HUMAN RIGHTS STANDARDS

2.6.1 Declaration on Social Progress and Development, 1969[130]

The Declaration on Social Progress and Development recognised the need for "*the provision for the protection of the physically or mentally disadvantaged*" as part of Article 11(d). It also provided for "*the institution of appropriate measures for the rehabilitation of mentally or physically disabled persons, especially children and youth, to enable them to the fullest possible extent to be useful members of society – these measures shall include the provision of treatment and technical appliances, education, vocational and social guidance, training and selective placement, and other assistance required – and the creation of social conditions in which the handicapped are not discriminated against because of their disabilities*" under Art. 19(d) of the Declaration. This Declaration recognised for the first time the need for protection and rehabilitation of the physically and mentally disadvantaged and the creation of social conditions in which there are no discrimination against physically and mentally disabled persons regarding disabilities.

2.6.2 UN Declaration on the Rights of Mentally Retarded Persons (1971)[131]

This Declaration recognised seven specific rights of mentally disabled persons to be protected to assist them in their development and lead as much everyday life as possible. The object of treatment was recognised as enhancing the individual skill and autonomy of persons with mental disabilities and enabling the individual to realise his maximum potential. The Declaration stated that a person with a mental disability has "*to the maximum degree of feasibility, the same rights as other human beings*", "*right to proper care and physical therapy, and such education, training, rehabilitation and guidance as will enable him to develop his abilities and maximum potential*", "*right to economic security, a decent standard of living and to perform productive work or to engage in any other meaningful occupation to the fullest extent of his capabilities*", "*right to live with and gain the assistance of his own family or foster family and participate in different forms of community life*", "*right to a qualified guardian to*

[129] Felicity Callard et al., *Chapter 14: International and Regional Instruments, Standards, Guidelines and Declarations, in* MENTAL ILLNESS, DISCRIMINATION AND THE LAW - FIGHTING FOR SOCIAL JUSTICE 194 (2012 ed.).

[130] Declaration on Social Progress and Development, (1969), https://www.ohchr.org/en/professionalinterest/pages/progressanddevelopment.aspx (last visited Feb. 28, 2021).

[131] Declaration on the Rights of Mentally Retarded Persons, (1971), https://www.ohchr.org/EN/ProfessionalInterest/Pages/RightsOfMentallyRetardedPersons.aspx (last visited Feb. 28, 2021).

protect his well-being and interests", "*right to protection from exploitation, abuse and degrading treatment*" and *"access to legal safeguards against abuse where there is a procedure restricting or denying the exercise of rights.*" The Declaration protects the right of persons with mental disabilities to community integration and societal inclusion. It provides for periodic review of the determination of incompetence.[132]

2.6.3 The Declaration on the Rights of Disabled Persons (1975)[133]

The Declaration of the Rights of Disabled Persons was proclaimed by the General Assembly Resolution 3447 (XXX) on 9 December 1975. It defined disabled persons and further affirmed the rights available to disabled persons. It provided that the rights granted under the Declaration would be available without any discrimination. The rights of the disabled person under the Declaration on the Rights of Disabled Persons include "*inherent right to respect for their human dignity*", "*civil and political rights*", "*entitlement to measures designed to enable them to become as self-reliant as possible*", "*right to treatment, rehabilitation and assistance to help their skills and capability development and social integration*", "*right to economic and social security, a decent level of living, secure and retain employment according to capabilities as well as join trade unions*", "*entitlement to have their particular needs taken into consideration at all stages of economic and social planning*", "*right to live with family or foster parents and to participate in all social and recreational activities*", "*protection from exploitation and discriminatory, abusive or degrading treatment*" and "*right to avail qualified legal aid when necessary for the protection of person and property*."

2.6.4 World Programme of Action concerning Disabled Persons

Following the UN Declaration of 1981 as the International Year of Disabled Persons, the UN General Assembly established the World Programme of Action concerning Disabled Persons. It proclaimed the period between 1983 to 1992 as the United Nations Decade of Disabled Persons. The World Programme of Action adopted the "traditional three-tier approach to disability (definition, prevention and rehabilitation of disability)." However, a new facet introduced by the World Programme of Action was the addition of recommendations to undertake national actions to achieve equalisation of opportunities for persons with disabilities. It further called upon the UN, governments and stakeholders to focus on the human rights of

[132] ROSENTHAL & SUNDRAM, *supra* note 55, at 20.

[133] Declaration on the Rights of Disabled Persons, (1975), https://www.ohchr.org/en/professionalinterest/pages/rightsofdisabledpersons.aspx (last visited Feb. 28, 2021).

persons with disabilities.[134] The subsequently developed Standard Rules was considered one of the significant outcomes of the World Programme of Action.[135]

2.6.5 The Principles for the Protection of Persons with Mental illness and for the Improvement of Mental Health Care (1991) [MI Principles]

The Sub-commission initially developed the MI Principles on the Prevention of Discrimination and Protection of Minorities in 1988. The UN Working Group on the MI Principles further revised it based on the comments of governments, specialised agencies and non-governmental organisations.[136] The MI Principles was a critical step towards establishing and recognising the international standard of human rights for persons with mental disabilities.[137] Though the Resolution was non-binding, it is a valuable guide to interpreting international and regional human rights conventions' related provisions.[138] The MI Principles apply to persons with mental "illness" and persons confined in a mental health facility.[139] The General limitation clause provides that the rights outlined in the MI Principles "*may be subject only to limitations laid down by law and as necessary to protect the health or safety of the person concerned or others or to protect public safety otherwise, order, health or morals or the fundamental rights and freedoms of others*." The MI Principles recognise the right of persons with mental disabilities to be treated and cared for, to the extent possible, in their community[140]. It also establishes "substantive standards and procedural protections against arbitrary detention" of persons with mental disabilities in a psychiatric facility.[141] A person's mental illness should be determined following "internationally accepted medical standards" under Principle 4(1). Additional criteria for mental illness warranting involuntary admission are provided under Principle 16(1)(a) and (b).

Principles 9(1) and 9(4) emphasise the right of persons requiring mental health care to the least invasive treatment possible in the least restrictive environment. In addition, Principle 9(4) reiterated the purpose of treatment as affirmed in the UN Declaration of the Rights of Disabled Persons by providing that "*the treatment of every patient shall be directed towards preserving*

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[134] Della Fina, Cera, and Palmisano, *supra* note 62 at 6. The recommendations broadly addressed the spheres of "legislation, physical environment, income, maintenance and social security, education, employment, recreation, culture, religion and sports."
[135] Callard et al., *supra* note 129, at 203–204.
[136] Angelika C. Moncada, *Involuntary Commitment and the Use of Seclusion and Restraint in Uruguay: A Comparison with the United Nations Principles for the Protection of Persons with Mental Illness*, 25 THE UNIVERSITY OF MIAMI INTER-AMERICAN LAW REVIEW 592 (1994).
[137] Perlin, *supra* note 56, at 9–10.
[138] ROSENTHAL & SUNDRAM, *supra* note 55, at 6.
[139] Hunt & Mesquita, *supra* note 60, at 337.
[140] Right to community integration provided in Principle 3 and 7(1) of the MI Principles.
[141] ROSENTHAL & SUNDRAM, *supra* note 55, at 22.

and enhancing individual autonomy." Through such recognition, the standard of care transcends the quality of care provided solely by custodial care.[142]

Principle 11(2) incorporates the right to free, informed consent on the "*diagnostic assessment, the purpose, method, likely duration and expected benefit of the proposed treatment, alternative modes of treatment, including those less intrusive and possible pain or discomfort, risks and side-effects of the proposed treatment*." Principle 11 is based on the need to respect individual choice in treatment. The right to individualised treatment places an obligation on the respective governments to provide professional services suited to individual needs, balancing the need to respect the individual's preferences and the professionals' best judgment.[143] The MI Principles offer inadequate protection on informed consent as the provision is also subject to exceptions and qualifications.[144] Procedural safeguards are provided against physical restraints or involuntary seclusion under Principle 11(11).

Principle 12(1) provides the right to patient information in a mental facility regarding all rights and mode of their exercise provided under the MI Principles and the domestic law. Such information should be conveyed directly in the form and language understood by the patient or through the patient's representative.

In a mental health facility, every patient's dignity is protected by recognising their right to personhood before the law, privacy, and freedom of communication and religion/belief under Principle 13(1). Principle 13(2) specifies the environment and living conditions for persons in mental health facilities.

Principle 16(1) to (3) lays down the procedural safeguards concerning involuntary admission of persons with mental disabilities. Under Principle 11(8), involuntary treatment without the patients' informed consent may be prescribed by a qualified medical practitioner for a period as strictly necessary for the purpose in case of urgent necessity "*to prevent immediate or imminent harm to the patient or other persons*. Principle 8(2) recognises the patients' right to protection from harm, abuse, and acts causing mental/physical distress.

Principle 25 stipulates that there can be "*no restriction upon or derogation from any existing rights of the patient, including rights recognised in applicable international or domestic law on the pretext that these Principles do not recognise such rights or that they recognise them to a lesser extent*."

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[142] ROSENTHAL & SUNDRAM, *supra* note 55, at 32.
[143] ROSENTHAL & SUNDRAM, *supra* note 55, at 30.
[144] Hunt & Mesquita, *supra* note 60.

The MI Principles have been criticised for the lesser degree of protection offered than existing human rights treaties concerning the necessity of prior informed consent to treatment and standards for involuntary treatment and detention.[145] However, the MI Principles clarify the role of independent and impartial tribunals in determining incapacity under Principle 6.[146] It further recognises that "the determination of mental illnesses does not automatically exclude the question of capacity".[147] The CRPD is considered to have superseded the MI Principles to the extent of any conflict.[148]

2.6.6 The Standard Rules for the Equalisation of Opportunities for Persons with Disabilities (1993) [The Standard Rules][149]

The UN General Assembly adopted this Resolution in pursuance of the recommendations of the World Conference of Human Rights meeting in Vienna[150] in 1993. This instrument is not specific to mental disability and applies to persons with any disability.[151]

The Standard Rules expressly established citizen participation by people with disabilities as an internationally recognised human right for the first time. It obligated the government to provide representation and involvement of people with disabilities in drafting legislation directly affecting them. The Standard Rules further called for every country's engagement in a national planning process "to bring legislation, policies and programs in conformity with international human rights standards."[152]

Through its focus on equalisation of opportunities and participation in all aspects of society, the Standard Rules adopted a broader approach to disability rights than the MI Principles. The Standard Rules fixed responsibility on the State to implement disabilities affirmative rights to access public facilities, adequate medical care and rehabilitation services, employment, education, and social security.

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[145] Freeman et al., *supra* note 61, at 14.
[146] Penelope Weller, *3. Lost in Translation: Human Rights and Mental Health Law*, *in* RETHINKING RIGHTS-BASED MENTAL HEALTH LAWS 64 (2010 ed.).
[147] *Id.* at 65.
[148] Tina Minkowitz, *7. Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities*, *in* RETHINKING RIGHTS-BASED MENTAL HEALTH LAWS 153 (2010 ed.).
[149] Standard Rules on the Equalization of Opportunities for Persons with Disabilities, https://www.ohchr.org/en/professionalinterest/pages/personswithdisabilities.aspx (last visited Jun. 24, 2021). This was adopted by General Assembly Resolution 48/96 of 20 December 1993.
[150] In the "Vienna Declaration" adopted in the World Conference, it was declared that "all human rights and fundamental freedoms are universal and thus, unreservedly include persons with disabilities." Further, the Declaration stated that "The World Conference calls on Governments, where necessary to adopt or adjust legislation to ensure access to life, welfare, education, work, living independently and active participation in all aspects of society and other rights for disabled persons."
[151] Gostin & Gable, *supra* note 67, at 40.
[152] ROSENTHAL & SUNDRAM, *supra* note 55, at 7.

Unlike the MI Principles, the Standard Rules had provided a mechanism to oversee implementation through a Special Rapporteur and enforcement committee.[153] In addition, the Standard Rules provided guidelines on active participation in society, which was not given attention in the MI Principles. The UN Convention on the Rights of Persons with Disabilities has superseded The Standard Rules.[154]

2.7 TECHNICAL AND PROFESSIONAL STANDARDS

2.7.1 WMA STATEMENT ON ETHICAL ISSUES CONCERNING PATIENTS WITH MENTAL ILLNESS[155]

The World Medical Association (WMA)[156] Statement lays down the physician obligation to patients, their ethical responsibilities to eliminate stigma and discrimination associated with psychiatry, respect patient autonomy, seek informed consent for treatment, treat patients with respect and solicitude and protect patients confidentiality and privacy. It further prescribes the conditions under which involuntary hospitalisation may be ethically justifiable and may be adopted.

2.7.2 THE DECLARATION OF HAWAII (1983)

The Declaration of Hawaii was approved by the General Assembly of the World Psychiatric Association (WPA)[157] in 1977 and subsequently updated in 1983, represented the first time that "the psychiatric profession had issued a position statement on ethical matters."[158] The Declaration stated that psychiatry is aimed at the treatment of mental illness and promotion of mental health. It also clarified the duties of the psychiatrist to the patient. The ethical guidelines under the Declaration of Hawaii were updated and revised through the Declaration of Madrid.

2.7.3 WPA STATEMENT AND VIEWPOINTS ON THE RIGHTS AND LEGAL SAFEGUARDS OF THE MENTALLY ILL (1989)[159]

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[153] Gostin & Gable, *supra* note 67, at 42.

[154] Callard et al., supra note 129.

[155] WMA Statement on Ethical Issues Concerning Patients with Mental Illness, (1995), https://www.wma.net/policies-post/wma-statement-on-ethical-issues-concerning-patients-with-mental-illness/ (last visited Jun. 24, 2021). The Statement was originally adopted by the 47th WMA General Assembly in September 1995 and was subsequently revised twice in 2006 and 2015.

[156] The World Medical Association was established in 1947 and is an international organisation that represents physicians. It seeks to ensure the physicians' independence and to establish and promote the highest ethical standards of care and behaviour to be adhered to by physicians at all times. The WMA has issued declarations and statements focusing on patient protection from abuse and unethical treatment. See, World Medical Association, https://www.wma.net/who-we-are/about-us/(last visited Jun. 24, 2021).

[157] The WPA is a global organisation that works to advance mental health and encourage psychiatry's highest clinical practice and ethical behaviour standards. The WPA has promulgated various charters and declarations dealing with psychiatric ethical standards.

[158] Callard et al., *supra* note 129, at 216.

[159] WPA Statement and Viewpoints on the Rights and Legal Safeguards of the Mentally Ill, https://www.wpanet.org/wpa-statement-and-viewpoints-on-the (last visited Jun. 24, 2021). The World Psychiatric Association General Assembly adopted the statement on 17 October, 1989.

The statement "extends and complements the Declaration of Hawaii". It focused on the rights of persons with mental illnesses and guided the national legislation concerning persons with mental illnesses. It also provided recommendations on treating persons with mental illnesses for both voluntary treatment and involuntary interventions.

2.7.4 THE DECLARATION OF MADRID (1996)

The World Psychiatric Association approved the Madrid Declaration on Ethical Standards for Psychiatric Care at the General Assembly in 1996 and further amended it in 1999 and 2002. The ethical standards established governs global psychiatric practice. The Declaration sets out the therapeutic relationship between psychiatrist and patient and the treatment and care procedure of persons with mental disabilities. The Declaration revised the Declaration of Hawaii's ethical guidelines.[160] The Ethical Standard 4 states that psychiatrists should consult with family and seek legal counsel if appropriate when the person with mental illness suffers from mental incapacity.

2.7.5 MENTAL HEALTH CARE LAW: TEN BASIC PRINCIPLES

In 1996, the WHO adopted "Mental Health Care Law: Ten Basic Principles" to interpret the MI Principles further. The Principles drew inspired from a comparative analysis of contemporary national mental health legislation in 45 countries conducted by WHO and the MI Principles. These principles were formulated for consideration by legislators and healthcare providers in an official capacity and persons with mental disabilities, their family and mental health advocates in a private capacity. The principles embody the description, components and implementation measures on the following aspects "*promotion of mental health and prevention of mental disorders, access to good quality, affordable and equitable basic mental health care, mental health assessments following internationally accepted principles, provision of mental health care which is the least restrictive on the person with mental disability's autonomy, self-determination or consent before any diagnostic procedure or treatment affecting physical and mental integrity and before taking considering hospitalisation, which may affect the individual liberty of the person with mental disabilities, right to be assisted in the exercise of self-determination, availability of review procedure for decisions of official or surrogate capacity*[161] *and health care providers, automatic periodical review mechanism of decisions affecting*

[160] World Psychiatric Association, *Declaration of Madrid* (1996), https://www.wpanet.org/current-madrid-declaration (last visited Apr. 25, 2021). Approved by the General Assembly of the World Psychiatric Association in 1996. It was further revised in 1999, 2002, 2005 and 2011.

[161] While decision-makers acting in official capacity refers to judges, surrogate (consent-giving) capacity is held by representatives of the persons with mental disabilities (relatives, friends, guardian).

physical and mental integrity and liberty of persons with mental disabilities, competent and knowledgeable decision-makers[162] *and respect of the rule of law*."[163]

2.7.6 WHO GUIDELINES FOR THE PROMOTION OF HUMAN RIGHTS OF PERSONS WITH MENTAL DISORDERS (1996)[164]

The Guidelines can serve as a tool to interpret the MI Principles, evaluate human rights conditions in institutions and draft mental health legislation.[165] It provides specific parameters and a checklist to assess compliance with the 25 principles outlined under the MI principles.

2.8 REGIONAL HUMAN RIGHTS INSTRUMENTS

In addition to the international human rights systems, regional human rights conventions in Africa, America, and Europe have also been established. Due to the well-developed mechanisms for implementation, the European and Inter-American regional systems are of great significance.[166] Moreover, the development of these regional systems has been concurrent with the development of the international human rights institutions of the UN. The European Court of Human Rights and the Inter-American Commission on Human Rights have considered and issued several significant judgements relating to psychiatric disabilities and healthcare. The leading decision by the African Commission on Human and People's rights in the field of mental health was Purohit and Moore v. The Gambia[167]. It is related to the domestic mental health legislation in the Gambia violating the African Charter.

2.8.1 THE EUROPEAN SYSTEM OF HUMAN RIGHTS[168]

2.8.1.1 The European Convention for the Protection of Human Rights

The European Convention for the Protection of Human Rights and fundamental freedoms ("European Convention"), signed in Rome on 4 November 1950 by all members of the Council

[162] The decision-making body in official and surrogate capacity should act independently and impartially and ideally be composed of more than one person from different relevant disciplines.
[163] Division of Mental Health and Prevention of Substance Abuse, WHO, *Mental Health Care Law: Ten Basic Principles* (1996), https://www.who.int/mental_health/media/en/75.pdf (last visited Apr. 8, 2021).
[164] Guidelines for the Promotion of Human Rights of Persons with Mental Disorders, (1996), https://apps.who.int/iris/bitstream/handle/10665/41880/WHO_MNH_MND_95.4.pdf?sequence=1&isAllowed=y (last visited Jun. 24, 2021).
[165] ROSENTHAL & SUNDRAM, *supra* note 55, at 26.
[166] ROSENTHAL & SUNDRAM, *supra* note 55, at 4–5.
[167] African Commission on Human and People's Rights, Communication No. 241/2001.
[168] The Council of Europe, the leading human rights organisation of the European Continent, is based in Strasbourg, France. It was instituted through the signing of the Treaty of London (also known as the Statute of the Council of Europe) on 5 May 1949 by ten countries. See, Council of Europe, https://www.age-platform.eu/council-europe-coe (last visited Apr. 8, 2021). The Council of Europe currently has 47-member states.

of Europe, was the first treaty created to give binding effect and adequate protection to the proclaimed rights in the UDHR. The Convention came into force on 3 September 1953.[169]

With the coming into force of the 11th Protocol to the European Convention in 1998, the functions of the European Commission of Human Rights and the European Court of Human Rights were merged into a single judicial organ of the Council of Europe, the European Court of Human Rights ("ECHR"). The ECHR can examine applications on instances of human rights violations by individuals, non-governmental organisations and States. Application to the ECHR is possible after exhaustion of appeal in the concerned member states.[170] The ECHR provides an alternative legal remedy to persons with mental disabilities where the domestic mental health laws' human rights protection was inadequate. The incorporation of the ECHR provisions into the domestic legislation of the Council of Europe member countries has provided an opportunity for the domestic courts to interpret further, expand and refine the human rights theory and practice.[171]

2.8.1.2 European Committee for Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

The European Convention on the Prevention of Torture and Inhuman or Degrading Treatment (1987) established this Committee. The Committee delegations periodically visit places of detention, including psychiatric establishments and social care institutions within States which are signatories to the Convention, to evaluate the treatment of people detained in such sites. The Committee has developed checklists for the evaluation of psychiatric hospital[172] and social care institutions[173]. The CPT has established standards concerning involuntary placement in psychiatric establishments[174] and means of restraint in adult psychiatric establishments[175].

2.8.1.3 Revised European Social Charter

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[169] The European Convention on Human Rights—A Living Instrument, (2020), https://edoc.coe.int/en/european-convention-on-human-rights/8528-the-european-convention-on-human-rights-a-living-instrument.html (last visited Apr. 8, 2021).

[170] The Council of Europe Guardian of Human Rights—A Summary, (2020), https://edoc.coe.int/en/an-overview/6206-the-council-of-europe-guardian-of-human-rights.html (last visited Apr. 8, 2021).

[171] Gostin & Gable, *supra* note 67, at 48–50.

[172] CPT Checklist for Evaluation of Psychiatric Hospital, https://rm.coe.int/16806fc231 (last visited Jun. 24, 2021).

[173] CPT Checklist for Evaluation of Social Care Institutions, https://rm.coe.int/16806fc22b (last visited Jun. 24, 2021).

[174] CPT Standards for Involuntary Placement in Psychiatric Establishments, https://rm.coe.int/16806cd43e (last visited Jun. 24, 2021). The 8th General Report of the CPT published in 1998 enumerated the minimum standards to be followed for involuntary placement in psychiatric establishments including prevention of ill-treatment of patients, specific arrangements to be made for particularly vulnerable patients, patient's living conditions and treatment, adequacy of staff, guidelines for means of restraint and procedural safeguards for involuntary placement.

[175] CPT Revised Standards for Means of Restraint in Psychiatric Establishments for Adults, https://rm.coe.int/16807001c3 (last visited Jun. 24, 2021).

The Revised European Charter recognises "the right of persons with disabilities to independence, social integration and participation in community life" under Art.15.[176] The Revised Charter provides for complaints regarding Charter violations to the European Committee of Social Rights.

2.8.1.4 The European Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (1997) – The Oviedo Convention

The European Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (1997) establishes professional standards concerning medical care and research (Article 4) and sets forth the provision for equitable access to health care principles (Article 3), informed consent (Article 6), need to protect persons with mental disabilities (Article 7) and right to information (Article 10).[177] The Convention's defect is that it does not provide a monitoring mechanism to examine its implementation by the State Parties.[178]

2.8.1.5 Council of Europe Recommendations

"The Committee of Ministers of the Council of Europe issues non-binding recommendations to the Member States on certain matters."[179] Recommendation No. R (92) 6 provided directives for establishing a coherent and global policy for people with disabilities, respecting their rights and specific needs. The definition of "Disability" was in adherence to the medical model of disability.[180] Recommendations 1235 on Psychiatry and Human Rights (1994) laid down the conditions and procedure for involuntary admission and the standards to be followed for psychiatric treatment and care.[181] Recommendation No. R (1999) on Principles concerning the legal protection of incapable adults lays down the principles applicable to adults who may have incapacity due to mental disability or illness affecting their autonomous decision-making.[182] The Recommendation No. Rec (2004) 10 concerning the protection of the human rights and

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[176] Council of Europe, *European Social Charter (Revised)* (1996), https://rm.coe.int/the-european-social-charter-treaty-text/1680799c4b (last visited Apr. 24, 2021). The Original Charter was adopted in 1961.
[177] Freeman et al., *supra* note 61, at 12.
[178] Callard et al., *supra* note 129, at 208–209.
[179] Callard et al., *supra* note 129, at 206–207.
[180] Council of Europe, *Recommendation No. R (92) 6: On a Coherent Policy for People with Disabilities* (1999), https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016804ce0f8 (last visited Jun. 24, 2021). Adopted on 9 April, 1999.
[181] Parliamentary Assembly, *Recommendation 1235: Psychiatry and Human Rights* (1994), http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=15269&lang=en (last visited Apr. 24, 2021). Adopted on 12 April, 1994.
[182] Council of Europe, *Recommendation 99(4): Principles concerning the Legal Protection of Incapable Adults* (1999), https://www.coe.int/t/dg3/healthbioethic/texts_and_documents/Rec(99)4E.pdf (last visited Jun. 24, 2021). Adopted on 23 February, 1999.

dignity of persons with mental disorder provided guidelines to "enhance the protection of the dignity, human rights and fundamental freedoms of persons with mental disorder especially those subject to involuntary placement or treatment."[183] Resolution ResAP(2005)1 laid down the principles and measures to safeguard adults and children with disabilities against all forms of abuse.[184] Recommendation CM / Rec (2009) 3 provided a checklist to ascertain State compliance with Recommendation No. Rec (2004) 10 protects the human rights and dignity of persons with mental disorders and appropriately provides for their care.[185]

2.8.1.6 <u>European Policy Regarding Mental Health</u>

In response to the World Health Organisation Mental Health Declaration for Europe,[186] the European Commission published a green paper on mental-health strategy titled, "Improving the mental health of the population. Towards a strategy on mental health for the European Union" in November 2005. Subsequently, the European Pact for Mental Health and Well-Being was introduced at the EU High-Level Conference, "Together for Mental Health and Well-Being" in Brussels, between 12 to 13 June 2008. The Pact aimed at addressing health inequalities through the development of appropriate recommendations and action plans in the areas of prevention of depression and suicide, mental health in youth and education, mental health in workplace settings, the mental health of older people, and to adequately tackle stigma and social exclusion faced by persons with mental disorders. The action plan to deal with stigma and social exclusion included anti-stigma campaigns, developing mental health services that are integrated into the society and focused on the person with mental disabilities, taking measures to promote social inclusion of persons with mental disabilities and encouraging the participation of caregivers, families and persons with mental disabilities in policy and decision-making processes. [187]

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[183] Council of Europe, *Recommendation No. Rec (2004) 10 concerning the protection of the human rights and dignity of persons with mental disorder and its Explanatory Memorandum* (2004), https://rm.coe.int/rec-2004-10-em-e/168066c7e1 (last visited Apr. 24, 2021). Adopted on 22 September, 2004.

[184] Council of Europe, *Resolution ResAP(2005)1: On safeguarding adults and children with disabilities against abuse* (2005), https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805daf83 (last visited Jun. 24, 2021). Adopted on 2 February, 2005.

[185] Council of Europe, *Recommendation CM/Rec(2009)3: On Monitoring the Protection of Human Rights and Dignity of Persons with Mental Disorder* (2009), https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805d1129 (last visited Jun. 24, 2021). Adopted on 20 May, 2009.

[186] WHO, *WHO Mental Health Declaration for Europe* (2005), https://www.euro.who.int/__data/assets/pdf_file/0008/88595/E85445.pdf (last visited Jun. 24, 2021). The Declaration sought to address the develop and implement comprehensive mental health policies and strengthen advocacy for persons with disabilities in partnership with inter-government organisations including the European Commission and the Council of Europe.

[187] European Pact for Mental Health and Well-Being, (2008), https://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf (last visited Jun. 24, 2021).

2.8.2 INTER-AMERICAN SYSTEM FOR THE PROTECTION OF HUMAN RIGHTS

The Inter-American human rights system originated in the 9th International Conference of American States held in Bologna in 1948. This Conference resulted in the Organisation of American States (OAS) constitution and the approval of the American Declaration of the Rights and Duties of Man (American Declaration) and the Inter-American Charter of Social Guarantees.[188] The three central bodies in the inter-American system of human rights are the OAS and the two official organs of the OAS, namely, The Inter-American Commission on Human Rights (Inter-American Commission) and the Inter-American Court of Human Rights (Inter-American Court).[189] Similar to the European Convention, human rights protection in the inter-American system is through multilateral treaties.

2.8.2.1 American Convention on Human Rights (Pact of San José)

The American Convention on Human Rights (American Convention) was signed in 1969 and came into force in 1978. The American Convention further developed and elucidated the rights provided in the American Declaration. Additionally, the American Convention empowered the Inter-American Commission and the Inter-American Court to interpret and implement the Inter-American human rights declarations, conventions, and protocols and examine human rights issues in the Americas.[190] The Inter-American Commission can review individual petitions from persons, groups of persons, and non-governmental organisations regarding alleged violations of the human rights protected in the American Convention and the American Declaration. It also monitors human rights compliances in member countries by conducting investigations and publication of country monitoring and thematic reports.[191] The Inter-American Court is an autonomous judicial organ for application and interpretation of the American Convention, having both contentious and broad advisory jurisdiction.[192,193]

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[188] Module 30: The Inter-American System for the protection of human rights and ESC Rights, http://hrlibrary.umn.edu/edumat/IHRIP/circle/modules/module30.htm (last visited Apr. 8, 2021).
[189] The Inter-American Human Rights System, https://theglobalamericans.org/reports/the-inter-american-human-rights-system/ (last visited Apr. 7, 2021).
[190] What is the Inter-American Human Rights System?, INTER-AMERICAN HUMAN RIGHTS NETWORK , http://interamericanhumanrights.org/background/what-is-the-inter-american-human-rights-system/ (last visited Apr. 8, 2021).
[191] The Inter-American Human Rights System, https://guides.ll.georgetown.edu/c.php?g=273364&p=6025373 (last visited Apr. 8, 2021).
[192] Gostin & Gable, *supra* note 67, at 51.
[193] International Norms and Standards Relating to Disability, UNITED NATIONS ENABLE, https://www.un.org/esa/socdev/enable/comp302.htm (last visited Apr. 9, 2021).

The American Declaration and the American Convention did not have specific provisions on the rights of persons with disabilities.[194] There is an Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, also known as "Protocol of Salvador" (1988). Art. 18 of the said Additional Protocol protected the right to personality development of persons with physical and mental disabilities. The Protocol called on the State Parties to adopt necessary measures for the welfare of these persons.[195]

2.8.2.1.1 Recommendation of the Inter-American Commission on Human Rights for the Promotion and Protection of the Rights of the Mentally Ill, (persons with mental disabilities as established by the current international human rights standards) (2001)

The Inter-American Commission on Human Rights provided recommendations to the State Parties to prevent and eliminate all forms of discrimination against persons with disabilities (physical or mental) and promote their full integration into society. The recommendations included creating awareness of the established international standards and human rights conventions protecting the rights of persons with mental illness, suitable amendments of existing mental health or disability laws, the organisation of community mental health services to enable full social integration of persons with mental illnesses and establishment of special initiatives to protect the human rights of persons with mental illnesses.[196]

2.8.2.2 Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities

This Convention was adopted in 1999 by the Organisation of American States. It has the distinction of being the first intergovernmental organisation to have a human rights treaty on disability with binding force. Though the treaty does not contain individual rights, it is the first regional human rights treaty defining disability-based discrimination.[197] The two objectives of The Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities are to "prevent and eliminate all forms of discrimination against

[194] *Id.*
[195] Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights "Protocol of Salvador," (1988), http://www.oas.org/juridico/english/Treaties/a-52.html (last visited Apr. 9, 2021).
[196] Recommendation of the Inter-American Commission on Human Rights for the Promotion and Protection of the Rights of the Mentally Ill, (persons with mental disabilities as established by the current international human rights standards) (2001), http://www.cidh.org/annualrep/2000eng/chap.6e.htm (last visited Jun. 24, 2021). The Recommendation was approved by the Inter-American Convention on Human Rights on April 4, 2001.
[197] Callard et al., *supra* note 129, at 213.

persons with disabilities" and to "promote the full integration of persons with disabilities into society" through cooperation and effective collaboration between the State Parties.[198]

2.8.2.3 Pan American Health Organisation (PAHO)

The Pan American Health Organisation is the specialised international health agency of the Inter-American system. It additionally serves as the Regional Office for the Americas of the World Health Organisation.[199]

2.8.2.3.1 The Caracas Declaration on the restructuring of Psychiatric Care in Latin America[200] (1990)

The Caracas Declaration focused on restructuring existing, conventional psychiatric services and care in Latin America within the local health systems to integrate community-based service models into social and healthcare networks.[201] The Declaration called for redrafting of national legislation to safeguard the personal dignity, human and civil rights of persons with mental illnesses and promote the organisation of community-based services that guarantee the enforcement of these rights.[202]

2.8.2.3.2 PAHO/WHO Resolution CD47.R1. Disability: Prevention and Rehabilitation in the Context of the Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health and Other Related Rights

The Resolution resolved to urge Member states to promote and protect the human rights and fundamental freedoms of persons with disabilities through measures including appropriate national policies, plans and programs on disability, community rehabilitation programs and strategies, promoting research and amendment of disability laws to conform to applicable international norms and standards. [203]

2.8.2.3.3 Montreal Declaration on Intellectual Disability (2004)[204]

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[198] Inter-American Convention on Elimination of All Forms of Discrimination against Persons with Disabilities, (1999), http://www.oas.org/juridico/english/treaties/a-65.html (last visited Apr. 13, 2021).
[199] PAHO, https://www.paho.org/en/who-we-are (last visited Jun. 24, 2021).
[200] The Declaration of Caracas was "adopted in Caracas Venezuela at the Conference on the Restructuring of Psychiatric Care in Latin America within Local Health Systems, convened by PAHO". See, The Caracas Declaration, (1990), https://www.globalhealthrights.org/wp-content/uploads/2013/10/Caracas-Declaration.pdf (last visited Apr. 24, 2021). It was adopted at a regional conference convened by PAHO and the WHO.
[201] Hunt & Mesquita, *supra* note 60, at 346.
[202] The Caracas Declaration, *supra* note 200.
[203] PAHO/WHO Resolution CD47.R1. Disability: Prevention and Rehabilitation in the Context of the Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health and Other Related Rights, https://iris.paho.org/bitstream/handle/10665.2/365/CD47.r1-e.pdf?sequence=1&isAllowed=y (last visited Jun. 24, 2021). The Resolution was adopted on 25 September, 2006 at the 47th Directing Council, 58th Session of the Regional Committee.
[204] The Montreal Declaration on Intellectual Disabilities, (2004), http://www.jaid.org.jm/membersdocs/declaration_eng.pdf (last visited Mar. 3, 2021).

The Montreal Declaration on Intellectual Disability was adopted on 6 October 2004 at an international conference organised by the Pan American Health Organization (PAHO)[205] and the World Health Organization (WHO).[206] The Declaration emphasised the right to equality, non-discrimination and self-determination of persons with mental/intellectual disabilities.[207] The Declaration recognised that the exercise of the right to health of persons with intellectual disability "*requires full social inclusion, access to work with just compensation and access to community services*."[208] It provided that laws and policies facilitating supported decision making should be promoted and recognised to benefit individuals having difficulty making independent choices and decisions[209]. It further prohibited considering an individual with an intellectual disability as entirely incompetent for making decisions owing to the disability, except under the most extraordinary circumstances. [210]

2.8.3 THE AFRICAN SYSTEM FOR PROTECTION OF HUMAN RIGHTS

2.8.3.1 African (Banjul) Charter on Human and Peoples' Rights

Though the Organisation for African Unity was founded in 1963, The African (Banjul) Charter on Human and People's Rights (1987) (African Charter), which forms the foundation of the African Human rights system, came into existence much later. The African Charter is different from other human rights instruments in two aspects. It establishes corresponding duties to the rights granted and appears to permit State Parties more autonomy in African Charter rights compliance.[211] The African Charter created the African Commission, which is authorised to investigate human rights violations, monitor state compliance with the African Charter and issue communications in response to complaints or petitions from member States, individuals, groups or NGO's on human rights violations. The African Court on Human and People's Rights (African Court)[212] has contentious and advisory jurisdiction for interpretation and application of the African Charter, Protocol and other human rights instruments and adjudication of human

[205] A Specialised Inter-American organisation dealing in health matters and WHO's Regional Office for the Americas (AMRO/WHO).
[206] Hunt & Mesquita, *supra* note 60.
[207] Jocelin Lecompte & Céline Mercier, *The Montreal Declaration on Intellectual Disabilties of 2004: An Important First Step*, Vol. 4 JOURNAL OF POLICY AND PRACTICE IN INTELLECTUAL DISABILITIES 66–69 (2007).
[208] Declaration No.4., The Montreal Declaration on Intellectual Disabilities, 2004.
[209] Declaration No. 6.a), The Montreal Declaration on Intellectual Disabilities, 2004.
[210] Declaration No. 6.b), The Montreal Declaration on Intellectual Disabilities, 2004. Such legal restrictions, if applicable, are permissible only "*for a limited time, subject to periodic review, and pertaining only to those specific decisions which the individual has been found by an independent and competent authority to lack legal capacity*." Declaration No. 6.c), The Montreal Declaration on Intellectual Disabilities, 2004 provides that the process adopted by the independent and competent authority to assess legal capacity should be "*guided by due process*" and based on "*clear and convincing evidence*".
[211] Gostin & Gable, *supra* note 67, at 54.
[212] The African Court was subsequently established in 2006 by the "Protocol to the African Charter on Human and People's Rights on the Establishment of an African Court on Human and Peoples' Rights".

rights matters between State Parties.[213] Direct petitions by individuals and NGO's could be made to the African Court only with the assent of the State Parties to the jurisdiction of the African Court.[214] The African Charter enshrines the right to the best physical and mental health state under Art.16 and the right to special protection of the aged and the disabled under Art.18(5).[215]

2.8.3.2 African Charter on the Rights and Welfare of the Child

Art. 13 of The African Charter on Rights and Welfare of the Child (1990), which came into force in 1999, recognises the right of children with physical and mental disabilities to "special measures of protection" "under conditions ensuring dignity and promoting self-reliance and active community participation."[216]

2.9 CONCLUSION

The international and regional human rights instruments have developed an elaborate and dynamic human rights framework to protect and guarantee the fundamental rights and freedoms of persons with mental disabilities, recognise human rights violations, and prevent these abuses.[217] The primary goal to be achieved within the framework of the human rights framework is substantive equality. The achievement of substantive equality calls for removing all the barriers and circumstances that prevent the individual from achieving equal opportunity and access.[218]

The CRPD adopted an inclusive definition of disability. The UN Convention on the Rights of Persons with Disabilities adopts the social model of disability. This approach significantly departed from the approach adopted by earlier Convention models, which "sought to achieve human rights through the assertion of rights." The CRPD thus recognised the need to achieve substantive equality to ensure the whole and effective exercise of the rights enjoyed by persons with disabilities.[219] The CRPD considered the basic human rights "of non-discrimination, equality and social participation as entitlements that must be constructed in the social fabric."

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[213] African Court on Human and People's Rights, http://www.african-court.org/wpafc/welcome-to-the-african-court/ (last visited Apr. 14, 2021).
[214] Gostin & Gable, *supra* note 67, at 55.
[215] The African (Banjul) Charter on Human and People's Rights, (1987), http://www.hrcr.org/docs/Banjul/afrhr4.html (last visited Apr. 14, 2021). Adopted by the Organisation of African Unity on 27 June, 1981 and entered into force on 21 October 1986.
[216] African Charter on the Rights and Welfare of the Child, (1990), https://www.un.org/en/africa/osaa/pdf/au/afr_charter_rights_welfare_child_africa_1990.pdf (last visited Apr. 17, 2021).
[217] Gostin & Gable, *supra* note 67, at 115.
[218] Burns, *supra* note 6 at 20. Substantive inequality was defined by the author as "equality of opportunity, within the context of prevailing structural inequalities in society."
[219] Burns, *supra* note 218.

In order to recognise and address the needs of persons with disabilities, the State Parties had to engage in a consultative process with persons with disabilities for goal-setting and the establishment of independent monitoring authorities.[220] Though the international human rights framework established through various UN instruments promotes human rights, the framework for implementing and protecting the rights is weak due to a single body's lack of direct responsibility for human rights enforcement.[221]

The regional human rights systems applicable to persons with mental disabilities emphasise the liberty and security of persons, lay down minimum standards for treatment and prevention of neglect and abuse of persons with mental illnesses [222] and provide detailed provisions on the right to health that set out State obligations.[223] In addition, the regional human rights systems have developed mechanisms to redress individual grievances concerning human rights violations.[224]

Despite the existence of the international human rights law and regional human rights instruments, violations of human rights of persons with mental disabilities are still observed in domestic jurisdictions due to the following "core factors": lack of, incomplete, vague, obsolete mental health legislation or failure to follow statutorily mandated procedure for consent and psychiatric treatment; non-availability of the protections of accessible free counsel and judicial review mechanisms to committed or institutionalised persons, inadequate infrastructure and lack of quality, humane care to institutionalised persons with mental disabilities and no alternative integrated community programs for persons with mental disabilities requiring conventional institutionalisation[225]

There is a need to improve awareness and protection of the rights of persons with disabilities within the domestic jurisdictions and ensure their empowerment. In addition, there is a requirement to develop an effective legislative framework and judicial review mechanisms in nations with dualist systems [226] to protect the rights of persons with mental disabilities, ensuring their equality of status and non-discrimination.

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[220] Weller, *supra* note 146, at 69.

[221] Michael Dudley, Derrick Silove & Fran Gale, *Mental Health, Human Rights and their relationship: An Introduction, in* MENTAL HEALTH AND HUMAN RIGHTS VISION, PRAXIS AND COURAGE 11 (First Ed. (2012) ed.).

[222] Gostin & Gable, *supra* note 67, at 78.

[223] *Id.* at 101.

[224] *Id.* at 116.

[225] Michael L. Perlin, *5. The Universal Factors, in* INTERNATIONAL HUMAN RIGHTS AND MENTAL DISABILITY LAW: WHEN THE SILENCES ARE HEARD 84–102 (2012 ed.).

[226] There are two European jurisprudential models: nations with monist systems, whereby "their constitutions expressly mandate the direct application of treaties" and nations with dualist systems where "treaties need to be implemented through separate domestic legislation" for its enforcement. See, Michael L. Perlin, *supra* note 56, at 126.

CHAPTER 3

EVOLUTION OF MENTAL HEALTH LEGISLATION IN INDIA

3.1. INTRODUCTION

The previous chapter discussed the evolution of the international human rights instruments and standards in mental health. The adoption of the CRPD in 2006 was a significant milestone as it expressly protected the rights, dignity, liberty and autonomy of persons with mental illnesses. As India was a signatory to and had ratified the Convention on Rights of Persons with Disabilities on 1 October 2007, it was required to align and harmonise the mental health legislation.[227] It was also realised that the Mental Health Act, 1987 could not adequately protect the rights of persons with mental illnesses and promote their access to mental health care. This resulted in the enactment of the Mental Healthcare Act, 2017.[228] The Act represents a significant transformation in India's approach towards mental healthcare by creating a justiciable right to mental healthcare.

Before the critical analysis of the Mental Healthcare Act, 2017, the history of mental health legislation [229] can be traced as follows:

3.2. EVOLUTION OF MENTAL HEALTH LEGISLATION IN INDIA

The definition of mental illnesses and disability in the mental health legislation significantly affects those who fall within the ambit of the categorisation under the legislation.[230]

The subject of mental healthcare in India can be addressed in 2 phases:

3.2.1. PRE-INDEPENDENCE PHASE

India did not lack provision for the care of persons with mental illnesses before the British Rule in India. Before the introduction of the allopathic medical system in India, the traditional medical practice was in use to treat persons with mental illnesses. Separate treatises in Ayurveda describe the different forms of mental disorders.[231] There is documented evidence in the Asoka Samhita of establishing hospitals for patients with mental illnesses during the reign

[227] In addition to the Mental Healthcare Act, 2017, India enacted Rights of Persons with Disabilities Act, 2016 (which received Presidential assent on 27 December 2016 and came into effect on 15 June 2017) to give effect to the CRPD and protect rights of persons with disabilities in India.

[228] Mental Healthcare Act, 2017 received Presidential assent on 7 April 2017 and came into effect on 29 May 2018. Due to the significant quantity of changes required to adhere to the CRPD provisions, the existing legislation in India (The Mental Health Act, 1987) had to be replaced rather than revised.

[229] The references to persons with mental illnesses or any other persons in the commentary of the provisions of the respective Acts in this chapter using male gender pronoun includes all genders.

[230] Callard et al., supra note 4 at 15.

[231] Saumitra Basu, *Madras Lunatic Asylum: A Remarkable History in British India*, 51 INDIAN JOURNAL OF HISTORY OF SCIENCE 479 (2016).

of King Asoka.[232] The treatises of the Siddha system of medicine described in detail certain types of mental illness and treatment.

Further, the Siddha system emphasised "the phenomenology of the various forms of abnormal behaviour." The Unani system of medicine was also introduced in India during the 12th and 13th centuries during the Mughal period. A mental hospital was established at Dhar, Madhya Pradesh, during the rule of Mahmud Khilji in the 15th century.[233]

During the period between 1500-1750, European medicine gained recognition in India due to the European influence.[234] Before the establishment of the British East India Company in 1600, India did not have an institutional or mental asylum-based care system for persons with mental illnesses.[235] The persons with mental illnesses were cared for and supported by the family. The British's early establishment of mental hospitals in India was to cater to European patients [236] in India. But the system of segregation and supervision of persons with mental disabilities in asylums was instituted by the British. The prevailing system in England and Europe significantly influenced the early mental health institutions established in India. There is clear evidence that modern medicine and hospitals were introduced to India by the Portuguese in Goa during the 17th century. The subsequent development and growth of mental institutions in India until the end of British rule reflected the interest and neglect by the colonial rulers.[237]

The mental health asylum system was focused on protecting the community and not care for persons with mental illnesses.[238] The institutional facility for persons with mental illnesses was available in Bombay from as early as 1670 when a hospital had set aside some rooms for their care.[239] During the rule of Lord Cornwallis, reference to the first mental hospital in Calcutta was made in the Calcutta Medical Board proceedings on 3 April 1787. Later, three private asylums were parallelly opened - one recognised by the mental Board under surgeon William

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[232] S. Haque Nizamie & Nishal Goyal, *History of Psychiatry in India*, 52 INDIAN JOURNAL OF PSYCHIATRY S7 (2010).

[233] O Somasundaram, *Presidential Address - The Indian Lunacy Act 1912: The Historical Background*, 29 INDIAN JOURNAL OF PSYCHIATRY 4,5 (1987).

[234] Sanjeev Jain, *11. Psychiatry and Confinement in India*, *in* THE CONFINEMENT OF THE INSANE: INTERNATIONAL PERSPECTIVE, 1800-1965 274 (2003).

[235] Shridhar Sharma & L.P. Varma, *History Of Mental Hospitals In The Indian Sub-Continent*, 26 INDIAN JOURNAL OF PSYCHIATRY 295–300 (1984).

[236] European soldiers employed with the East India Company.

[237] Shridhar Sharma, *Psychiatry, Colonialism and Indian Civilization: A Historical Appraisal*, 48 INDIAN JOURNAL OF PSYCHIATRY 111 (2006).

[238] Prior to the establishment of the asylums in the Presidency towns, the European persons with mental illnesses with symptoms persisting for more than a year were sent back to England. See, Jain, *supra* note 234, at 275.

[239] Walter Ernst, *Chapter 2 - Asylums in an alien place: the treatment of European insane in British India*, III *in* THE ANATOMY OF MADNESS: ESSAYS IN THE HISTORY OF PSYCHIATRY 59–60 (Reprint ed. 2004).

Dick and rented to the East India Company, and others at Monghir[240] in Bihar and Kilpauk[241], Madras. In Bombay, the first mental hospital was opened at Colaba in 1806. The mode of treatment used for the 'excited patients' included administration of opiates and morphia, hot baths, blood-letting and blistering. Music as a form of treatment was first tried in an asylum opened in Murli Bazar[242], Dacca, in 1855. Until 1857, there was no further expansion of lunatic asylums in parts of India other than Calcutta, Madras and Bombay. [243] There were 26 asylums operational in India by 1900.[244]

While large asylums in Calcutta, Bombay and Madras catered to European patients, the Indian patients were confined to smaller asylums[245]. The European doctors monopolised the medical profession, forcing Indians to take up tedious jobs at the asylum.[246] The British definition of "lunatic" in India was broad and ambiguous, including "a wide range of illnesses and social improprieties." The asylums housed alcoholics, vagrants, drug addicts and even the elderly, in addition to persons with mental illnesses. The British failed to comprehend the fundamental difference in cultural and spiritual philosophy in India, where vagrancy in the quest of asceticism was an accepted social practice.[247] Throughout the 1900s, the British had significantly shaped the mental health legislation in India.

3.2.1.1. Lunatics Removal (India) Act, 1851[248]

This Act, which was the first law related to mental illness in British India, aimed to facilitate the repatriation of British offenders with mental illnesses. The Act allowed for persons of unsound mind to be removed from India by orders of the Supreme Courts at the Presidencies.[249]

[240] The second mental asylum mentioned was opened on 17 April 1795, specially meant for soldiers with mental illness. Another hospital was subsequently established at Patna in 1821.
[241] This was the first mental hospital in South India and was established in 1794. The second mental hospital in Madras was started by the Government on leased premises in 1799.
[242] This area now forms part of Bangladesh.
[243] Sharma and Varma, *supra* note 235.
[244] James Mills, *The History of Modern Psychiatry in India 1858-1947*, 12 HISTORY OF PSYCHIATRY 434 (2001).
[245] Europeans and Indians were mostly detained in separate asylums. But in the few instances when they were housed together, better living conditions were available to the Europeans. While work was advocated as a means of 'moral management' of mental illness in Britain, the use of hard labour was not used on the soldiers and working-class Europeans as it was considered 'impracticable' due to the harsh climate. However, Indian patients were put into hard labour as part of their therapy at the asylums.
[246] Basu, *supra* note 231, at 481-482.
[247] Kymberly C. Brumlik, *Lunacy for Profit: The Economic Gains Of "Native-Only" Lunatic Asylums In The Bengal Presidency, 1850s-1870s*, 2 JOURNAL OF SOUTH ASIAN STUDIES 3–4 (2014).
[248] (14 & 15 Vict., c. 81). This was a short Act with VII sections.
[249] Lunatics Removal (India) Act, 1851, §V.

The Act ceased to be in force in 1891.[250] It was repealed by the Statute Law Revision Act, 1958.[251]

3.2.1.2. The Lunacy (Supreme Courts) Act, 1858,[252] The Lunacy (District Courts) Act, 1858 [253] and The Indian Lunatic Asylum Act, 1858 [254]

All the said Acts were passed on 14 September 1858. The Lunacy Act of 1858 provided guidelines for establishing mental asylums and elucidated the admission procedure of persons with mental illnesses. The Act was subsequently modified in 1888 to include detailed guidelines and instructions to regulate the admission and treatment of criminal lunatics.[255] The Act reflected the legalistic view for managing persons with mental illnesses followed in the contemporary English Lunacy Acts.[256] The period between 1858-1912 saw the overcrowding of asylums and a consequent deterioration in the maintenance and upkeep of these places.[257]

The Lunacy (Supreme Courts) Act, 1858, was passed to regulate the lunacy proceedings[258] in the Supreme Courts in India. The Lunacy Regulation Act, 1853 of England, formed the basis for the said Act. The Act empowered the Supreme Court to direct an enquiry to determine the lunacy of a person, the nature of his property or any other matter as deemed proper, on application to the Court by any of his relatives by blood or marriage by the Advocate General.[259] The Court was empowered to make orders on matters connected with lunacy.[260] Where the

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[250] Muhammad Mudasir Firdosi & Zulkarnain Z. Ahmad, *Mental Health Law in India: Origins and Proposed Reforms*, 13 BJPSYCH INTERNATIONAL 65 (2016).

[251] Statute Law Revision Act, 1958, First Schedule.

[252] Ramani Kanta Doss, *Chapter I. The Lunacy (Supreme Courts) Act, 1858, Being Act XXXIV of 1858*, *in* THE LAW OF LUNACY IN BRITISH INDIA 5–21 (1906), http://ndl.iitkgp.ac.in/document/Y2pHN2dub3JmTnRGTkJtVkMxZFkySCt5cS9uZm83M29HOGdoREJBRjBUST0 (last visited Aug 14, 2021). The Act had 32 sections.

[253] Ramani Kanta Doss, *Chapter II. The Lunacy (District Courts) Act, 1858, Being Act XXXV of 1858*, *in* THE LAW OF LUNACY IN BRITISH INDIA 22–40 (1906), http://ndl.iitkgp.ac.in/document/Y2pHN2dub3JmTnRGTkJtVkMxZFkySCt5cS9uZm83M29HOGdoREJBRjBUST0 (last visited Aug 14, 2021). The Act had 23 sections.

[254] Ramani Kanta Doss, *Chapter XI. The Indian Lunatic Asylums Act, 1858, Being Act XXXVI of 1858*, *in* THE LAW OF LUNACY IN BRITISH INDIA 179–200 (1906), http://ndl.iitkgp.ac.in/document/Y2pHN2dub3JmTnRGTkJtVkMxZFkySCt5cS9uZm83M29HOGdoREJBRjBUST0 (last visited Aug 14, 2021). The Act had 18 sections and a Schedule.

[255] Sharma and Varma, *supra* note 235.

[256] Somasundaram, *supra* note 233, at 7.

[257] Anand Mishra, Thomas Mathai & Daya Ram, *History of Psychiatry: An Indian Perspective*, 27 INDUSTRIAL PSYCHIATRY JOURNAL 23 (2018).

[258] The lunacy proceedings included proceedings: (a) for appointment of guardians and keepers of the persons and estates of lunatics, (b) to enquire into, hear and determine the questions of lunacy. Prior to the enactment,the determination on the questions of lunacy were usually made by inquisition before a jury. The Act aimed to lessen the cost and alter mode of enquiry into such determination and empowered Courts to make provision for management of estates of lunatics.

[259] The Lunacy (Supreme Courts) Act, 1858, §1 read with §2.

[260] The Lunacy (Supreme Courts) Act, 1858, §17.

unsoundness of mind of the alleged lunatic [261] was found to have ceased, the Court had the power to order all lunacy proceedings to cease or be set aside on such terms and conditions as deemed proper for the case.[262]

The Lunacy (District Courts) Act, 1858, was enacted to better provide for the care of estates of lunatics who were not subject to the jurisdiction of the Supreme Courts. The Act empowered the Civil Courts to institute enquiry when the possessor of the property within its jurisdiction was alleged to be a lunatic.[263] The orders made by the Civil Court or any Subordinate Courts under the Act were appealable.[264]

The Lunacy (Supreme Courts) Act, 1858 and The Lunacy (District Courts) Act, 1858 were not exhaustive and only dealt with the question of inquisition, the appointment of committees of the person and property of the lunatic and the management of his estate. The Lunacy (Supreme Courts) Act 1858 did not provide guidelines on who may be appointed as committees, their entitlement to remuneration, if any, their duties, liabilities and conditions for their removal. The general provisions under Sections 13, 17 and 30 of the Act were to decide these matters. However, these matters were explicitly covered under The Lunacy (District Courts) Act, 1858.[265]

The Indian Lunatic Asylums Act, 1858, was enacted to provide for the reception and detention of lunatics in asylums. The Act was based to some extent on the Lunacy Act, 1853.[266] The district police officer had the duty to apprehend wandering and dangerous lunatics and send them to the Magistrates for orders for committal to the care of a friend or relative or for reception in asylums in appropriate cases.[267] The district police officer was dutybound to report instances of neglect or cruel treatment of the lunatic, which came within his knowledge, to the

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[261] The word "lunatic" as used in the Act meant any person found by due course of law to be of unsound mind and incapable of managing his affairs. This includes plural form and both genders. (The Lunacy (Supreme Courts) Act, 1858, §32.) (The Lunacy (District Courts) Act, 1858, §23.)

[262] The Lunacy (Supreme Courts) Act, 1858, §29.

[263] The Lunacy (District Courts) Act, 1858, §2. The Court was also empowered to institute enquiry to ascertain whether a person has ceased to be of unsound mind. Where it was adjudged that such person had ceased to be of unsound mind, the Court was required to make a final order for delivery of his estate to him. (The Lunacy (District Courts) Act, 1858, §21).

[264] The Lunacy (District Courts) Act, 1858, §22.

[265] Ramani Kanta Doss, *Introduction, in* THE LAW OF LUNACY IN BRITISH INDIA 2–3 (1906), http://ndl.iitkgp.ac.in/document/Y2pHN2dub3JmTnRGTkJtVkMxZFkySCt5cS9uZm83M29HOGdoREJBRjBUST0 (last visited Aug 15, 2021).

[266] (6 & 17 Vict.c.96).

[267] The Indian Lunatic Asylums Act, 1858, §4. For reception in a lunatic asylum, a signed certificate of Medical Officer after the examination of the lunatic by the Magistrate with the assistance of the Medical Officer was necessary. (The Indian Lunatic Asylums Act, 1858, §4.) If defective or incorrect, the certificates, could be amended by the person/s who signed the same, with the sanction of 2 or more visitors of the asylum which included a Medical Officer. (The Indian Lunatic Asylums Act, 1858, §12.)

Magistrate.[268] Where the Court of Wards or the Collector or the Civil Court had not appointed a guardian, any friend or relative of such person, desiring his admission to a lunatic asylum, could make an application to the Civil Court. When the Court adjudged a person to be a lunatic, it could make appropriate orders for such a person to receive care and treatment in a lunatic asylum.[269]

3.2.1.3. Military Lunatic Act, 1877 [270]

The Act facilitated the admission of European Military Lunatics into asylums, on such orders made by the Surgeons-General either of the British forces or the Indian Medical Service.[271]

3.2.1.4. The Indian Lunacy Act, 1912 [272]

In the early 20th century, the adverse publicity about the conditions of the mental asylums spurred a series of reforms to improve the mental health system. The Government, under Lord Morley, transferred the charge of mental hospitals from the Inspector General of Prisons to the Civil Surgeons. Specialists in the field of psychiatry were appointed on a full-time basis in these hospitals. Further, central supervision of all lunatic asylums was effectuated under the Indian Lunacy Act, 1912.[273]

The Indian Lunacy Act 1912 consolidated, revised and replaced all the preceding acts dealing with Lunacy. The Act drew significantly from the English Lunatics Act, 1845. The statement of object and reasons for the introduction of the Bill echoed the prevailing fear of "false detention of same people." The English Lunacy Act, 1890, formed the basis for the procedure set out for the issue of reception orders under the Indian Lunacy Act, 1912. The provision for voluntary admission in asylums was made in India [274] through the 1912 Act much before its introduction in England and Wales by the Mental Treatment Act, 1930. The Act further provided for the procedure of judicial inquisitions [275] as to lunacy, care of wandering or

[268] The Indian Lunatic Asylums Act, 1858, §5. Duty of the Magistrate and the district police officers as authorised by §4 and §5 could be performed by the Commissioner of Police and an officer not below the rank of inspector respectively, in the Presidency towns. (The Indian Lunatic Asylums Act, 1858, §6.)

[269] The Indian Lunatic Asylums Act, 1858, §8(3). Such orders by court could also be made under §8(2) of the Act where a guardian had been appointed for the person adjudged to be a lunatic by the Court of Wards or the Collector or the Civil Court, where such guardian desires the admission of such person in a lunatic asylum, and makes such application to the Civil Court.

[270] The Act had 9 sections.

[271] Military Lunatics Act, 1877, §3.

[272] The Act had 8 Chapters, 101 Sections and a Schedule with 8 forms.

[273] Sharma and Varma, *supra* note 235.

[274] Such a provision for inclusion of a new category of patients (voluntary boarders) was introduced through the efforts of the then Governor of Madras. The provision for voluntary boarders was made in Indian Lunacy Act, 1912, §4.

[275] The procedures were provided for Presidency Towns in Chapter IV and other towns outside the Presidency Towns in Chapter V. The procedures specified were similar to the provisions of the Lunacy (Supreme Courts) Act, 1958. The patients forming part of this group corresponded to the 'Chancery Lunatics' of England. The

dangerous lunatics and lunatics not treated or under proper control [276], and special subgroups [277] of the mentally ill.[278]

The Act defined a lunatic as "an idiot or person of unsound mind." As the provision was broadly drafted, issues concerning the status of schizophrenics and persons with dementia were left to be determined by the Courts. An example of such a determination by the Court is the Calcutta High Court decision[279], where it was held that all schizophrenics are lunatics, but not all lunatics are schizophrenics.[280]

Sections 5 to 11B of the Act provided the procedure for obtaining a reception order on petition to the Magistrate within whose territorial jurisdiction the alleged lunatic resided.

Section 18 provided the specifications in a medical certificate. Section 18(2) of the Act prohibited the Court from making a reception order on a petition based on a medical certificate founded solely upon facts communicated by others. The reception order was valid only for 30 days from the date of order.[281] The authority making the reception order was to send its certified copy to the person in charge of the asylum in which the lunatic was to be admitted.

Section 25 of the Act provided for admission into an asylum after the inquisition by the High Court or District Court. Section 26 specified the power of such courts to make orders for payment of the cost of maintenance of the lunatic. Section 28 and 29 of the Act dealt with the appointment and monthly inspection by visitors, respectively. The monthly inspection by the visitors provided for in the Act was the closest to a periodic review process for detained patients.[282]

Section 36 authorised the police officer or the person in charge of such asylum or any other person authorised by him to re-capture the lunatic after escape for detention in the asylum. In cases where the lunatic was neither a criminal lunatic nor a lunatic regarding whom a reception order was made, the power to re-take such a person could be exercised only for a month from the date of escape.

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procedure "was derived from the Praerogativa Regis of Edward II, which is taken as the starting point of lunacy legislation."

[276] Under Sections 13, 14 and 15 of the Act of 1912. These patients corresponded to England's 'vagrant and pauper lunatics', who were regulated under the Vagrancy Acts of 1714 and 1744.

[277] Mentally ill in the armed forces and mentally abnormal offenders. This group included undertrials and those serving a sentence.

[278] Somasundaram, *supra* note 233, at 8-10.

[279] Pronab KR Ghosh v. Krishna Ghosh (AIR 1975 Cal. 109).

[280] Karthik 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*, 31 COMMONWEALTH LAW BULLETIN 45.

[281] Indian Lunacy Act, 1912, §20.

[282] Richard M. Duffy & Brendan D. Kelly, *4. History of Mental Health Legislation in India*, *in* INDIA'S MENTAL HEALTHCARE ACT, 2017: BUILDING LAWS, PROTECTING RIGHTS 99 (2020).

Section 37 to 45 of the Act provided the procedure for the inquisition to determine the lunacy of a person, on application by a relative or the Advocate General to the High Courts at Fort William, Madras or Bombay (Presidency towns). Section 60 provided that when the Court found the unsoundness of mind to have ceased, it could order all proceedings in the lunacy to cease or be set aside on terms and conditions as deemed fit by the Court. Sections 84 of the Act provided that the State Government could establish or license the establishment of asylums. Section 84-A provided the State Government with the power to cancel the license if provision for curative treatment was insufficient. Section 86 to 90 related to provision for expenses of lunatics related to their maintenance.

Along with efforts to improve the condition of mental health asylums, newer hospitals were also opened for providing care to persons with mental illnesses. In 1922, the terminology 'lunatic asylum' was changed to 'mental hospitals' in the Act in India.[283] The use of occupational therapy and rehabilitation was emphasised for the treatment of persons with mental illnesses.

The British Government had appointed The Health Survey and Development Committee under the chairmanship of Sir Joseph Bhore in 1943 to review and make recommendations on the prevailing health conditions and health organisation in British India, which was a pioneering initiative in India.[284] In its report submitted in 1946, [285]observations regarding mental disorders and mental deficiency were provided under Chapter IX. It noted the acute shortage of beds in mental health institutions, lack of training of Superintendents and subordinate medical staff employed, inadequate number of medical officers, nursing staff and ward attendants in the then existing mental hospitals. It further suggested the need for training for mental health medical and non-medical personnel.[286] Further recommendations were provided regarding administrative changes [287] in the healthcare delivery system, capacity addition and improvement of infrastructure facilities of mental health institutions, replacement of asylums with hospitals[288], provision of training facilities for medical professionals and allied mental

[283] Sharma and Varma, *supra* note 235.
[284] Mishra, Mathai, and Ram, *supra* note 257.
[285] Bhore Committee Report, https://www.nhp.gov.in/bhore-committee-1946_pg (last visited Jul 15, 2021).
[286] VOL.1 (SURVEY), CHAPTER IX. HEALTH SERVICES FOR CERTAIN IMPORTANT DISEASES, REPORT OF THE HEALTH SURVEY AND DEVELOPMENT COMMITTEE (BHORE COMMITTEE) 130–132 (1946), https://www.nhp.gov.in/sites/default/files/pdf/Bhore_Committee_Report_VOL-1.pdf (last visited Jul 15, 2021).
[287] Creation of mental health organisations as part of establishments under the Director-General of Health Services (Central and Provincial).
[288] It was noted that asylums only served to segregate the persons with mental illnesses from the general community. Replacement of this system with hospital care was recommended to ensure that persons with mental illnesses receive "medical attention and sympathetic handling" required for their recovery.

health staff.[289] The Indian Lunacy Act, 1912, continued to be used until its replacement by the Mental Health Act, 1987.

3.2.2. POST-INDEPENDENCE PHASE

3.2.2.1. The Mental Health Act, 1987 [290]

As a stark parallel to the developments in mental healthcare in the West, where social psychiatry and community care had developed in the twilight years of asylum care, such comparable development did not occur in India. There was an acute shortage of ancillary professional staff.[291] The role of asylums in the care of persons with mental illnesses was rapidly diminishing due to the development of psychiatric drugs.[292]

The focus of the Indian Government post-independence had been on the creation of psychiatric departments in general hospitals rather than on standalone mental hospitals.[293] This strategy was adopted keeping in view the contemporary international shift "towards de-institutionalisation" and the persisting poor State of existing mental hospitals.[294]

Psychiatric units began to be established within general hospitals from the 1930s, and this practice became increasingly popular from the 1960s. Such a model allowed for voluntary admission of persons with mental illnesses with the support of the family during the treatment in the hospital. Such facilities gradually became more preferred than standalone mental hospitals due to the reduced stigma attached to such treatment.[295]

Following the shift towards establishing general hospital psychiatric beds, a new initiative emerged in 1975, referred to as the community psychiatry initiative, which sought to integrate mental health with general health services. While it initially started as isolated extension psychiatric clinics in primary health clinics, there was a move towards integrating mental health care in general services, covering over 127 districts and serving about 20% of the population in 2011.[296]

Following India's independence, the revised mental Healthcare Bill submitted by the Indian Psychiatric Society in 1949 was enacted as The Mental Health Act, 1987. The Act was not

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[289] VOL.2 (RECOMMENDATIONS), CHAPTER XI. HEALTH SERVICES FOR CERTAIN IMPORTANT DISEASES, REPORT OF THE HEALTH SURVEY AND DEVELOPMENT COMMITTEE (BHORE COMMITTEE) 206–217 (1946), https://www.nhp.gov.in/sites/default/files/pdf/Bhore_Comittee_Report_Vol2.pdf (last visited Jul 15, 2021).

[290] The Act had 10 Chapters and 98 Sections.

[291] Psychologists, psychiatric social workers, mental health nurses.

[292] Jain, *supra* note 234, at 298.

[293] Sharma and Varma, *supra* note 235.

[294] Mishra, Mathai, and Ram, *supra* note 257.

[295] R. Thara, R. Padmavati & T.N. Srinivasan, *Focus on psychiatry in India*, 184 BRITISH JOURNAL OF PSYCHIATRY 366–367 (2004).

[296] R. Srinivasa Murthy, *Mental Health Initiatives in India (1947-2010)*, *in* SOCIAL WORK IN MENTAL HEALTH - CONTEXTS AND THEORIES FOR PRACTICE 29–30 (2014).

reflective of the changes that had taken place in mental health delivery since it was drafted.[297] The Act came into force in 1993. It emphasised treatment and the need to protect the interests of persons with mental illnesses. It additionally provided guidelines for the establishment and maintenance of psychiatric hospitals and nursing homes.[298] However, the effective implementation of the Act only took place after the 'Erwadi tragedy' in which 28 shackled inmates died following a fire accident in a faith-based mental health facility. The inmates were not offered any therapy and were tied to trees by day and beds by night.[299]

The Mental Health Act, 1987 was passed "to consolidate and amend the law relating to the law concerning the treatment and care of persons with mental illnesses, to make better provision for their property and affairs and related matters." The Central Government was empowered to establish the Central Authority for Mental Health Services for the regulation, development, direction and coordination of mental health services and all matters under the ambit of the Central Government, supervision of psychiatric hospitals, psychiatric nursing homes and other Mental Health Service Agencies under Central Government control, advise Central Government and discharge other required functions on all matters relating to mental health.[300] The Act authorised the State Government to establish the State Authority for Mental Health Services to perform similar functions as the Central Authority concerning mental health services under the State Government.[301]

The Central Government and the State Government were responsible for establishing and maintaining psychiatric hospitals or nursing homes for the admission, treatment, and care of persons with mental illness within the limits of their respective jurisdictions. The Central and State Government could also establish separate psychiatric hospitals and psychiatric nursing homes for minors under sixteen years of age, persons convicted of any offence, treatment of alcohol and substance abuse resulting in behavioural changes and any other prescribed class or category of persons.[302] The psychiatric hospitals or psychiatric hospitals could only be

[297] Richard M. Duffy & Brendan D. Kelly, *Concordance of Indian Mental Healthcare Act 2017 With World Health Organisation's Checklist On Mental Health Legislation*, INTERNATIONAL JOURNAL OF MENTAL HEALTH SYSTEMS 3 (2017).
[298] Mishra, Mathai, and Ram, *supra* note 257 at 24.
[299] B.N. Raveesh, Swaran P. Singh & Soumitra Pathare, *Chapter 16. Coercion and Mental Health Services in the Indian Subcontinent and the Middle East*, *in* COERCION IN COMMUNITY MENTAL HEALTH CARE INTERNATIONAL PERSPECTIVES 258–262 (2016).
[300] The Mental Health Act, 1987, §3.
[301] The Mental Health Act, 1987, §4.
[302] The Mental Health Act, 1987, §5.

established or maintained on grant of a valid license under the Act by the Central Government or the State Government, which was to be periodically renewed.[303]

The Mental Health Act, 1987 permitted involuntary treatment based on the level of risk posed by the mental illness and the potential benefits of treatment as assessed by the treating team (medical officer) or the Magistrate (substitute decision-making). There was little to no involvement expected of the person receiving involuntary treatment.[304]

Any person who attained majority, considering himself to be a mentally ill person desiring admission to any psychiatric hospital or psychiatric nursing home, could request the medical officer in charge to admit him as a voluntary patient.[305] The guardian of a minor considering such minor to be a mentally ill person and desiring the minor's admission in any psychiatric hospital or psychiatric nursing home for treatment could request the medical officer in charge for his admission as a voluntary patient.[306] Upon receiving the request, the medical officer inquired into the matter within 24 hours and could admit the application as a voluntary patient, subject to his satisfaction that the applicant required inpatient treatment.[307]

The voluntary patient could be discharged by the medical officer in charge of the psychiatric hospital or nursing home on request by the voluntary patient or the guardian of a minor voluntary patient. Where a minor voluntary patient admitted as an inpatient in any psychiatric hospital or psychiatric nursing home attained majority, the medical officer in charge of the hospital or nursing home was to intimate the patient of his attainment of majority at the earliest. Such a patient was to be discharged unless he requested continued inpatient treatment within one month of intimation of his majority. However, where the medical officer in charge was satisfied that such discharge was not in the best interest of the voluntary patient, he could constitute a Board consisting of two medical officers to seek its opinion on the need for treatment. Such a Board was to be constituted within seventy-two hours of either receiving the request from a voluntary patient or expiry of one month from his intimation of the voluntary patient's attainment of majority. If the Board opined affirmatively on the need for further treatment, the medical officer would continue the treatment of such voluntary patient for a period not exceeding ninety days at a time.[308]

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[303] The Mental Health Act, 1987, §6, §9. The license granted under the Act was valid for a period of 5 years from date of grant of license.

[304] Vasudevan Namboodiri, *Capacity For Mental Healthcare Decisions under the Mental Healthcare Act*, 61 INDIAN JOURNAL OF PSYCHIATRY S676 (2019).

[305] The Mental Health Act, 1987, §15.

[306] The Mental Health Act, 1987, §16.

[307] The Mental Health Act, 1987, §17.

[308] The Mental Health Act, 1987, §18.

A medical officer in charge could admit a person with mental illness who did not or was unable to express willingness for admission as a voluntary patient in a psychiatric hospital or psychiatric nursing home, on application by a relative or friend of the person with mental illness[309]. The medical officer in charge could make such an admission on his satisfaction of its necessity in the person's interest. Such admission could not exceed ninety days except under the other provisions of the Act. Such persons admitted or his relative or friend could apply to the Magistrate for his discharge. The Magistrate could allow or dismiss the petition after giving notice to the person who secured the admission of the psychiatric hospital or psychiatric nursing home and making such enquiry as deemed fit.[310]

Section 20 to 22 provided the procedure for obtaining reception orders on application. Section 24 provided the procedure for obtaining reception orders on the production of persons with mental illness by the police officer in charge of the police station before a Magistrate.[311] Section 25 provided that an officer in charge of the police station or any private person could report to the Magistrate that a person with mental illness was ill-treated or neglected by relatives or persons having his charge or not under proper care and control. The Magistrate could by order require the relative or other person to take proper care of the person with mental illness. If such a person wilfully neglected to comply with the order, he could impose a fine of up to two thousand rupees. Section 26 to 29 provided for the admission of specific categories of persons with mental illness.[312]

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[309] The application was to be made in the prescribed form accompanied by two medical certificates from two medical practitioners certifying the need for inpatient observation and treatment in a psychiatric hospital or psychiatric nursing home given the condition of the person with mental illness. One of the medical practitioners was required to be in Government service. The medical officer in charge of the psychiatric hospital or psychiatric nursing home could also cause a person with mental illness to be examined by two medical practitioners working in the hospital or nursing home instead of the medical certificates.

[310] The Mental Health Act, 1987, §19.

[311] The police officer in charge of the police station had the duty to produce the detained persons (whom he believed to be wandering or dangerous lunatics, took into protection and detained) before the nearest Magistrate within 24 hours of taking him into such protection excluding the time necessary for the journey to the Court of the Magistrate. Further detention beyond the said period was not permissible without the authority of the Magistrate. (The Mental Health Act, 1987, §23.) The Magistrate could send such a person for treatment to any particular licensed psychiatric hospital or psychiatric nursing home if any of his relative or friend desires so and expressly undertakes to pay the cost of maintenance incurred at such hospital or nursing home. The Magistrate could make a reception order for such admission after obtaining the consent of the medical officer in charge of the hospital or nursing home. The Magistrate could also hand over the person with mental illness to the care of a relative or friend who entered into a bond with or without sureties for such amount as determined by the Magistrate and on undertaking that the person would be properly taken care of and prevented from causing injury to himself or others. (The Mental Health Act, 1987, §24.)

[312] Section 26 provided for admission as inpatient in psychiatric hospital or nursing home after inquisition by the District Court. Section 27 provided for admission and detention of prisoners with mental illness. Section 28 provides for detention of persons alleged to have mental illness authorised by the Magistrate, pending medical officer's report for a period not exceeding 10 days at a time and total period not exceeding 30 days in aggregate. Section 29 authorises the detention of a person with mental illness for a period not exceeding 30 days pending his removal to a psychiatric hospital or psychiatric nursing home.

The Act provided for the joint monthly inspection by not less than three visitors of the psychiatric hospital or nursing home in respect of which they were appointed and for recording their remarks relating to the management and condition of such hospital or nursing home and the inpatients.[313]

Section 40 to 44 provided for modes of discharge of persons from the psychiatric hospital or nursing home.[314] The person who had earlier applied for admission of the person with mental illness who had attained majority[315] could apply for leave of absence on his behalf to the medical officer in charge for a maximum of sixty days.[316] The Act authorised the Magistrate[317] to grant leave of absence where the medical officer in charge had refused the application.[318] The Act allowed for a final appeal against any order of the Magistrate to the District Court within the territorial jurisdiction of which the Magistrate exercised his powers.[319]

Sections 50 to 77 (Chapter VI of the Act) made provisions for the judicial inquisition by the District Court into the mental condition of a person alleged to have a mental illness possessing property to determine the necessity of the appointment of a guardian[320] for the custody of the person and a manager[321] for management of his property. The District Court had the power to

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[313] The Mental Health Act, 1987, §38.

[314] The order of discharge could be made by a medical officer in charge of a psychiatric hospital or nursing home on the recommendation of two medical practitioners, including preferably a psychiatrist of patients other than voluntary patients or mentally ill prisoners. Where the detention is under the order of any authority, the medical officer had to immediately forward a copy of the discharge order to that authority. (The Mental Health Act, 1987, §40.) Discharge order could be made on application to the medical officer in charge. However, where the medical officer in charge certified in writing that the person with mental illness was dangerous and unfit to be at large, he would not be discharged. (The Mental Health Act, 1987, §41.) A discharge order could be made on the application by any relative or friend of a person with mental illness to the medical officer and their undertaking to take proper care of such person. (The Mental Health Act, 1987, §42.) The discharge of the person could be made on an application of the person who felt he had recovered from the mental illness to the Magistrate supported by a medical certificate either by a psychiatrist or the medical officer in charge of the psychiatric hospital or nursing home where the applicant was treated. The Magistrate could after making an inquiry pass a discharge order or dismiss the application. (The Mental Health Act, 1987, §43.) Where any person detained in a psychiatric hospital or nursing home under a reception order was subsequently found on an inquisition to be of sound mind or capable of taking care of himself and managing his affairs, the medical officer in charge could discharge such person on production of a copy of such finding duly certified by the District Court. (The Mental Health Act, 1987, §44.)

[315] This could be either the husband or wife of the person admitted or any other relative duly authorised by the husband or wife in their absence from India or otherwise or any other person.

[316] The Mental Health Act, 1987, §45. This provision was not applicable to minors and voluntary patients.

[317] The application was to be made to the Magistrate within whose territorial limits the psychiatric hospital or nursing home was situated.

[318] The Mental Health Act, 1987, §45.

[319] The Mental Health Act, 1987, §49.

[320] The Mental Health Act, 1987, §52, §53, §57, §58.

[321] The Mental Health Act, 1987, §52, §54 - 56, §57, §58, §57, §59-64, §67. The manager of the property could also be appointed by the District Collector when the District Court entrusted the property to the District Collector. (The Mental Health Act, 1987, §55.) The relatives of the person with mental illness or the District Collector could institute proceedings before the District Court to impugn the accuracy of the inventory or annual accounts. (The Mental Health Act, 1987, §66.) The relatives could, with the leave of the District Court, sue for an account with respect to property or sums of money from the manager or other persons specified under the section. (The Mental Health Act, 1987, §68.)

pass orders on any matter connected with the person with mental illness and his property on application by any person.[322] The District Court could set aside the action taken regarding the person with mental illness after an inquisition on finding that the mental illness had ceased.[323] The Act provided for an appeal from the orders of the District Court to the High Court.[324]

The Act's provisions fixed the liability to meet the maintenance cost of persons with mental illness detained in the psychiatric hospital and nursing home. The cost of maintaining such a person was to be borne by the Government in certain cases[325] or recoverable out of the estate of such person or from the person who was legally bound to maintain him.[326]

The Act addressed some human rights aspects of persons with mental illnesses. It prohibited their subjection to physical or mental indignity or cruelty during treatment. The person with mental illness under treatment was not to be used as a subject for research purposes unless such research was directly beneficial for his diagnosis or treatment or such voluntary patient has consented[327] in writing for such research. Further, the Act prohibited the interception, detention or destruction of communication or letters sent by or to the person with mental illness under treatment.[328]

The Act makes provision for the State to provide legal aid to persons with mental illness where such person does not have the sufficient means to engage a legal practitioner to represent him in proceedings before the District Court or the Magistrate.[329]

The Act brought many positive changes in the field of mental healthcare in India. Stigmatising terminologies like asylum and lunatic under the Indian Lunacy 1912 were replaced with terms like psychiatric hospital or nursing home and mentally ill person. The Act established a system of mental hospital licensing for the establishment and maintenance of psychiatric hospitals and psychiatric nursing homes. It prohibited research on inpatient subjects without obtaining consent. However, relatives were permitted to grant consent on behalf of the patient. It further provided for separate areas to accommodate children with mental illness and mentally ill prisoners. The Act simplified the procedures for admission and discharge of persons with

[322] The Mental Health Act, 1987, §65.
[323] The Mental Health Act, 1987, §75.
[324] The Mental Health Act, 1987, §76.
[325] The Mental Health Act, 1987, §78.
[326] The Mental Health Act, 1987, §79.
[327] The guardian or other competent person could also give written consent for such research in case the person is incompetent due to his minority or otherwise. The consent on behalf of such person can be given in cases of both voluntary and other patients.
[328] The Mental Health Act, 1987, §81.
[329] The Mental Health Act, 1987, §91.

mental illness.[330] It was the first Indian mental health legislation to consider outpatient treatment, theoretically helping the focus of psychiatric care shift from psychiatric hospitals to the community[331].

The inability to form and allocate a budget for the functioning of the State Mental Health Authority in many states was considered a reason for the failure of The Mental Health Act, 1987.[332] The Act focused on the admission and treatment of persons with severe mental illnesses in mental hospitals when involuntarily detained. The Act was not implemented across India due to a severe shortage of resources[333]. Additional challenges leading to failure in implementing the Act included "unrealistic minimum standards set for mental hospitals, restrictive licensing requirements, exclusion of government institutions and traditional health sector from its ambit and divergent perspectives among psychiatrists, government and the legal viewpoint".[334] Further, the Act assumed that persons with mental illnesses are violent and dangerous. The Act did not give due regard to community-based mental health care and did not align with the government policy laid down by the National Mental Health Program. It did not provide adequate attention to care after discharge and rehabilitation. It failed to address social stigma and insufficient social awareness of mental health issues.[335] The non-availability of review by a judicial body in cases where the personal liberty of persons with mental illnesses was curtailed was also severely criticised. The inadequate treatment facilities also posed significant financial, social and economic burdens on the caregivers and families.[336] The Act did not give adequate importance to the role of the family and community in the treatment and care of persons with mental illness. It did not have any punitive provisions to deter relatives and other persons from requesting unnecessary detention to psychiatric hospitals and nursing homes.[337] The Act only regulated the establishment and maintenance of psychiatric hospitals and nursing homes and was silent on integrating psychiatric units within general hospitals.[338]

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[330] Dr. Prateek Rastogi, *Mental Health Act, 1987—An Analysis*, 27 JOURNAL OF INDIAN ACADEMY OF FORENSIC MEDICINE 176–178 (2005).
[331] Duffy and Kelly, *supra* note 282 at 102.
[332] Suresh Bada Math et al., *Cost Estimated For the Implementation of the Mental Healthcare Act, 2017*, 61 INDIAN JOURNAL OF PSYCHIATRY S654 (2019).
[333] Suresh Bada Math et al., *Mental Healthcare Act, 2017—Aspiration to Action*, 61 INDIAN JOURNAL OF PSYCHIATRY S661 (2019).
[334] KS Jacob et al., *Mental health systems in countries: where are we now?*, 370 LANCET 1073 (2007).
[335] Pavitra KS et al., *Family Matters! - The Caregivers' Perspective of Mental Healthcare Act 2017*, 61 INDIAN JOURNAL OF PSYCHIATRY S833 (2019).
[336] Firdosi and Ahmad, *supra* note 250.
[337] S. Nambi, Siva Ilango & Lakshmi Prabha, *Forensic Psychiatry in India: Past, Present and Future*, 58 INDIAN JOURNAL OF PSYCHIATRY S177 (2016).
[338] Rastogi, *supra* note 330.

3.2.2.2. The Mental Healthcare Act, 2017 [339] – Critical Analysis

Since the development of community psychiatry approaches, there has been an expansion in community initiatives to address the diverse mental health needs in the community, including programmes for suicide prevention, care of the elderly and de-addiction. There has been a rapid growth of psychiatry in the private sector in urban areas, and day-care centres, half-way homes, long-stay homes, and rehabilitation facilities have been set up to cater to the mental health needs of persons.[340] The range of initiatives aimed at improving mental healthcare services in India included the shift of care delivery from the mental hospitals to general hospital psychiatric units, formulation of the National Mental Health Programme (NMHP), the District Mental Health approach to integrate mental health into general healthcare, the establishment of community treatment facilities, provision of support to families, use of traditional systems of healthcare, legislative changes, public education and research to support these initiatives.[341] The scope of legislative changes envisioned under the Mental Healthcare Act, 2017, is very broad and affects every aspect of mental health services.

The Mental Healthcare Act, 2017 attempted to regulate almost all mental health establishments.[342] The Preamble of the Mental Healthcare Act, 2017, stated that the Act sought to "provide mental healthcare and services for persons with mental illnesses" and "protect, promote and fulfil the rights of persons with mental illnesses during mental healthcare delivery."

The Act expressly recognised the vulnerability of and discrimination faced by persons with mental illnesses. It acknowledges the financial, emotional and social burden borne by the families and relatives of persons with mental illness for their treatment and care. The Act appreciated the need for equal treatment of mental illness at par with other health problems. It seeks to ensure a conducive and least restrictive environment for treatment and rehabilitation of persons with mental illnesses to facilitate their recovery, rehabilitation and full social participation safeguarding their rights and dignity. The Act provides that the treatment, care and rehabilitation efforts should improve the person's capacity to develop his full potential and facilitate effective community integration. The Act regulates the public and private mental health system within a rights-based framework. A new feature of the Act is its focus to enhance

[339] The Act is divided into 16 Chapters and has 126 sections.
[340] Murthy, *supra* note 296.
[341] *Id.*at 37.
[342] Bada Math et al., *supra* note 333.

accessibility in mental healthcare by providing quality public mental health services and ensure non-discrimination in health insurance.[343]

3.2.2.2.1. Preliminary matters and definitions

A "caregiver" under the Act is "a person who resides with a person with mental illness and is responsible for providing care to that person. It includes a relative or any other person who performs this function for free or with remuneration."[344] The Act defines "family" and "relative" as persons related by blood, adoption or marriage.[345]

The Authority under the Act is either the Central Mental Health Authority (CMHA) constituted under Section 33 or the State Mental Health Authority (SMHA) established under Section 45.[346] The Authorities (Central Mental Health Authority and State Mental Health Authority) are authorised to register all mental health establishments, maintain and publish a register of such establishments, develop quality and service provisions for different types of mental health establishments, supervise all mental health establishments and receive complaints about service deficiencies under the Central Government or in the State respectively, register and publish the list of registered mental health professionals, provide training on provisions and implementation of the Act to all persons including the law enforcement officials, mental health professionals and other health professionals and discharge such other functions relating to mental health matters as decided by the Central Government and State Government respectively. The Central Mental Health Authority should advise the Central Government on all mental healthcare and services matters.[347]

The Act defines "least restrictive alternative or least restrictive environment or less restrictive option" as a treatment option or treatment setting that meets the person's treatment needs and imposes the least restriction on his rights.[348]

The medical officer in charge refers to the psychiatrist or medical practitioner in charge of that medical establishment for the time being.[349]

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[343] Statement of Objects and Reasons, The Mental Healthcare Act, 2017.
[344] The Mental Healthcare Act, 2017, §2(e).
[345] The Mental Healthcare Act, 2017, §2(h), §2(za).
[346] The Mental Healthcare Act, 2017, §2(c), §2(f), §2(zb). Chapter VII and VIII of The Mental Healthcare Act, 2017 makes provisions for establishment, composition, term of office, salaries and allowances of Chairperson and members, resignation, filling of vacancies, functions etc. of the Central Mental Health Authority and the State Mental Health Authority respectively.
[347] CMHA, The Mental Healthcare Act, 2017, §43. SMHA, The Mental Healthcare Act, 2017, §55.
[348] The Mental Healthcare Act, 2017, §2(j).
[349] The Mental Healthcare Act, 2017, §2(m).

The medical practitioners under the Act include persons having the recognised medical qualification under Allopathy, Indian medicine[350] and Homeopathic system of medicine and enrolled as prescribed in the respective acts[351].[352]

"Mental Healthcare" under the Act includes analysis and diagnosis of the person's mental health condition and his treatment, care and rehabilitation.[353]

"Mental health professional" includes the following categories of professionals - a psychiatrist, clinical psychologists, mental health nurses and psychiatric social workers in the State registered with the concerned State Authorities under Section 55 of the Act or a professional having the required post-graduate degree[354] as prescribed in Ayurveda, Homeopathy, Unani or Siddha system of medicine.[355]

The Act defines mental illness as "*a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgement, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol or drugs, but it does not include mental retardation which is a condition of arrested or incomplete development of the mind of a person, specially characterised by subnormality of intelligence*."[356] The Act thus expressly excludes mental retardation from the ambit of mental illness.

3.2.2.2.2. Determination of Mental Illness and Capacity to make decisions relating to mental healthcare and treatment [357]

Determination of mental illness under the Act should be according to nationally and internationally accepted medical standards, including the latest edition of the ICD[358], as notified by the Central Government. The Act prohibits the classification of a person as having mental illness by any person or authority for purposes relating to the treatment of mental illness or matters covered under the Act or other law in force. The Act proscribed determining mental

[350] Ashtang Ayurveda and Siddha medicine. The medical health establishments under the Act as defined under Section 2(p) include Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy establishments.
[351] Indian Medical Council Act, 1956, Indian Medicine Central Council Act, 1970 and Homeopathy Central Council Act, 1973.
[352] The Mental Healthcare Act, 2017, §2(n).
[353] The Mental Healthcare Act, 2017, §2(o).
[354] The prescribed requirements for professionals in Indian Medicine and Homeopathy are: Post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a postgraduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam a Post-graduate degree (Homeopathy) in Psychiatry.
[355] The Mental Healthcare Act, 2017, §2(r).
[356] The Mental Healthcare Act, 2017, §2(s).
[357] Chapter II, The Mental Healthcare Act, 2017.
[358] International Classification of Diseases (ICD) of the World Health Organisation (WHO).

illness on any basis or reasons [359] not directly relevant to a person's mental health. The Act further provides that determining a person's mental illness does not automatically imply or mean unsoundness of mind unless a competent court makes such a declaration.[360]

The Act deems a person with mental illness to have the capacity for decision making concerning his mental healthcare or treatment based on his ability to "understand relevant information [361] for decision-making on treatment or admission or personal assistance and communicate such decision through speech, expression, gestures or other means or appreciate any reasonably foreseeable consequences of a decision or a lack of decision on treatment or admission or personal assistance." The lack of capacity for decision making cannot be inferred merely because of others' perception that the decision made by a person regarding his mental healthcare or treatment is perceived as inappropriate or wrong, provided he has the capacity for decision making as stipulated under the section. [362]

3.2.2.2.3. <u>Advance Directive</u> [363]

The Act provides persons who are not minors the right to make a written advance directive, specifying how the person wishes to be cared for [364] or not cared for [365] and treated for mental illness and the individuals he would like to appoint as his nominated representative in order of precedence [366]. An advance directive could be made by a person regardless of his past mental illness or treatment. The decisions made by a person while he has the capacity for decision making related to mental healthcare and treatment overrides his advance directive. Advance directives could be invoked only when a person ceases to have mental healthcare and treatment decision-making capacity and remains effective until he regains such decision-making capacity. An advance directive that violates any Indian law would be void ab initio.[367] The Central Authority regulations may specify how to make, revoke, amend or cancel advance directives.[368] The Central Authority is authorised to periodically review the use of and procedure for making advance directives and make suitable recommendations or modifications

[359] This includes political, economic or social status or cultural, racial or religious group membership or non-conformity with moral, social, cultural, work or political values or religious beliefs prevailing in the community. Present or future determination is also not justified by past treatment or hospitalisation alone.
[360] The Mental Healthcare Act, 2017, §3.
[361] Such information is to be provided in a manner easily understandable by the person using simple language or sign language or visual aids.
[362] The Mental Healthcare Act, 2017, §4.
[363] Chapter III, The Mental Healthcare Act, 2017.
[364] The Mental Healthcare Act, 2017, §5(1)(a).
[365] The Mental Healthcare Act, 2017, §5(1)(b).
[366] The Mental Healthcare Act, 2017, §5(1)(c).
[367] The Mental Healthcare Act, 2017, §5.
[368] The Mental Healthcare Act, 2017, §6, §8.

of the procedure or make additional regulations governing the procedure for advance directives to ensure the protection of rights of persons with mental illness.[369] The Mental Health Board constituted by the State Authority must maintain an online register of all registered advance directives to provide the mental health professionals as required.[370] The advance directive made by the person is not applicable in cases of emergency treatment.[371] The medical officer in charge of a mental health establishment and the psychiatrist in charge of the treatment of a person is dutybound to follow the wishes expressed by such person in his valid advance directive.[372] The mental health professional or relative, or caregiver of a person who does not desire to follow the advance directive made by the person being treated for mental illness, should apply to the concerned Mental Health Review Board for review, alteration, modification or cancellation of the advance directive. After hearing the parties, including the person who made the advance directive, the Board is authorised to uphold, modify, alter or cancel the advance directive after considering whether:

- The person who made the advance directive did so it out of his free will and free from vitiating factors, intended the application of the advance directive to the current circumstances, had sufficient information to make the decision and had capacity for decision-making related to healthcare or treatment at the time of making the advance directive
- The contents of the advance directive adhere to the constitutional provisions and the other Indian laws.

The person making the advance directive and his nominated representative have the duty to ensure access to the advance directive to the medical officer in charge of a mental health establishment, medical practitioner or mental health professional when required. The legal guardian has a right to make an advance directive on behalf of the minor, which shall remain applicable till such minor attains majority.[373] The Act exempts the medical practitioner or mental health professional from liability for any unforeseen consequences on following a valid advance directive and not following the wishes expressed in the advance directive if he was not provided with a copy of the same.[374]

3.2.2.2.4. <u>Nominated Representative</u> [375]

[369] The Mental Healthcare Act, 2017, §12.
[370] The Mental Healthcare Act, 2017, §7.
[371] The Mental Healthcare Act, 2017, §9.
[372] The Mental Healthcare Act, 2017, §10.
[373] The Mental Healthcare Act, 2017, §11.
[374] The Mental Healthcare Act, 2017, §13.
[375] Chapter IV, The Mental Healthcare Act, 2017.

Every person who has attained majority has the right to appoint a nominated representative. The person should make such a nomination in writing together with the signature or thumb impression of the nominated person (nominated representative). The nominated representative should not be a minor and should be competent to discharge the duties and functions under the Act. The person appointing the nominated representative could revoke or alter the appointment according to the same procedure prescribed under the Act for making the appointment. He should also give his written consent to the mental health professional to perform his duties and functions assigned under the Act. Where a person with mental illness has not appointed the nominated representative, the Act deems the following persons as his nominated representative in the following order of precedence: the individual appointed under Section 5(1)(c) in the advance directive [376] or a relative [377] or a caregiver [378] or a suitable person as appointed by the concerned Mental Health Board [379] or the Director, Department of Social Welfare or his designated representative.[380] The Act permits the mental health professional to temporarily appoint a person [381] to discharge duties of a nominated representative, pending the concerned Mental Health Board's appointment of a nominated representative. The Act authorises the Mental Health Board to revoke its appointment and appoint a different representative in the interest of the person with mental illness. The Act provides that the appointment or inability to appoint a nominated representative should not be construed as a lack of capacity for decision-making relating to the mental health care and treatment of the person with mental illness. The Act deems "*all persons with mental illness to have the capacity to make mental health care or treatment decisions but require varying levels of support from their nominated representative to make the decision*" [382,383] Unless the Mental Health Board orders otherwise[384], the legal

[376] The Mental Healthcare Act, 2017, §14(4)(a).
[377] The Mental Healthcare Act, 2017, §14(4)(b).
[378] The Mental Healthcare Act, 2017, §14(4)(c).
[379] The Mental Healthcare Act, 2017, §14(4)(d).
[380] The Mental Healthcare Act, 2017, §14(4)(e). The Board's order of appointment under this sub-section could be revoked, altered or modified on application by the person with mental illness or his psychiatrist or his relative or the medical officer in charge of the mental health establishment. (The Mental Healthcare Act, 2017, §16.)
[381] Such a person should be working with the person with mental illness. He should represent an organisation registered under the Societies Registration Act, 1860 or any other law in force. Such temporary appointment will be on written application of the person to the medical officer in charge of the mental health establishment or the psychiatrist in charge of the persons' treatment.
[382] The Mental Healthcare Act, 2017, §14(9).
[383] The Mental Healthcare Act, 2017, §14.
[384] The Board is authorised to make orders to appoint another suitable nominated representative of the minor with mental illness, on application by a mental health professional or any other person acting in the best interest of the person and on substantiating evidence presented and when the Board is of opinion that the legal guardian is not acting in the minor's best interests or is otherwise unfit to act as the minor's nominated representative. Where no individual is available for appointment as nominated representative, the Board may appoint the Director in the Department of Social Welfare of the State where the Board is located or his nominee as nominated representative

guardian shall be the nominated representative of a minor.[385] The nominated representative should discharge his duties considering "the wishes, life history, values, background and best interests of the person with mental illness" and support his treatment decision-making. "Access to family or home-based rehabilitation services" should be granted to the nominated representative to benefit the person with mental illness. The nominated representative is empowered to seek diagnosis and treatment-related information to adequately support the person with mental illness, "be involved in his discharge planning", apply for admission to the mental health establishment, "apply to the Board on behalf of the person with mental illness for discharge" or against violation of the person's rights in the mental health establishment, "appoint a suitable attendant" and "give or withhold consent for research" under conditions mentioned under the Act.[386]

3.2.2.2.5. <u>Securing Rights of Persons with Mental Illnesses</u> [387]

A novel feature of the Act is its express provision of rights of persons with mental illness. The statutory recognition of these rights makes them justiciable right.

The rights elucidated under the Act include:

a) <u>Right to access mental healthcare</u>[388]: Right to access mental healthcare denoted affordable, good quality[389], geographically accessible mental healthcare and treatment without discrimination on any basis and provided acceptably to persons with mental illness, their families and caregivers.[390] To effectuate this right, the Government is authorised to "make sufficient provisions as may be necessary[391]" to provide mental health services, including "acute mental healthcare services (outpatient and inpatient services), half-way homes, sheltered accommodation and supported accommodation, mental health services to support the family of the person with mental illness or home-based rehabilitation, hospital or community-based rehabilitation establishments and services, child mental health services and old age mental health services" [392] at all general government hospitals. The Government

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of the minor with mental illness. (The Mental Healthcare Act, 2017, §15(2).) The Board's order of appointment under this sub-section could be revoked, altered or modified on application by the person with mental illness or his psychiatrist or his relative or the medical officer in charge of the mental health establishment. (The Mental Healthcare Act, 2017, §16.)

[385] The Mental Healthcare Act, 2017, §15.

[386] The Mental Healthcare Act, 2017, §17.

[387] Chapter V, The Mental Healthcare Act, 2017.

[388] The Mental Healthcare Act, 2017, §18.

[389] The quality of the mental health services provided by the Government should be at par with other general health services. (The Mental Healthcare Act, 2017, §18(8).) The State Authority was empowered to make regulations on the minimum quality standards of mental health. (The Mental Healthcare Act, 2017, §18(9).)

[390] The Mental Healthcare Act, 2017, §18(2).

[391] The Mental Healthcare Act, 2017, §18(3).

[392] The Mental Healthcare Act, 2017, §18(4).

should also make available basic and emergency mental health services at all community health centres.[393] Poor, destitute or homeless persons with mental illness are entitled to free mental health treatment and services at mental health establishments funded or run or designated by the Government.[394] The Act stipulates that the Government should provide mental health services integrated into all levels of healthcare and all its health programmes. The treatment provided should support the person with mental illness for community living with their families. Long term mental health treatment and care in a mental health institution should be used as a last resort, for as short a duration as possible, only when appropriate community-based treatment has failed. The Government has to ensure access and bear the cost of mental healthcare treatment if the minimum mental health services for children and the elderly are not available in the district where such person resides.[395] The Government was to make available all essential drugs free of cost to all persons with mental illness at Government-funded or run mental health establishments.[396]

b) Right to community living [397]: The persons with mental illness have a right to live in and be part of society. Such persons should not be required to remain in a mental health establishment solely due to not having a family, lack of familial acceptance, homelessness, or absence of community-based facilities. The Government should appropriately support mentally ill persons who cannot live with their families or are abandoned by families or relatives by "providing legal aid and facilitating them to exercise their right to the family home and living in the family home."[398] The Government should also make less restrictive community-based establishments available for persons no longer requiring treatment in mental health establishments.[399]

c) Right to live with dignity and be protected from cruel, inhuman and degrading treatment and all forms of abuse[400]: The person with mental illness has the "right to live in a safe, hygienic environment with adequate sanitary conditions, provision for wholesome food, sanitation, space, access to personal hygiene articles, proper clothing and privacy, have reasonable facilities for leisure, recreation, education and to practice religion." He should

[393] The Mental Healthcare Act, 2017, §18(6).
[394] The Mental Healthcare Act, 2017, §18(7).
[395] The Mental Healthcare Act, 2017, §18(5).
[396] The Mental Healthcare Act, 2017, §18(10).
[397] The Mental Healthcare Act, 2017, §19.
[398] The Mental Healthcare Act, 2017, §19(2).
[399] The Mental Healthcare Act, 2017, §19(3).
[400] The Mental Healthcare Act, 2017, §20. The Act provides that every person with mental illness should be protected from "all forms of physical, verbal, emotional and sexual abuse." (The Mental Healthcare Act, 2017, §20(2)(k).)

"not be compelled to perform work in a mental health institution" or "subject to compulsory tonsuring" or "forced to wear uniforms in the mental health establishment". He has the right to "have adequate provision to prepare for community living."

d) Right to equality and non-discrimination[401]: The person with mental illness should be "treated as equal to persons with physical illness" and should have access to emergency facilities and emergency services for mental illness, use of ambulance services, living conditions and other health services to the same extent and quality as that provided to persons with physical illness, without any discrimination on any basis.

   The Act provides that a woman shall not ordinarily be separated from her child under three years of age during her stay at a mental health establishment except if temporary separation is in the interest and safety of the child in the opinion of the treating Psychiatrist. The decision for such temporary separation should be reviewed every fifteen days during the woman's stay in the mental health establishment and should be terminated as soon as conditions improve. Such separation exceeding thirty days at a stretch requires the approval of the appropriate Authority under the Act.

   The Act further mandates every insurer to provide medical insurance for mental illness treatment on the same basis as physical illness treatment. However, insurance parity for mental illness with physical illness is yet to be achieved in India.

e) Right to information[402]: The Act provides the right to information to a person with mental illness and his nominated representative concerning the "provision of the Act or any other law" or stipulated criteria under which his admission was made, nature of the mental illness and the proposed treatment, his right to apply for a review of admission to the concerned Board and to receive information in such language and form as the receiver can understand."

f) Right to confidentiality[403] : The person with mental illness is entitled to confidentiality concerning mental health, treatment, and physical health care. The person with mental illness' right to confidentiality also applies to all stored electronic or digital information.

   It is the duty of the health professionals caring for or treating the person with mental illness to maintain the confidentiality of information, except for the "release of information to the nominated representative to fulfil his duties under the Act, other mental health professionals for care and treatment of the person with mental illness, to protect any other person from harm identified or violence or prevent a threat to life, upon orders by the Mental Health

[401] The Mental Healthcare Act, 2017, §21.
[402] The Mental Healthcare Act, 2017, §22.
[403] The Mental Healthcare Act, 2017, §23.

Board or the courts or competent Statutory Authorities or in the interest of public safety and security." The Act further prohibits the release of any photograph or information on the mental health of the person with mental illness to the media without his consent.[404]

g) Right to access medical records[405] : Persons with mental illness have the right to access their medical records. The mental health professional in charge of such records could specifically withhold disclosure of information, resulting in "serious mental harm to the person with mental illness or likelihood of harm to other persons." When the mental health professional withholds medical records related information from a person with mental illness, he should inform such person of his right to apply for an order to release information from the concerned Board.

h) Right to personal contacts and communication[406] : The person with mental illness who is admitted to a mental health establishment has the right to refuse or receive visitors or calls or make calls (telephone or mobile calls) at reasonable times subject to such mental health establishment norms and also to access email communication. However, the exceptions to the right include visits or calls or emails from specified judicial officers, statutory authorities, members of the legislature, other persons authorised by the Government, the treating medical practitioners, the nominated representative, lawyer or legal representative of the person with mental illness.

i) Right to legal aid[407] : The person with mental illness has the right to receive free legal services to exercise his rights under the Act.

j) Right to complain regarding deficiencies in the provision of care, treatment and services[408]: The person with mental illness or his nominated representatives has the right to complain regarding deficiencies in the care, treatment and services provided in a mental health establishment to the medical officer or mental health professional in charge of the establishment or the concerned Board or the State Authority in ascending order of preference where the response is not satisfactory.

3.2.2.2.6. Duties of appropriate Government[409]

The Government has the duty to "plan, design and implement" mental health promotion programmes and mental illness prevention programmes in India.[410] The Government should

[404] The Mental Healthcare Act, 2017, §24.
[405] The Mental Healthcare Act, 2017, §25.
[406] The Mental Healthcare Act, 2017, §26.
[407] The Mental Healthcare Act, 2017, §27.
[408] The Mental Healthcare Act, 2017, §28.
[409] Chapter VI, The Mental Healthcare Act, 2017.
[410] The Mental Healthcare Act, 2017, §29.

take adequate steps to create mental health awareness and reduce the stigma associated with mental illness,[411] address the human resource requirements to provide mental health services in the country[412] and ensure effective coordination between the services provided by the concerned Ministries and Departments.[413]

3.2.2.2.7. Central Mental Health Authorities[414]

The Central Mental Health Authority should be composed of the following members:

Chairperson ex-officio: Secretary or Additional Secretary to the Government of India in the Department of Health and Family Welfare

Members ex-officio: Joint Secretary to the Government of India in the Department of Health and Family Welfare, in charge of mental health, Joint Secretary to the Government of India in the Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy, Director-General of Health Services, Joint Secretary to the Government of India in the Department of Disability Affairs of the Ministry of Social Justice and Empowerment, Joint Secretary to the Government of India in the Ministry of Women and Child Development, Directors of the Central Institutions for Mental Health and other such ex-officio representatives from relevant Central Government Ministries or Departments

Members nominated by the Central Government: A mental health professional, a psychiatric social worker, a clinical psychologist and a mental health nurse, each with at least 15 years of experience, two persons representing persons who had or have a mental illness, two persons representing caregivers of persons with mental illness or organisations representing caregivers, two persons representing non-governmental organisations that provide services to persons with mental illness and two persons representing areas relevant to mental health, if considered necessary.[415]

The Act further prescribes the term of office, salaries and allowances of Chairperson and members[416], procedure for resignation[417], filling of vacancies[418], the effect of vacancies on proceedings of the Central Authority[419], restriction on members to participate in meetings[420],

[411] The Mental Healthcare Act, 2017, §30.
[412] The Mental Healthcare Act, 2017, §31.
[413] The Mental Healthcare Act, 2017, §32.
[414] Chapter VII, The Mental Healthcare Act, 2017.
[415] The Mental Healthcare Act, 2017, §34.
[416] The Mental Healthcare Act, 2017, §35.
[417] The Mental Healthcare Act, 2017, §36.
[418] The Mental Healthcare Act, 2017, §37.
[419] The Mental Healthcare Act, 2017, §38.
[420] The Mental Healthcare Act, 2017, §39.

officers and other employees of Central Authority[421], functions of chief executive officer of Central Authority[422], transfer of assets and liabilities of Central Authority[423], functions of the Central Authority[424] and meetings of Central Authority[425].

3.2.2.2.8. State Mental Health Authority[426]

The State Mental Health Authority should be composed of the following members:

Chairperson ex-officio: Secretary or Principal Secretary in the Department of Health of State Government

Members ex-officio: Joint Secretary in the Department of Health of the State Government, in charge of mental health, Director-General of Health Services or Medical Education, Joint Secretary in the Department of Social Welfare of the State Government and such other such ex-officio representatives from the relevant State Government Ministries or Departments

Members nominated by the State Government: Head of any of the mental hospitals in the State or Head of Department of Psychiatry at any Government Hospital, one eminent psychiatrist from the State not in Government service, a mental health professional, psychiatric social worker, a clinical psychologist and a mental health nurse, each with at least 15 years of experience, two persons representing persons who had or have a mental illness, two persons representing caregivers of persons with mental illness or organisations representing caregivers and two persons representing non-governmental organisations that provide services to persons with mental illness.[427]

The Act further prescribes the term of office, salaries and allowances of Chairperson and members[428], procedure for resignation[429], filling of vacancies[430], the effect of vacancies on proceedings of the State Authority[431], restriction on members to participate in meetings[432], officers and other employees of Central Authority[433], functions of chief executive officer of Central Authority[434], transfer of assets and liabilities of Central Authority[435], functions of the

[421] The Mental Healthcare Act, 2017, §40.
[422] The Mental Healthcare Act, 2017, §41.
[423] The Mental Healthcare Act, 2017, §42.
[424] The Mental Healthcare Act, 2017, §43.
[425] The Mental Healthcare Act, 2017, §44.
[426] Chapter VIII, The Mental Healthcare Act, 2017.
[427] The Mental Healthcare Act, 2017, §46.
[428] The Mental Healthcare Act, 2017, §47.
[429] The Mental Healthcare Act, 2017, §48.
[430] The Mental Healthcare Act, 2017, §49.
[431] The Mental Healthcare Act, 2017, §50.
[432] The Mental Healthcare Act, 2017, §51.
[433] The Mental Healthcare Act, 2017, §52.
[434] The Mental Healthcare Act, 2017, §53.
[435] The Mental Healthcare Act, 2017, §54.

Central Authority[436] and meetings of Central Authority[437]. The Act additionally lays down provisions relating to grants by the Central Government and the State Government to the Central Authority and State Authority respectively, accounts, audit and preparation of the annual report of the Central Authority and State Authority and establishment of the Central Mental Health Authority Fund and State Mental Health Authority Fund.[438]

3.2.2.2.9. Mental Health Establishments[439]

The person or organisation establishing or running a mental health establishment should ensure its registration with the Central Mental Health Authority if under the control of the Central Government or the State Mental Health Authority for mental health establishments in the State.[440] Section 66 of the Act provides the procedure for registration, inspection and inquiry of mental health establishments. Section 67 provides the procedure for the audit of the mental health establishment by the Authority. Section 68 details the provisions relating to inspection or inquiry of a mental health establishment "suo motu or on receipt of a complaint from any person regarding non-adherence of minimum standards under the Act or contravention of its provisions." The mental health establishment could appeal to the High Court against any order passed by the Authority refusing to grant registration or renewal of or cancellation of registration within thirty days from such order.[441]

S.70 mandates the display of certificate of registration of every mental health establishment in a manner visible to visitors, provides for issue of a duplicate certificate in the event of destruction, loss, mutilation or damage of the certificate, and the procedure to be followed in the event of a change of ownership or category of the mental health establishment. Additionally, every mental health establishment must display the concerned board's contact details within the establishment.[442] The Authority has to maintain a digital Register of Mental Health Establishments and a separate register to record the certificates of registration granted in the prescribed form and manner.[443]

3.2.2.2.10. Mental Health Review Boards[444]

The State Authority should constitute Mental Health Review Boards by notification. In consultation with the State Governments, the State Authority should specify the Boards'

[436] The Mental Healthcare Act, 2017, §55.
[437] The Mental Healthcare Act, 2017, §56.
[438] Chapter IX, The Mental Healthcare Act, 2017, §57-64.
[439] Chapter X, The Mental Healthcare Act, 2017.
[440] The Mental Healthcare Act, 2017, §65.
[441] The Mental Healthcare Act, 2017, §69.
[442] The Mental Healthcare Act, 2017, §72.
[443] The Mental Healthcare Act, 2017, §71.
[444] Chapter XI, The Mental Healthcare Act, 2017.

number, location, and jurisdiction. The Central Government is authorised to frame rules regulating the constitution of Mental Health Boards by the State Authority for districts or groups of districts in the State. While framing rules regarding the constitution of Boards, the Central Government should consider the expected or actual workload, number of mental health establishments, number of persons with mental illness in the State, population, geographic and climatic conditions of the district.[445] The Mental Health Review Board in a district of a State is composed of the Chairperson of the Board,[446] a representative of the District Collector or District Magistrate or Deputy Commissioner of the district, a psychiatrist, a medical practitioner and two members including a person with mental illness or caregivers or persons representing organisations of persons with mental illness or caregivers or non-governmental organisations working in the field of mental health. The Act further provides the conditions for removal or disqualification for appointment as Chairperson or member of a Board[447] and terms and conditions of service of Chairperson and Members of Board.[448] The Authority or the Board is to make decisions "by consensus, failing which by a majority of votes of members present and voting." In case of equality of votes, the President or Chairperson shall have a second or casting vote. A meeting of the Authority or the Board requires a quorum of three members.[449] Application to the Mental Health Board seeking redressal or appropriate relief for violation of rights under the Act or against a decision of a mental health establishment can be made by any person with mental illness or representatives of registered non-governmental organisation with his consent or the nominated representative of such person.[450] The Mental Health Review Board should dispose of applications regarding independent admissions in mental health establishments[451] , and applications other than that referred to in S.80(3) within ninety days from applying.[452] The applications for appointment of a nominated representative[453], challenging a minors' admission[454] or challenging a supported admission[455] should be disposed

[445] The Mental Healthcare Act, 2017, §73.
[446] The Chairperson of the Board is either a District Judge or retired District Judge or an officer of the State judicial services who is qualified to be appointed as a District Judge.
[447] The Mental Healthcare Act, 2017, §74.
[448] The Mental Healthcare Act, 2017, §75.
[449] The Mental Healthcare Act, 2017, §76.
[450] The Mental Healthcare Act, 2017, §77.
[451] Application to the Mental Health Review Board under S.85(1).
[452] The Mental Healthcare Act, 2017, §80(1).
[453] Application to the Mental Health Review Board under S.14(4)(d).
[454] Application to the Mental Health Review Board under S.87.
[455] Application to the Mental Health Review Board under S.89(10) or S.89(11). S.80(3) provides that applications to the Mental Health Review Board challenging supported admissions under S.90 should be disposed within twenty-one das from date of receiving the application.

of within seven days from the date of receiving such applications.[456] The Act further stipulates the procedural guidelines for the Board proceedings.[457]

The Mental Health Review Board is empowered to "register, review, alter, modify or cancel an advanced directive, appoint a nominated representative, receive and decide applications" as prescribed under the Act, adjudicate complaints concerning care and services deficiencies, "visit and inspect prisons or jails and seek clarification from the medical officer in charge of such prisons or jails" and conduct inspection and inquiry on receiving notice of violation of rights of persons with mental illness by a mental health establishment and take appropriate action either independently or in consultation with the Authority. The Mental Health Board can also impose a penalty of up to five lakh rupees on a mental health establishment for non-compliance or willful neglect of its orders or directions.[458]

The mental health establishment or any person aggrieved by the decision of the Authority or the Board can prefer an appeal to the High Court within thirty days from such decision.[459]

The Act bars the Civil Court from having jurisdiction to entertain any suit or proceeding regarding any matter the Board or Authority is authorised to determine under the Act. [460]

3.2.2.2.11. <u>Admission, treatment and discharge</u>[461]

The Act encourages voluntary admission of persons with mental illness in a mental health establishment as independent patients or independent admissions unless conditions make supported admission unavoidable.[462] The medical officer or the health professional in charge of the mental health establishment could make an independent admission for treatment on request of the person with mental illness, on his satisfaction of the severity of the mental illness, benefit of admission and that such request is free and voluntary. Treatment should be administered to the independent patient only with his informed consent.[463]

The independent patient may be discharged on his request to the medical officer or mental health professional in charge of the mental health establishment or if he disagrees with such admission. A minor admitted to a mental health establishment attaining majority during his admission period should be treated as an independent patient.

[456] The Mental Healthcare Act, 2017, §80(2).
[457] The Mental Healthcare Act, 2017, §80(5) to §80(14).
[458] The Mental Healthcare Act, 2017, §82.
[459] The Mental Healthcare Act, 2017, §83.
[460] The Mental Healthcare Act, 2017, §116.
[461] Chapter XII, The Mental Healthcare Act, 2017.
[462] The Mental Healthcare Act, 2017, §85.
[463] The Mental Healthcare Act, 2017, §86.

The Act allows for the prevention of the discharge of independent patients for 24 hours to enable his assessment for admission if a mental health professional opines on the patients' need for substantial decision-making support from the nominated representative, his risk of self-harm or harm to others or his inability to care for himself to the degree that places him at risk of self-harm. Such a patient may either be admitted as supported patients or discharged from the establishment within 24 hours or after completing assessments for admission for a supported patient, whichever is earlier.[464]

The Act further provides for the admission of a minor on request of the nominated representative to the medical officer in charge of a mental health establishment. The decision for admission is based on an independent assessment by a medical team[465] on the day of admission or preceding seven days or both and on their satisfaction of the severity of the mental illness, need for admission considering the best interests of the minor and the unsuitability of community-based alternatives to meet his needs. The minor should be admitted separately from adults in a suitable environment considering his age and developmental needs and quality-wise at par with the inpatient environment in other hospitals for minors. The nominated representative or the attendant appointed by him should stay with the minor during his entire admission at the mental health establishment. The informed consent of the nominated representative should be obtained for the minor's treatment. The medical officer or the mental health professional in charge of the mental health establishment should intimate the Board within 72 hours of the admission. Any admission of a minor which continues beyond thirty days should immediately be informed to the concerned Board. The Board should mandatorily review all minor admissions which extend beyond 30 days within a week of receipt of such information and every subsequent 30 days. The nominated representative could request for the minor's discharge when he no longer supports the admission.[466]

The Act provides for the procedure for supported admission and treatment of persons with severe mental illness, at risk of self-harm or harm to others, and who cannot care for themselves to the degree that places them at the risk of self-harm. Such admission is limited to a period of 30 days. The treatment of a supported patient admitted to a mental health establishment should take into account the advance directive, if any, and the patient's informed consent obtained with the support of the nominated representative. But if the supported patient requires nearly

[464] The Mental Healthcare Act, 2017, §88.
[465] The team could either consist of two psychiatrists or a psychiatrist and a mental health professional or a psychiatrist and a medical practitioner.
[466] The Mental Healthcare Act, 2017, §87.

100% support from his nominated representative in treatment-related decision-making, the nominated representative can temporarily consent to the treatment plan on behalf of the supported patient. Where such consent of the nominated representative is obtained, the medical officer or the mental health professional in charge of the mental health establishment should review the capacity of the supported patient every week.

The medical officer or mental health professional in charge of the mental health establishment should report to the Mental Health Review Board within three days of supported admission of a woman or a minor and within seven days of other supported admissions. The person with mental illness or his nominated representative or a representative of a registered non-governmental organisation, with the person's consent, could apply for a review of the decision for admission to the Board. The Board should review the decision for admission and give its findings on the same within seven days of receiving the request for such a review.

When conditions that required the supported admission cease to exist, the medical officer or the mental health professional in charge of the mental health establishment could terminate the admission and inform the supported patient and his nominated representative accordingly. Where the medical officer or mental health professional in charge of the mental health establishment opines on the requirement of supported admission and further treatment beyond 30 days, such medical officer or mental health professional should refer the matter for examination by two psychiatrists for the supported admission. When a person admitted as a supported patient is discharged, he cannot obtain supported readmission within seven days from the date of his discharge. Where readmission is required within seven days from the date of discharge, the provisions for supported admission beyond 30 days would be applicable.[467]

The Act allows supported admission beyond 30 days on application by the nominated representative to the medical officer or mental health professional in charge of the mental health establishment for a period of up to ninety days in the first instance. Two psychiatrists should independently examine and conclude the necessity of supported re-admission for such supported patients, taking into account the advanced directive, if any, and certifying that such supported admission is the least restrictive care option possible under the circumstances. The medical officer or mental health professional in charge of the mental health establishment should report to the Mental Health Review Board on the supported admission or readmission within seven days of such admission or readmission. Within twenty-one days from the date of last admission or readmission, the Board should permit the same or order discharge of the

[467] The Mental Healthcare Act, 2017, §89.

supported patient after evaluating the person's need for institutional care and availability of other community-based, less restrictive care options. The period of supported admission can be extended beyond ninety days for 120 days at the first instance and after that for 180 days each time. Such extended admission should comply with the requirement of independent examination by two psychiatrists to determine the necessity of supported admission, reporting and obtaining the permission of the Board for the supported admission or re-admission. The treatment of supported patients should be given after obtaining the person's informed consent with the support from his nominated representative and considering the advanced directive if any. But where the supported patient requires nearly a hundred per cent support from the nominated representative for making treatment-related decisions, the nominated representative could temporarily consent to the treatment plan on behalf of the supported patient. In such a case, the medical officer or the mental health professional in charge of the mental health establishment should record such consent in the supported patients' medical records and review the capacity of such person to give consent every fortnight. The supported patient or his nominated representative or a representative of a registered non-governmental organisation, with the consent of the supported patient, could apply to the Mental Health Review Board for reviewing the decision of the medical officer or the mental health professional in charge of the mental health establishment. The decision of the Board after review would be binding on all parties.

When the medical officer or mental health professional in charge of the mental health establishment believes that conditions that require the supported admissions cease to exist, he can discharge such a person from the mental health establishment and inform the persons and his nominated representative accordingly. [468] The medical officer or mental health professional in charge of the mental health establishment can grant leave of absence to the admitted minors or supported patients for any duration as necessary.[469]

The Act permits any registered medical practitioner to provide emergency medical treatment to a person with mental illness either at the mental health establishment or in the community, subject to the nominated representative's informed consent, if available. Such emergency treatment is administered where it is immediately necessary to prevent death, self-harm or harm to others from behaviour considered to directly consequent to the person's mental illness. The duration permitted for the emergency treatment is 72 hours or till an assessment at a mental

[468] The Mental Healthcare Act, 2017, §90.
[469] The Mental Healthcare Act, 2017, §91.

health establishment has been made of the person with mental illness, whichever is earlier., this period of emergency treatment can extend up to 7 days during a disaster or a Government declared emergency.[470]

The Act expressly prohibits the following treatments: use of electroconvulsive therapy without muscle relaxants and anaesthesia on persons with mental illness, electroconvulsive therapy on minors, sterilization of men and women as a treatment for mental illness and use of chains in any manner or form. However, if the psychiatrist in charge of a minor's treatment opines on the necessity of electroconvulsive therapy, such treatment should be administered with the informed consent of the guardian and the permission of the Mental Health Review Board.[471] Further, the Act prohibits psychosurgery as a treatment for mental illness without the person's informed consent and without approval to perform surgery from the Mental Health Review Board.[472] The Act prohibits the subjection of persons with mental illness to seclusion or solitary confinement. Physical restraints are only permitted where necessary under the regular ongoing supervision of medical personnel if authorised by the person's treating psychiatrist and the only means to avoid immediate and imminent self-harm or harm to others. Physical restraint should not be used for a longer duration than necessary to prevent the immediate risk of significant harm. The medical officer or mental health professional in charge of the mental health establishment should immediately record the method, nature of the restraint, justification for its imposition and the duration of restraint in the person's medical notes. The mental health establishment should report the instances of restraint to the Mental Health Review Board every month. Where the Board considers that a mental health establishment is persistently and wilfully violating the provisions for the use of physical restraints under the Act, it can order the mental health establishment to desist from applying restraints.[473]

When the person undergoing treatment is to be discharged into the community or to a different mental health establishment or when a new psychiatrist takes charge of his treatment and care, his current psychiatrist in charge should consult him, his nominated representative, caregiver, his future psychiatrist and such other persons as appropriate, to develop a suitable treatment and discharge plan.[474]

While conducting any research on persons with mental illness which involves psychological, physical, chemical or medicinal intervention, the researchers should obtain their free and

[470] The Mental Healthcare Act, 2017, §94.
[471] The Mental Healthcare Act, 2017, §95.
[472] The Mental Healthcare Act, 2017, §96.
[473] The Mental Healthcare Act, 2017, §97.
[474] The Mental Healthcare Act, 2017, §98.

informed consent. But when the person cannot give free and informed consent but does not resist participation in such research, the researcher should obtain permission to conduct such research from the concerned State Authority. The State Authority may permit the researcher to conduct his research after obtaining the informed consent of the nominated representative on its satisfaction of the inability to perform the research on persons who are capable of giving free and informed consent and the necessity of the research to obtain knowledge relevant to the mental health needs of persons with mental illness and promote the mental health of the population represented by the person. Further, the State Authority should be satisfied that the researcher has fully disclosed the interests of persons and organisations conducting the proposed research and there is no conflict of interest involved. The proposed research should comply with all national and international guidelines and regulations concerning such research. The researcher should also have obtained the ethical approval of the institutional ethics committee. The person with mental illness or his nominated representative could withdraw the informed consent given for participation in any research under the Act at any time during the period of the study.[475]

3.2.2.2.12. Responsibilities of other agencies[476]

The Act stipulates that the officers in charge of a police station must take under protection persons believed to have mental illness found wandering or at risk to himself or others within the police station's limits. The officer should inform the person of the grounds of taking him into such protection. The officer should inform the nominated representative if he believes that such a person has difficulty understanding the grounds. Such a person should not be detained in police lock-up or prison in any circumstances. The person taken into protection should be assessed to determine his healthcare needs at the nearest public health establishment within 24 hours. If the person does not have a mental illness of the degree or nature requiring admission, the medical officer or mental health professional in charge of the mental health establishment should inform the police officer of the same. The police officer should then take the person to the person's residence or a Government establishment for homeless persons if the person is homeless. A First Information Report should be lodged with the police station when a person with mental illness is found to be homeless or wandering in the community. On receiving such information, the station house officer must trace and inform the family of such person of his whereabouts.[477]

[475] The Mental Healthcare Act, 2017, §99.
[476] Chapter XIII, The Mental Healthcare Act, 2017.
[477] The Mental Healthcare Act, 2017, §100.

Any person can report to the police officer in charge of the police station regarding the ill-treatment or neglect of any person with mental illness who resides within the police station's jurisdiction. The officer in charge of a police station should report instances of ill-treatment or neglect of any person with mental illness residing within the police station's limits to the Magistrate within whose jurisdiction the person resides. If the Magistrate has reason to believe that the person with mental illness is being ill-treated or neglected based on the report of the police officer or otherwise, he could cause the production of such a person before him and pass an order[478] either for having the person conveyed to a public mental health establishment for assessment and treatment or authorising his admission in a mental health establishment for assessment and treatment planning for a period not exceeding ten days. In cases where the Magistrate had authorised the person's admission for assessment, the medical officer or the mental health professional in charge of the mental health establishment should submit a report to the Magistrate on completing the specified assessment period. [479]

The Act makes provision for admission and transfer of prisoners with mental illness to a mental health establishment.[480] If a prisoner with mental illness absents himself from the mental health establishment without leave or discharge, he should be taken into police protection at the request of the medical officer or mental health professional in charge of the mental health establishment and sent back immediately to the mental health establishment.[481] The Act allows the transfer of persons and prisoners with mental illness from one mental health establishment to another within and outside the State.[482]

The person in charge of a State-run custodial institution[483] is authorised to take any institution resident likely to have a mental illness to the nearest mental health establishment run or funded by the appropriate government for assessment and treatment.[484]

The Act provides that where proof of mental illness produced by a party is challenged by the other party in a judicial process before any competent court, the Court should refer the same to the concerned Mental Health Review Board for further scrutiny. The Board should submit its opinion to the Court after examining the person alleged to have mental illness either by itself or through an expert committee.[485]

[478] The Mental Healthcare Act, 2017, §101.
[479] The Mental Healthcare Act, 2017, §102.
[480] The Mental Healthcare Act, 2017, §103.
[481] The Mental Healthcare Act, 2017, §92.
[482] The Mental Healthcare Act, 2017, §93.
[483] Custodial institutions include beggar homes, orphanages, women's protection homes and children homes.
[484] The Mental Healthcare Act, 2017, §104.
[485] The Mental Healthcare Act, 2017, §105.

3.2.2.2.13. Restriction to discharge functions [486]

The Act prohibits mental health professionals and medical practitioners from discharging any duty or performing any function not authorised by the Act and from specifying or recommending any medicine or treatment not authorised by his profession.[487]

3.2.2.2.14. Offences, penalties and other miscellaneous matters[488]

The Act prescribes penalties and punishment for establishing or maintaining mental health establishments in contravention of provisions of the Act or the rules or regulations made thereunder[489] and for offences by companies[490].

The Act made special provisions for the North-East and Hill States[491], for constitution of their Mental Health Review Boards and allowing certain relaxations in the time-periods specified in some provisions[492] considering the difficulties in communication, travel and transportation in these States.[493]

The Act's provisions are given an overriding effect in case of inconsistency with any other law in force.[494]

3.2.2.2.14.1. Decriminalisation of attempts to suicide

S. 115(1) of the Mental Healthcare Act, 2017 provides a presumption of severe stress favouring persons who attempt to commit suicide. It further prohibits the trial and punishment of persons attempting suicide under the Indian Penal Code.

In a recent case before the Supreme Court[495], a petition was filed seeking directions to prevent attempts to commit suicide by persons by throwing themselves in the zoo animal enclosures. In its order dated 11 September 2020, the Supreme Court observed that "S.115 of the Mental Healthcare Act, 2017, which creates a presumption, impacts S.309, IPC." Hence the Supreme Court "issued notice to the Attorney General of India and directed the Union of India to justify

[486] Restriction to discharge functions by professionals not covered by profession, Chapter XIV, The Mental Healthcare Act, 2017.
[487] The Mental Healthcare Act, 2017, §106.
[488] Chapter XV, Offences and Penalties, The Mental Healthcare Act, 2017. Chapter XVI, Miscellaneous Matters, The Mental Healthcare Act, 2017.
[489] The Mental Healthcare Act, 2017, §108.
[490] The Mental Healthcare Act, 2017, §109.
[491] States of Assam, Meghalaya, Tripura, Mizoram, Manipur, Nagaland, Arunachal Pradesh and Sikkim.
[492] The provisions where relaxation of time-period is provided includes proceedings before the Board, admission of minor, discharge of independent patients, supported admissions and emergency treatment. These provisions are also applicable to the States of Uttarakhand, Himachal Pradesh, Jammu and Kashmir and the Union Territories of Lakshadweep and Andaman and Nicobar Islands.
[493] The Mental Healthcare Act, 2017, §114.
[494] The Mental Healthcare Act, 2017, §120.
[495] Red Lynx Confederation v. Union of India and Ors. (SLP (Crl.) No. 3185/2020).

the validity of Section 115 of the Mental Healthcare Act, 2017 which virtually negates S.309, IPC.[496]

3.2.2.2.15. Rules framed under the Act

The following Rules have been framed pursuant to specific sections under The Mental Healthcare Act, 2017:

3.2.2.2.15.1. The Mental Healthcare (Rights of Persons with Mental Illness) Rules, 2018

The Central Government framed The Mental Healthcare (Rights of Persons with Mental Illness) Rules, 2018, exercising its power to make rules under Section 121 of the Mental Healthcare Act, 2017. Chapter II of The Rules provide measures to effectuate the rights of persons with mental illness. The Rules authorise the Central and State Government to establish halfway homes, sheltered accommodation, supported accommodation [497] and hospital and community-based rehabilitation establishments [498] to effectuate the right to access mental healthcare of persons with mental illnesses. The Rules recognise the right of persons with mental illnesses to access their basic medical records and provide the procedure to apply and obtain the basic inpatient medical records from the mental health establishment. The mental health professional or the mental health establishment may apply to the Mental Health Review Board if perceived ethical, legal, or other sensitive issues are involved in disclosing information or providing basic medical records. The Board should give appropriate directions to the mental health professional or mental health establishment after hearing the concerned person with mental illness.[499] Custodial institutions should display on a signage board the contact details to avail free legal services under the Legal Services Authorities Act, 1987 or other relevant laws or court orders, if applicable, for the benefit of its residents or any person with mental illness residing in such institution or his nominated representative in a prominent place in English, Hindi and the local language. Chapter III of the Rules provide the forms for admission, discharge and leave of absence.[500] Chapter IV of the Rules further provides the procedure for transferring prisoners with mental illness and the minimum standards and procedures of mental health services in prison.[501]

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[496] Radhika Roy, *SC Asks Centre To Justify Validity Of Provision In Mental Health Care Act Decriminalising Attempt To Suicide [Section 309 IPC]*, September 11, 2020, https://www.livelaw.in/top-stories/sc-asks-centre-to-justify-validity-of-provision-in-mental-health-care-act-decriminalizing-attempt-to-suicide-section-309-ipc-162792 (last visited Sep 20, 2021).

[497] The Mental Healthcare (Rights of Persons with Mental Illness) Rules, 2018, Rule 3.

[498] The Mental Healthcare (Rights of Persons with Mental Illness) Rules, 2018, Rule 4.

[499] The Mental Healthcare (Rights of Persons with Mental Illness) Rules, 2018, Rule 6.

[500] The Mental Healthcare (Rights of Persons with Mental Illness) Rules, 2018, Chapter III, Rules 8-9.

[501] The Mental Healthcare (Rights of Persons with Mental Illness) Rules, 2018, Chapter IV, Rules 10-11 and Schedule.

3.2.2.2.15.2. The Mental Healthcare (Central Mental Health Authority and Mental Health Review Boards) Rules, 2018

The Central Government framed The Mental Healthcare (Central Mental Health Authority and Mental Health Review Board) Rules, 2018, exercising its power to make rules under Section 121 of the Mental Healthcare Act, 2017. Chapter II of the Rules provides the guidelines for eligibility for nomination as ex-officio members and non-officio members of the Central Mental Health Authority (Central Authority) and procedure for nomination, term of office and allowances of non-official members of Central Authority.[502] Chapter III of the Rules stipulates the procedure for provisional registration of mental health establishments by the Central Authority, period of validity and procedure for renewal of the certificate of registration, issue of a duplicate certificate and maintenance of the digital register.[503] Chapter IV of the Rules provides for maintenance of finance, accounts and Audit and procedure relating to the preparation of an annual report of the Central Authority.[504] Chapter V of the Rules specifies the guidelines regarding the constitution of the Mental Health Review Boards, the appointment of Chairman and members of the Board, disqualification and removal of Chairman and members of the Board and the honorarium, allowances and other terms and conditions of service of the Chairman and members of the Board.[505] Chapter VI of the Rules deals with audit, inspection and enquiry of mental health establishments.[506]

3.2.2.2.15.3. The Mental Healthcare (State Mental Health Authority) Rules, 2018

The Central Government framed The Mental Healthcare (State Mental Health Authority) Rules, 2018, exercising its power to make rules under Section 121 of the Mental Healthcare Act, 2017. Chapter II of the Rules provides the guidelines for eligibility for nomination as ex-officio members and non-officio members of the State Mental Health Authority (State Authority) and procedure for nomination, the term of office and allowances of non-official members of State Authority.[507] Chapter III of the Rules stipulates the procedure for provisional registration of mental health establishments by the State Authority, period of validity and

[502] The Mental Healthcare (Central Mental Health Authority and Mental Health Review Boards) Rules, 2018, Rules 3-10.
[503] The Mental Healthcare (Central Mental Health Authority and Mental Health Review Boards) Rules, 2018, Rules 11-14.
[504] The Mental Healthcare (Central Mental Health Authority and Mental Health Review Boards) Rules, 2018, Rules 15-16.
[505] The Mental Healthcare (Central Mental Health Authority and Mental Health Review Boards) Rules, 2018, Rules 17-20.
[506] The Mental Healthcare (Central Mental Health Authority and Mental Health Review Boards) Rules, 2018, Rules 21-22.
[507] The Mental Healthcare (State Mental Health Authority) Rules, 2018, Rules 3-10.

procedure for renewal of the certificate of registration, issue of a duplicate certificate and maintenance of the digital register.[508] Chapter IV of the Rules provides for maintenance of finance, accounts and Audit and procedure relating to the preparation of an annual report of the State Authority.[509] Chapter V of the Rules deals with audit, inspection and enquiry of mental health establishments.[510]

3.3. NATIONAL MENTAL HEALTH PROGRAMME

The need to establish district psychiatric clinics was first recognised in the Mudaliar Committee Report in 1962. Subsequently, between 1975-1981, pilot programmes were initiated in Bangalore and Chandigarh to integrate mental health with general health services. The experiences at these centres aided the development of the National Mental Health Programme (NMHP).[511]

The development of community psychiatry resulted in integrating mental health care in the community under the National Mental Health Program (NHMP).[512] India was one of the pioneers among developing countries to have adopted a Mental Health Program (NMHP) in 1982. But the program suffered a series of setbacks and implementation failures which eventually led to its underperformance.[513] The National Mental Health Programme was established to ensure that basic mental health care is universally available and accessible to all sections of the population in India. It sought to integrate mental health care into primary healthcare.[514] It further aimed to promote community participation in the development of mental health services and encourage efforts towards self-help in the community. The 1982 model emphasized only the curative aspect rather than the preventive aspect and promotion of mental health care. The NHMP also did not clearly outline the administrative structure and the financial estimate for its implementation.[515] The NHMP launched in 2003 comprised five interrelated strategic components: redesigning the DMHP around a nodal institution.

The District Mental Health Programme (DMHP) helped develop the model for integrating mental health into primary healthcare. It was first developed between 1984-1990, extending to 4 states and further expanding coverage to 25 districts in 20 States between 1995 and 2002.[516]

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[508] The Mental Healthcare (State Mental Health Authority) Rules, 2018, Rules 11-14.
[509] The Mental Healthcare (State Mental Health Authority) Rules, 2018, Rules 15-16.
[510] The Mental Healthcare (State Mental Health Authority) Rules, 2018, Rules 17-18.
[511] Murthy, *supra* note 296, at 38-39.
[512] Raveesh, Singh, and Pathare, *supra* note 299.
[513] Preetam B. Mahajan et al., *Analyzing Indian Mental Health Systems: Reflecting, Learning and Working towards a better future*, 5 JOURNAL OF CURRENT RESEARCH IN SCIENTIFIC MEDICINE 5 (2019).
[514] Thara, Padmavati, and Srinivasan, *supra* note 295.
[515] Murthy, *supra* note 296 at 39-40.
[516] *Id.*

The DMHP signalled a critical shift of focus from custodial care to primary health care level treatment and care. However, there is still scope for improvement regarding funds allocation, availability and adequacy of training programmes to enable mental hospitals to fulfil their roles as envisioned in the National Mental Health Program.[517] The XIIth Plan District Mental Health Program (2012) was based on six key perspectives: life course, recovery, equity, evidence-based, health systems and rights-based. [518]

3.4. CONCLUSION

The mental health legislation in India preceding the Mental Health Act, 1987 was greatly influenced by the English mental health legislation. However, the negative attitude towards persons with mental illness as violent and dangerous persons continued even under the Mental Health Act, 1987. The Act did not make any efforts to address the issues of stigma and discrimination faced by persons with mental illness. Further, it did not take adequate measures to enable community integration and rehabilitation of persons with mental illness after their discharge. The Mental Healthcare Act,2017 differs radically from the previous mental health legislation in its rights-based approach towards persons with mental illnesses. The Act makes provision for the application by the persons with mental illnesses or his nominated representatives to Mental Health Review Boards to review the decisions of the medical officer or the mental health professional in charge of the mental health establishment. The Act uses the term independent admission instead of voluntary admission.

The Central Authority has not yet specified by regulations how to make an Advance Directive. However, the Act allows mental health professionals, relatives, and carers to apply to the Mental Health Review Board to modify, alter, or cancel the advance directive under S.11(2). It may also be practically challenging to verify the genuineness of the document appointing the nominated representative made under S.14 of the Act. Unless the appointment of the nominated representative is verified to be bonafide, there is a scope of abuse of the provisions of the Act by unauthorised persons using fraudulent means to be appointed. There should be provisions in the Act or subsequent Rules or regulations framed under the Act to ascertain and review the genuineness and validity of the document appointing the nominated representative. The Act gives the family the right to appeal to the Mental Health Review Board under S.16 of the Act on the choice of nominated representative of the person only in the case of Board appointed nominated representatives or where the legal guardian of a minor does not act in the best

[517] Mishra, Mathai, and Ram, *supra* note 257.
[518] Mahajan et al., *supra* note 513.

interests of the minor or is unfit to act as the nominated representative of the minor. The Act lays much emphasis on the role of the nominated representative in comparison to the family members and caregivers of the person with mental illness. The Act does not seem to adequately recognise and involve the family members and caregivers in the person's treatment plan and discharge. It does not provide them with the right to appeal against involuntary treatment admission and treatment decisions before the Mental Health Review Board. In the Indian context, families play a vital role in healthcare decisions. The family provides the required social and financial support and undertakes the caregiving burden of persons with mental illnesses. It may not be culturally appropriate to exclude family members and give predominance to the nominated representative in treating and caring for persons with mental illness. This is especially relevant given that there are no guidelines in place yet or mechanisms to check the authenticity of the appointment of the nominated representative.

Though the Act and the Rules framed thereunder provide representation to persons with mental illnesses or their caregivers on the Board, it did not expressly specify their role and functions as members of the Board. However, under the Act, the family members and caregivers are given representation on the Central and State Authorities and the Mental Health Review Boards, allowing for their involvement in developing mental health policy, legislation and service planning. The Act allows the psychiatrist to consult with family members or caregivers if the person is being discharged to live with them. The Act also recognises the duty of the police to trace and inform the family when an individual with mental illness is found homeless or wandering in the community. The relatives and caregivers are deemed to be nominated representatives of the person with mental illness when the person with mental illness has not nominated a representative.

The effectuation of the right to access mental healthcare requires significant investment and infrastructure development by the appropriate Government to ensure adequate community-based alternatives for treatment and rehabilitation of persons with mental illness. The right of persons with mental illness to equality and non-discrimination can only be realistically achieved through active social campaigns[519] focused on creating awareness about mental health and illness and reducing the stigma associated with mental illness.

The restriction under S.25 of the Act to release information regarding mental illness can be problematic if the person escapes from the mental health establishment.

[519] The social campaigns can be spearheaded by the Government, NGO, support groups of persons with mental illnesses, mental health establishments or organised groups of persons who have recovered from mental illness.

Though there is a presumption of capacity to make mental healthcare and treatment decisions under S.4 of the Act, certain mental conditions due to neurodegenerative disease, psychosis and some types of personality and mood disorders may significantly impair a person's capacity to make decisions. This impaired capacity may also significantly affect the person's ability to give informed consent for treatment, necessitating the assessment of capacity for decision-making and giving informed consent.

The Act fails to clearly define the categories of professionals and the skill level required to diagnose and determine a mental illness in a person. The silence of the legislation on this aspect could be related to the limited availability of psychiatrists and mental health professionals in India. The minimum standards to be maintained by the mental health establishments are also not expressly specified in the Act. The Act also does not make provision for community treatment orders.

The Act takes significant measures to comply with the CRPD requirements. The Act affirms the right of persons with mental illness, including women and children, to equality and non-discrimination under S.21 of the Act as required under Art. 5,6, and 7 [520] of the CRPD. It requires the appropriate government to create awareness about mental health and illness and reduce the stigma associated with mental illness under S.30, complying with Art.8 [521] of the CRPD. The Act enumerates the right of persons with mental illness to access mental healthcare and receive information easily understandable under S.18 and 4(2) as required under Art.9 [522] of the CRPD. The right to be protected from cruel, inhuman and degrading treatment is expressly provided under S.20 of the Act, as recognised in Art.15 [523] of the CRPD. The Act also protects persons with mental illness from all forms of physical, verbal, emotional and sexual abuse under S.20 of the Act, corresponding to Art.16 [524] of the CRPD. The right to community living under S.19 complies with Art.19 and 23 [525] of the CRPD. The right to access information recognised under S.4(2) and 22 of the Act relates to Art.21 [526] of the CRPD. The Act ensures the right to privacy to persons in mental health establishments under S.20(2)(d) as stipulated in Art.22[527]of the CRPD. The Act safeguards the right to health mandated by Art.25

[520] Art.5, 6 and 7 of the CRPD deal with equality and non-discrimination, women with disabilities and children with disabilities respectively.
[521] Art. 8 addresses the need for awareness-raising.
[522] Art. 9 relates to accessibility to all facilities and services provided to public.
[523] Art.15 envisages freedom from torture or cruel, inhuman or degrading treatment or punishment.
[524] Art.16 focuses on freedom from exploitation, violence and abuse.
[525] Art.19 affirms the right of persons with disabilities to live independently and be included in the community. Art.23 safeguards respect for home and the family.
[526] Art.21 provides freedom of expression of opinion and access to information.
[527] Art.22 ensures respect for privacy.

of the CRPD by recognising the right to access mental healthcare under S.18 and equality and non-discrimination under S.21. The Act expressly affirms the right to habilitation and rehabilitation as provided under Art.26 of the CRPD by defining mental healthcare as inclusive of rehabilitation under S.2(o) and providing for rehabilitation under S.18(4) of the Act.[528]

The Act also makes some significant departures from the mandates of the UN Convention on Rights of Persons with Disabilities. The Act makes a minimal recognition of disaster and humanitarian emergencies as required under Art.11 [529]. It only provides a slightly relaxed period of emergency treatment during a disaster or Government declared emergency under Art.94(4). It allows physical restraints to be used on persons with mental illness if authorised by the treating psychiatrist in charge of the mental health establishment. However, physical restraints are allowed only in cases of absolute necessity, with required documentation to report to the Mental Health Review Board and inform the nominated representative. The Act provides explicitly that physical restraints cannot be used as a form of punishment. It also allows for the use of electroconvulsive therapy on persons with mental illness using muscle relaxants and anaesthesia. It also allows for supported admissions or involuntary admissions of persons with mental illnesses based on their tendency for self-harm or causing harm to others as assessed by the psychiatrist before admission, which conflicts with Art.14 [530] of the CRPD (which recognises the security and liberty of a person). Despite instances of non-compliance with the UN Convention on Rights of Persons with Disabilities and some challenges in its effective implementation. The Mental Healthcare Act, 2017 represents a marked shift in the approach towards persons with mental illnesses. This shift has been achieved by focusing on protecting and promoting the rights of persons with mental illnesses and ensuring their treatment and rehabilitation in the least restrictive environment possible while protecting their rights and dignity.

[528] Richard M. Duffy & Brendan D. Kelly, *8. Incorporation of the United Nations' Convention on the Rights of Persons with Disabilities into Indian Law Through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017*, *in* INDIA'S MENTAL HEALTHCARE ACT, 2017: BUILDING LAWS, PROTECTING RIGHTS 196–251 (2020).

[529] Art.11 seeks to ensure safety and protection of persons with disabilities in situations of risk and humanitarian emergencies.

[530] Art.14 protects the liberty and security of a person.

CHAPTER 4

COMPARATIVE ANALYSIS: THE UNITED KINGDOM (ENGLAND AND WALES), NEW ZEALAND AND SRI LANKA

4.1. INTRODUCTION

The preceding chapter traced the evolution of mental health legislation in India. In order to have a comparative perspective of mental health legislation in other commonwealth countries, this chapter will cover the salient mental health legislation in the UK, New Zealand and Sri Lanka.

4.2. CONTEMPORARY EVOLUTION OF MENTAL HEALTH LEGISLATION – BROAD TRENDS

Mental health legislation has evolved in its content, approach, and the quality of protection offered to persons with mental disabilities over time. The broad stages of the evolution of mental health legislation could be laid down as follows:

4.2.1. PROPERTY PROTECTION (1324 - PRESENT)

Before the late 18th century, Legislations focusing on protecting the property of people with mental health illnesses in the UK emerged as early as 1324. The legal regime to safeguard the property of persons with mental illnesses[531] was derived from the Royal Prerogative. The King had the right and duty to care for those who could not care for themselves as parens patriae. The King personally delegated this jurisdiction to the Lord Chancellor. The jurisdiction was expressly declared in 1324 in the statute, De Prerogativa Regis.[532,533] Until the early 19th century, the law focused on protecting the property and not caring for persons with mental illnesses.[534] An additional example of such legislation in England was the Chancery Regulation Act, 1862. However, it did not provide for persons who were homeless or paupers.[535]

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[531] In the UK, the persons with mental illnesses and disabilities were referred to as lunatics till the enactment of the Mental Treatment Act, 1930. This chapter variably uses the terms 'persons with mental illnesses' and persons with mental disabilities' instead of the term 'lunatics' in the earlier legislation.

[532] The statute mentioned the duty to safeguard the land of the lunatic, use profits from the land to maintain him, to return the land to him in case of he regained sanity or to pass to heirs on his death if he did not recover. The persons covered under the statute were referred to as 'Chancery Lunatics' as the Lord Chancellor was assigned responsibility on behalf of the King to take charge of their property.

[533] Chantal Stebbings, *Protecting The Property Of The Mentally Ill: The Judicial Solution In Nineteenth Century Lunacy Law*, 71 THE CAMBRIDGE LAW JOURNAL 390 (2012).

[534] Clive Unsworth, *Law And Lunacy In Psychiatry's "Golden Age"*, 13 OXFORD JOURNAL OF LEGAL STUDIES 490 (1993). See also, William Ll. Parry-Jones, *2. The 'Trade In Lunacy" In Its Historical And Legal Perspective*, *in* THE TRADE IN LUNACY: A STUDY OF PRIVATE MADHOUSES IN ENGLAND IN THE EIGHTEENTH AND NINETEENTH CENTURY 6 (First ed. 1972).

[535] Richard M. Duffy & Brendan D. Kelly, *Introduction*, *in* INDIA'S MENTAL HEALTHCARE ACT, 2017: BUILDING LAWS, PROTECTING RIGHTS 45 (2020).

4.2.2. ASYLUM-BASED CARE OF THE POOR, HOMELESS AND PERSONS WITH MENTAL ILLNESSES (THE 1800s – 1960s)[536]

Historically, from the beginning of the 18th century, psychiatry has been associated with institutional psychiatry as practised in the asylum or mental hospital. In the 19th century, institutional care for persons with mental illnesses was considered the solution for their care. The building of mental institutions was part of Victorian philanthropic efforts intended to aid the people who could not independently care for themselves due to poverty or other reasons. Further, such institutions were meant to help relieve the burden of families and local communities of directly caring for persons with mental disabilities.

The conditions existing in the asylums meant for "pauper lunatics" and "inferior paying patients" in the UK were inhumane. The institutions were overcrowded, filthy, lacked adequate ventilation and misused mechanical restraints[537]on persons with mental disabilities.[538] Instances of prolonged wrongful confinement and their mistreatment for corrupt motives were also observed in this period.[539]

4.2.3. ADVANCEMENT IN THE FIELD OF PSYCHIATRY AND THE CLOSE OF "ASYLUM-ERA" (THE 1960s-1980s)[540]

Developments in mental healthcare since World War II show two broad trends: expansion in the scope of mental healthcare[541] shaped by new insurance provisions and social welfare benefits and a marked shift away from institutional care[542] towards a hybrid system including psychiatric units in general hospitals, outpatient clinics, daycare hospitals and newer community-based care settings to enable social rehabilitation of the persons with mental

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[536] Asylum based care in this period was not limited to UK but was also observed in legislations of Japan *(Mental Patients' Custody Act, 1900)* and France *(The Law of 1838)*.

[537] The mechanical restraints used included the "straight-waist coat, strong dresses made of canvas, handcuffs, muffs and gloves, hobbles, leg-locks, and various forms of the 'coercion chair'. In addition, an apparatus comprising linen or leather straps, chains or a combination of both was used, involving attachment to the wall, bed or chair." See, William Ll. Parry-Jones, *7. Aspects of the Care of the Insane in Private Madhouses and the Outcome of Treatment, in* THE TRADE IN LUNACY: A STUDY OF PRIVATE MADHOUSES IN ENGLAND IN THE EIGHTEENTH AND NINETEENTH CENTURY 176 (First ed. 1972).

[538] W L Parry-Jones, *English Private Madhouses In The Eighteenth and Nineteenth Centuries*, 66 PROCEEDINGS OF THE ROYAL SOCIETY OF MEDICINE 662 (1973).

[539] William Ll. Parry-Jones, *8. The Principal Abuses And Defects Of The Private-Madhouse System: A Review Of Evidence, in* THE TRADE IN LUNACY: A STUDY OF PRIVATE MADHOUSES IN ENGLAND IN THE EIGHTEENTH AND NINETEENTH CENTURY 222 (First ed. 1972).

[540] Parallel legislative developments towards de-institutionalisation and development of community services as well as efforts towards promotion of autonomy of persons with mental disabilities were found in US *(Mental Retardation and Community Mental Health Centers Construction Act, 1963)* and Italy *(Italian Mental Health Act, 1978)*.

[541] Progress made in the science of psychiatry enabled the definition and diagnosis of newer mental illnesses in the field of mental healthcare.

[542] Mental hospitals, as the primary place of care.

illnesses. The move towards diversification of care settings occurred through three partly overlapping phases: an initial reform phase where efforts were made to "liberalise, revitalise and humanise traditional mental hospital-based care", the intermediate phase where a new practice of early release of persons with mental illnesses from mental hospital-based care was adopted, and the third phase focused on developing alternatives to mental hospital-based care and integrating and coordinating the working of the new diversified system of care.

There was an increasing number of professionals who were not physicians involved in providing care in non-medical settings in mental health. The field of psychiatry[543] , which earlier occupied primacy in mental healthcare, now forms a part of a cluster of mental health professions and other allied disciplines in the field of 'psychological well-being'. The move away from a treatment system centred on mental hospital care towards diversification of modality of mental healthcare delivery was driven by policy choices. [544] The 1950s also saw the development of new medication, which enabled relief from mental distress. The use of Electro-convulsive therapy also became popular in this period for the treatment of mental illnesses.[545]

This period saw inadequate beds and care for persons with mental disabilities requiring inpatient treatment. The community-based services were underdeveloped and insufficient to meet the growing care needs of persons with disabilities, with the increasing move away from institutionalisation to the community.[546]

4.2.4. PATIENT-CENTRED, DE-STIGMATISING LEGISLATION PRE-CRPD (THE 1990s – 2006)

Further attempts were made by legislation in countries to enhance the dignity of persons with mental disabilities. The emergence of effective psychiatric treatments and the growing 'anti-psychiatry' and 'survivors of psychiatry' movements impelled acknowledging the rights of persons with mental illnesses. There was a move away from the use of coercive treatments. Where coercive treatment was used, provision of enhanced safeguards was made. Examples of such legislation included the Mental Healthcare Act, 2002 in South Africa and the Mental Health Ordinance, 2001 in Pakistan. These legislations faced some criticisms from Patient

[543] The field of Psychiatry was hospital based and with exclusive focus on insanity.
[544] Michael Donnelly, *Chapter 1. Trends in Mental Health Care*, *in* THE POLITICS OF MENTAL HEALTH IN ITALY 1-4,22-23 (First ed. 1992).
[545] Carl Walker, Angie Hart & Paul Hanna, *1. Introduction: Conceptualising Mental Health in the Twenty-First Century*, *in* BUILDING A NEW COMMUNITY PSYCHOLOGY OF MENTAL HEALTH: SPACES, PLACES, PEOPLE AND ACTIVITIES 3 (2017).
[546] Duffy and Kelly, *supra* note 535.

advocacy groups due to inadequate reforms and excessive coercive measures within the legislation.[547]

4.2.5. CRPD-INFORMED, RIGHTS-BASED MENTAL HEALTH LEGISLATION (2006-PRESENT)

Post the Convention, the State Parties who had signed and ratified the Convention were obligated to align their legal framework to the CRPD framework. The State Parties were to reform their legal system to affirm the rights of the persons with mental illnesses, aimed at preserving their dignity and autonomy. The new approach also considered a paradigm shift from "substitute decision-making" to "supported decision-making". Examples of legislation adopting this approach include Law 29973, the General Law on People with Disabilities, 2012 in Peru and Mental Healthcare Act, 2017 in India.

4.3. THE UNITED KINGDOM (ENGLAND AND WALES)[548]

4.3.1. VIEWS REGARDING DECISION-MAKING RESPONSIBILITY IN MENTAL HEALTH LEGISLATION

There existed a fundamental conflict regarding how and by whom decisions should be made regarding the person with mental disabilities and his individual needs seen throughout the history of mental health legislation in England and Wales.

4.3.1.1. Legalism (or Liberalism) View:

The legalistic view maintains that constructing a legal framework is essential for protecting persons with mental disabilities. Such an approach is necessitated by the incompatibility between the interests of persons with mental illnesses and the psychiatrists. While persons with mental illnesses desire freedom from control, psychiatrists seek control over them. Legal controls are required to assure that the psychiatrist will use compulsory powers only in the best interests of persons with mental illnesses. Legalism focuses on regulating the coercive aspects of psychiatry such as detention, forcible treatment and restraint by the imposition of due process safeguards.

4.3.1.2. Medicalism (or Welfarism) View

This view encourages professional discretion in administering programmes for persons with mental disabilities. The medicalists believe that medical practitioners are best positioned to make decisions concerning treatment and care programmes. This viewpoint urges that trust be

[547] *Id.* at 45,49.

[548] Both Scotland and Ireland have separate mental health legislation for care and treatment of persons with mental illness: The Mental Health (Care and Treatment) (Scotland) Act 2003 (as amended by the Mental Health (Scotland) Act 2015) and Mental Health Act, 2001 respectively.

reposed in the psychiatric profession. Legal rules are viewed to interfere with the effective treatment of persons with mental illnesses, which involve exercising clinical expertise and judgement in their best interests to fulfil their subjective clinical needs.

The policy adopted in the Lunacy Act, 1890, reflected a legalist reaction to the "unstructured and exploitative provision of care" for persons with mental illnesses. However, with confidence being re-established in the medical profession, the medicalist approach was favoured in the Mental Treatment Act, 1930 and the subsequent Mental Health Act, 1959. The Mental Health Act, 1983 reflected a swing back towards the legalist approach, propelled by the growing awareness of human rights and the pessimism regarding the power vested in the psychiatrists.[549]

4.3.2. PRE-SECOND WORLD WAR MENTAL HEALTH LEGISLATION

The main early legislation in England and Wales comprised the Madhouses Act, 1774, the County Asylums Act, 1828 and the Criminal Lunatics Act, 1800. These legislations were concerned with the "placement or containment" of persons with mental illnesses.[550]

4.3.2.1. Madhouses Act 1774

From the early 17th century, institutions variably referred to as 'houses for lunatics', 'madhouses', 'private madhouses'[551], 'private licensed houses' and 'private asylums' were established to provide care for persons with mental illness.[552] The Madhouses Act 1774 introduced the requirement of licenses and a system for inspection of the madhouses in the English Mental Health legislation. It recognised persons with mental illnesses (insane) as a distinct group with separate needs for the first time.[553] There were no licensing laws and no evaluation of the care offered at these institutions before the 1774 Act. In 1763, a Parliamentary investigation of private London 'madhouses' was carried out, which revealed the inadequacy of care provided. However, there was vehement opposition from the Royal College of Physicians towards attempts for legislation, as many of its members were involved in the business of running private 'madhouses'. This investigation eventually resulted in the

[549] Nicola Glover-Thomas, *Chapter 1. Historical Trends in the Development of Mental Health and Law*, *in* RECONSTRUCTING MENTAL HEALTH LAW AND POLICY 1–3 (2002).

[550] Richard M. Duffy & Brendan D. Kelly, *1. Background to Mental Health Law*, *in* INDIA'S MENTAL HEALTHCARE ACT, 2017: BUILDING LAWS, PROTECTING RIGHTS 44 (2020).

[551] A 'private madhouse' referred to "a privately-owned establishment for the reception and care of insane persons". It was established with the aim of personal profit of the proprietors.

[552] William Ll. Parry-Jones, *1. Introduction*, *in* THE TRADE IN LUNACY: A STUDY OF PRIVATE MADHOUSES IN ENGLAND IN THE EIGHTEENTH AND NINETEENTH CENTURY 1 (First ed. 1972).

[553] Prior to this legislation, persons with mental disabilities and their families received no public support and were dependent on charitable support and parish aid. Until the end of the 17th century, persons with mental disabilities were cared for by their families.

enactment of the Madhouses Act 1774[554]. The Madhouses Act 1774, however, was ineffective. Despite the compulsory licensing requirement, the Licensing Board had no powers to reject licensing applications or impose sanctions for violation of standards.

4.3.2.2. The Backdrop to The Lunacy Acts

The medical interest in mental illnesses expanded when King George III began experiencing psychiatric problems in 1788. This led to the development of 'moral therapy,'[555,556] which incorporated a more humane and sensitive approach to caring for persons with mental disabilities. This model slowly emerged as the primary source of treatment.

By the 19th century, asylums began to emerge, focusing on maximising the possibility of curing persons with mental illnesses. Overcrowding became a significant problem faced by these institutions signifying the inability of the asylum model to treat effectively or cure persons with mental illnesses. The conditions within the asylum and the fear of abuse and sane persons being 'falsely or wrongly' confined within the asylum system became a matter of public concern. This period also saw the growth of psychiatry as a distinct profession. There was no legal regulation or established standards for the profession until the enactment of the Medical Registration Act, 1858. The medical profession became more involved in the care and treatment [557]of persons with mental disabilities[558]. The use of mechanical restraints continued. But the moral therapy, as innovated by laypersons, gradually became the preferred approach and undermined the medical profession's primacy in caring for persons with mental illnesses. The increasingly prominent role and representation of the medical profession were reflected in

[554] The Madhouses Act, 1774 was aimed at protection of wealthy, private patients and ensure certain standards to be adhered to in the running and maintenance of private madhouses.

[555] Moral Treatment provided an alternative to "medicalisation of madness". The medical model of insanity defined madness as a medical category with a biological basis conceived to be a disease of the mind. Moral treatment recognised insanity as a varying state with periods of lucidity during which a person was sensitive to his surrounding environment. As a 'disordered' mind was perceived to be linked to a disordered environment, restoration to 'normality' required an orderly environment to be provided. See, Annie Rogers & David Pilgrim, *3. The Rise of the Asylum, in* MENTAL HEALTH POLICY IN BRITAIN: A CRITICAL INTRODUCTION 41 (First ed. 1996).

[556] Moral treatment was pioneered by William Tuke, a philanthropist who founded The York Retreat, which adopted the model of moral therapy and was managed by laypersons. The inmates were treated with kindness and respect.Moral treatment adopted the "non-use of restraints, availability of adequate attendants for care, classification and separate management of patients according to their clinical state, provision of indoor and outdoor amusements, facilities for exercise and employment for working classes, attention to religious activities and accommodation of patients in light, well-ventilated facilities. However, such facilities were only accessible to persons with mental illnesses who were wealthy. See. Parry-Jones, *supra* note 537, at 181, 185.

[557] The medical treatment in the 18th and early 19th century was "influenced by physiological concepts concerned with body humours". It involved the use of techniques of blood-letting, blistering and cupping used with emetics, laxatives and purgatives, tonics, opiates and camphor. See, Parry-Jones, *supra* note 537, at 192-193.

[558] The profession comprised 3 categories: (i) physician, who possessed a degree in medicine and was a member of the Royal College of Physicians, (ii) Surgeons and Apothecary who gained their skills through Apprenticeship.

the contemporary legislation - The Madhouses Act 1828 [559] and the Lunatics Act 1845.[560] Doctors also campaigned to maintain control over the profession and counter the threat posed by moral therapy. They argued that provable physical abnormalities caused insanity as opposed to the commonly held belief that insanity arose from the mind. The methods of moral therapy were eventually subsumed into ordinary psychiatric medicine. As a result, the role of laypersons in the management of persons with mental illnesses gradually became non-existent. The Lunacy Act 1845 [561] strengthened the medical profession's position in the care of persons with mental illnesses. The support for the medical profession was due to their claim that mental illnesses could be cured within a certain period. But with the inability for such a cure to materialise, the role of medicine was disintegrating, and the need to improve the legal framework of civil commitment to mental health was recognised. A Select Committee was established in 1877 to review the lunacy legislation, which resulted in the Lunacy Acts (Amendment) Act 1889 and the consolidating Lunacy Act 1890, both reflecting the legalist approach. The Act attempted to curb the authority of psychiatry and protect persons from unjust detention. The decision to detain an individual in the asylum was made by a justice of peace rather than a doctor under the Lunacy Act 1890 [562]. While the Lunacy Act 1890 was in force, mental health services were integrated into the health services for the first time. This integration was aimed to reduce stigma related to mental health care by promoting parity between mental health services and other health services.

4.3.2.3. <u>The Mental Treatment Act 1930</u>

The National Council for Mental Hygiene was founded in 1922, which saw unified attempts by psychiatrists, psychologists and social workers to improve the contemporary mental healthcare system. The medical profession saw the introduction of psychological treatment and newer approaches for caring for persons with mental illnesses. The significance of social

[559] 5 of 15 Metropolitan Commissioners under the Act were physicians. The Act reflected greater concern for the welfare of the confined persons with mental illnesses, in comparison to the Act of 1774. It inserted additional stipulations before reception of persons with mental illnesses (Admission of private patients required the certificates with signature by 2 medical persons. Admission of pauper lunatics required an order signed by two magistrates or by an overseer and an officiating parish clergyman together with a medical certificate). The Act also gave more effective powers for licensing and inspection of private madhouses. See, Parry-Jones, *supra* note 534, at 17-18.

[560] The Lunatics Act 1845 replaced the Metropolitan Commissioners by the Board of Commissioners. See, Parry-Jones, *supra* note 534 at 20.

[561] The Lunacy Act, 1845 did not provide for the right of persons admitted under the Act to challenge the detention through courts. See, Duffy and Kelly, *supra* note 535, at 47.

[562] The Lunacy Act of 1890 attempted to restrict the further expansion of private asylums by preventing grant of new licenses (except under specified circumstances) and prohibiting the enlargement of existing houses. It also provided for inspection of proposed private asylums by Commissioners before issue of licenses by Magistrates. See, Parry-Jones, *supra* note 534, at 26.

welfare in the care of persons with mental illnesses was recognised. In the field of psychiatry, greater emphasis was placed on early diagnosis and treatment as well as preventive intervention. With the enactment of the Mental Treatment Act 1930, the medicalism approach re-emerged. This shift in approach was propelled by the perceived failure of the legalist approach to reduce levels of hospitalisation and protect the rights and individual liberty of persons with mental illnesses. The shift in legislative policy originated in the 1926 MacMillan Report, which the Royal Commission published[563]. The Report suggested that the justices of peace should seek clarification from one or more certifying doctors while deciding on detention. The Commission recommended the overhauling of the existing certification procedure and suggested the introduction of treatment without certification. The Commission's suggestion to make provision for voluntary admission of patients, without a need for medical recommendation and who could leave the facility after providing 72 hours' notice, which was adopted in the Act. A provision for treatment of persons with mental incapacity was included through the 'Temporary Treatment Order'. The word 'hospital' was used instead of 'asylum' in the Act.[564]

4.3.3. POST SECOND WORLD WAR DEVELOPMENTS IN MENTAL HEALTH LEGISLATION

The UK has a well-developed mental health system and was among the first few industrialised countries to move away from institutionalised mental health services[565] in the 1970s and 1980s.[566] The transition towards community care from the inpatient system gradually progressed in the post-war period. Several factors significantly influenced the post Second World War developments in the field of mental health:

a) Developments in psychiatric medication in the 1950's allowing for community integration and better quality of life for persons with mental illnesses
b) Increased recognition of newer modes of psychological therapies or treatment like 'talking treatment', which enabled the introduction of groups and therapeutic communities for treatment

[563] The Royal Commission was set up in 1924 to examine the law and administrative machinery in England and Wales relating to the certification, detention and care of persons with mental disabilities.
[564] Glover-Thomas, *supra* note 549, at 3-26.
[565] Until the mid-20th century, services for the mentally ill consisted of large-scale inpatient institutions.
[566] WHO, *2. Good Practice Services That Promote Rights and Recovery*, *in* GUIDANCE ON COMMUNITY MENTAL HEALTH SERVICES - PROMOTING PERSON-CENTRED AND RIGHTS-BASED APPROACHES 124 (2021).

c) In 1947, the mental and health services domain was transferred to the newly created National Health Services (NHS) from the local authorities[567]. The enactment of the Mental Health Act, 1959 fixed the responsibility for mental health detention psychiatrists on psychiatrists instead of magistrates. This represented a shift in perception of mental illness as located within the sphere of healthcare service "as opposed to being a matter of public order."

d) By the mid-1950s, the Government recognised the inadequacy of the existing mental health provision and the need for investment to develop mental health facilities.

e) The mental health institutions gained increasing censure in the post-war period. [568] In 1961, the UK Government adopted a policy to close down large-scale inpatient mental hospitals and relocate services[569] to the community.[570] In the 1980s, the number of community mental health centres expanded considerably.[571]

With the enactment of the National Health Services Act, 1946, there was an increasing demand to reform the mental healthcare legislation to reflect psychiatry policy and practice changes. The Mental Health Act attempted to provide comprehensive mental health services harmonised with the social welfare reforms undertaken by enacting the National Health Services Act, 1946, National Assistance Act, 1946 and National Insurance Act, 1946. The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (Percy Commission) which was set up to evaluate the necessity for law reforms, published its report with its final recommendations in May 1957. The Commission recommended the availability of informal admissions to willing persons and the use of compulsory powers only as a last resort[572]. The decision with respect to detention was considered to be a medical decision, and the role of magistrates in the decision-making process was abolished. The Commission further recommended the introduction of Mental Health Review Tribunals to review the application of compulsory powers. The Mental

[567] Prior to the creation of the NHS, mental health institutions were managed by local authorities and regarded as part of social welfare services. The mental health legislation further linked mental health institutions to the criminal justice system. See, Mark McGrath & Nick Wrycraft, *9. Secure Inpatient and Forensic Mental Health Care for Adults*, *in* INTRODUCTION TO MENTAL HEALTH NURSING 129–130 (First ed. 2009).

[568] Geoffrey Amoateng & Nick Wrycraft, *8. Mental Health Services in the Community*, *in* INTRODUCTION TO MENTAL HEALTH NURSING 118–119 (First ed. 2009).

[569] This included relocating psychiatric beds to the District General Hospitals.

[570] David A. Hingley, *14. Recovery*, *in* INTRODUCTION TO MENTAL HEALTH NURSING 197 (First ed. 2009).

[571] Annie Rogers & David Pilgrim, *2. Policy Formation and Mental Health Services*, *in* MENTAL HEALTH POLICY IN BRITAIN: A CRITICAL INTRODUCTION 32 (First ed. 1996).

[572] The Commission recommended the use of certain guiding principles when invoking compulsory care: appropriateness of inpatient care and treatment, the 'treatability test', the treatment should be for the protection of both the patients and other persons. These 3 principles have been incorporated into the Mental Health Act, 1983 as threshold criteria for involuntary detention or civil commitment. See, Nicola Glover-Thomas, *Chapter 2. The Mental Health Act, 1983*, *in* RECONSTRUCTING MENTAL HEALTH LAW AND POLICY 47–48 (2002).

Health Act 1959 [573] aimed at a more inclusive healthcare approach to de-stigmatise mental healthcare. The Act resulted in normalising voluntary, informal admissions for psychiatric hospital admissions.[574] The Act made provisions for guardianship [575] and leave of absence from the hospital [576]. The Act sought to prevent patient institutionalisation through the introduction of community care. It eliminated the distinction between asylums and other types of hospitals.[577] It was reflective of contemporary mental health practice. It further introduced Mental Health Review Tribunals in accordance with the Commission recommendations.

In Britain, community services[578] had evolved in a "piecemeal" manner. The first wave of statutory recognition emerged with the enactment of The Mental Deficiency Act 1913 introduced two new community measures: guardianship order and supervision. The acceptance of a less restrictive environment for the care of persons with mental disabilities was slowly made in the Mental Treatment Act 1930 and Mental Health Act 1959. There was also a gradual realisation that persons with mental disabilities could gain self-help using voluntary admission to the hospital.[579]

It was initially assumed that the National Health Service (NHS) had adequately provided a comprehensive system of hospitals, outpatient care, general practitioner services and limited community service. Medication was relied on to manage persons with mental illnesses outside hospitals, allowing them to draw on family and community networks for support and care. Gradually, the existing health and welfare systems proved to be inadequate. The local mental health services were under-resourced as the financial burden of community support had not been fully anticipated. The psychiatrists oriented towards social-psychiatry lobbied for more community-based healthcare services, but their care was not integrated with the efforts of the psychiatric social workers. Due to a lack of integration between the efforts of psychiatrists and psychiatric social workers, the responsibility to care for persons with mental illnesses was split between hospital-based psychiatrists and the social workers employed by local authorities.

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[573] MENTAL HEALTH ACT 1959, c.72 (1959), https://www.legislation.gov.uk/ukpga/Eliz2/7-8/72/introduction/enacted (last visited Jul 3, 2021).

[574] Basant K. Puri et al., *1. History of Mental Health Legislation*, *in* MENTAL HEALTH LAW: A PRACTICAL GUIDE 8 (Reprint ed. 2006).

[575] Mental Health Act 1959, c.72, §§ 33-34 (UK).

[576] Mental Health Act 1959, c.72, § 39 (UK).

[577] Duffy and Kelly, *supra* note 535, at 48.

[578] There are 2 models of community treatment used: (i) community treatment as a condition of leave or discharge from the hospital and (ii) community treatment, used as an alternative to hospitalisation. See, Nicola Glover-Thomas, *Chapter 5. Community Care: Law and Policy*, *in* RECONSTRUCTING MENTAL HEALTH LAW AND POLICY 128–129 (2002).

[579] Nicola Glover-Thomas, *Chapter 3. Re-orienting Psychiatric Support*, *in* RECONSTRUCTING MENTAL HEALTH LAW AND POLICY 65–67 (2002).

Consequently, there was an administrative split which created coordination issues between the NHS and the local authorities. The "rundown" of mental hospitals created accountability issues due to the inability to track persons with mental illnesses released into the communities and ensure appropriate care.[580] The successive governments of different political ideologies between the 1960s and 1990s regarded the closure of mental hospitals as an opportunity to save public money rather than working on the need to develop alternative service provisions for care.[581]

4.3.4. Mental Health Act, 1983[582]

With the increasing awareness of human rights and the recognition of individuals as bearers of rights, there emerged a consensus that professional control over patients should be regulated. The Mental Health Act, 1983 focused on protecting persons with mental disabilities by introducing legal safeguards during detention. The Act represented the emergence of a 'new legalism' focused on protecting the rights of detained persons with mental illnesses. As reflected in the Lunacy Act 1890, the traditional concept of legalism was based on the "notion of segregation" of the mentally ill from the other social groups who were institutionalised. It was further prompted by fear of wrongful civil commitment. Traditional legalism was not focused on the protection of rights of persons with mental illnesses.

The Mental Health Act 1983 provided four categories[583] of mental disorders - "mental illness, mental impairment and severe mental impairment, psychopathic disorder"[584] and any other disorder or disability of the mind.[585] The Act allowed for compulsory admission of persons who have a mental disorder [586]of such a nature warranting such detention for assessment in a hospital, in the interest of his health and safety and to protect others. The maximum detention period is 28 days from the day of admission. The Act allows the detained person to apply to the Mental Health Review Tribunal within 14 days of his detention. The Act further enabled the admission to the hospital on the application of a social worker or the nearest relative [587]and assessment in emergency cases.[588] The person detained under S.2 or admitted under S.3 could

[580] Michael Donnelly, *supra* note 544, at 22–23.
[581] Amoateng and Wrycraft, *supra* note 568.
[582] MENTAL HEALTH ACT 1983, c.20 (1983), https://www.legislation.gov.uk/ukpga/1983/20/contents (last visited Jul 3, 2021).
[583] Mental Health Act 1983, c.20, § 1 (UK).
[584] Nick Wrycraft, *3. Mental Health and Recognition of Mental Illness*, *in* INTRODUCTION TO MENTAL HEALTH NURSING 37 (First ed. 2009).
[585] Both word "mental illness" and "any other disorder or disability of the mind" were not defined under the Act.
[586] Mental Health Act, 1983, c.20, §2.
[587] Mental Health Act, 1983, c.20, §3.
[588] Mental Health Act, 1983, c.20, §4.

be discharged by the responsible medical officer, hospital managers or the nearest relatives. The Act made provisions for the application of guardianship of a person with mental illness who has attained sixteen years of age, in his interest or for the protection of other persons, by the nearest relative of such person or an approved social worker to the hospital managers, on the recommendation of two medical practitioners.

In comparison to the Mental Health Act, 1959, the 1983 Act created the Mental Health Act Commission[589] to oversee compulsory admissions [590]and evaluate the treatment of detained patients.[591] The Act further introduced the requirement of patient consent for treatment[592], involved social workers[593] in involuntary admission decision-making, mandatory aftercare planning[594] after discharge from involuntary admission.[595] The requirement of patient consent to treatment depends upon "the type and gravity of treatment administered." The Act provides for the constitution of Mental Health Review Tribunals, the procedure for making applications to the Tribunal, and the Tribunal's powers to direct discharge in suitable cases as elucidated under the Act.[596] The Act made the ill-treatment and wilful neglect of patients by managers, officers, or staff of a hospital or nursing home as separate offences that incur liability to punishment with imprisonment, fine, or both.[597] The Act had been criticised for its inability to effectively balance patient rights to liberty and autonomy, third party protection and patient welfare.[598] The Mental Health Act Commission [599] was also ineffective in dealing with complaints of mistreatment, abuse and brutality.[600]

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[589] Mental Health Act 1983, c.20, § 121 (UK).

[590] Compulsory detention application is made by the nearest relative of the person with mental illnesses or an approved social worker. Such detention is appropriate only when the patient requires hospitalisation for treatment. Such compulsory detention can be for a maximum period of 6 months. The Act also provides for 72-hour detention for emergency assessment. See, Glover-Thomas, *supra* note 549, at 49.

[591] *Id.* at 27-63.

[592] Mental Health Act 1983, c.20, §§ 56-64 (UK).

[593] Mental Health Act 1983, c.20, §§ 13,114 (UK).

[594] Mental Health Act 1983, c.20, § 117 (UK). The Act places an individual duty on the District Health Authorities and local social services authority to provide after-care services for persons who are no longer detained in the mental health hospital. See, Glover-Thomas, *supra* note 579, at 86-87.

[595] Shulamit Ramon, *1. Emerging Policy Perspectives*, *in* MENTAL HEALTH IN EUROPE: ENDS, BEGINNING AND REDISCOVERIES 40–41 (First ed. 1996).

[596] Mental Health Act 1983, c.20, §§ 65-79 (UK).

[597] Mental Health Act 1983, c.20, § 127 (UK).

[598] Glover-Thomas, *supra* note 572549, at 27-63.

[599] Some of the functions of the Mental Health Commission with respect to the Mental Health Act included: review of the operation of the Mental Health Act,1983 in respect of patient detention, investigation of complaints within its ambit, appointment of medical practitioners and others to give second opinion in required cases, to receive and examine reports on treatment administered under the consent to treatment provisions.See, Basant K. Puri et al., *10. The Mental Health Act Commission*, *in* MENTAL HEALTH LAW: A PRACTICAL GUIDE 111 (Reprint ed. 2006).

[600] Annie Rogers & David Pilgrim, *5. After 1979*, *in* MENTAL HEALTH POLICY IN BRITAIN: A CRITICAL INTRODUCTION 88–90 (First ed. 1996).

4.3.5. National Health Service and Community Care Act, 1990[601]

The 1990 Act established a uniform framework of service organisations for the four constituent countries of the UK – England, Wales, Scotland and Northern Ireland. Before its enactment, the health service was managed by regional health authorities. The Act incorporated the statutory duty laid on the health and local service authorities under the Mental Health 1983 to provide after-care services. The local authorities were made responsible for providing community care services[602] by implementing the Care Program Approach (CPA).[603] They were tasked with assessing persons with mental health needs, providing care packages and coordinating services between the different responsible agencies. The Act provided more significant powers to the local authorities to provide services to vulnerable persons. It further created the NHS Trust for the provision and management of hospitals, other establishments or facilities.[604]

Despite the implementation of the CPA to ensure the availability of adequate after-care services, there were complaints regarding the inadequacy of the community care provision. Judicial review proceedings were also instituted to review decisions concerning after-care assessment.[605] The CPA was revised in 2008 to refocus on enhanced support services. The approach raises ethical concerns specifically with respect to the balance between the necessity to work with persons requiring enhanced support but reluctant to engage and the need for services to not infringe on their human rights by compelling them to be in contact.[606]

4.3.6. Mental Health (Patients in the Community) Act, 1995

The Mental Health (Patients in the Community) Act 1995 was enacted to provide after-care under supervision[607] for persons with mental disorders above the age of 16 years who have previously been in hospital detention under the Mental Health Act, 1983 and at substantial risk

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[601] NATIONAL HEALTH SERVICE AND COMMUNITY CARE ACT 1990, c.19 (1990), https://www.legislation.gov.uk/ukpga/1990/19/introduction/enacted (last visited Jul 3, 2021).

[602] Community Care Services defined in National Health Service and Community Act 1990, c.19, § 46 (UK).

[603] The CPA was a care package introduced in 1990 to address the shortcomings in community mental health care. The CPA helps to assess, plan and support persons with mental health needs to aid their recovery. Under the CPA, persons are allotted a care coordinator to coordinate, monitor and review their care plan. The key persons identified for CPA assessment include persons with parenting responsibilities, who are carers, who misuse drugs or alcohol, have a history of violence or self-harm or who are homeless or in temporary accommodation. The Program further supports people who were involuntarily detained under the Mental Health Act, after their discharge and persons having a community treatment order (CTO). See, Rethink Mental Illness, *Care Program Approach*, https://www.rethink.org/advice-and-information/living-with-mental-illness/treatment-and-support/care-programme-approach-cpa/ (last visited Jul 1, 2021).

[604] Rogers and Pilgrim, *supra* note 600, at 91.

[605] Glover-Thomas, *supra* note 579, at 94.

[606] Amoateng and Wrycraft, *supra* note 568, at 120-124.

[607] The Act inserted S.25A to 25J to Mental Health Act 1983 through S.1 of Mental Health (Patients in the Community) Act 1995.

of harm or exploitation or the safety of others. The supervised discharge order allows the persons discharged from the hospital to receive structured support within the community. The after-care supervision is performed through the community responsible medical officer and the supervisor. The Act places mutual obligations on the persons under the supervision and the social services authorities.[608] After-care under supervision has not been actively used in the UK for multiple reasons, including the restrictive nature of the supervised discharge order and the complexity involved in applying the order. However, both community treatment orders and the after-care under supervision excessively emphasised the enforcement of medication rather than the other advantages of community living like social independence and maintaining a familial, social network.[609]

4.3.7. Mental Health Act, 2007

Mental Health Act, 1983 was amended through the Mental Health Act, 2007, which received Royal Assent on 19 July 2007. Mental Health Act, 2007 applies to a person who has a mental health problem but refuses to accept the necessary treatment or poses a risk to the well-being of themselves or others or is vulnerable due to mental illness.[610]

A single definition of mental illness replaced the four categories of mental disorders under the Mental Health Act 1983 in the Mental Health Act, 2007, "…any disorder or disability of mind." A person with a mental disorder may be admitted either for assessment for a period of up to 28 days or treatment or assessment in emergency cases. The Act broadened the group of professionals who could carry out functions performed by the approved social worker and the responsible medical officer before introducing the Mental Health Act, 2007.

The Act allows persons under 18 in in-patient mental health care to be accommodated in age-appropriate settings, subject to their needs. The consent or refusal to consent of a child under 18 regarding hospital admission cannot be overridden by a person with parental responsibility. The Act intends to ensure that such persons receive appropriate care and treatment required to prevent further mental health deterioration. Further, the Act seeks to protect the rights and independence of the persons using the least restrictive option for their care. The people subject to involuntary detention under the Act are encouraged and supported in exercising their right

[608] The person being supervised under the Act is required to fulfil the conditions attached with the order. The social services authority is under a duty to ensure contact with and provide the needed after-care services to the person under supervision.

[609] Glover-Thomas, *supra* note 578, at 134-136.

[610] James Trueman & Richard Khoo, *5. Mental Health Nursing and the Law*, *in* INTRODUCTION TO MENTAL HEALTH NURSING 68–70 (First ed. 2009).

to an independent review by the Mental Health Review Tribunal. They are also to be provided information on how to access advocacy services.

The Act provides additional safeguards concerning the use of Electroconvulsive Therapy (ECT). A second doctor's opinion is required for persons under 18 years of age for the requirement of ECT. Such opinion is needed irrespective of such persons' consent to ECT or type of admission[611] under the Mental Health Act, 2007.

The Act allows a civil partner to be named as next of kin in the same manner of recognition of a spouse. It also allowed persons with mental disorders to apply to the Court to nominate their own choice of representative instead of their nearest relative.

The 1983 Act initially did not have provision for community treatment or community supervision order.[612] It was introduced under the Mental Health Act, 2007.[613] It allows for the use of community treatment orders after placing certain conditions on the person placed under the order. The person can be discharged from the community treatment order on his recovery. If the person becomes unwell or breaks conditions specified in the CTO, the responsible Clinical may recall the person to the hospital. The community treatment order could also be renewed or revoked.[614]

In the UK, the Mental Health Act gains precedence over the Mental Capacity Act. Treatment under the Mental Health Act could be administered without reference to capacity if deemed essential. The Act provides for safeguards such as the Mental Health Tribunal and Second Opinion Appointed Doctors to ensure appropriate treatment and the use of the least restrictive option.

4.3.8. Mental Capacity Act, 2005

The Mental Capacity Act was enforced in 2007 to protect and empower persons with mental disabilities who may be facing mental incapacity for decision-making related to their care and treatment-based. The Act is based on five principles: there should be a presumption of the person's mental capacity unless there is evidence to the contrary, support for capable decision-making should be made available to individuals, the persons retain the right "to make eccentric or unwise decisions", the law considers in the best interests of the person and choice of the least restrictive intervention should be made where the individual is unable to make a choice.[615]

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[611] Type of Admission could be informal admission or detention under the Mental Healthcare Act, 2007.

[612] Marian Barnes & Ric Bowl, *1. Mental Health and Empowerment, in* TAKING OVER THE ASYLUM: EMPOWERMENT AND MENTAL HEALTH 12 (First ed. 2001).

[613] Trueman and Khoo, *supra* note 610.

[614] Tony Zigmond, *Chapter 7. Supervised Community Treatment and Community Treatment Orders, in* A CLINICIAN'S BRIEF GUIDE TO THE MENTAL HEALTH ACT 55–60 (Reprint ed. 2012).

[615] *Id.* at 71.

The Mental Capacity Act, 2005, further provides the procedural requirements for a mental capacity evaluation in specific instances. It adopts the principle of the least restrictive alternative. In case courts appoint guardians for individuals with incapacity, the guardians cannot make a personal decision on behalf of such individuals if the individual has the capacity to make such a decision at the time of decision-making. The Mental Capacity Act, 2005 specifically provides for the use of Deprivation of Liberty Safeguards when persons with mental incapacity are deprived of liberty to receive the care in their best interests and protection. This involves two assessments to be carried out on the person whose liberty is proposed to be taken away[616]. A doctor performs a mental health assessment. The 'best interests' assessment is carried out by assessors who are not involved in the treatment and care of the person assessed. The terms "incapacity" and "best interests" are statutorily defined. The 'best interests' assessment process should be carried out with the support and representation of the appointed representative[617] of the person assessed. [618] The Act newly introduced the role of the Independent Mental Health Capacity Advocate (IMCA) to represent the interests of persons with mental incapacity. Ill-treatment and neglect have been made a criminal offence under the Act, punishable with a fine or imprisonment for up to 5 years or both. The Act also makes provisions for future decision-making through advance decisions, advance statements, and Lasting Power of Attorney (LPA).[619]

4.4. NEW ZEALAND

The Government substantially funds the healthcare system in New Zealand. The percentage allocation of the health budget on mental health in New Zealand is 10%. The mental health care in the country had de-institutionalised mental healthcare and is now predominantly community focused. It has 21 inpatient beds per 100,000 population. The 2014 Ministry of

[616] The process commences with a recommendation for assessment by the hospital staff to the relevant health authority or the care home staff to the local authority when they consider that the person cannot be cared for or treated without deprivation of liberty.

[617] The representative can be a family member or friend. Where the assessed person does not have family or friends, an Independent Mental Capacity Advocate (IMCA) supports and represents the person in the assessment process.

[618] Callard et al., *supra* note 7, at 46.

[619] Trueman and Khoo, *supra* note 610, at 71-72. An "advance decision" refers to a person's refusal of future treatment. Such a decision would impliedly be considered as the person's refusal to consent at the moment it is requested, where the advance decision relates to the circumstances experienced. "Advance statements" refer to expressions of general treatment. These statements are not considered legally binding and may be subject to the determination of best interests by the medical professionals involved in care. A "Lasting Power of Attorney " enables a person to nominate another person to make decisions on his behalf in the event of his or her loss of mental capacity. There is also a provision for the Court of Protection to appoint Court-appointed deputies with more limited powers where the person lacking capacity had not arranged for LPA.

Health report indicated that 64% of mental health contact occurred in community settings. (Ministry of Health 2014a).

The current mental health legislation operational in New Zealand, Mental Health (Compulsory Assessment and Treatment) Act, was passed in 1992 and was last amended in 1999. The Act provides for outpatient treatment of "mentally disordered" persons as described in the Act.[620] The legal criteria which must be satisfied for the use of the CTO include: 'abnormal state of mind' of the patient, to such a degree as posing a danger to the person's or others' health or safety or seriously diminishing the person's capacity for self-care, necessitating involuntary treatment and when adequate out-patient care and community support is available. Persons under CTO are required to accept house visits from a community nurse, regularly attend their out-patient psychiatric appointments and take the prescribed medication. The responsible clinician may revoke the CTO and recall the person to in-patient care for failure to comply with the CTO conditions. A mental health professional [621] responsible for supervising the community treatment order (CTO) provides treatment, including medication to persons with mental disorders. The duration of the CTO is for six months and can be renewed by appeal to the Mental Health Tribunal.[622] The mental health legislation allows for the use of community treatment orders (CTO), but CTO's clinical outcomes have not yet been systematically evaluated. There is a lack of data availability on the length of time spent by patients under CTO. The mental health legislation also allows persons with mental illness access to legal representation and a review tribunal. The review tribunal is authorised to order the release from compulsory treatment.[623] A responsible clinician may authorise the discharge of the person with a mental disorder at any time.

The Act allows for ECT use if the same is administered either with the person's written consent or if it is considered by the Review tribunal appointed psychiatrist to be in the person's interest. The Act also allows brain surgery to be done on a person with a mental disorder with his written consent, and if the Review Tribunal is satisfied that the person had given his consent freely having understood the nature, purpose and effects of the surgery. Further, the surgery should be considered in the person's interest by the responsible clinician and a psychiatrist appointed

[620] Magnus M'foafo-M'Carthy & Wes Shera, *Beyond Community Treatment Orders: Empowering Clients to Achieve Community Integration*, 41 INTERNATIONAL JOURNAL OF MENTAL HEALTH 65 (2012).
[621] Experienced community mental health nurses are usually responsible for the implementation of the CTO. See, John Dawson, *Community Treatment Orders in New Zealand*, 6 INTERNATIONAL PSYCHIATRY 59–60 (2009).
[622] M'foafo-M'Carthy and Shera, *supra* note 620.
[623] Anthony J. O'Brian, *Chapter 20. Compulsory Community Mental Health Care: Oceania*, *in* COERCION IN COMMUNITY MENTAL HEALTH CARE INTERNATIONAL PERSPECTIVES 315–319 (2016).

[624] by the Review Tribunal. Brain surgery is not allowed to be performed on persons under 17 years of age.

The Act recognises eleven core patient rights guaranteed to persons with mental disorders under treatment – right to information, patient's right to respect for their cultural identity, right to an interpreter competent in New Zealand sign language, right to appropriate treatment, right to be informed about treatment, to refuse video-recording, to ask for a second opinion from an independent psychiatrist, to independent legal advice, right to company, to have visitors and make telephone calls and to receive and send mail.[625]

4.5. SRI LANKA

In Sri Lanka, mental health services are integrated with primary care services. People with mental health problems constitute one of the most marginalised groups in the country.

Sri Lankan mental health law dates back to the Lunacy Ordinance of 1873 during British rule in Sri Lanka. This law is still operational and has since undergone minor amendments, the most recent revision being in 1956. The current legislation in force is the Mental Diseases Ordinance, 1956, based on the Lunacy ordinance of 1873 and regulates the "custody, hospitalisation and detention of persons with mental illnesses". The assessment of unsoundness of mind is made through civil court enquiry. The district court may order the person to be admitted to a mental asylum for further observation or release the person to a relative or friend who is prepared to take responsibility for such a person. The Act allows for voluntary admission of patients. The Act additionally mentions the concept of a temporary patient who may be admitted on the application of the person's spouse or relative or any other person to the hospital superintendent accompanied by the recommendation by two medical practitioners[626]. A temporary patient may be committed for up to one year. The legislation does not address the human rights of persons with mental illness. The Mental Health Policy of Sri Lanka adopted in 2005 has adopted a rights-based approach to mental health. The Policy mandated new mental health legislation to assimilate human rights for detained persons with mental illnesses. The Act does not define the clinician's role. It also does not provide for review of detention under an independent Tribunal. Though a new mental health law had been drafted in 2007 incorporating human rights safeguards, addressing capacity to consent and focused on

[624] The psychiatrist appointed by the Review Tribunal should consult with at least 2 health professionals involved in the person's care while forming his opinion.

[625] Ian Soosay & Rob Kydd, *Mental Health Law in New Zealand*, Vol.13 BJPSYCH INTERNATIONAL 43–45 (2016).

[626] The medical practitioners should have examined the person within five days of making the application for admission. A temporary patient under the Act is "a person who is suffering from mental illness and is likely to benefit by a temporary treatment in a mental hospital but is for the time being incapable of expressing himself as willing or unwilling to receive such treatment."

rehabilitation, it has not yet been enforced "due to bureaucratic processes and lack of consensus among key stakeholders."[627]

The mental health policy permits involuntary treatment only at the National Institute of Mental Health, Sri Lanka's premier mental health facility. People with mental illnesses usually undergo treatment at regional centres. Involuntary admission of such persons is often unchallenged due to social stigma, lack of awareness, and financial constraints.[628]

CONCLUSION

The history of the Indian mental health legislation shared common origins with the mental health legislation in the UK due to its colonial heritage. The Mental Capacity Act, 2005 deals with the issue of capacity in the UK. The Mental Health Act, 2007, further allows ECT use with certain safeguards and is compulsory as under the Indian Mental Healthcare Act, 2017. The Act does not explicitly recognise the specific rights available to persons with mental illness within the Act. The need to create mental health awareness to address stigma is also not recognised specifically under the Act.

Though the UK has ratified and is bound by the CRPD, mental healthcare in the UK faces significant hurdles due to lack of funding, access and the stigma associated with mental illness. Some authors argue that access to care provided through the NHS has made meeting the aims of CRPD in the UK challenging.[629] Though the Mental Health Act in the UK recognises the role of nearest relatives in some aspects of the care and treatment, the person with mental illness is given the right to apply to the county courts to displace his nearest relatives on reasonable grounds.

The community treatment orders used in New Zealand and the UK have not yet gained popularity in India. The Mental Healthcare Act, 2017 does not have any specific provision enabling the use of community treatment orders. However, The Mental Healthcare Act, 2017 recognises the right to community living of persons with mental illness. The Mental Health Act of New Zealand has recognised the rights of persons with mental illness. However, no specific provision is made recognising the role of family or caregivers in the Act. The Act provides for clinical and tribunal reviews of persons under treatment. The Act does not specifically address the need to create mental health awareness and address stigma related to mental illness. But the Mental Health and Wellbeing Commission established under the Mental

[627] Sangeeta Dey et al., *Comparing legislation for involuntary admission and treatment of mental illness in four South Asian Countries*, 13 INTERNATIONAL JOURNAL OF MENTAL HEALTH SYSTEMS 4–5 (2019).
[628] Raveesh, Singh, and Pathare, *supra* note 299.
[629] Nicholas Wilson, *Minding Your Noggin: A Comparative Analysis of Mental Health Care Law in the US, UK and China*, 30 TRANSNATIONAL LAW AND CONTEMPORARY PROBLEMS 175–176 (2021).

Health and Wellbeing Commission Act 2020 in New Zealand is involved in advocacy in the collective interest of persons experiencing mental distress and people supporting them.

New Zealand is also currently contemplating the full repeal and replacement of the Mental Health (Compulsory Assessment and Treatment) Act 1992 with new legislation reflecting a human rights approach, promoting supported decision-making, aligning with the recovery and well-being model of mental health and providing measures to minimise compulsory or coercive treatment.[630]

Sri Lanka is yet to adopt new mental health legislation recognising the human rights of persons with mental illness. The current Mental Diseases Ordinance, 1956 does not clearly define the role of clinicians in mental health care. There is a lack of focus on obtaining informed consent of persons with mental illnesses for their treatment and care. Further, the Act does not provide for the assessment of the capacity of the persons. The person's relatives are allowed to petition the court to determine the person's unsoundness of mind, apply for emergency orders, and receive his custody for his care and maintenance. There are no provisions for the review of persons detained under the Act through an independent tribunal. The Mental Diseases Ordinance Act does little to address the issue of stigma and discrimination widely faced by persons with mental illness. The Mental Healthcare Act, 2017 fares better in comparison to the Mental Diseases Ordinance, 1956.

[630] Manatū Hauora Ministry of Health, *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992* (2020), https://www.health.govt.nz/system/files/documents/publications/human-rights-mental-health-compulsory-assessment-treatment-act-1992-28august2020v2.pdf (last visited Sep 30, 2021).

CHAPTER 5

RESEARCH FINDINGS, CONCLUSIONS AND SUGGESTIONS

15.1. RESEARCH FINDINGS AND CONCLUSIONS

15.1.1. DISCUSSION ON THE MENTAL HEALTHCARE ACT, 2017 IN PSYCHIATRY LITERATURE

Some psychiatry literature propounds that there was no need for the new Act and that revision of the Mental Health Act, 1987 would have been sufficient. However, such discussions acknowledge the need to understand the practical and legal implications of the Act.

15.1.2. COMPARISON OF THE MENTAL HEALTH ACT, 1987 AND MENTAL HEALTHCARE ACT, 2017

15.1.2.1. Definition of Mental Illness

The "mental illness" definition under the Mental Healthcare Act, 2017 is more conceptually clear than that under The Mental Health Act, 1987. The Mental Health Act, 1987 described a mentally ill person only with reference to the need for treatment due to a mental disorder other than mental retardation, without expressly mentioning the nature of mental disorders. The definition under the Mental Healthcare Act, 2017 also excludes mental retardation.

15.1.2.2. Admission and Discharge Procedure for Minors

There is a difference in procedural requirements to be followed before admission of minors. The Mental Health Act, 1987 required the minor's evaluation only by the medical officer-in-charge to determine the need for admission. The Mental Healthcare Act, 2017 mandates examination by at least two medical professionals, including a Mental Health Professional.

Another area of difference is in provisions when the minor attains majority during inpatient treatment. The Mental Health Act, 1987 did not consider the admission as voluntary once the inpatient attained majority. It provided that a minor attaining majority would be discharged from inpatient care unless he makes a specific request to continue the inpatient care within a month of intimating the majority status by the doctor-in-charge. The Mental Healthcare Act, 2017 stipulates the discharge of such a patient who has attained majority during inpatient care on his request. The provision under The Mental Health Act, 1987, which provided for discharge by default unless a specific request for continuance of inpatient care was made, is replaced by the provision for optional discharge on the patient's request.

15.1.2.3. Separate inpatient facilities for minors

Section 5 of Chapter III of The Mental Health Act, 1987 proposed that the Central Government of India should set up separate psychiatric hospitals and psychiatric nursing homes for those under 16 years of age. The Mental Healthcare Act, 2017, provided that separate facilities are needed for all minors under 18 years instead of 16 years as provided in The Mental Health Act, 1987. The Mental Healthcare Act, 2017 does not specify whether the separate facilities could be within the same premises as the adult facilities or if they should be separate standalone hospitals for minors. The Mental Healthcare Act, 2017 also provided that the facilities for minors should be appropriate for their developmental needs. However, the minimum standards required for such a facility were not clearly defined.

15.1.2.4. New mandates introduced in Mental Healthcare Act, 2017 vis-à-vis Mental Healthcare, 1987

The Mental Healthcare Act, 2017 introduced the following provisions in Indian mental health legislation - the role of Nominated Representatives in Advance Directives for minors, provision for change of Nominated Representative if he is deemed unfit, provision for children aged three years or below to stay with their mothers while undergoing treatment for mental illness unless there is any risk to the child, the mandatory requirement of Nominated Representatives to accompany minors during inpatient treatment, the requirement to report to the Mental Health Review Board within 72 hours of admission of a minor patient and prohibition of electroconvulsive therapy on minors[631]

15.1.3. INTER-LAPPING OBJECTIVES OF MENTAL HEALTH LEGISLATION

According to Brenda Hale, mental health laws continuously struggle to reconcile "three overlapping but often competing goals:" protection of the public, ensuring access to services to persons with mental illnesses and safeguarding their civil rights.[632] The CRPD, through its recognition of a confluence of all facets [633] of rights, aims to provide a framework to ensure that the mental health legislations addressing treatment and detention recognises the rights of persons with mental illnesses.[634]

15.1.4. DRAFTING OF MENTAL HEALTHCARE ACT, 2017 – GRIEVANCES FROM MEDICAL COMMUNITY

[631] Eesha Sharma & John Vijay Sagar Kommu, *Mental Healthcare Act 2017, India: Child and Adolescent Perspectives*, 61 INDIAN JOURNAL OF PSYCHIATRY S759 (2019).
[632] Brenda Hale, *Justice and Equality in Mental Health Law: The European experience*, 30 INTERNATIONAL JOURNAL OF LAW AND PSYCHIATRY 19 (2007).
[633] The CRPD adopts a comprehensive approach which recognises the civil, political, economic, social and cultural rights of persons with disabilities.
[634] Bernadette McSherry, *International Trends in Mental Health Laws: Introduction*, 26 LAW IN CONTEXT: A SOCIO-LEGAL JOURNAL 8 (2008).

There were some areas of contention concerning drafting the Mental Healthcare Act, 2017 among the medical community. It was perceived that the legislators did not trust psychiatrists in the drafting of the Act. Unlike during drafting The Mental Health Act, 1987, the Indian Psychiatric Society (IPS) were excluded from drafting the Mental Healthcare Act, 2017. The Mental Health Act, 1987 was conceived, piloted and drafted by the IPS. But during the drafting of the Mental Healthcare Act, 2017, the IPS was not assigned any significant role though invited for consultation process at different stages. The concerns raised by the IPS regarding various provisions in the new Act, which was perceived to not be in the best interest of the persons with mental illness, were not addressed. The drafting process was considered to be driven by human rights activists and NGOs with very little involvement from stakeholders involved in delivering mental health care. The Act does not adequately address the caregiver rights and burden of care.[635]

15.1.5. CONCORDANCE WITH CRPD AND WHO CHECKLIST

There are two internationally recognised standards specific to mental health legislation against which the Mental Healthcare Act, 2017 can be compared – the WHO Checklist [636]and the CRPD. The Mental Healthcare Act, 2017 addresses 96 of the 175 indicators (55.4%) in mental health legislation as per the WHO checklist. In conjunction with the Rights of Persons with Mental Disabilities Act, 2016, 118 of the 175 indicators (68.0%) are addressed by the Indian legislative framework for persons with mental disabilities.[637] With the exclusion of areas of complex comparison from the analysis and areas where non-concordance can be justified, the

[635] Jagadish A, Ali Furkhan & Mahesh R Gowda, *Mental Healthcare Act 2017 - The way ahead: Opportunities and Challenges*, 41 INDIAN JOURNAL OF PSYCHOLOGICAL MEDICINE 113–114 (2019).

[636] The WHO Checklist on Mental Health Legislation formed part of the WHO's Resource Book on Mental Health, Human Rights and Legislation published in 2005. Though the WHO Resource Book was withdrawn with the publication of the CRPD in 2006, it comprehensively considered the aspects required to be covered within the mental health legislation for Persons with Mental Illness. Subsequently in 2007, the WHO published the checklist for evaluating a mental health policy. The WHO currently publishes "QualityRights" which is concordant with CRPD. QualityRights has also published the WHO QualityRights Tool Kit in 2012 to enable countries to "assess and improve quality and human rights of their mental health and social care facilities." See, Richard M. Duffy & Brendan D. Kelly, *Introduction*, *in* INDIA'S MENTAL HEALTHCARE ACT, 2017: BUILDING LAWS, PROTECTING RIGHTS 15 (2020). See also, WHO Checklist on Mental Health Legislation, (2005), https://www.healthrights.mk/pdf/Zdravstveni%20Rabotnici/Publikacii/Mentalno%20zdravje/Dopolneti/%D0%9B%D0%B8%D1%81%D1%82%D0%B0%20%D0%B7%D0%B0%20%D0%BF%D1%80%D0%BE%D0%B2%D0%B5%D1%80%D0%BA%D0%B0%20%D0%BD%D0%B0%20%D0%A1%D0%97%D0%9E%20%D0%B7%D0%B0%20%D0%BB%D0%B5%D0%B3%D0%B8%D1%81%D0%BB%D0%B0%D1%82%D0%B8%D0%B2%D0%B0%D1%82%D0%B0%20%D0%B7%D0%B0%20%D0%BC%D0%B5%D0%BD%D1%82%D0%B0%D0%BB%D0%BD%D0%BE%20%D0%B7%D0%B4%D1%80%D0%B0%D0%B2%D1%98%D0%B5.pdf (last visited Jul 8, 2021).

[637] Duffy and Kelly, *supra* note 297 at 1.

Indian legislations for the protection of persons with disabilities meet 129 of 167 indicators (77.2%) of the WHO checklist.[638]

Areas of concordance with WHO Checklist concerning child and adolescent mental health include: involuntary placement of minors in mental health institutions is limited to instances where all feasible community alternatives have been tried, minors placed in mental health facilities should have a living area separate from adults, if minors are placed in mental health facilities, the environment should be age-appropriate and take into consideration the minor's developmental needs, and all minors should have an adult to represent them in all matters affecting them, including consent to treatment.

Some areas of non-concordance between the Mental Healthcare Act, 2017 and the WHO Checklist include: the definition of mental illness does not expressly mention the Act's stance on the spectrum of neurodevelopmental disorders, the Act does not specify the minimum conditions to be maintained in mental health facilities for the maintenance of a safe, therapeutic and hygienic clinical environment, the Act does not expressly specify the level of professional skills required or the categories of professionals who may be involved in the personal assessment for the determination of a mental disorder and the Act neglects the need to consider the opinion of minors depending on their age and maturity on issues that directly affect them, including consent to treatment.[639]

The Mental Healthcare Act, 2017 represents the first mental health legislation drafted to comply with the principles under the CRPD. Where there is divergence from the CRPD principles, the Mental Healthcare Act, 2017 has incorporated protections through the Mental Health Review Boards. The non-concordance with the CRPD arose from mutually balancing the competing CRPD rights for persons with mental illnesses. The areas of non-concordance include the aspects of capacity and insufficient protection afforded during emergency treatment. However, the limitations to achieve complete concordance needs to be looked at in the context of limited resources for implementation.[640]

15.1.6. SIGNIFICANT AREAS OF DIVERGENCE OR NON-CONCORDANCE WITH CRPD [641]

15.1.6.1. Capacity

[638] Duffy and Kelly, *supra* note 48, at 17.
[639] Sharma and Kommu, *supra* note 631 at S761.
[640] Duffy and Kelly, *supra* note 48, at 18-19.
[641] Richard M. Duffy & Brendan D. Kelly, *9. Compliance of India's Mental Healthcare Act, 2017 with the United Nations' Convention on the Rights of Persons with Disabilities*, *in* INDIA'S MENTAL HEALTHCARE ACT, 2017: BUILDING LAWS, PROTECTING RIGHTS 259–274 (2020).

Under mental health legislation, the determination of mental capacity and the evaluation of the decision-making capacity of persons with mental illness is applied. Such a practice may be discriminatory considering that persons without mental illnesses have the freedom for autonomous decision-making without determining their capacity for the same. The alternative approach is applying a uniform law for decision-making in healthcare which evaluates mental or physical health in all persons making such decisions equally. The Mental Healthcare Act, 2017 does not adhere to the alternative approach suggested and hence deviated from the CRPD in capacity and the principle of equality and non-discrimination. Due to the peculiarities of different mental illnesses and their effects on the person, it may not be appropriate not to consider the effects of the mental illness on the person's capacity for decision making. Such an approach would also prove unfair to the person as he may not get the necessary support for the intervention required for his path to recovery and well-being.

15.1.6.2. Advance Directive

The CRPD provides that the time when an advance directive becomes operational and ceases to have effect should be decided by the person making the advance directive and included in the directive's text. Such time should not be based on an assessment of the lack of capacity of the person. But the Mental Healthcare Act fails to comply with the requirements of the CRPD. Under S.5(3) of the Mental Healthcare Act, 2017, the advance directive only applies when a person ceases to have the required capacity to make mental health care or treatment decisions and remains in force until the person regains such capacity. S.8 of the Act also provides for the revocation, amendment or cancellation of the advance directive by the person who made it at any time, without any reference to capacity. S.10, read with S.9, provides that mental health professionals should follow the advance directive under all circumstances, except in emergency treatments. The relatives, caregivers or the mental health professionals may apply to the Mental Health Review Boards for review, alteration, modification or cancellation of the Advance Directive on grounds specified under S.11 of the Act.

15.1.6.3. Supported Decision-Making and Research

Art.12(3) of the CRPD provides that the State Parties should take adequate measures to enable persons with disabilities to access the support required to exercise their legal capacity. This provision allows for supported decision making considering the person's rights, will and preferences. This view is supported by S.17(a) of the Mental Healthcare Act, 2017, which provides that the nominated representative should consider the "current and past wishes, life history, values, cultural background and best interests" of the person with mental illness while discharging his duties. But concerning research on persons with mental illnesses unable to

give informed consent, the Act allows the research to proceed subject to certain specified conditions even without such consent for the greater good. This provision allowing for research without consent violates the requirement under Art.15(1), which provides that no one should be subjected to medical or scientific experimentation without his free consent.

15.1.6.4. Use of Physical Restraints

Art.14(1)(b) stipulates that persons with disabilities should not be unlawfully or arbitrarily deprived of their liberty. Any deprivation of liberty should be according to law, and the existence of a disability cannot justify such deprivation in any case. The Mental Healthcare Act, 2017 allows for the use of physical restraints only when necessary, subject to certain safeguards. But the use of physical restraints due to the person's mental illness, even if justified based on preventing harm, violates the provision prohibiting deprivation of liberty based on the existence of a disability.

15.1.7. OTHER KEY ISSUES UNDER THE MENTAL HEALTHCARE ACT, 2017

15.1.7.1. The scarcity of Fiscal and Human Resources in mental healthcare

As of 2021, less than 1% of India's national healthcare budget was allocated towards mental health.[642] A comparative analysis with England for 2020 would show mental health budget allocation in India to be 0.05% of the total budget [643] instead of 14% of the National Health Service Budget in England.[644] As per the data of country-wise mental health workers, India had only 0.3 psychiatrists and 0.8 mental health nurses per 100,000 people compared to 28.5 psychiatrists and 75.1 mental health nurses per 100,000 people in New Zealand (WHO 2016d). Sri Lanka fares slightly better than India, with 0.5 psychiatrists and 3.2 mental health nurses per 100,000 people (WHO 2017d).[645] There is a need for adequate fund allocation to enable investment to develop infrastructure and train human resources to provide high-quality mental healthcare services.

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[642] In the 2021-22 budget, the budgetary allocation towards mental healthcare amounted to just Rs. 5.97 Billion which contributes only to 0.8% of the total annual budget. Of this amount, only 7% was allotted towards the National Mental Health Programme. See, Pooja Priyamvada, *Budget 2021: Mental Healthcare of Indians Not a Priority For the Government, Despite Rising Numbers in 2020* (2021), https://www.womensweb.in/2021/02/budget-2021-no-allocation-for-mental-health-of-indians-feb21wk1sr/ (last visited Jul 8, 2021). See Also, Richa Nigam, *India's Budget For Mental Health Leaves A Lot To Be Desired* (2021), https://mediaindia.eu/society/mental-health-budget-2021/ (last visited Jul 8, 2021).

[643] Atish Mathur, *Mind Over Matter: India's Mental Health Policy*, November 30, 2020, https://www.thehindu.com/brandhub/mind-over-matter-indias-mental-health-policy/article33212760.ece (last visited Jul 8, 2021).

[644] NHS Mental Health Dashboard, https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/ (last visited Jul 8, 2021).

[645] WHO - Global Health Observatory Data Repository, *Mental Health Workers: Data By Country*, https://apps.who.int/gho/data/view.main.HWF11v (last visited Jul 8, 2021).

15.1.7.2. Unaddressed issues on the inter-relationship between Rights of Persons with Disabilities Act, 2016 and Mental Healthcare Act, 2017

The Mental Healthcare Act, 2017 and the Rights of Persons with Disabilities Act, 2016 do not synchronise on essential aspects such as the relationship between the guardian and the nominated representative. It is also uncertain whether the specific challenges presented by mental illnesses could be adequately addressed by the general provisions of the Rights of Persons with Disabilities Act, 2016. This aspect gains relevance as the Mental Healthcare Act, 2017 does not directly address many aspects of discrimination or social rights highlighted in the CRPD.[646]

15.1.7.3. Inter-relationship between the National Mental Health Policy, 2014 and the Mental Healthcare Act, 2017

The National Mental Health Policy, 2014, was adopted in India to guide all actions directed towards scaling up mental health programs and provisions. The policy especially emphasised the mental health needs of vulnerable groups such as orphans with mental illnesses, children of persons with mental illnesses and children in custodial institutions. However, the Mental Healthcare Act, 2017 is silent about this vulnerable population, their needs, and ensuring their mental health needs are addressed.[647]

15.1.7.4. The grey area of a suicide attempt – Conflict between IPC and the Mental Healthcare Act, 2017

While S.309 of the Indian Penal Code, 1860 criminalises suicide, S. 115(1) of the Mental Healthcare Act provides for the decriminalisation of attempt to suicide by providing for a presumption of severe stress in such cases.

15.1.7.5. Role of Families in Care of Persons with Mental Illnesses

Under the Mental Health Act, 1987, admission of patients with mental illnesses was at family members' request. There was the involvement of family members in the assessment and review of progress in a clinical setting. However, under the Mental Healthcare Act, 2017, patients' rights and preferences are given precedence.[648] The Act ensures the involvement of family members and other caregivers in developing mental health policy, legislation and service planning. But it does not provide for the participation of families in the formulation and implementation of the individualised treatment plan of the persons with mental illnesses. The

[646] Duffy and Kelly, *supra* note 637.
[647] Sharma and Kommu, *supra* note 631631 at S760.
[648] Vijaykumar Harbishettar & Pratibha Murthy, *Reorientation of Postgraduate Training in the background of the Mental Healthcare Act, 2017*, 61 INDIAN JOURNAL OF PSYCHIATRY S833 (2019).

law does not give families the right to appeal involuntary admission and treatment decisions.[649] The Act is silent on addressing the specific mental health needs of older children and adolescents, depending on their developmental level and health, when either parent has a mental illness.

15.1.7.6. Primacy to Nominated Representative who is not a family member unsuitable in the Indian context

In India, the caregiver burden predominantly falls on the family. The family members are responsible for supporting persons with mental illnesses financially and socially. While the provisions of The Mental Healthcare Act, 2017 allow for privacy from family by allowing the person with mental illness to choose his nominated representative, such a provision may not be feasible in the Indian cultural context as the family may be responsible for bearing the financial cost of the person's treatment.

15.1.7.7. Provision of Emergency Treatment

S.94 of the Act impliedly allows for emergency treatment to be administered to persons with mental illness even without the informed consent of the nominated representative if such a person is unavailable. The definition of an emergency situation allows emergency treatment as including immediate risk of serious damage to one's own or others' property where such behaviour is attributable to a mental illness. The other provisions of the Act for treatment without obtaining informed consent are justified based on risk to life or health or safety of the person or others. The use of emergency treatment on the apprehension of immediate risk of property damage appears to be drastic, especially when such treatment can proceed involuntarily and without the consent of a nominated representative. Such a provision could also be stigmatising to the person with mental illness.

15.1.7.8. Cases of difficulty in finding nominated representative when a person with mental illness is taken into police protection

The Act provides that the officer in charge of the police station should inform the nominated representative of the person believed to have mental illness taken under his protection if such person has difficulty understanding the grounds. However, it may be practically challenging to ascertain who the nominated representative is and convey the information in such circumstances, especially when the nominated representative is not a family member.

15.1.7.9. Issues in the use of Psychiatric Advance Directives

[649] Duffy and Kelly, *supra* note 297, at 3.

The legal regulation of Advance Directives helps establish and protect the right to self-determination in future medical decisions of its author ("patient") in the event of the patient's personal incapacity to express his wishes for his care. It also increases legal certainty for both the patient and the physicians treating the author. The patient is ensured that their will, will be respected. The treating physician can ascertain the patient's wishes and proceed to act accordingly.

However, there may be a lack of certainty on the aspects to be addressed explicitly in the Advance directive – diseases to provide for, specific diagnosis and prognosis, determining the treatment options available and the attendant risks associated with it. It may not be possible to foresee or predict the future situations to which the advance directives would be applicable. The statements made in the advance directive may require additional interpretation where there is ambiguity.[650]Further problems may also arise due to significant variance between expressed wishes and terms mentioned in the advance directive or the inability to verify the authenticity of the Advance Directive.

15.2. SUGGESTIONS

15.2.1. CHALLENGES FOR MENTAL HEALTHCARE IN INDIA

A significant treatment gap exists in the community due to the disparity between the number of persons with mental illness and treatment facilities and trained professionals. There is a lack of awareness and deep social stigma concerning mental health issues which form a barrier to mental health care. The available mental health facilities and services have not been adequately utilised by persons with mental illnesses and their families. Modern medical care for the treatment of mental illness has limited acceptance in Indian society. India's current mental health infrastructure lacks focus on the recovery and reintegration of persons with mental illness into society. There is also a lack of adequate programs to support the families and caregivers of persons with mental illness.[651]

15.2.2. AWARENESS AND ADVOCACY

There should be social awareness campaigns to sensitise society on the needs and the rights of persons with mental disabilities. Such movements would help address stigma, discrimination and social exclusion experienced by persons with mental disabilities.

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[650] Peter Lack, Nikola Biller-Andorno & Susanne Brauer, *Chapter 1. Historical Review of Advanced Directives*, *in* ADVANCED DIRECTIVES 11–13 (2014).

[651] R. Srinivasa Murthy, *Mental Health Initiatives in India (1947-2010)*, *in* SOCIAL WORK IN MENTAL HEALTH - CONTEXTS AND THEORIES FOR PRACTICE 31–36 (2014).

Stigma is a Greek word that means 'mark'. It is derived from the verb *stizein* meaning, 'tattoo', 'prick' or 'puncture'.[652] Stigma is a social construct linked to values posited on social identities. Stigma as a negative attitude results in the shared recognition by the given society of a differentiating attribute ('mark') and the consequent 'devaluation' of the person associated with having the same attribute. Stigmatising conditions may include physical deformities, cultural or religious identities and perceived blemishes of character[653]. Through a common association and class identity process, society equally stigmatises all persons with mental disabilities, irrespective of the degree of illness or disability. The identification with the class (belonging to a commonly perceived stereotype) reinforces the stigma against the person. The stigma towards mental disability is further attributable to fear of harm, fear of the condition of the person with mental illness and resultant social exclusion. However, it is a dynamic concept that changes with time and cultural evolution through bringing about change in the perceptions of and reaction towards the stigmatising attribute.[654] The stigma prevailing against persons with mental disabilities leads to discrimination and prejudice. Discrimination refers to the behaviour "aimed at depriving legal rights and legally recognised entitlements" of the stigmatised person. Prejudice originates from ignorance. As stigma, prejudice and discrimination are inextricably related, advocacy and awareness campaigns can address and mitigate these issues.[655] In addition to mental health awareness focused on eliminating stigma and protecting human rights, the advocacy should also focus on other related aspects of mental health promotion at the workplace, schools, and parents and prevention programmes, including early childhood development stimulation, violence prevention, and suicide prevention.[656]

There should be efforts by governmental and non-governmental organisations and mental healthcare centres towards building peer-support mental health services[657], self-help groups and counselling support services. Such additional services would enable community inclusion and provide a platform for peer support and social interaction for persons with mental disabilities. Support could also be extended in access to housing, education, employment, vocation training and participation in social and leisure activities. The details of the support services should be

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[652] Juan J. López-Ibor Jr., Olga Cuenca & María-Inés López-Ibor, *5. Stigma and Health Care Staff, in* UNDERSTANDING THE STIGMA OF MENTAL ILLNESS 69 (2008).

[653] Mental illness and disabilities fall within the ambit of perceived blemishes of individual character.

[654] Julio Arboleda-Flórez & Norman Sartorius, *1. The Rights of a Powerless Legion, in* UNDERSTANDING THE STIGMA OF MENTAL ILLNESS 3 (2008).

[655] *Id.* at 5.

[656] WHO, *5. Mental Health Promotion and Prevention, in* MENTAL HEALTH ATLAS 2017 51 (2017).

[657] Peer support mental health services involves providing support through individual or group sessions led by people with similar lived experiences.

made available to all the mental healthcare centres to enable active reference of the persons with mental disabilities under their care to avail these services within their community.

The advocacy service can also facilitate legal assistance to ensure redressal of complaints of human rights violations.

15.2.3. PARTICIPATION OF ALL STAKEHOLDERS IN DRAFTING, IMPLEMENTATION AND MONITORING OF LEGISLATION AND NATIONAL DISABILITY AND MENTAL HEALTH STRATEGIES

There should be a law review process to carefully assess the existing legislation and policies and locate the matters that adversely affect persons with mental disabilities. The efforts towards redrafting and implementation of such legislation should be made with the representation and active participation of all the stakeholders: state actors, non-governmental organisations involved in efforts related to mental health, persons with mental disabilities, their caregivers and families, social workers, lawyers, psychologists, psychotherapists, support staff working in mental healthcare and psychiatrists. Such new or amended legislation should promote the rights of persons with disabilities and enable their full and active citizen participation and inclusion in society without any discrimination. The National Disability Strategy should provide a comprehensive framework to ensure the protection of human rights, ensuring justice, inclusion and access, advocacy and robust complaint resolution mechanisms.

15.2.4. SOCIAL SECURITY AND SOCIAL PROTECTION

Art. 28 of the CRPD provides for the right to an adequate living standard and the right to social protection without any disability-based discrimination. It further provided the obligation of State Parties to ensure access by persons with disabilities to social protection programmes, poverty reduction programs, state assistance for disability-related expenses to individuals and families living in poverty and retirement benefits and programmes. The CRPD uses the broader term ‘social protection’ instead of social security as referred to in Art. 9 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and Art. 26 of the UN Convention on Elimination on All Forms of Discrimination against Women. Social security refers to “a wide variety of social protection programmes established by legislation” intending to provide financial security to individuals to meet certain contingencies. Traditionally, social security and welfare legislation addressed disability through a legislative approach adhering to the medical model of disability. Such an approach deepened the social exclusion and disability-based discrimination through its provision of separate services. It is imperative for welfare and social security legislation to be framed based on social justice and recognition of the rights of persons with mental disabilities to enable full civil participation in society. Social and welfare

law should address the structural barriers to equal opportunities and employment typically faced by persons with disabilities. Social protection and welfare legislation can further help in moving towards adequately funded community support programmes. Such programmes would ensure social inclusion and directly tackle the issues of segregation and institutionalisation.[658] There should be efforts directed to establishing state-funded community mental health[659] centres to ensure community integration.

15.2.5. DEVELOPMENT OF ADEQUATE SOCIAL INFRASTRUCTURE TO COMPLEMENT THE HEALTHCARE DELIVERY SYSTEM

There should be adequate social infrastructure development to enable community reintegration of persons with mental disabilities inclusively. The Government needs to budget for sufficient funding and develop a social action strategy to address structural inequalities such as poverty, unemployment, lack of access to education, housing and adequate infrastructure to enable a decent standard of living for persons with mental disabilities. The healthcare delivery system needs to be complemented by adequate social infrastructure and funding to enable persons with mental disabilities to exercise their rights and fully participate in society meaningfully. The state should direct efforts to develop adequately funded community mental health centres that adhere to internationally accepted human rights standards. The community mental health centres could include a network of mental health crisis centres[660], hospital-based mental health services[661], community outreach mental health services[662] and supported living services[663] for mental health. Such services should actively include family and close friends' care and support within the community life setting. The care and support offered at these centres should be holistic and person-centred, following a human-rights based and recovery approach. Such support can complement other mental health care services such as counselling, therapy, and medication. The community mental health centres network should also provide support to enable access to education, vocation training, skill development, and opportunities for

[658] Felicity Callard et al., *Chapter 8: Social Security and Social Protection*, *in* MENTAL ILLNESS, DISCRIMINATION AND THE LAW - FIGHTING FOR SOCIAL JUSTICE 109–118 (2012 ed.).

[659] Community mental health centres are designed to provide community-based care and support options for persons with mental disabilities. These centres aim to provide support in a non-institutional setting and close to the places of residence of the persons seeking support.

[660] Crisis response services endeavour to support persons experiencing acute mental distress.

[661] The hospital-based care in general hospital settings should be community-based - integrated with the general health system and the rest of the community.

[662] Community outreach services engage in delivering care and support to persons with mental disabilities in their homes or in other suitable settings. Such services could also be provided through mobile teams including community-based volunteers, healthcare and social service workers.

[663] Supported living services encourage independent living by either offering accommodation or lending support to find accommodation to people who are homeless and with severe, long-term mental disabilities. It may also include support for basic necessities for a certain period of time.

employment to allow effective civil participation of persons with mental disabilities and their independent living.

15.2.6. GAPS IN THE APPROACH TOWARDS MENTAL HEALTH SERVICES

The WHO provides the following principles to be adopted while providing mental health service:

a) Accessibility: Affordable and high quality essential mental health care should be available in the close vicinity of the residence of persons with mental disabilities
b) Comprehensiveness, continuity and coordination of needs-led care: The mental health services provided should be coordinated and integrated to address their treatment and community integration needs. The mental health services should be based on a continuing-care approach to holistically address all the necessities, including the social, occupational and psychological needs of persons with mental disabilities. Mental health policy should focus on equity of access to high quality, effective mental health services.
c) Respect for human rights: The mental health services provided should respect the rights of persons with mental disabilities enshrined in the International human rights instruments and standards.[664]

15.2.7. THE SHIFT IN THE APPROACH OF PSYCHIATRIC HEALTHCARE DELIVERY

The mental health services' practices towards persons with mental disabilities should shift towards a holistic, person-centred and recovery-oriented approach. To the extent possible, their care should respect the will and preferences in treatment, using the least restrictive alternatives available and enabling them to effectively exercise their right to full participation and community inclusion and integration. The mental health services and mental health and disability legislation and policies should be oriented towards advancing the human rights of persons with mental disabilities, especially for ensuring their full participation and community inclusion, use of non-coercive practices, respect for their legal capacity and the recovery approach. The recovery and human rights approach respect the personal choices and dignity of persons with mental disabilities, "recognise the social and structural determinants of health", and advances the rights of "equality, non-discrimination, legal capacity and community

[664] WHO, *Improving Health Systems And Services For Mental Health* 25–26 (2009), https://apps.who.int/iris/bitstream/handle/10665/44219/9789241598774_eng.pdf?sequence=1&isAllowed=y (last visited Feb 27, 2021).

inclusion" of persons with mental disabilities.[665] The coercive practices are usually justified on considerations that may involve elements of subjectivity and personal bias. While assessing the need for coercive practices, such a determination should be based on objective evaluation parameters to limit the scope for subjectivity and the clinician's personal bias.

15.2.8. INDIAN CASE STUDIES FOR EFFORTS DIRECTED TOWARDS COMMUNITY INCLUSIVE MENTAL HEALTH CARE

15.2.8.1. Atmiyata (Gujarat) [666]

Atmiyata is a rural community-based volunteer service working with rural communities in Gujarat. It identifies individuals experiencing distress and supports them through a specific number of structured counselling sessions. The service additionally works towards building community awareness on social determinants of mental health, referring persons with severe mental disabilities to public health systems when required and enabling access to social care benefits to enhance the financial stability of persons seeking their support. Atmiyata has established linkages with the District Mental Health Program run by the state to assist people in accessing the psychiatric services at the District Hospital. The service employs two tiers of village-based community volunteers: Atmiyata Mitras (trained to identify persons experiencing distress) and Atmiyata Champions (trained to provide structured counselling sessions based on the needs of those experiencing distress). The Atmiyata Champions are identified and trained by trained social workers (Atmiyata's Community Facilitators).[667]

15.2.8.2. Naya Daur (West Bengal)[668]

Naya Daur is a project founded by Kolkata-based NGO Iswar Sankalpa in 2015. It provides community-based outreach, including support, treatment and care of homeless persons with mental disabilities. The project is spearheaded by a team including a coordinator, social workers, psychiatrists, counsellors, support staff, and community volunteers. The team provides consent-based long-term relationships with homeless persons, assisting in their physical and mental health care and providing necessities. They further support them by enabling access to social entitlements. The outreach field workers consult with mental health professionals to identify the persons needing support (referred as clients). After identification,

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[665] WHO, *1. Overview: Person-Centred, Recovery and Rights-based Approaches in Mental Health*, *in* GUIDANCE ON COMMUNITY MENTAL HEALTH SERVICES - PROMOTING PERSON-CENTRED AND RIGHTS-BASED APPROACHES 5–6 (2021).

[666] Atmiyata, , https://cmhlp.org/projects/atmiyata/ (last visited Oct 7, 2021).

[667] WHO, *2. Good Practice Services That Promote Rights and Recovery*, *in* GUIDANCE ON COMMUNITY MENTAL HEALTH SERVICES - PROMOTING PERSON-CENTRED AND RIGHTS-BASED APPROACHES 88–89 (2021).

[668] Iswar Sankalpa, , https://isankalpa.org/programmes/ (last visited Oct 7, 2021). See also, Hope Foundation, , http://hope-foundation.in/WhatWeDo/NayaDaur (last visited Oct 7, 2021).

the clients are offered psychiatrist assessment, followed by rehabilitation and recovery activities based on their personal recovery goals.

Further, Naya Daur also facilitates access to their day centres and supported employment. The team also assists in reunion with the client's family with consent. Ishwar Sankalpa also runs women shelters where the team may refer clients vulnerable to violence.[669]

15.2.8.3. Home Again (Chennai)[670]

Home Again is an initiative based in Tamil Nadu, Kerala and Maharashtra, founded by The Banyan, a non-profit organisation providing institution and community-based mental health services in 2017. It provides housing services to women with long-term mental disabilities, living in poverty and homeless, and unable to live with family members. The service is freely provided to the users and is financed by donor funding. The accommodation is provided in rural or urban environments in rented houses, apartments or gated communities, based on the residents' preferences. Home Again facilitates the transition from institutionalised care to independent community living through providing access to a family environment. It also provides access to social entitlements, rights awareness programs and mental and general health care and offers on-site personal assistance to persons needing such additional support. The residents are supported in writing an Advance Directive which may be reviewed on an annual basis. The Banyan also provides emergency care and recovery services in addition to its housing programmes. [671]

[669] WHO, *supra* note 667 at 103.
[670] About The Banyan, https://www.mhinnovation.net/organisations/banyan (last visited Oct 7, 2021). See also, The Banyan, , https://thebanyan.wordpress.com/about/ (last visited Oct 7, 2021).
[671] WHO, *supra* note 667 at 119-122.

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