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Women with Mental Illness in India - A Healthcare and Legal Analysis

GENDER, HUMAN RIGHTS AND LAW

Volume - 10

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CENTRE FOR WOMEN AND THE LAW
NATIONAL LAW SCHOOL OF INDIA UNIVERSITY

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EDITOR'S NOTE

This Volume 10 of the Gender Human Rights and Law, covers a seldom delved into topic: women with mental illness in India. The book is unique because of the combination of three perspectives from which the study is made- law, healthcare, and feminism.

The Mental Health Care Act, 2017 is a recent legislation, repealing the earlier law on the topic, that is, the Mental Health Act, 1987. The 2017 Act is a legislation introduced to upgrade the legal framework to meet with the requirements of the United Nations Convention on the Rights of Persons with Disabilities, which was ratified by India in 2007. New concepts find a place in the law, like that of psychiatric advance directives and nominated representatives. However, this law has also faced stringent criticisms in delivering too little and non compliance with India's obligations under the UNCRPD.

The Author Dr. Kirandeep Kaur, in the pursuit of her research has conducted key informant interviews and surveys, both online and offline to ascertain on ground working of law. The publication also briefly draws upon good practices from the mental healthcare laws of six other countries to better evaluate the Indian legal framework.

A few key areas on women's mental health looked at include- perceptions of women with mental illness, the human rights of women with mental illness, including their right to access mental healthcare, right to equality, and their right to protection from cruel, inhuman and degrading treatment among others.

Dr. Kirandeep has made suggestions on the need to address the stigma, discrimination and exclusion of women with mental illness in India. Among the other important suggestions include facilitating care-giver support, increasing the number of women personnel in mental healthcare in India, and the protection of the privacy and autonomy of women with mental illness. She points to the need for gender sensitization, particularly with respect to the special needs of women with mental illness not just in general populations but also in the law. These may go a long way in a realisation of rights of women with mental illness if recognised and acted upon.

This publication has been delayed due to many reasons and I am glad to present it now.

I would like to acknowledge the assistance of Ashwini C, Secretarial Assistant at the Centre for Women and the Law, for providing secretarial assistance and Pushpa S, Consultant Editor, for the language editing of this volume.

Prof. (Dr.) Sarasu Esther Thomas
Coordinator, Centre for Women and the Law

PRELUDE

In a predominantly patriarchal society like ours, the position of a woman is vulnerable, particularly if she suffers from mental illness. The dichotomous opinions pertaining to the decision-making power of a person with mental illness have been aired time and again in the legal and medical circles. However, the health rights and autonomy of women with mental illness find very little presence in the above discourse.

The Mental Healthcare Bill, 2013, was introduced in the Rajya Sabha in August, 2013. After multiple considerations and changes, it was passed by both the houses of the Parliament and received the President's assent in April, 2017, to become the Mental Healthcare Act, 2017. The 2017 Act came into force very recently, that is, from 29th May, 2018,[1] on which date the Mental Health Act, 1987, stood repealed. The Preamble to the 2017 Act voices the aim of the Act[2] to be as follows:

> *"To provide for mental health care and services for persons with mental illness and to protect, promote and fulfill the rights of such persons during delivery of mental health care and services and for matters connected therewith or incidental thereto."*

1 Notification No.: S.O. 2173(E), Ministry of Health and Family Welfare, Government of India (29th May, 2018)

2 The Mental Health Care Act, 2017, was introduced as the Mental Healthcare Bill, 2013, to bring the legal framework pertaining to mental health care in India in consonance with the provisions of UN Convention on Rights of Persons with Disabilities (UNCRPD), signed and ratified by India in October, 2007.

Chapter III of the 2017 Act introduces the concept of psychiatric advance directives and Chapter IV comprises provisions pertaining to the nominated representative of the person with mental illness. The Act states that any person, not being a minor, has the right to make an advance directive in writing, specifying the way the person wishes to be cared for and treated for a mental illness, and the individual or individuals, in order of precedence, he wants to appoint as his/her nominated representative.

There have been both legal and medical discourses about the moral authority of an advance directive and the real stance of advance directives vis-à-vis autonomy of the patient with mental illness who has issued the directive.[3] However, issues relating to advance directives from the perspective of the autonomy of a female patient with mental illness have not gathered much attention.

Chapter V of the 2017 Act enumerates the rights of persons with mental illness: one of the rights being the right to protection from cruel, inhuman and degrading treatment in any mental health establishment, which includes *inter alia* the right to proper clothing so as to protect such person from exposure of his/her body to maintain his/her dignity; and, the right to be protected from all forms of physical, verbal, emotional and sexual abuse.

In the background of the above discussion, it is pertinent to note some of the following facts:

- According to WHO, many of the negative experiences leading to mental health risks and responsible for the prevalence of psychological disorders among women predominately, *"involve serious violations of their rights as human beings, including their sexual and reproductive rights."*[4]
- According to a Report submitted by Disabled Peoples' International (India), "Almost 80% of women with disabilities are victims of

3 *See* Guy Widdershoven and Ron Berghmans, *Advance Directives in Psychiatric Care: A Narrative Approach,* Journal of Medical Ethics 92-97 (2001)

4 WHO, Gender Disparities in Mental Health, Available at http://www.who.int/mental_health/media/en/242.pdf?ua=1 (Last visited on May 10, 2020)

violence, and they are four times more likely than other women to suffer sexual violence."[5]

- According to a Report titled "Violence against Women with Disabilities" submitted to the UN Special Rapporteur,[6] "Patients are covertly discouraged to keep themselves clean and attractive on grounds that they could sexually provoke members of the male ward."

It is thereby submitted that there is an urgent need to analyse some of the provisions of the 2017 Act from the perspective of autonomy and rights of women with mental illness in the background of the ground reality.

The primary aim of the book is to analyse the Mental Healthcare Act, 2017, and its plausible implications for women with mental illness in India. Also, analysed in detail are various relevant issues significant for the mental healthcare discourse. The discussion is from the women's rights perspective. The aim is to generate the *"woman question"*[7] and analyse the legal framework on the existent issue from the perspective of women with mental illness. Concepts like the psychiatric advance directives and their implications are analysed. Critical analysis of the National Mental Health Policy of India and the decisions of various Indian Courts on mental healthcare are discussed in the light of the issues concerned.

The Mental Healthcare Act, 2017, came into force very recently, that is, from 29th May, 2018[8] on which date the Mental Health Act, 1987, stood repealed. The Mental Health Care Act, 2017, is read with the Mental Health Act, 1987, which it repeals. The 2017 Act is juxtaposed with

5 *See* also Ashwaq Masoodi, *Sexual Rights of Disabled Women,* LIVE MINT (December 3, 2014), Available at http://www.livemint.com/Politics/FDPpol4lJ0pX037spUU1kL/Sexual-rights-of-disabled-women.html (Last visited on May 5, 2020)

6 Id.

7 Katherine T. Barlett, *Feminist Legal Methods,* 103 (4) Harvard Law Review 829 (1990)

8 Notification No.: S.O. 2173(E), Ministry of Health and Family Welfare, Government of India (29th May, 2018)

the provisions of UNCRPD,[9] which this Act incorporates, and various other International instruments. Also, analysed are the National Mental Health Policy of India, 2014,[10] and the Mental Healthcare (Rights of Persons with Mental Illness) Rules, 2018,[11] from the perspective of women with mental illness.

9 Available at http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf (Last visited on October 10, 2020)

10 The National Mental Health Policy of India (2014), Available at https://www.nhp.gov.in/sites/default/files/pdf/national%20mental%20health%20policy%20of%20india%202014.pdf (Last visited on April 5, 2020)

11 Notification No.: G.S.R. 509(E), Ministry of Health and Family Welfare, Department of Health and Family Welfare, Government of India (29th May, 2018)

I. Defining Mental Illness

The definition of "mental illness" for the purpose of the mental healthcare law in India has undergone significant changes with the introduction of the Mental Healthcare Act, 2017. This Chapter critically analyses the definition of mental illness under the 2017 Act. A comparison is also drawn with the definition of the term as had been provided in the Mental Health Act, 1987. Clarity is provided with respect to the difference between the often less understood concepts of "mental illness" and "mental retardation." Various categories of mental illnesses are discussed thereafter.

1. Mental Illness & Mental Retardation

"Mental illness" and *"mental retardation"* are two such concepts which are often misunderstood and used inter-changeably and incorrectly. Almost all definitions of mental illness exclude mental retardation from the ambit of mental illness. It is therefore very important to understand what comprises *"mental retardation"* to successfully understand the concept of *"mental illness"* and to differentiate between the two concepts.

Mental illness is not only different from mental retardation; its causes, implications and symptoms are also very different from that of mental retardation. A person with mental illness may be absolutely socially sound and viable,[12] and mental illnesses can affect persons of any age and from any background,[13]and mental illness can be treatable and curable if diagnosed within sufficient time.

Mental retardation, often also referred to as *"intellectual disability,"* on the other hand, affects a person's intelligence and cognitive abilities.[14] Mental retardation is a neurodevelopment disorder. A person with mental retardation generally has a below average intelligence, and the same limits his/her normal life with

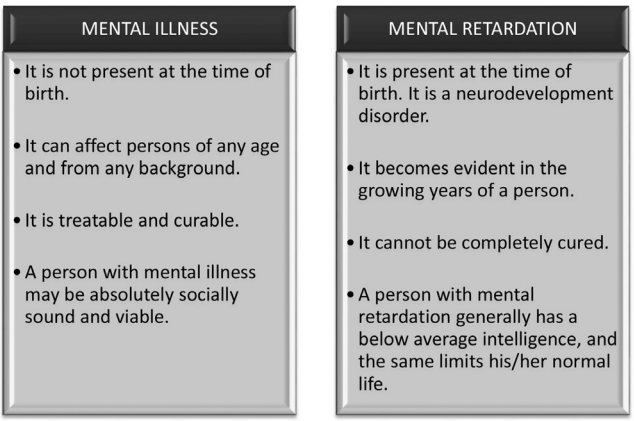
12 See http://lucasdd.info/wp/wp-content/uploads/2015/12/Mental-Retardation-and-Mental-Illness_201405161349276399.pdf (Last visited on November 1, 2017)

13 *Id.*

14 *See* http://www.wisegeekhealth.com/what-is-the-difference-between-mental-retardation-and-mental-illness.htm (Last visited on November 1, 2020)

an IQ[15] of less than 70-75 as compared to the normal average of 100,[16] which results in a sub-average intellectual functioning.[17]

Mental retardation is present at birth, but it eventually becomes evident with the onset of development during the growing years of the person. Mental retardation involves lack of skills which are necessary for normal and independent existence of the person;[18] for example, disability pertaining to thinking, planning, learning, action, solving, etc. Mental retardation is generally life-long and cannot be completely treated.[19] Fanconi anemia, Down syndrome, hydrocephalus and cerebral palsy are some of the examples of mental retardation.



2. The Definition of Mental Illness

Section 2(s) of the Mental Healthcare Act, 2017, defines mental illness as follows:

> *"'mental illness' means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality*

15 Intelligence Quotient

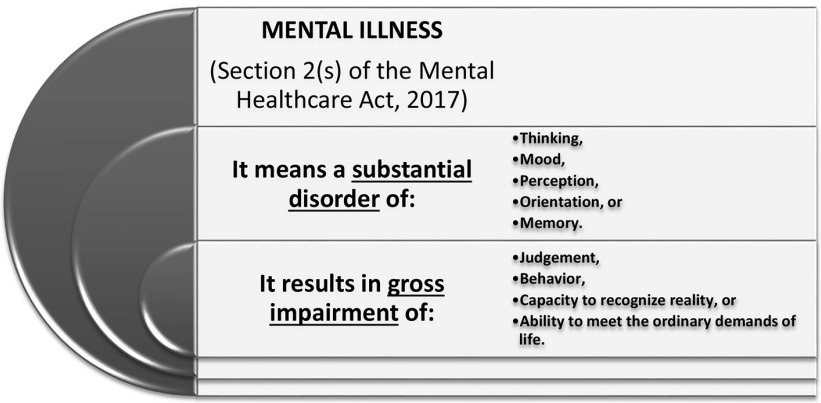
16 *See* http://www.humanillnesses.com/original/Men-Os/Mental-Retardation.html (Last visited on November 1, 2020)

17 *See* http://lucasdd.info/wp/wp-content/uploads/2015/12/Mental-Retardation-and-Mental-Illness_2014051613492763 99.pdf (Last visited on November 1, 2017)

18 *See* https://www.psychologytoday.com/conditions/intellectual-disability-intellectual-developmental-disorder (Last visited on November 1, 2020)

19 *Id.*

or ability to meet the ordinary demands of life, or mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub-normality of intelligence."



Section 2(l) of the Mental Health Act, 198720 stated that a mentally ill person means "a person who is in need of treatment by reason of any mental disorder other than mental retardation." The Mental Health Act, 1987, did not enumerate any of the above factors and effects of mental illness that find place in the definition of the Act of 2017.21 The 1987 Act did not throw light on what composed mental disorder, by just saying that the term excluded cases of mental retardation. The definition given under the 2017 Act filled this vacuum and provided for quite an exhaustive definition of mental illness.

It is, however, noteworthy that terms like *'thinking', 'mood', 'perception', 'orientation' or 'memory,'* as used in the definition of *"mental illness"* under the 2017 Act, can be made subject to different interpretations with respect to different contents and extents, respectively. The same is necessary keeping in mind that unlike in the case of physical illness where the degree and extent of harm or adverse effect on the body can be gauged or quantified (for example, recording the temperature of the body, blood sugar level, blood pressure), disorders in *"thinking, mood,*

20 Available at http://ncw.nic.in/acts/THEMENTALHEALTHACT1987.pdf (Last visited on October 25, 2017)

21 The Mental Health Act, 1987, Section 2(i)

perception, orientation and memory" cannot be strictly segregated into the black and white of normal and not normal, respectively.

The definition in the 2017 Act aids in examining the disorder and their effect/s on the daily lifestyle of the person; that is, when it is of such magnitude that it results in gross impairment of ability to judge, general behavior, capacity to recognize reality or the ability to meet the ordinary necessities of life, the person is considered to have mental illness.

These disorders could be caused by factors like heredity, lifestyle, drug/alcohol abuse, deficiency in the body, etc. Mental disorders comprise symptoms existent in the form of or a combination of *"abnormal thoughts, emotions, behavior or relationships with others."*[22] Mental illness is detectable and can be treated with the help of medicines and/or counselling and therapy.

Section 3 of the 2017 Act states that mental illness should be determined according to such nationally and internationally[23] accepted medical standards as the Central Government notifies from time to time.[24] It is also important to note that no person should be classified as a person with mental illness except for the purpose of treatment of mental illness, only. Section 3 also clarifies that external factors, like the following, should not be considered as the basis for determining the mental illness of a person:

- Factors not *"directly relevant"* to the mental health status of the person like:
  - o economic, political or social status in the society; or
  - o membership of a religious, cultural or racial group, etc.;
- Not adhering to certain specific social, moral, work, political or cultural values;
- Religious beliefs of the person's community;

22 *See* http://www.who.int/mediacentre/factsheets/fs396/en/ (Last visited on November 5, 2020)

23 *See* WHO, The ICD-10 Classification of Mental and Behavioral Disorders – Clinical Descriptions and Diagnostic Guidelines, Available at http://www.who.int/classifications/icd/en/bluebook.pdf (Last visited on November 1, 2019)

24 The 2017 Act, Section 3(1)

- Past treatment or hospitalization in a mental health establishment. (Even though, this can be considered relevant; however, it cannot be the sole justification considered for determining mental illness of the person.)[25]

It is noteworthy that mere determination of mental illness for the purposes of the 2017 Act does not in itself imply that such a person is of unsound mind, unless the same is declared by a competent court.[26]

World Health Organization's document titled *"ICD-10 Classification of Mental and Behavioral Disorders – Clinical Descriptions and Diagnostic Guidelines"*[27] enumerates various categories and sub-categories into which mental disorders can be classified[28] and is based on Chapter V of the 10th Revision of the "International Statistical Classification of Diseases and Related Health Problems (ICD-10)."[29]

Categories of mental disorders (*ICD-10 Classification of Mental and Behavioral Disorders – Clinical Descriptions and Diagnostic Guidelines):*[30]

Categories	Sub-categories
Organic, including symptomatic, mental disorders	Dementia in Alzheimer's disease; Vascular dementia; Dementia in other diseases classified elsewhere like Pick's disease, Parkinson's disease, Huntington's disease; Unspecified dementia; Organic amnesic syndrome, not induced by alcohol and other substances;

25 The 2017 Act, Section 3(4)
26 The 2017 Act, Section 3(5)
27 WHO, The ICD-10 Classification of Mental and Behavioral Disorders – Clinical Descriptions and Diagnostic Guidelines, Available at http://www.who.int/classifications/icd/en/bluebook.pdf (Last visited on November 1, 2020)
28 *See* Brenda Hale, Mental Health Law (2010)
29 *See* http://apps.who.int/iris/handle/10665/37958 (Last visited on November 1, 2020)
30 WHO, The ICD-10 Classification of Mental and Behavioral Disorders – Clinical Descriptions and Diagnostic Guidelines, Available at http://www.who.int/classifications/icd/en/bluebook.pdf (Last visited on January 1, 2020)

	Other mental disorders due to brain damage and dysfunction and due to physical disease; Personality and behavioral disorder due to brain disease, damage and dysfunction; Unspecified organic or symptomatic mental disorder.
Mental disorder and behavioral disorders due to psychoactive substance use	Mental and behavioral disorders due to use of alcohol, opioids, cannabinoids, sedatives or hypnotics, cocaine and other stimulants, including caffeine. It also includes mental and behavioral disorders due to use of hallucinations, tobacco, volatile solvents and multiple drug use and use of other psychoactive substances.
Schizophrenia, schizotypal and delusional disorders	Schizophrenia; Schizotypal disorder; Persistent delusional disorders; Acute and transient psychotic disorders; Induced delusional disorder; Schizoaffective disorders; Other nonorganic psychotic disorders.
Mood [affective] disorders	Manic episode, bipolar affective disorder, depressive episode, recurrent depressive disorder, persistent mood (affective) disorders and other mood (effective) disorders.
Neurotic, stress-related and somatoform disorders	Phobic anxiety disorders; other anxiety disorders like panic and mixed anxiety disorders; obsessive - compulsive disorder; reaction to severe stress, and adjustment disorders; dissociative (conversion) disorders; somatoform disorders; other neurotic disorders like neurasthenia, depersonalization and other specified neurotic disorders.

Behavioral syndromes associated with physiological disturbances and physical factors	Eating disorders; nonorganic sleep disorders; sexual dysfunction, not caused by organic disorder or disease; psychological and behavioral factors associated with disorders or diseases classified elsewhere; abuse of non-dependence-producing substances like steroids, hormones, vitamins, anti-depressants, etc.; mental and behavioral disorders related to puerperium and behavioral syndromes associated with physiological disturbances and physical factors.
Disorders of adult personality and behavior	
Behavioral and emotional disorders, onset of which generally occurs in childhood and adolescence and disorders of psychological development	

It cannot be forgotten that the above disorders cannot be categorized into black and white and might sometimes co-exist and overlap, thereby making it difficult to demarcate these categories as exclusive in nature. It is to be noted that unlike the 2017 Act, the World Health Organization document on ICD-10 Classification of Mental and Behavioral Disorders – Clinical Descriptions and Diagnostic Guidelines[31] also includes mental retardation and its various types in the list of mental and behavioral disorders. A comparative reading of the categories of mental illness with the definition of mental illness laid down in the 2017 Act throws light on the viability of the definition and the clarity in concept introduced by the definition of the term.

> *Studies reveal that women, often perceived as the weaker section of the society, are more vulnerable and susceptible to oppression and neglect in case of a mental disorder. Gender disparity plays an influential role in mental health.*

31 Available at http://www.who.int/classifications/icd/en/bluebook.pdf (Last visited on November 1, 2020)

In furtherance of its purpose, this Chapter draws an analysis of HRW Report (2014) on "'Treated Worse than Animals': Abuses against Women and Girls with Psychosocial or Intellectual Disabilities in Institutions in India," which was instrumental in the decision of NCW and NIMHANS to take

II. Asking the "Woman Question"

cognizance of the issue, which culminated in the Report (2016) by NCW and NIMHANS on "Addressing concerns of women admitted to psychiatric institutions in India: An in-depth analysis"

1. Perceptions about Women and their mental health

Gender disparity plays an influential role in mental health. Factors that affect the same include the disparity in the control women and men exercise over their lives, respectively. Their diverse positions in the societal setup and the difference in treatment meted out to them in the society, thereby results in difference of their susceptibility to various risks associated with mental illness.[32]

Women, often perceived as the weaker section of the society, are more vulnerable and susceptible to oppression and neglect in case of a mental illness.[33] The explanations offered, both in the scientific circles and the magic and faith-healers' dominated thought processes, since time immemorial was that a woman is weak, physically and mentally, and/or that she is easily influenced by the supernatural and the bad spirits.[34] Therefore, she is more susceptible to mental instability and emotional breakdowns.[35]

English literature and the annals of sociological history are replete with such accounts from olden times. Women in the nineteenth century were sent to asylums and were made subject to correctional treatments, if their behavior did not fit into the societal set-up. Some of the many grounds cited were over-education,[36] refusal to marry, simple ill will towards the woman, suppressed menstruation, depression after a loss or just using

32 WHO, *Gender Disparity and mental health: The Facts,* Gender and Women's Mental Health, Available at http://www.who.int/mental_health/prevention/genderwomen/en/

33 *See* Bruce Lubotsky Levin, Et. al., Women's Mental Health Services - A public Health Perspective (1998)

34 Cecilia Tasca, et. al., *Women and Hysteria in the History of Mental Health,* Clin Pract Epidemiol Ment Health. 2012; 8: 110–119.Published online 2012 Oct 19. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3480686/

35 The History of Women's Mental Illness, Available at http://www.epigee.org/the-history-of-womens-mental-illness.html

36 Showalter, E. The Female Malady: Women, Madness, and English Culture 1830-1980 (1985)

of abusive language.[37] Genuine cases of mental illness were addressed with the general understanding about women and their expected role in the society, including their sexuality and expected physical functions. Women were labelled as insane and were locked in madhouses for reasons like depression, post-natal symptoms, menopausal symptoms, alcoholism, dementia, infidelity, etc. In the west, till the 1800s,[38] women who suffered from any kind of mental illness were considered to have a disease of the soul for which there was no remedy, and therefore, the only treatment meted out to them was ostracizing them to asylums for the insane. In these asylums, the inmates were often put in cages, treated worse than cattle and were given limited food, with lack of proper sanitation and hygiene.

The nineteenth century witnessed growing interest in the medical fraternity pertaining to illnesses of the mind. Since there was sparse existent research on this area, doctors who indulged in such research resorted to experiments of their own.[39] One such experiment was that of the *"rotary chair"* where the patient was made to sit in a chair which was spun at great speed with an attempt to *"reset the brain."*[40]

Mere expression of anger or unhappiness by a woman was equated with madness, and any conduct by a woman which fell outside the set notions of the society were perceived as hysteria.[41] The milder forms of treatment included abstaining from socializing, eating of bland food,

37 Pouba, K., and Tianen, A., Lunacy in the 19th Century: Women's Admission to Asylums in United States of America, Oshkosh Scholar, Volume I, April 2006. Wisconsin: University of Wisconsin Board of Regents, Available at https://minds.wisconsin.edu/handle/1793/6687, Ritgerð, et. al., *Women and Madness in the 19th Century – the effects of oppression on women's mental health* (2013), Available at https://skemman.is/bitstream/1946/16449/1/BA-ElisabetRakelSigurdar.pdf (Last visited on April 5, 2020)

38 The History of Women's Mental Illness, Available at http://www.epigee.org/the-history-of-womens-mental-illness.html(Last visited on April 5, 2017)

39 Showalter, E. The Female Malady: Women, Madness, and English Culture 1830-1980 (1985)

40 The History of Women's Mental Illness, Available at http://www.epigee.org/the-history-of-womens-mental-illness.html

41 *See* Charlotte Perkins Gillman, The Yellow Wallpaper (1892); *See* also Ehrenreich and *Deirde/DEIRDRE English, For Her Own Good: Two Centuries of the Experts Advice to Women (2005)

abstaining from reading/writing and solitary confinement.[42] Sending her to an asylum (public/private) or mad house was considered the ultimate remedy, and the treatment meted out to her there was animal-like.[43] By the mid-nineties, mental disorders linked to pregnancy and child-birth accounted for over ten percent admissions of women in asylums.[44] The medical fraternity associated a woman's mental setup pertaining to her reproductive cycles of puberty, pregnancy, childbirth and menopause to her nervous condition.[45] The term associated with the same was that of the *"wondering womb,"* which lead to such conditions.[46]

Reasons for mental illness and treatment for mental illness were very different and were backed by completely different reasoning for men and women, respectively.[47] Hysteria was linked to intellectual women.[48] Women were made to abstain from socializing, reading and writing and forced into being limited to the *"passive housewife role."*[49] Anorexia loomed as an attempt by women to fit into standards of an ideal beauty in the society, a trophy to be exhibited by the husbands. Nymphomania was labeled on women feared as being aggressive. Women who showed strong beliefs, desires or inclinations were, thus, put into asylums, to set an example for the other women to keep away from following in their footsteps. Spinsters and lesbians were also generally labelled as insane, because such women were considered as a threat to the patriarchal

42 Gail A. Hornstein, Agnes's Jacket: A Psychologist's Search for the Meanings of Madness (2009)

43 *See* Bruce M. Z. Cohen, Psychiatric Hegemony: A Marxist Theory of Mental Illness (2016)

44 Hilary Marland, *Women and Madness,* Available at https://warwick.ac.uk/fac/arts/history/chm/outreach/trade_in_lunacy/research/womenandmadness/ (Last visited on January 5, 2020)

45 The Treatment of Women for Mental Illness 1850-1900, Available at https://gver2013.wordpress.com/ (Last visited on January 5, 2020)

46 Katie L. Frick, *Women's Issues then and now - A Feminist Overview of the Past two centuries*, Available at http://batstar.net/item/ulrichmi.htm (Last visited on December 10, 2019)

47 The Treatment of Women for Mental Illness 1850-1900, Available at https://gver2013.wordpress.com/ (Last visited on January 5, 2020)

48 Katie L. Frick, *Women's Issues then and now - A Feminist Overview of the Past two centuries*, Available at http://batstar.net/item/ulrichmi.htm (Last visited on December 10, 2019)

49 *Id.*

societal set-up.[50] Treatment meted out to women in asylums included *"pouring water on the head, compressing the supraorbital nerve, stopping the patient's breathing, slapping the face and neck with wet towels and exercising pressure in some tender area."*[51]

2. Why talk about the mental health of women?[52]

Asking *"the woman question"*[53] is many a time not encouraged. Objections are often raised pertaining to the same on the ground that men are equally vulnerable, and their rights need to be protected, too.[54] However, when one observes the socio-political setup of India, there is a huge disparity in rights, privileges and vulnerabilities of men and women in every sphere and walk of life.[55]

Similarly asked is the question of *"Why talk of women's mental health?"*[56] Some psychiatrists object to talking about mental health of women in particular on the ground that when we are not talking about mental health of men, why treat the women differently. The Indian Psychiatric Society which was formed as early as in 1947 brought out

50 *Id.*

51 The Treatment of Women for Mental Illness 1850-1900, Available at https://gver2013.wordpress.com/ (Last visited on January 5, 2020)

52 Indira Sharma and Abhishek Pathak, *Women Mental Health in India,* Indian J Psychiatry57(Suppl 2) S201–S204 (2015), Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539862/ (Last visited on October 29, 2020);
Savita Malhotra and Ruchita Shah, *Women and Mental Health in India: An overview,* Indian J Psychiatry 57 (Suppl 2): S205–S211 (2015), Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539863/ (Last visited on October 29, 2020)

53 *Women Questions"* can be defined as questions *"designed to identify the gender implications of rules and practices which might otherwise appear to be neutral and objective,"* and would include questions like, *"have the women been left out of consideration? If so, in what way; how might that omission be corrected? What difference would it make to do so?"* - Katherine T. Barlett, *Feminist Legal Methods,* 103 (4) Harvard Law Review 829 (1990)

54 *See* Sharlene Nagy Hesse-Biber, Handbook of Feminist Research, Theory and Praxis (2012)

55 *See* Sally Sheldon and Michael Thomson, Feminist Perspectives on Health Care Law (1998)

56 Indira Sharma and Abhishek Pathak, *Women Mental Health in India,* Indian J Psychiatry 57(Suppl 2) S201–S204 (2015), Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539862/ (Last visited on October 29, 2020)

its first paper with a special focus on women's health only in the year 1969.[57] Critics state that in the wake of gender equality and equal rights of women, considering them more vulnerable is questionable. In reply to this criticism, it can be argued that the Constitution of India, despite providing for the right to equality and the right to equal protection of law under Article 15, provides for positive discrimination in favor of women, wherein a law can make discrimination in the favor of women to protect their interest in the society.

One has to understand the present discourse in light of the societal setup of the country. The WHO Checklist on Mental Health Legislation (Annexure 1 to WHO Resource Book on Mental Health, Human Rights and Legislation, 2005)[58] in its checklists for mental health legislation enumerates women with mental illness as part of the vulnerable section of persons with mental illness.

The World Health Report, 1998, states that *"Women's health is inextricably linked to their status in society. It benefits from equality and suffers from discrimination."*[59] Despite being financially independent, many a woman in the Indian household is looked down upon and ridiculed. The dowry system in various hues and colours is still prevalent in the nation. Joint family system, preference of the male child, status of the daughter-in-law at her marital home, marriage being sacrosanct and, preferably, permanent are among the many factors that are responsible for the scenario. Some of the important roles of an Indian woman are child-bearing, child rearing and taking care of the matrimonial household. Women who are unable to get accustomed to this family setup and find it difficult to cope become victims of depression and other forms of mental illness over time.

Crimes against women, including sexual assault, rape, marital rape, domestic violence are on a rise in the nation.[60] Being bereft of their

57 D. Bhattacharya, J.N. Vyas, *Puerperal psychosis*, Indian J Psychiatry 11:36–9 (1969)

58 Available at https://ec.europa.eu/health/sites/health/files/mental_health/docs/who_resource_book_en.pdf (Last visited on April 5, 2020)

59 Available at http://www.who.int/whr/1998/en/whr98_en.pdf (Last visited on March 15, 2020)

60 Rashida Manjoo, Report of the Special Rapporteur on violence against women, its causes and consequences, A/HRC/26/38/Add.1(2014), Available at http://evaw-

dignity and self-esteem, such women find it difficult to recoup from the trauma and slip into the abyss of post-traumatic stress disorder (PTSD).[61] Common outcomes of violence are not only PTSD, but also suicidal behaviour, depression and anxiety.[62]

The provisions of WHO's Ottawa Charter for Health Promotion (1986) [63] recognizes the multi-dimensional scenario of healthcare in the following words:

> *"To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept, emphasizing social and personal resources, as well as physical capacities."*[64]

Common mental disorders like depression, anxiety and somatic symptom disorder (SSD)[65] are found more prevalent among women

global-database.unwomen.org/-/media/files/un%20women/vaw/country%20report/asia/india/india%20srvaw.pdf (Last visited on January 5, 2018)

61 *See* WHO, *Women's Mental Health: An Evidence Based Review* (2000), Available at http://apps.who.int/iris/bitstream/handle/10665/66539/WHO_MSD_MDP_00.1.pdf; jsessionid =DC96E59F98CE54D041B6BF0E0C04D4D8?sequence=1 (Last visited on January 5, 2018); *See* ES DeJonghe, et.al., *Women survivors of intimate partner violence and post-traumatic stress disorder: Prediction and prevention,* J Postgrad Med October Vol 54 Issue 4 (2008), Available at http://www.bioline.org.br/pdf?jp08102 (Last visited on January 5, 2018);
See Su-Ying Chung, et.al., *Emotional Memory and Posttraumatic Stress Disorder: A Preliminary Neuropsychological Study in Female Victims of Domestic Violence,* J Psychiatry 17:6 (2014), Available at https://www.omicsonline.org/open-access/emotional_memory_and_posttraumatic_stress_disorder_a_preliminary_148.php?aid =32408 (Last visited on January 5, 2020)

62 *See* WHO, *Women's Mental Health: An Evidence Based Review* (2000), Available at http://apps.who.int/iris/bitstream/handle/10665/66539/WHO_MSD_MDP_00.1.pdf; jsessionid=DC96E59F98CE54D041B6B F0E0C04D4D8?sequence=1 (Last visited on January 5, 2020)

63 WHO's Ottawa Charter for Health Promotion (1986), Available at http://www.who.int/healthpromotion/conferences/previous/ottawa/en/ (Last visited on January 25, 2018)

64 *Id.*

65 Somatic symptom disorder (SSD) involves a person feeling extreme levels of

than among men in India. Authors have linked this scenario to the social set-up, including status of women in Indian families, patriarchy, self-esteem issues of women, gender roles of women, discrimination at workplace and violence meted out to women at various set-ups.[66]

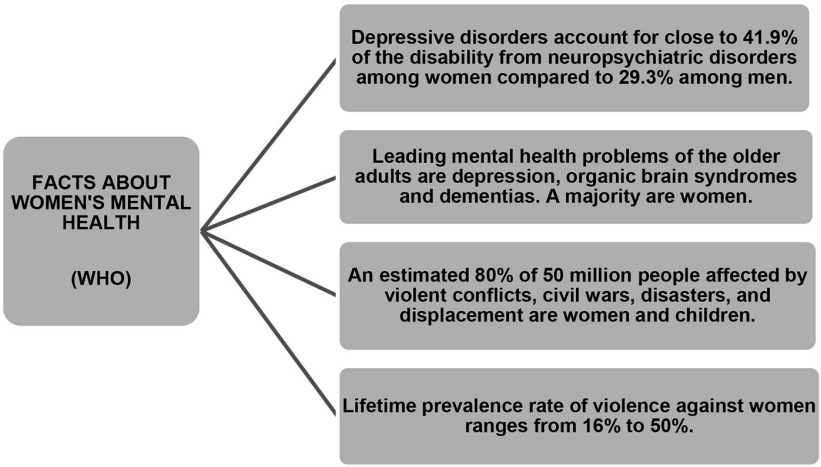
Generally, whenever mental health of women is brought up, many of us relate it to the mental health issues that women face because of their reproductive role. Postpartum depression (PPD)[67] is a major form of mental illness among middle-aged women, but the discourse of mental health issues of women cannot be merely limited to just that. The relation between reproductive functions of women and their mental health has been receiving more attention, while the other areas, aspects and perspectives of mental healthcare for women remain comparatively ignored.[68]

anxiety about some physical symptoms like pain, fatigue, etc. The person has disturbing thoughts, behaviors and feelings related to the pain, fatigue, etc., which negatively affects his/her normal daily life.
Available at https://medlineplus.gov/ency/article/000955.htm (Last visited on January 5, 2020)

66 *See* WHO, *Women's Mental Health: An Evidence Based Review* (2000), Available at http://apps.who.int/iris/bitstream/handle/10665/66539/WHO_MSD_MDP_00.1.pdf;jsessionid=DC96E59F98CE54D041B6BF0E0C04D4D8?sequence=1 (Last visited on January 5, 2020)

67 Postpartum depression (PPD) is a mental illness associated with mood disorders related to childbirth and include symptoms ranging from extreme sadness, low energy, anxiety, sleep disorder to eating disorder, etc. PPD generally sets in such women between one week and one month of childbirth.

68 WHO, Department of Mental Health and Substance Abuse, *Gender Disparities in Mental Health,* Available at http://www.who.int/mental_health/media/en/242.pdf?ua=1 (Last visited on April 4, 2020)



WHO, Facts about Women's Mental Health[69]

3. Human Rights Watch Report (2014)[70] – Drawing a picture of violence against and abuse of women in Mental Hospitals and other institutions

Published in 2014, the Report by Human Rights Watch, titled, *"'Treated Worse than Animals': Abuses against Women and Girls with Psychosocial or Intellectual Disabilities in Institutions in India,"*[71] is very vital and relevant to understand why there is a need to delve into mental healthcare from the perspective of women with mental illness. This report highlighted the ugly side of mental healthcare for women in India, the side which was replete with examples of human rights violations, abuse, exploitation and the absence of informed consent.

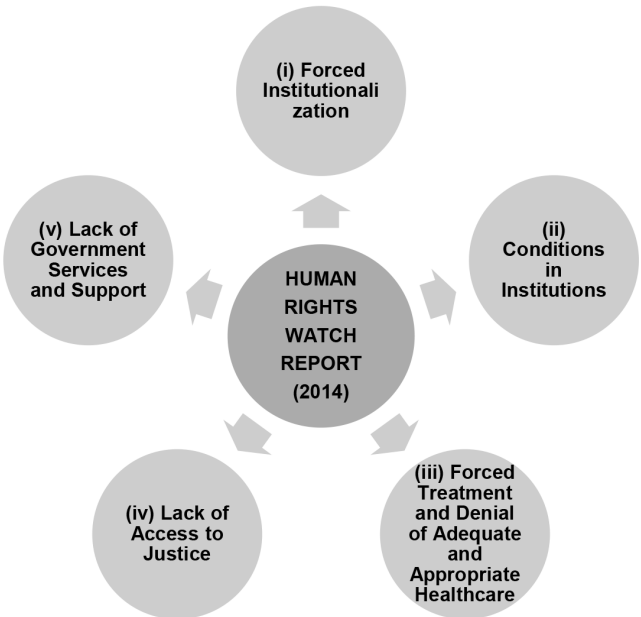
From 2012 to 2014 HRW team visited twenty-four mental hospitals (public and private) and state facilities for residential care. Around two hundred persons were interviewed, including fifty-two women/girls were

69 WHO, Gender and Women's Mental Health, Available at http://www.who.int/mental_health/prevention/genderwomen/en/ (Last visited on March 5, 2020)

70 HRW, *Treated Worse than Animals - Abuses against Women and Girls with Psychological and Intellectual Disabilities in Institutions in India* (2014), Available at https://www.hrw.org/report/2014/12/03/treated-worse-animals/abuses-against-women-and-girls-psychosocial-or-intellectual (Last visited on April 5, 2020)

71 *Id.*

interviewed who had *"psychological or intellectual disabilities"* and were, or had been, in mental healthcare institutions. Also, interviewed were families of some of these women, professionals of mental healthcare, service providers, police officers and some government officials. This Report focused on issues, including involuntary/forced admissions to mental health establishments; overcrowding in such institutions, leading to lack of access to general healthcare, inadequate hygiene, improper sanitation and inappropriate clothing facilities, etc.; forced treatment which included electro-convulsive therapy; abuse and violence, both physical and sexual. The Report also threw light on the inability of women to get proper access to justice, legal redressal mechanisms or government services and support.



Factors discussed in HRW Report (2014)[72]

Drawing a causal relation to the above factors, HRW Report (2014) observed that the stigma surrounding mental illness, shortage of community services, and lack of proper awareness among the family

72 *Id.*

members of the patients were the main causes leading towards forced institutionalization of women with mental illness. According to the HRW Report, the common notion in society pertaining to persons with mental illness, especially women, is that such women lack the capacity to comprehend and are therefore not capable of taking any logical and reasoned decision for their own welfare.

Twenty-five cases were found where the family members of the women with mental illness had either hidden or abandoned them in mental hospitals or residential facilities; the reason for the same being, mainly, stigma surrounding mental illness and the lack of support and understanding from society, pertaining to the situation.

HRW Report (2014) summarizes some of the following deplorable conditions meted out to the women in some of the mental health establishments visited by its team:

- Prolonged detention;
- Involuntary treatment;
- Sexual abuse;
- Physical abuse;
- Over-crowding;
- Lack of proper sanitation;
- Lack of privacy;
- Forced treatment without choice, etc.

HRW Team also reported usage of derogatory language for women with mental illness in such institutions including terms like *"pagal"* (Hindi for *'mad'*) or *"mentally retarded"* for them. This was proof enough of the reinforcement of the stigma and derogation towards such women in the Indian society.

In the background of the above report, it becomes quite pertinent that *"asking the woman question"* pertaining to mental healthcare is the need of the hour, especially in the wake of the passing of the 2017 Act. HRW Report (2014) was instrumental in NCW and NIMHANS, India, to take cognizance of the issue, which culminated in the Report (2016) by them on *"Addressing concerns of women admitted to psychiatric institutions in India: An in-depth analysis"*[73] which is analysed in the forthcoming Chapter.

73 NCW and NIMHANS Report (2016)

III. Critical Analysis of the Report by NCW and NIMHANS 2016 on "Addressing Concerns of Women Admitted to Psychiatric Institutions in India: An in-Depth Analysis"

This Chapter analyses the Report by the National Commission for Women, India, and the National Institute of Mental Health and Neurosciences, India, published in 2016, titled: "Addressing concerns of women admitted to psychiatric institutions in India: An in-depth analysis." In the process of analysis, a summary of the vital findings in the report is also drawn.

1. Scope of the Report

NCW and NIMHANS treaded the path of research on women admitted in psychiatric institutions in India by visiting ten psychiatric institutions in the country and published a Report in 2016 with respect to the same.[74] The research involved visit by the NIMHANS and NCW teams to ten mental hospitals, chosen on the basis of higher number of long-stay patients, namely:

- Regional Mental Hospital (RMH), Yerwada, Pune
- Government Mental Health Centre (GHMC), Kozhikode, Kerala
- Regional Mental Hospital (RMH), Thane, Maharashtra
- Institute of Psychiatry and Human Behaviour, Bambolim, Goa
- Calcutta Pavlov Hospital
- Behrampore Mental Hospital, Murshidabad
- Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS), Jharkhand
- Institute of Mental Health and Hospital (IMHH), Agra
- Mental Hospital, Bareilly
- Institute of Mental Health (Government Mental Hospital), Amritsar, Punjab

74 NCW and NIMHANS, *Addressing concerns of women admitted to psychiatric institutions in India: An in-depth analysis* (2016) Available at http://ncwapps.nic.in/pdfReports/Addressing_concerns_of_women_admitted_to_psychiatric_institutions_in_INDIA_An_in-depth_analysis.pdf (Last visited on October 10, 2020)

This study was initiated in the background of the HRW Report (2014) which only focused on abuses meted out to women in mental hospitals and women's homes. The NIMHANS and NCW Teams wanted to find out the other side of the story, too, the side of the caretakers and health care providers along with women with mental illness in such institutions and, thereby, analyse the generalization portrayed by HRW Report (2014). The research was women-centric and limited to their status in the institutions.

Mrs. Lalitha Kumarmangalam, the erstwhile Chairperson of NCW in the foreword to the Report published in 2016, states that:

> *"Mentally ill women experience social and economic marginalization which is exacerbated not only due to gender inequity and inequality, but also stigma and insensitivity surrounding mental illness in India."*

This Chapter analyses the NCW and NIMHANS Report (2016). In the process of analysis, a summary of the vital findings in the report is also drawn. The Report analyses the following factors that affect or are likely to affect women with mental illness in the psychiatric institutions, namely:

- Clinical factors;
- Social factors;
- Cultural factors;
- Familial factors;
- Economic factors; and
- Legal factors.

2. Analysis of the Data Collected in The Ten Hospitals by the NCW and NIMHANS Teams

The visiting teams from NCW and NIMHANS to the ten psychiatric institutions collected data pertaining to **female patients** in each of these institutions with respect to the following matters in particular:

- Facilities like food, clothing, environment, personal care, etc;
- Circumstances of admissions to the institutions;

- Issues pertaining to treatment;
- Consent to treatment;
- Participation and involvement in treatment;
- Involvement of family care givers;
- Addressing of the concerns and needs specific to women;
- Rehabilitation; and
- Rights within the community.

The data was collected by a coordinated combination of the following three methods, which are:

- Observations by the NCW/NIMHANS teams that visited each institution, respectively;
- Interviews with the following group of persons in each of these institutions, namely:
    - o Women patients;
    - o Family care-givers;
    - o Service providers and
    - o Administrators
- Questionnaire based self-reports from these institutions.

i. Regional Mental Hospital (RMH), Yerwada, Pune

RMH, Pune, celebrated the centenary of its foundation in 2005. It was established in Colaba in 1907 and was later shifted to Yerwada, Pune, in 1915. The bed strength of this hospital presently is 2540. The NCW and NIMHANS team reported multiple deficiencies in mental and physical healthcare in RMH, Pune.

Some of the important observations by the NCW and NIMHANS team that visited RMH, Pune, are enumerated herein below:

- Shortage of staff and insufficient training of staff;

- Lack of enough financial resources;
- Scarcity of rehabilitation facilities and options;
- Presence of insects and mosquitoes in the living areas;
- Lack of emergency healthcare, both physical and mental;
- Lack of privacy; when the patients conversed with family members or communicated through letters, the same were heard and read by authorities;
- Almost two-third of patients had not given informed consent for treatment and were not apprised of their rights pertaining to healthcare;
- Closed wards with inadequate lighting and ventilation;
- Overcrowding of wards and shortage of mattresses and beds;
- Water for bathing and washing clothes was inadequate, and no hot water facilities were provided for the same;
- Patients were compulsorily made to wear uniforms of the hospital, some of those uniforms being torn and dirty;
- Lack of privacy during bathing;
- Patients were provided with sanitary napkins during their periods, but many of them did not know how to use them;
- Medical rounds were not very frequent;
- Sufficient space for spiritual and religious purposes was given to the patients;
- Rehabilitation rates were very low;
- Wrong addresses had been provided by family members of some patients, thereby resulting in many patients being long term patients with a future of perpetual stay at the hospital.

The hospital team requested for prompt action by the government to address their needs and requirements. They were in favour of

facilitating autonomy of the patients in healthcare decision making to ensure welfare in healthcare.

ii. Government Mental Health Centre (GHMC), Kozhikode, Kerala

GHMC, Kerala, was established in Kozhikode in 1872, originally with nine beds as a lunatic asylum. Presently, GHMC houses 700 beds. The Hospital was reviewed by the Director General of Health Services in the year 2004, and they had recommended renovation or change of hospital buildings, increasing of staff and working towards a more effective rehabilitation process. The NHRC Report of 2008 on GHMC reported a slight enhancement in the budget of the hospital resulting in new constructions, including an open ward, a new canteen, new medical record section, etc. However, over-crowding still continued to be a concern in GHMC.[75]

Some of the pertinent observations by the NCW and NIMHANS team that visited GHMC are enumerated herein below:

- Over-crowding in wards;
- Few women were found in lock-ups, and some were found moving about naked;
- Unwanted visitors from schools, just for a tour, were a common practice;
- Poor hygiene in toilets, bathing areas and dining space;
- Some bathroom doors were partially broken; thereby, affecting privacy of the patients during bathing and changing of clothes;
- Bedbugs and mosquitoes were seen in wards, and sometimes pillows were not given to some patients;
- Healthcare needs of bedridden patients were not properly addressed;
- Funds to the Hospital arrive from the State budget, and regular delay in arriving of funds, leads to delay in payment of electricity and water bills, resulting in administrative hitches;

75 *See* NHRC, Care and Treatment in Mental Health Institutions - Some glimpses in the Recent Period (2012).

- Two patients reported sexual advances by the male members of the staff;
- Instead of sanitary napkins, cloth was given during periods;
- Open female ward was where patients were admitted with a family member, and this ward witnessed regular discharge of the patients post treatment;
- Support from families of the patients admitted for long-term was almost absent;
- Most of the patients were admitted to the hospital through reception orders, and their family members were not traceable; thereby, leaving very little scope for rehabilitation and reconciliation with their families;
- No access to newspapers or magazines;
- Majority of patients, however, reported being treated with respect and dignity;
- Paucity of female attenders, female caregivers and female security staff is another vital concern in GHMC.

One of the most important recommendations of the visiting NCW and NIMHANS team was that the hospital should work towards better non-psychiatric medical care of its patients and, also, rehabilitating them into the society. Positive work of the hospital staff and authorities along with increase in beds in proportion to the patient intake were also recommended as vital for the betterment of conditions in GHMC.

iii. Regional Mental Hospital (RMH), Thane, Maharashtra

RMH, Thane, was established in the year 1901. It was the hospital with the largest bed strength of 1880 in the year 1998. Presently the hospital houses around 750 female patients divided into separate clinic units. There are separate wards for the following, respectively:

- Acutely ill female patients;
- Female patients who have stabilized a bit;

- Women with intellectual disabilities and epilepsy; and
- Long-stay female patients.

The NCW and NIMHANS team reported one of the major concerns at RMH as being that of insufficient financial resources and shortage of human resources. Patients were either dumped in the hospitals or were picked up from the streets in a chronically ill state, wherein the mental illness had long set in.

Some of the important observations by the NCW and NIMHANS team are enumerated herein below:

- Female wards were old with leaking ceilings and poor ventilation;
- Over-crowding in the wards, with around 60 patients in a small ward;
- One toilet is shared by 50 female patients;
- Gross inadequacy in hygiene facilities is a major concern;
- Chronic wards are in better condition, with proper lighting and ventilation;
- Kitchens were clean, and some patients had been identified as *helpers* in the kitchens;
- As a result of limited water supply, the female patients had no privacy while bathing, using the toilet or changing clothes;
- The government has provided petticot-kurta as the uniform for the female patients, which were not only found to be uncomfortable by some patients, but were also not available in all sizes, thereby causing discomfort to the patients;
- Less than half the number of female patients were provided with footwear; the rest moved about bare feet;
- Most of the patients were not permitted to keep personal possessions or have access to telephones;
- There is a sick room for women with physical illness, with basic facilities for healthcare, including oxygen facilities;

- Electro-convulsive therapy is available, with a full time anesthetist in the hospital.

It was observed by the NCW and NIMHANS team that the dilapidated and unhygienic conditions in the Hospital had made it a breeding ground for multiple illnesses. Leakage during rainfall makes most of the wards damp and, therefore, uninhabitable during the rainy season. Neptune[76] and Tarasha[77] are two NGOs that have been working in active coordination with RMH, Thane, and have helped in reuniting some female patients with their family members. Tarasha, a TISS project, aided in providing vocational training to the patients and has helped them in getting jobs.

iv. Institute of Psychiatry and Human Behaviour (IPHP), Bambolim, Goa

The Institute of Psychiatry and Human Behaviour (IPHP) is a relatively smaller hospital, with 300 beds set up in 2001 under the Goa Medical College.

Some of the important observations by the NCW and NIMHANS team are enumerated herein below:

- Existence of separate children's ward, peri-natal ward and de-addiction ward;
- Disorganized inpatient wards, without separate areas for dining, recreational activity or exercise;
- Forensic ward of both males and females is located inside the female closed ward, which causes discomfort to the patients because of regular presence of police escorts, male prison patients, etc;
- The out-patient department is over-crowded;
- There is a small occupational therapy unit accessible to only some inpatients;

76 Neptune Foundation, Available at http://www.neptunefoundation.in/ (Last visited on May 5, 2017)

77 Tarasha, Available at http://www.tiss.edu/view/11/projects/all-projects/tarasha/ (Last visited on May 5, 2017)

- Two-third of the patients interviewed complained of violation of confidentiality and not being provided with information relating to their treatment.

The NCW and NIMHANS team observed that there was a need to fill up vacant posts at IPHP for the proper administration of the institution. The team also recommended improvement in the open ward facilities, taking of steps to ensure the setting up of community rehabilitation facilities and long-stay facilities for the patients.

v. Calcutta Pavlov Hospital, Kolkata, West Bengal

The Calcutta Pavlov Hospital was set up in the year 1966. It is managed by the Government of West Bengal and has the active involvement of the National Medical Hospital. There are a total of 270 female patients who are kept in a three-storeyed living area with some space around it. The building is locked.

Some of the important observations by the NCW and NIMHANS team are enumerated herein below:

- Existence of proportionately large number of out-of-state patients from Uttar Pradesh and Bihar and from remote villages of West Bengal;
- Most of the admissions to the hospital were involuntary;
- Mosquitoes and pests, because of poor drainage system;
- No dining space;
- Hair of inmates is cut short for convenience, but their consent is obtained for the same; a barber visits every week to cut their hair short;
- Existence of bed bugs was reported by some patients;
- Sanitary napkins provided were inadequate, and patients reported that they had to share undergarments with other female patients;
- Involvement of clinical psychologists, but there were no psychiatric social workers;

- Increased focus on medical management; however, staff-patient ratio is low, making intensive management difficult;
- ECT is rarely used on patients;
- Lack of lockers to keep personal belongings, and no place to wash and dry clothes, thereby making personal hygiene a major concern;
- Some patients reported being threatened, beaten up and being verbally abused by the staff members;

The NCW and NIMHANS team observed that most of the female patients in the Hospital were chronic and were very less likely to be taken back into the families, thereby making discharge a concern. The team praised the active involvement of two NGOs, namely, Anjali[78] and Paripurnita for facilitating involvement of the female patients into productive work.

vi. Behrampore Mental Hospital, Murshidabad, West Bengal

The Behrampore Mental Hospital is the only hospital in India with more beds for female patients than male patients.[79] The Hospital was initially a jail and was later converted into a mental hospital in the year 1980. The NHRC Report of 1999 had observed that the conditions in this hospital were deplorably poor and the 2008 Report noted that there had been very little improvement in the conditions and facilities since 1999.

The NCW and NIMHANS team found that the admissions in the Behrampore Mental Hospital were predominantly involuntary. Some of the important observations by the NCW and NIMHANS team are enumerated herein below:

- Community bathing for patients being a blatant violation of the right to privacy, most patients were bathed together in the corridor in front of the taps;
    - Patients were not provided with undergarments;
    - There is irregular supply of sanitary napkins and no instructions

78 *See* more at http://www.anjalimentalhealth.org/ (Last visited on January 2, 2018)
79 116 beds for female patients and 114 beds for male patients.

are given to the patients regarding the disposal of the napkins (used sanitary napkins were found randomly lying on the corridor floors);

- There is very little opportunity for the patients to interact with the treating team, the doctors were seen to mainly rely on the nurses' report for treating the patients;
- Most of the mental health faculty members were found to be involved in private practice outside the hospital;
- There have been incidents of patient abuse by the members of the staff;
- Medication and treatment facilities are adequate and up to date;
- There is a small rehabilitation unit, which however, does not suffice the purpose of rehabilitation for all the patients;
- Inadequate number of toilets; some patients even defecate in the corridors which are not very regularly cleaned;
- Linen is not cleaned regularly, and there are no locker facilities to keep personal belongings;
- Sleeping space is inadequate, and patients are huddled close to each other on the floor to sleep;
- The space surrounding the building housing the female ward is unclean, thereby raising the possibility of health risks to the women patients;
- Window panes are broken, and kitchen space is dirty and not at all well kept;
- Verbal abuse of patients has been reported and, also, instances of physical fights among patients;

In one of its observations in the report, the NCW and NIMHANS team states that *"the overall condition of the mental hospital is terrible… and continues to have gross inadequacies and gross violation of human rights."* The team reported the involvement of the NGO Anjali which engaged 20 women from the female ward in certain social and

recreational activities. The NGO has been allotted two rooms in the OPD of the Hospital for the purpose. The team strongly recommended the imminent need for the hospital to cater to issues pertaining to cleanliness, disposal of sewage and sanitation; and that the hospital kitchen should be relocated to a cleaner place. It is to be noted that privacy of female patients emerges as one of the primary areas of concern in this institution.

vii. Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS), Jharkhand

The Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS), Jharkhand, has a bed strength of 600, out of which 200 beds are for female patients with mental illness. Almost 60% of the female patients are long stay patients who have been in the hospital for around 10 years. There is a full-fledged half-way home built in the hospital, with a strength of 100 beds (50 for male patients and 50 for female patients), but the same was not found functional because of lack of sufficient human resources.

Some of the important observations by the NCW and NIMHANS team are enumerated herein below:

- 85% of the long-stay female patients were admitted into the hospital by reception orders, and only 15% had been admitted to the hospital by their relatives;
- Shortage of staff - last recruitment having been made in the year 2004;
- The psychiatrist-bed ratio is 1:100, and the nurse-bed ratio is 1:80;
- The buildings are very old, dating to over 80 years ago, and the building structure is very jail-like;
- Majority of the patients rated the following facilities in the hospital as good:
    - o Food and dining facilities;
    - o Personal hygiene;

  - Comfort;
  - Sleeping facilities;
  - Resting facilities;
  - Medication facilities; and
  - Treatment facilities.

- Patients are bathed in groups;
- Toilets are located outside; the patients complain of difficulty in going out in the night;
- Patients did not report incidents of abuse at the hospital;
- Most patients were not in contact with the members of their families.

Despite the human resources crunch, the team was of the opinion that the hospital staff was dedicated and was providing quality care to the best of their abilities. The NCW and NIMHANS team recommended collaboration with NGOs for rehabilitation of patients by encouraging the NGOs to set up sheltered workshops, homes and day care centers in the community for female patients with mental illness, so that they can gradually be reintegrated into the society. The report emphasized upon the need to track the family members of the patients with the help of the police, in order to reunite them with their family.

viii. Institute of Mental Health and Hospital (IMHH), Agra

The hospital was started as an asylum way back in the year 1859. In 1995 it was declared autonomous and a State-owned hospital. It was renamed the Institute of Mental Health and Hospital (IMHH), Agra, in the year 2001.The hospital is spread across a vast area of 170 acres. There are a total of 10 wards, with each ward having 30 patients. Some patients are also admitted in the family wards, where family members accompany the patient during the treatment and take them back home on improvement.

The admissions in the hospital are mostly involuntary in nature.

Admissions in the hospital are through one of the following ways:

- Through reception orders by the Chief Judicial Magistrate;
- Through Protection Homes for Women in the State of UP;
- Through family members;
- Local residents, social workers and NGOs also bring patients for admission in the hospital.

Some of the important observations by the NCW and NIMHANS team are enumerated herein below:

- Poor privacy while bathing; 2-3 patients bathe together at a time;
- Staff members arrange group activities and cultural events for the patients on a regular basis;
- Majority of the patients rated the following facilities in the hospital as good:
    - o Food and dining facilities;
    - o Personal hygiene;
    - o Comfort;
    - o Sleeping facilities;
    - o Resting facilities;
    - o Medication facilities; and
    - o Treatment facilities.
- Patients did not report physical, verbal or sexual abuse;
- Hospital uniforms are compulsory;
- Social and religious requirements are reasonably catered to;

The major concern of the female patients was the desire to return home. The NCW and NIMHANS team recommended in its report the need to involve NGOs and the setting up of half-way homes, so that the cured patients could be reintegrated into the society.

ix. Mental Hospital, Bareilly

The Mental Hospital of Bareilly was established as an asylum in the year 1862. The architecture of the Hospital is jail-like. It was rated very poorly by the NHRC Report of 1999. However, there have been considerable improvements since then.

Some of the important observations by the NCW and NIMHANS team are enumerated herein below:

- Majority of the patients rated the treatment and other facilities in the hospital as satisfactory;
- Patients expressed concern about the cleanliness of the drinking water;
- Patients have to wear hospital uniforms, but are not provided undergarments;
- Some patients complained of being verbally abused by the staff and 16% reported having been beaten;
- Patients' hair are cut short without their consent;
- Lack of human resources;
- Doctors do not see the patients on a regular basis.

The hospital had a small recreational center. However, activities in the recreational center were very rare. Patients also reported that they were forced to work in wards and were verbally abused by the staff on refusing to do work.

x. Institute of Mental Health (Government Mental Hospital), Amritsar, Punjab

Government Mental Hospital, Amritsar, was set up in the year 1948. It was later renamed as the Institute of Mental Health, Amritsar. In 2001, the administrative control of the hospital was given to the Punjab Health Systems Corporation. A new building with 450 beds was set up in 2003. The hospital spans over an area of 60 acres and is the only hospital that caters to the mental healthcare needs of the people of Punjab, Haryana and Chandigarh.

Some of the important observations by the NCW and NIMHANS team are enumerated herein below:

- The Hospital receives out-of-state patients also;
- There is shortage of staff;
- 90% of the patients in the hospital had been admitted through reception orders[80];
- All the patients were of the opinion that the basic facilities in the hospital were good;
- Cleanliness was a very positive feature of this hospital. Not only were the wards, kitchen and corridors clean, the floor and the beds of the patients were neat and tidy, too;
- The patients were not satisfied with the physical, outdoor and cultural activities in the hospital;
- Family members do not want to take back the patients and want the hospital to take care of the patients for life;
- There are power-cuts for 8-10 hours continuously; thereby, making the need for 24 hours supply of electricity a matter of immediate concern.

There are no half-way homes, long stay homes or NGOs working on this area in the city of Amritsar. There are *Nari Niketans* meant for juvenile offenders, where some women with mental illness find shelter, but the Niketans are not well-equipped to cater to the needs of the mentally ill women. The Hospital, however, has close co-operation from the Pingalwaras. Pingalwaras is an NGO having around 3000 beds spread across the state of Punjab, gives shelter and care to orphans, destitutes, old, poor, homeless, differently abled, abandoned persons, including persons with mental retardation and mental illness among others.[81] The mentally ill persons among them in Pingalwara are brought to the Hospital for mental healthcare and treatment.

80 On being brought through reception orders, patients are initially admitted for a period of 89 days and are discharged on the 90th day. However, they then re-apply for reception orders.

81 *See* more at http://pingalwara.org/ (Last visited on February 23, 2018)

3. Summarizing the Findings of the Report:

This Report by NCW and NIMHANS holds great significance to the present study. It is the latest and most important secondary data on the situation of women with mental illness in Mental Hospitals/ Psychiatric Institutions in the country researched by two premiere institutions of the country. The Report acknowledges the vulnerability of women with mental illness in the country and concludes with very vital suggestions pivotal to remedying the existent situation. The ten hospitals visited by the NCW and NIMHANS team throw light on the practicalities and detailed conditions and situations in these hospitals. Treatment meted out to women is elaborately observed and succinctly summarized by the Report. Being a report, the research and study for which was spread over a span of a long time, and having been published as recently as in 2016, it was considered pivotal to authenticate the propositions of the present research.

IV. Human Rights in Mental Health Care

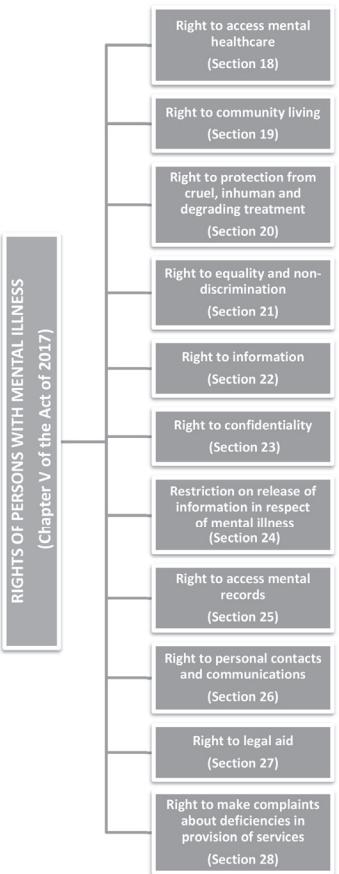
The Mental Healthcare Act, 2017, aims to provide for mental health care and services for persons with mental illness in India and to protect, promote and fulfill the rights of such persons during delivery of mental health care and services. Chapter V of the Act enumerates the rights of persons with mental illness, including the right to equality, right to confidentiality, the right to protection from cruel, inhuman and degrading treatment in any mental health establishment (which includes the right to proper clothing, so as to protect such person from exposure of his/her body to maintain his/her dignity, and the right to be protected from all forms of physical, verbal, emotional and sexual abuse), right to community living, etc. After having discussed the NCW and NIMHANS Report (2016) in Chapter III, this Chapter treads towards the path of analysing the provisions of the Act from the perspective of rights of women with mental illness in need of mental health care.

1. Introduction

Women with mental illness are scarcely discussed in the legal arena. Very little thought is put into their predicament and position in the Indian society. Their rights are discussed in the academic circles; however, a confluence of the same in the legal and medical world is mostly missing in the present scenario. The Preamble of the 2017 Act states *inter alia* that the Act aims to: *"provide for mental health care and services for persons with mental illness and to protect, promote and fulfill the rights of such persons during delivery of mental health care and services and for matters connected therewith or incidental thereto."* Rights of persons with mental illness in mental health care and services have found express mention for the first time in India.[82] Chapter V of the Act lays down the human rights of persons with mental illness. It is a beacon of hope, filling up a vacuum in this sphere. This Chapter aims to analyse the human rights enumerated in Chapter V of the Mental Healthcare Act, 2017, from the perspective of women with

82 Right to health recognized as a part of the right to life guaranteed under Article 21 of the Constitution of India in Parmanand Katara v. Union of India, (1989) 4 SCC 286; Consumer Education and Research Centre v. Union of India, (1995) 3 SCC 42; Paschim Banga Khet Mazdoor Samity and Ors. v. State of West Bengal, (1996) 4 SCC37; Bandhua Mukti Morcha v. Union of India, AIR 1984 SC 802

mental illness in India. Chapter V covers the arena of rights in healthcare for mental illness, something which the Mental Health Act, 1987, failed to do. The rights vary in their nature and are vast, proper implementation of which in letter and spirit is something on which the success of this Act depends. Right to access mental healthcare is the first and most important right protected under the Act of 2017. Right to be protected from cruel, inhuman and degrading treatment in mental healthcare is another important right which aims at addressing the atrocities, glimpses of which could be seen in the HRW Report and the NCW-NIMHANS Reports discussed in detail in Chapters 3 and 4 of the Book respectively. All the eleven human rights guaranteed under the Act of 2017 are enlisted in the chart below and discussed in detail thereafter.



2. Right to Access mental healthcare

Section 18 of the Act gives to every person the right to have access to mental health care and treatment from mental health services run or funded by the Appropriate Government.[83] Around 650-700 lakhs of people in India are in need of care for various kinds of mental disorder, out of which 70-80% do not get sufficient care and protection.[84] Access to healthcare is indispensable for being able to exercise all other rights pertaining to mental healthcare in the Act. Impediments to this right come from various arenas like family, society, financial status, location, etc. There is a tendency to ignore mental health issues as mere temperamental issues which would heal with time, and this is coupled with a lack of awareness and stigma attached towards accessing mental healthcare treatment. The faith in traditional methods of curing mental health in India is another major reason why many persons with mental illness are unable to reach out to get proper mental healthcare, the situation, as always, being worse in the case of women with mental illness.

In the above fact matrix, the recognition of the right to access mental healthcare under Section 18 of the Act becomes relevant. The *"right to access mental healthcare and treatment"* for the purposes of Section 18 of the Act means *"mental health services*":

- Available at costs that are affordable;
- Available in the required quantity and of good quality;
- Accessible territorially;

83 Appropriate Government means - *"(i) in relation to a mental health establishment established, owned or controlled by the Central Government or the Administrator of a Union territory having no legislature, the Central Government; (ii) in relation to a mental health establishment, other than an establishment referred to in sub-clause (i), established, owned or controlled within the territory of— (A) a State, the State Government; (B) a Union territory having legislature, the Government of that Union territory."* (The 2017 Act, Section 2(b))

84 Report of the National Commission on Macroeconomics and Health, Ministry of Health and Family Welfare, Government of India (2005), Available at http://www.who.int/macrohealth/action/Report%20of%20the%20National%20Commission.pdf (Last visited on May 23, 2020)

There should not be any discrimination on the basis of gender, sexual orientation, caste, culture, religion, political or social beliefs, disability, class or any other basis for that matter. The services should be available in such a manner that is acceptable and usable by the person with mental illness, and the treatment should be such that the family members and care-givers of the person should be ready to acknowledge the same. If this provision is followed in letter and spirit, access to mental healthcare would be accessible by and available to one and all. However, implementation of this right in large scale and at intensive levels is a very long drawn process in India in the background of the present infrastructure of the country and the ability and tendency to spend towards healthcare, especially mental healthcare.

According to the Mental Health Atlas 2011 which was prepared by WHO's Department of Mental Health and Substance Abuse, there were only[85]:

- 43 state-run mental hospitals in India;
- 10,000 beds for psychiatric patients in the general hospitals
- Generally states had only one/two mental hospitals located in remote areas
- 72 percent population of India, which is in the rural areas, had access to 25 percent of the locations where there was availability of mental health care facilities.[86]

Section 18 also states that the *"right to access mental healthcare"* includes the right to have access to mental health care treatment without any prejudice pertaining to sex or sexual orientation.[87] The Appropriate Government is required to provide facilities required by the persons with mental illness, including provisions of acute mental healthcare services, sheltered accommodation, half-way homes, supported accommodation, etc.[88] Appropriate Government should also make concerted efforts

85 WHO, Department of Mental Health and Substance Abuse, *Mental Health Atlas 2011*, Available at http://www.who.int/mental_health/evidence/atlas/profiles/ind_mh_profile.pdf (Last visited on May 13, 2017)

86 HRW Report (2014)

87 The 2017 Act, Section 18(2)

88 The 2017 Act, Sections 18(3) and 18(4)

to integrate mental health services into general healthcare services at all strata of healthcare, including secondary, primary and tertiary healthcare, and in all health programmes run by it. The WHO Resource Book on Mental Health, Human Rights and Legislation (2005)[89] also recommends the integration of mental health services into primary health care and with other social services.

However, it is a matter of concern that in the societal setup of India, integrating mental healthcare with general healthcare will further hinder persons with mental illness, especially women with mental illness, from reaching out for mental healthcare because of the fear of being noticed by others in the mental health section of a general hospital. Furthermore, the healthcare requirements in case of mental healthcare are specialized and endemic to mental healthcare in particular, and integrating the same into general healthcare would entail sensitization and training of both general and mental healthcare personnel and staff. Integrating is a process and is not a one-off event, and the same would require more human and financial resources to cater to the process.[90] Ensuring the confidentiality of the patient and upholding her privacy would also be important to make this integration fulfill its purpose in spirit.

WHO, in its report titled *"Integrating mental health into primary care – A global perspective"* published in 2008, states that training both at the pre-service and/ or in-service level of primary care workers on mental health issues is very important.[91] The integration of mental health services into primary care must, therefore, also include complementary services having secondary care components to which primary care workers can turn for referrals and supervision.

It is relevant to quote excerpts from the HRW Report (2014) here:

> *"Rachna Bharadwaj, the superintendent of the female wing of Asha Kiran, a residential facility, told us about a girl with an intellectual and psychosocial disability who was sent to a mental hospital for treatment for a month and returned*

89 Available at https://ec.europa.eu/health/sites/health/files/mental_health/docs/who_resource_book_en.pdf (Last visited on April 5, 2020)

90 *Id.*

91 *Id.*

> *with a broken arm. Although the girl was in pain and could not move her arm, which was hanging limp on her side, staff in the mental hospital had not bothered to take her to a general hospital to treat her injury. In the end, the injury required two surgeries to mend… In another case, one woman came back to the institution after staying in a mental hospital for treatment with an ulcer on her foot that was infected with fat black worms that the mental hospital hadn't bothered to treat."*[92]

The battle to get access to mental healthcare in the spirit of the law is a tough uphill process, especially for women with mental illness, in the fact matrix of the existent scenario in patriarchal India. Sensitization and awareness in society and in the healthcare arena are, therefore, very important. Moreover, accessibility to mental health services is only possible with availability of those services, which needs to be worked upon with greater rigor.

3. Right to Equality

Right to equality is very significant for the healthcare, treatment and rehabilitation of persons with mental illness. Section 19 purports the right of every person with mental illness to live in and be a part of the society and to not be ostracized and segregated. Just because a mentally ill person does not have a family or is homeless, he/she should not be left to languish in a mental health establishment when no further treatment is required by him/her. Section 19 recognizes the significance of community-based facilities. It is stated that when it is not possible for a mentally ill person to live with his/her family or relatives and when he/she is abandoned by them, and such a person is no longer required to get treatment in restrictive mental health establishments, the Appropriate Government should step in to the picture by providing support which should include legal aid. His/her right to family home and living in a family home should be facilitated by setting up less restrictive community-based establishments like group homes, half-way homes, etc.

92 *Id.*

It is noteworthy that community living can be made possible with coordinate cooperation of NGOs, voluntary groups and human resource provided by the Government. Particular care needs to be taken that the entire set-up is enabling in nature, to prevent the mentally-ill person's mental health from deteriorating in any form.

Equality entails not just equality in mental healthcare, but also equality in physical healthcare. Mental illness should not be a factor for discrimination in other forms of healthcare. Section 21 states that in all realms of healthcare, every person with mental illness should be treated equally with persons with physical illness, irrespective of his/her gender, sexual orientation, caste, religion, etc. It is further stated that medical insurance for treatment of persons with mental illness is to be made available by the medical insurance in the same way as is made available to persons with physical illness.[93]

Section 21 also gives specific protection to a woman with mental illness who has a small child. A child below three years of age should not be, in ordinary circumstances, separated from his/her mother if the mother is receiving treatment/rehabilitation at a mental health establishment, unless the mother's mental illness makes it a risk for the child to be with her. The mother will, however, continue to have access to the child during the period of separation under the supervision of a staff member of the establishment. Such a decision of separating the mother from her child has to be reviewed in fifteen days, and the separation shall be terminated whenever it is resolved that the conditions/factors that were posing a risk to the child because of the mental illness of her mother have ceased to exist.

4. Right to protection from cruel, inhuman and degrading treatment

Section 20 of the Act recognizes the right of persons with mental illness to be protected from cruel, inhuman and degrading treatment in mental healthcare establishments. It states that *"every person with*

93 Gaurav Kumar Bansal v. Union of India and Another, available at https://www.livelaw.in/top-stories/sc-issues-notice-on-plea-to-direct-insurers-to-provide-medical-insurance-for-mental-illness-treatment-158402 (Last visited on June 18, 2020)

mental illness shall have a right to live with dignity."[94] This Section recognizes various facets of cruelty that have been meted out to persons with mental illness over the years and, thereby, states that the right to protection from cruel, inhuman and degrading treatment includes within its ambit the following rights:

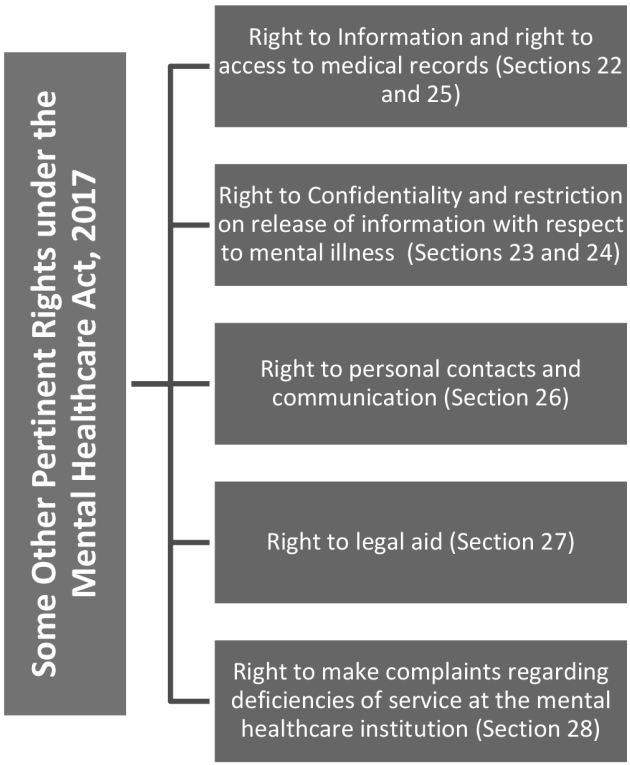
> *"(a) to live in safe and hygienic environment;*
>
> *(b) to have adequate sanitary conditions;*
>
> *(c) to have reasonable facilities for leisure, recreation, education and religious practices;*
>
> *(d) to privacy;*
>
> *(e) for proper clothing, so as to protect such person from exposure of his body to maintain his dignity;*
>
> *(f) to not be forced to undertake work in a mental health establishment and to receive appropriate remuneration for work when undertaken;*
>
> *(g) to have adequate provision for preparing for living in the community;*
>
> *(h) to have adequate provision for wholesome food, sanitation, space and access to articles of personal hygiene, in particular, women's personal hygiene be adequately addressed by providing access to items that may be required during menstruation;*
>
> *(i) to not be subject to compulsory tonsuring (shaving of head hair);*
>
> *(j) to wear own personal clothes, if so wished, and to not be forced to wear uniforms provided by the establishment; and*
>
> *(k) to be protected from all forms of physical, verbal, emotional and sexual abuse."*[95]

Section 20 recognizes the right to live with dignity of persons with mental illness in various aspects of their life - right from basic decision-making pertaining to clothes, to privacy, to remuneration for work

94 The Mental Healthcare Act, 2017, Section 20(1)
95 The Mental Healthcare Act, 2017, Section 20(2)

done, and to be protected from all possible forms of abuse, including physical, verbal, emotional and sexual. This Section acknowledges that protection of these rights is indispensable for any person with mental illness to live with dignity. Recognition of these rights in the above Section is a very positive step, and the existent situation and the future scenario can be congenial for persons with mental illness if the provisions are followed in letter and spirit.

5. Other important positive rights guaranteed under the Act



Right to information and access to medical records (Sections 22 and 25):

Section 22 recognizes the right to information of the person with mental illness, and states that the person with mental illness and his nominated

representative shall have the right to information pertaining to the following:

- **Admission:** The criteria for admission; the provision of the law under which he/she is being admitted; and his/her right to make an application before the concerned Board to review his admission;
- **Treatment:** Nature of illness; and treatment plan proposed. Information pertaining to the treatment plan must also include information pertaining to the plausible side-effects of the proposed treatment;

The information should be provided in a language which the person and his/her nominated representative can understand. If it is not possible to provide the afore-discussed information to the person with the mental illness at the time of admission or start of treatment, the medical officer or psychiatrist-in-charge shall give the information to the nominated representative of the person with mental illness; and provide the information to the person with mental illness as soon as the person is in a position to receive the same.

Section 25 states that all persons with mental illness have the right to access their basic medical records as maybe prescribed. However, the mental health professional in-charge may withhold such information in the records as is deemed necessary, because disclosure of the same would result in serious mental harm to the person with mental illness, or if there is a likelihood of harm to other persons. It is important to note that when any information in the medical records is withheld from the person with mental illness, the concerned mental health professional shall inform the person with mental illness of his/her right to apply to the respective Board for the release of such information.

Right to confidentiality and restriction on release of information with respect to mental illness (Sections 23 and 24):

A person with mental illness has the right to confidentiality in respect of his/her:

- Mental health;

- Mental healthcare;
- Treatment; and
- Physical healthcare.[96]

All health professionals treating or taking care of the person with mental illness are supposed to keep all the information pertaining to the above, obtained during care/treatment, confidential. This applies also to all information stored in electronic or digital format in real or virtual space.[97]

However, under the following situations, such information can be released as is necessary:[98]

- Release of information to the nominated representative to enable him/her to fulfill his/her duties;
- Release of information to other mental health professionals and other health professionals to enable them in providing healthcare to the person with mental illness;
- Release of information is necessary to protect someone from harm or violence; (It is to be noted that only as much information as is necessary to protect the person from harm/violence, and if the harm/violence is likely to be a threat to life, shall be released)
- Release of information if an order/direction for releasing the same has been issued by concerned Board or the Central Authority or High Court or Supreme Court or any other statutory authority competent to do so;
- Release of information is necessary in the interest of *"public safety and security."*

Section 24 states that no photograph or other information pertaining to the person with mental illness who is undergoing treatment at a mental health establishment shall be released to the media without the consent of the person himself/herself.

96 The Mental Healthcare Act, 2017, Section 23(1)
97 The Mental Healthcare Act, 2017, Section 24(2)
98 The Mental Healthcare Act, 2017, Section 23(2)

Right to personal contacts and communication (Section 26):

A person with mental illness who has been admitted to a mental health establishment has the *"right to refuse or receive visitors and to refuse or receive and make telephone or mobile phone calls"* at reasonable times, subject to the norms of such mental health establishment. He/she has the right to receive/send mail through electronic mode, including emails. Whenever the person with mental illness informs the medical officer/ mental health professional in-charge that he does not wish to receive mail/email from any named person, the health official may restrict such communication by the named person with the person with mental illness. However, the same shall not apply to calls to/from, mails and emails to/from the following persons, namely:

- any Judge or officer authorized by a competent court;
- members of the concerned Board or the Central Authority or the State Authority;
- any member of the Parliament or a Member of State Legislature;
- nominated representative, lawyer or legal representative of the person;
- medical practitioner in charge of the person's treatment;
- any other person authorized by the appropriate Government.

Right to legal aid (Section 27):

A person with mental illness has the right to free legal services to exercise his/her rights under this Act. It is the duty of *"magistrate, police officer, person in charge of such custodial institution as may be prescribed or medical officer or mental health professional in charge of a mental health establishment"* to inform the person with mental illness that he/she has the right to free legal services under the Legal Services Authorities Act, 1987, or other relevant laws or under any order of the court if so ordered; and to also provide the contact details of the availability of such services.

Right to make complaints about deficiencies in provision of services (Section 28):

A person with mental illness has the right to *"complain regarding deficiencies in provision of care, treatment and services in a mental health establishment"* to any of the following, namely:

- the medical officer or mental health professional in charge of the establishment, and if not satisfied with the response,
- the concerned Board, and if not satisfied with the response,
- the State Authority.

It is to be noted that the above right can be exercised without prejudice to the rights of the person to seek any judicial remedy for violation of his/her rights in a mental health establishment or by any mental health professional under this Act or any other law for the time being in force.

V. Understanding Psychiatric Advance Directives and their Plausible Implications on Women with Mental Illness in India

Chapter III of the Mental Healthcare Act, 2017, introduces the concept of psychiatric advance directives, and Chapter IV comprises provisions pertaining to the nominated representative of the person with mental illness. The Act states that any person, not being a minor, has the right to make an advance directive in writing, specifying the way the person wishes to be cared for and treated for a mental illness; the individual or individuals, in order of precedence, he wants to appoint as nominated representative. There have been both legal and medical discourses about the moral authority of an advance directive and the real stance of advance directives vis-à-vis autonomy of the patient with mental illness who has issued the directive. This Chapter analyses the issues relating to advance directives from the perspective of the autonomy of women with mental illness in India.

1. Understanding the concept of "psychiatric advance directives"

Advance planning of treatment for a situation of mental illness in the future, by way of written advance directives has been debated among the contemporary mental health care professionals and academicians.[99]

The concept of psychiatric advance directives is often explained in common parlance as the concept of *living will*, wherein the person states in a competent state of mind how he/she wishes to be treated during the state of incompetency. Advance directives are meant to establish a person's preferences for treatment if the person becomes incompetent in the future or is unable to communicate those preferences.[100]

Psychiatric advance directives, as stated by some academicians, owe their origin to the concept of a Ulysses contract or a self-binding contract. A Ulysses contract/pact[101] is a contract entered into voluntarily

99 Guy Widdershoven, *Advance directives in psychiatric care: a narrative approach,* Journal of Medical Ethics, Vol. 27 No. 2 92-97 (2001)

100 Debra S. Srebnik, et. al., *Advance Directives for Mental Health Treatment,* Psychiatric Services, Vol 50 No. 7 (1999)

101 The term *"Ulysses contract/pact"* owes its origin to the story of the pact that Ulysses had entered to with his men when they were approaching the Sirens.

in the present, with consequences which are binding on the person entering into the contract in the future when he/she is incompetent to take a decision.

Psychiatric advance directives, also referred to as *"mental health advance directives,"* are considered by some as an ideal mechanism for persons with mental health issues to express their treatment preferences in the future.[102] Advance directives are particularly vital with respect to mental illness which is many a time characterized by alternating periods of competence and incompetence; and these advance directives afford a person with mental illness the opportunity to state their treatment preferences when they are in a competent state.[103] Unlike persons making decisions with respect to end-of-life treatment, psychiatric patients have generally experienced both the disorder and the treatment on previous occasions and, therefore, are in a stronger position to make informed choices and meaningful decisions.[104]

2. Types of "psychiatric advance directives"

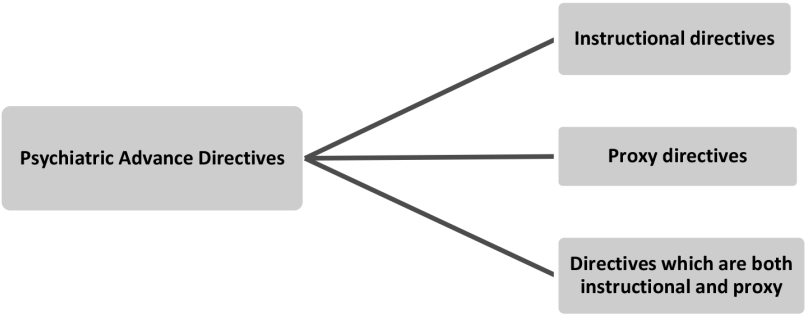
Psychiatric advance directive (also referred to as mental health advance directive) is a written document, wherein a person who has the legal capacity in the present states how he/she wants to be treated in the future when, because of any mental illness, he/she is incapable of taking decisions with respect to his/her health and treatment. The two broad categories of psychiatric advance directives are: *instructional directive* and *proxy directive.* An advance directive may also have both the elements of an instructional directive and a proxy directive.

Ulysses desired to listen to the Siren's song, knowing full well that doing the same would render him incapable of exercising rational thought. He directed his men to tie him to the mast so that he could listen to the song, and ordered his men to not change the course of the ship under any circumstances, and to keep their swords pointed at him, thereby restraining him from breaking free from the bonds. His men were asked to put wax in their ears, so that they did not have to listen to the Siren's song.

102 Paul S. Appelbaum, Commentary: Psychiatric Advance Directives at Crossroads - When Can PADs be Overriden? J Am Acad Psychiatry Law 34: 395-397 (2006)

103 Debra S. Srebnik, et. al., *Advance Directives for Mental Health Treatment,* Psychiatric Services, Vol 50 No. 7 (1999)

104 Paul S. Appelbaum, *Commentary: Psychiatric Advance Directives at Crossroads - When Can PADs be Overriden?* J Am Acad Psychiatry Law 34: 395-397 (2006)



Types of Psychiatric Advance Directives

i. Instructional directives

Instructional directives include instructions by the person with mental illness about his/her treatment preferences and the reasons for those preferences. Instructional directives generally contain detailed instructions given by the person himself/herself directing the treatment providers, in advance, what to do in the case of a mental health crisis when the person becomes incompetent and unable to communicate his/her decisions pertaining to medical treatment.[105] Instructional directives include the treatment directives and may include the reasons for giving such directives. Such directives may be given with respect to the following points[106]:

- *Medication details:* medications to be administered, dosage, method and timing of administration of medication;
- *Medical emergencies:* issues relating to addressing emergency medical situations through restraint, sedation, etc.[107]
- *Preference for particular doctor, hospital, medical clinic, etc.*

105 Debra S. Srebnik, et. al., *Advance Directives for Mental Health Treatment,* Psychiatric Services, Vol 50 No. 7 (1999)

106 *See* Debra S. Srebnik, et. al., *Advance Directives for Mental Health Treatment,* Psychiatric Services, Vol 50 No. 7 (1999); Guy Widdershoven, *Advance directives in psychiatric care: a narrative approach,* Journal of Medical Ethics, Vol. 27 No. 2 92-97 (2001); Janet Heinrich and Virginia P. Tilden, *Policy Perspectives: Advance Directives,* The American Journal of Nursing, Vol. 100 No. 12 49-51(Dec., 2000)

107 Advance directives are not applicable to emergency treatments under the Mental Health Care Act, 2017.

- *Specific treatments:* for example: electro-convulsive therapy, group therapy, etc.
- *Identification of persons:* who are permitted for hospital visit; who are to take care of the child, parents, financial care, home of such a person.
- *Experimental treatments or research studies:* willingness to be a part of, or to not be a part of experimental treatments.
- Other matters relating to medical care.

Drawing an exhaustive list of what can form a part of an instructional psychiatric advance directive is difficult, keeping in mind the facts, circumstances and sensitivity of each person respectively.[108]

ii. Proxy psychiatric advance directive:

Proxy advance directive enables the person to designate someone else as a health-care proxy to take medical decisions on behalf of such person when he/she becomes incapable of taking such decisions because of mental illness.[109] A proxy psychiatric advance directive authorizes the proxy to legally take decisions pertaining to mental health care of the person during the time of the person's incompetency. The proxy acts at such a time of incompetency of the person making the directive, by using substituted judgement standard, that is, act on behalf of the person and in the same way as the person would have acted had he/she been competent to take the decisions on his/her own. Best-judgement is, therefore, exercised by the proxy keeping in mind the gravity of the situation and the wishes of the person, which is also the major reason why proxy directives are used more frequently than sheer instructional directives.

iii. Psychiatric advance directives which are both instructional and proxy:

A directive which has both the elements of an instructional directive and a proxy directive specifies both the instructions as to the way the person

108 Janet Heinrich and Virginia P. Tilden, *Policy Perspectives: Advance Directives,* The American Journal of Nursing, Vol. 100 No. 12 49-51(Dec., 2000)

109 Debra S. Srebnik, et. al., *Advance Directives for Mental Health Treatment,* Psychiatric Services, Vol 50 No. 7 (1999)

wishes to be treated during incompetency, and also nominates a proxy who will act on behalf of the person to execute those directions. In common day parlance, psychiatric advance directives are a combination of both instructional and proxy. The person gives certain instructions in his/her advance directives, pertaining to his/her mental health care for when, and if, the situation of incompetency arises; and authorizes a proxy to execute those instructions and to take decisions pertaining to any other issues that may crop up during the person's mental illness.

3. Capacity to make Decisions Pertaining to Mental Healthcare and Treatment

Section 4 of the 2017 Act states that it shall be deemed that every person, including a person who has mental illness, has the capacity to make decisions regarding his/her mental healthcare if such a person has the capability to:

- Understand the information provided;
- Understand the reasonably foreseeable consequences;
- Communicate his/her decision.[110]

If a decision made by a person with mental illness under this Section is perceived by others to be a wrong decision, the same would not entail questioning the decision making capacity of such a person under the Act as long as the other provisions of Section 4 are fulfilled.

This right of a person under Section 4 is a precursor to the right to make decisions in advance about one's mental healthcare and, therefore, reinforces the capacity of a person to make an advance directive pertaining to his/her mental healthcare in the future.

4. Psychiatric advance directives under the Mental Health Care Act, 2017

Chapter III of the 2017 Act provides for advance directives, and Chapter IV of the 2017 Act lays down provisions pertaining to nominated representative.[111] Both the chapters work in tandem with each other.

110 The 2017 Act, Section 4

111 *See* also Jeffrey Swanson, et. al., *Psychiatric Advance Directives Among Public Health Consumers in Five US Cities: Prevalence, Demand and Correlates,* 34J

Section 5 states that every person who is not a minor shall have a right to make an advance directive in writing, specifying any or all of the following:

- the way the person wishes to be cared for and treated for a mental illness;
- the way the person wishes not to be cared for and treated for a mental illness;
- the individual or individuals, in order of precedence, he/she wants to appoint as his nominated representative as provided under Section 14.

An advance directive can be made by a person irrespective of his/her past mental illness or treatment for the same.[112] According to the Act, it can be invoked only when such person ceases to have capacity to make mental health care or treatment decisions and shall remain effective until such person regains capacity to make those decisions.[113] Any decision made by a person while he has the capacity to make mental health care and treatment decisions shall over-ride any previously written advance directive by such person; and an advance directive contrary to any law for the time being in force is considered void ab initio.[114] An advance directive can be revoked, amended or cancelled any time by the person making the same.[115] Section 6 of the Act discusses about the manner of making an advance directive. It is to be noted that advance directives are not applicable to emergency treatments under the Mental Health Care Act, 2017.[116]

Enforceability of an advance directive under the Act:

It is the duty of every medical officer in charge of a mental health establishment and the psychiatrist in charge of a person's mental healthcare to provide treatment and mental healthcare to the person with

Am Acad Psychiatry 3443–57 (2006)

112 The 2017 Act, Section 5

113 *Id.*

114 *Id.*

115 The 2017 Act, Section 8

116 The 2017 Act, Section 9

mental illness in accordance with the person's valid advance directive.[117] Following a valid advance directive bears no adverse consequences for a medical practitioner or a mental health professional in case of unforeseen circumstances.[118] However, the medical practitioner or mental health professional is not liable for not following an invalid advance directive, if the copy of a valid directive was not provided to him/her.[119] The person writing the advance directive and his nominated representative have the duty to ensure that the medical officer in charge of a mental health establishment or a medical practitioner or a mental health professional, as the case may be, has access to the advance directive when the situation arises.[120]

When a mental health professional or a relative or a care-giver of a person desires not to follow an advance directive: While treating a person with mental illness, if the mental health professional or the relative or care-giver of the person wishes not to follow an advance directive, an application to the concerned Board has to be made to review, alter, modify or cancel the advance directive.[121] Upon receipt of such an application, the Board has the power to review, alter or modify or cancel the advance directive in question. The opportunity of hearing to all concerned parties (including the person whose advance directive is in question) should be given by the Board. Before arriving at a decision, the Board should take into consideration the following factors:[122]

- whether the person making the advance directive had the capacity to make decisions relating to his/her mental healthcare or treatment when such advance directive was made; or
- whether the advance directive was made by the person out of his own free will and was well-informed before making the decision;
- whether the person intended the advance directive to apply to the existing circumstances, which may be different from those anticipated; or

117 The 2017 Act, Section 10
118 The 2017 Act, Section 13(1)
119 The 2017 Act, Section 13(2)
120 The 2017 Act, Section 11(3)
121 The 2017 Act, Section 11
122 *Id.*

- whether the content of the advance directive is contrary to the other laws of India.[123]

Nominated representative: Chapter IV of the Mental Health Care Act, 2017, lays down provisions pertaining to nominated representative. Every person who is not a minor has the right to appoint a nominated representative for the purposes of this Act.[124] Where no nominated representative is appointed by a person, the following persons, in the order of precedence shall be deemed to be the nominated representative of a person with mental illness for the purposes of this Act, namely:

- the person appointed as the nominated representative in the advance directive;
- a relative;
- a care-giver;
- a suitable person appointed by the concerned board
- if no such person is available to be appointed as a nominated representative, the Board shall appoint the Director, Department of Social Welfare, or his designated representative, as the nominated representative of the person with mental illness. Any person representing an organization registered under the Societies Registration Act, 1860, or any other law for the time being in force, working for persons with mental illness may temporarily be engaged by the mental health professional to discharge the duties of a nominated representative, pending appointment of a nominated representative by the concerned Board.

  All persons with mental illness have the capacity to make mental healthcare or treatment decisions; however, each of them may require varying levels of support from their nominated representative to make decisions.[125] While fulfilling his duties under this Act, the nominated representative is required to[126]:

123 *Id.*
124 The 2017 Act, Section 14
125 *Id.*
126 The 2017 Act, Section 17

- consider the current and past wishes, the life history, values, cultural background and the best interests of the person with mental illness;
- give particular importance to the views of the person with mental illness to the extent that the person understands the nature of the decisions under consideration;
- provide support to the person with mental illness in making treatment decisions;
- have right to seek information on diagnosis and treatment to provide adequate support to the person with mental illness;
- have access to the family or home based rehabilitation services on behalf of, and for the benefit of, the person with mental illness;
- be involved in discharge planning;
- be informed about every instance of restraint[127] within a period of twenty-four hours;
- apply to the mental health establishment for admission;
- apply to the concerned Board against violation of rights of the person with mental illness in a mental health establishment;
- have the right to give or withhold consent for research, etc.

5. Psychiatric Advance Directive & Women with mental illness

Persons with mental illness form a part of the marginalized sections of society because of their incapacity to exercise their rights in times of their mental illness. The situation gets gravely difficult, particularly when it is the case of a woman with mental illness.[128] In a society with a strong hue of patriarchy, women with mental illness qualify as one of the most marginalized sections.[129]

Self-determination is vital for any person's well-being and existence. The right to decide about one's future health care needs is considered an

127 The 2017 Act, Section 97
128 Bhargavi Davar And T.K. Sundari Ravindran, Gendering Mental Health (2015)
129 *Id.*

indispensable part of one's autonomy.[130] However, the exercise of this autonomy by persons with mental illness receives limited recognition and the facility to be implemented in very rare cases. The introduction of psychiatric advance directives under the 2017 Act can, therefore, be considered a significant development.

6. Addressing the apprehensions pertaining to psychiatric advance directives:

Some mental illnesses are periodic in nature, examples being, schizophrenia, obsessive compulsive disorder, bipolar disorder, etc. Psychiatric advance directives are vital in these situations. Even if a person with mental illness complies with the mandates of medication, a future manic condition cannot always be obviated.[131] A person who has lived the experience of his/her mental illness, therefore, is in the best position to determine how he/she wishes to be treated in the case of a future bout of mental illness.[132]

Appointing of a nominated representative under the Act is in the nature of a proxy psychiatric advance directive. Appointing a nominated representative through an advance directive in whom the patient has confidence entitles the patient to ensure that his/her rights will be protected and the medical care will be properly taken care of.

Corollaries with respect to the advance directives provisions in the Mental Health Care Act, 2017, can be drawn to similar provisions in statutes recognizing advance directives in the legal systems of other countries in the world. The Federal Patient Self-Determination Act, 1991, in the US introduced the government requirements to implement advance-directive policies at health care facilities receiving funding through Medicaid and Medicare.[133] The Mental Capacity Act, 2005, of UK which lays down similar provisions about advance care planning,

130 Sheila A. M. McLean, Autonomy, Consent and the Law (2010)

131 Guy Widdershoven and Ron Berghmans, *Advance Directives in Psychiatric Care: A Narrative Approach,* Journal of Medical Ethics 92-97 (2001)

132 The Mental Health Legal Centre Inc., Advance Directives Project – Information for Clinicians, Available at http://www.communitylaw.org.au/mentalhealth/cb_pages/images/AD_Clinicians_Info_Feb09.pdf (Last visited on April 10, 2017)

133 *See* also Jeffrey Swanson, et. al., *Psychiatric Advance Directives Among Public Health Consumers in Five US Cities: Prevalence, Demand and Correlates,* 34J Am Acad Psychiatry 3443–57 (2006)

categorizes the same into three categories, namely: advance statements, advance decision to refuse treatment and lasting power of attorney.

As part of the research, the researcher had the opportunity to interview five psychiatrists with multiple years of experience. All the interviews were focused interviews and the questions asked were open-ended.[134] All the doctors were of the opinion that the Mental Healthcare Act, 2017, as a whole was a welcome change; however, the concept of advance directives was received with apprehension and skepticism. One of these Doctors was of the view that in the Indian societal setup, majority of patients with mental illness are brought for medical treatment by a family member; and an advance directive may bring the patient at crossroads with the very family which wishes the patient's welfare.[135] This view is subject to contradiction because of the fact that an invalid advance directive can be amended and repealed under the Mental Healthcare Act, 2017, at any point of time.

The apprehensions of one of the Doctors, whom the researcher interviewed was that advance directives under the Act will lead to unnecessary formalities. This criticism can be put to rest by ensuring that the mandates and requirements of a valid advance directive are adhered to at the very beginning when the advance directive is written. The provision for amendment or cancellation of one's advance directives under the Act gives these directives flexibility and validates the patient's wishes by giving him/her the opportunity to change his/her directions with time and with his/her changing situations.

A corollary can be drawn to advance directive with respect to passive euthanasia, from the decision of the Supreme Court of India in *Common Cause (A Regd. Society) v. Union of India and Another*[136] wherein the Supreme Court upheld the constitutionality of passive euthanasia and laid down guidelines for advance directive relating to the same. The advance directive which the Supreme Court discusses in this case can only be executed by an adult who is of sound mind and is in a position to communicate. The advance directive becomes operative subject to various checks and conditions, only when the executor of the directive

134 *See* Annexure 1.
135 *See* Annexure 1.
136 W.P. (CIVIL) NO. 215 OF 2005

becomes terminally ill, has been through, and is also presently going through, prolonged medical treatment with *"no hope for recovery and cure of the ailment."* Though the ethos of the advance directive pertaining to passive euthanasia and the advance directive pertaining to mental healthcare is predominantly different, the common factors between the two are that both are given by the executor in a fit state of mind and are made with respect to treatment when the person will not be in the state of mind to take decisions. Having upheld the constitutionality of advance directives pertaining to passive euthanasia in *Common Cause (A Regd. Society) v. Union of India and Another,*[137] the Supreme Court has upheld the concept of advance directive in general as well, which can be considered as an indirect affirmation of the legality and constitutionality of psychiatric advance directives envisaged in the 2017 Act.

7. Implications:

People with mental illness very easily lose their right to participate in decision making in the present societal setup.[138] In this background, the concept of psychiatric advance directives play an enabling role for the person with mental illness to be an active part in, at least, the decision making of his/her own health care. One of the mandates of a valid advance directive under the Mental Healthcare Act, 2017, is that an advance directive can only be made by the person in the state when he is able to understand the meaning and implications of his directions.

Women with mental illness in India find a lesser role in the societal and family setup when it comes to their decision making power and are, sometimes, even abstained from their right to a family, food, shelter, etc. In situations like these, and also in situations where the female patient is in a better status and is able to exercise her rights, psychiatric advance directives is a big tool of entitlement for such women. The entitlement is towards autonomy, towards the fulfillment of the right to decide how/where/when/by whom she wishes to be treated if and when she is not competent to take decisions in the future because of her mental illness.

137 *Id.*

138 The Mental Health Legal Centre Inc., Maximising Consumers autonomy, dignity and control, Available at http://www.communitylaw.org.au/mentalhealth/cb_pages/living_wills.php (Last visited on April 12, 2017)

Psychiatric advance directives, as recognized under the Act, have the potential to ensure that female patients get the full opportunity to have a say in and influence the treatment they receive and, also, that their preference is respected and fulfilled in all possible situations.

The Draft Central Regulations, 2017,[139] lay down the regulations pertaining to the manner of making an advance directive. It is stated that an advance directive for the purposes of the 2017 Act should be made according to Form CR-A of the Draft Central Regulations, 2017. A nominated representative who is named in the advance directive should sign in the advance directive, thereby consenting to the same.[140] He/she may withdraw his/her consent at any time, from the same, by writing an application to that effect to the Mental Health Review Board and handing over a copy of the application to the person who made the advance directive.[141] All advance directives are to be countersigned by two witnesses stating that the advance directive was signed by the person making the same in their presence.[142] A person making the advance directive is required to keep a copy with himself/herself and give a copy to his/her nominated representative.[143] Release of a copy of the advance directive to the media or any unauthorized person is not permitted.[144] All advance directives are to be registered with the concerned Mental Health Review Board free of cost.[145] An advance directive should be made online by the Board within 14 days of receiving the same.[146] A person can change his/her advance directives any number of times; there are no restrictions on the number.[147] Each change in an advance directive is required to undergo the same process and regulations as an

139 Draft Central Regulations, 2017, made by the Central Government in exercise of the powers conferred under Section 122 of the 2017 Act on behalf of the Central Mental Health Authority subject to modification by the Central Mental Authority on its constitution. Draft Central Regulations, 2017, Available at https://mohfw.gov.in/sites/default/files/Final%20Draft%20Rules%20MHC%20Act%2C%202017%20%281%29.pdf (Last visited on April 27, 2018)

140 Draft Central Regulations, 2017

141 *Id.*

142 *Id.*

143 *Id.*

144 *Id.*

145 *Id.*

146 *Id.*

147 *Id.*

advance directive to be considered valid.[148] Every time a new advance directive is made, the person making the advance directive and/or his/her nominated representative must inform the treating mental health professional about the same.[149]

It is submitted that the checks to the viability of a psychiatric advance directive are sufficiently placed in the provisions of the 2017 Act, and proper implementation of the law in its letter and spirit will help in fulfilling the goal with which this concept is being introduced in India. The Draft Central Regulations, 2017, add further regulations and checks to ensure the smooth functioning and proper implementation of psychiatric advance directives. Subject to the implementation of the laws, psychiatric advance directives will have positive implications on the autonomy of women with mental illness and the exercise of their right to choice over the treatment meted out to them. The concept of psychiatric advance directives is a welcome change to entitle the female patients with mental illness to come out of the shackles and consequences of labelled incompetency and existent marginalization. It is a positive step and will enable women in need of mental healthcare to exercise autonomy and their right to independent decision making with respect to their mental healthcare requirements and choices. However, it is important to note that independence, free consent and autonomy of the woman making an advance directive should be particularly facilitated and ensured at all stages of the process, so that the psychiatric advance directive is her own decision taken by her for her best interest.

148 *Id.*
149 *Id.*

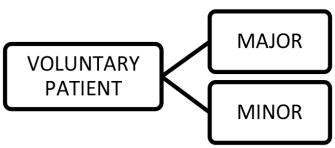
VI. Comparing the Provisions of The Mental Healthcare Act, 2017, with the Relevant Provisions of The Mental Health Act, 1987

The Mental Healthcare Act, 2017, replaces the Mental Health Act, 1987. In order to address the present and future, it is important to analyse and draw a link with what was the situation in the past. This Chapter compares two major aspects of the 2017 Act and the 1987 Act, namely: (i) the procedures pertaining to admission, treatment and discharge under the two Acts; (ii) various Authorities under the two Acts. This Chapter holds significance because one cannot ignore the fact the 2017 Act has not been introduced in a vacuum but is replacing a 31 year old legislation. Therefore, it becomes important to understand the major administrative changes in the law enforcement mechanism that have been brought about by the virtue of the new law.

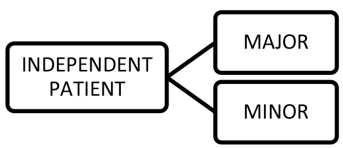
1. ADMISSION, TREATMENT AND DISCHARGE – A COMPARISON OF THE 1987 ACT AND THE 2017 ACT

i. Admission and discharge of a '***voluntary'*** patient under the 1987 Act; and an ***'independent'*** patient in a mental health establishment under the 2017 Act

Mental Health Act, 1987



Mental Healthcare Act, 2017



A corollary can be drawn between admission of a person with mental illness on a voluntary basis under the 1987 Act[150] with the admission of a person with mental illness as an independent patient in a mental health establishment under the 2017 Act.[151] The 2017 Act is more circumspect with respect to admissions in mental healthcare institutions and lays down more elaborate criteria to confirm admission in such an institution. Voluntary admission is further categorized both under 1987 Act and the 2017 Act into voluntary admission of an adult and a minor, respectively.

150 The 1987 Act, Sections 15 to 18.
151 The 2017 Act, Sections 85 to 88.

Admission:

- **Adult:**

The 1987 Act states that any person who is of the opinion that he/she is mentally ill can approach a psychiatric hospital or psychiatric nursing home for treatment and request to be admitted as a *"voluntary patient."* The medical officer concerned shall conduct an inquiry, and within a period of 24 hours, on being satisfied that the person needs treatment as an in-patient has to, thereby, admit the person as a voluntary patient.

The 2017 Act defines an *"independent patient or an independent admission"* for the purposes of the Act as admission of a person with mental illness to a mental health establishment who has the capacity to make mental healthcare and treatment decisions or requires minimal or negligible support in arriving at such decisions. Any person who is of the opinion that he/she is mentally ill can approach a psychiatric hospital or psychiatric nursing home for treatment and request for being admitted as an independent patient.

The 2017 Act encourages all admissions to a mental health establishment to be independent admissions, unless the conditions are such that supported admission becomes inevitable. The medical officer or the mental health professional in charge of the establishment has to be satisfied that the applicant has a mental illness of such severity that he/she requires admission to a mental health establishment and is likely to benefit from such an admission. The medical officer should also ensure that the person has understood the nature and implications of such an admission and is acting with free and informed consent.

The 1987 Act, however, did not lay down any of the express aforementioned criteria enumerated in the 2017 Act. The 2017 Act further adds that an independent person has to be admitted at his own request, and the presence of a nominated representative or a care-giver at the time of admission is not required. The 2017 Act also states that an independent patient will not be made subject to any treatment without his informed consent.

- **Minor:**

The 1987 Act[152] states that if the guardian of the minor is of the opinion that he/she is mentally ill, he/she can approach a psychiatric hospital or psychiatric nursing home for treatment and request for the minor to be admitted as a voluntary patient. The medical officer concerned shall conduct an inquiry, within a period of 24 hours, and on being satisfied that the minor needs treatment as an in-patient has to, thereby, admit the minor as a voluntary patient.[153]

Under the 2017 Act,[154] the nominated representative of the minor can apply to the medical officer of a mental health establishment for the admission of the minor in the mental health establishment. The minor may be admitted to the establishment, provided that two psychiatrists[155] have independently examined the minor on the day of admission or seven days preceding thereto, and both of them, based on their independent examination, independently conclude that the minor has a mental illness of such severity that he/she requires admission to a mental health establishment, and it is in his/her best interest and that he/she is likely to benefit from such an admission, and that it would not be possible to fulfil the mental healthcare requirements of the minor without the admission. Best interest of the minor includes best interest of the minor with regard to his/her health, safety and well-being. As far as possible, the wishes of the minor should be taken into account. Before arriving at the decision to admit the minor, it also needs to be ascertained that all community oriented and community based alternatives to admission have failed or are unsuitable for the situation, condition and needs of the minor. With respect to the treatment of the minor in the mental health establishment, the 2017 Act lays down some important conditions to be fulfilled by the establishment, and the same are enumerated herein below:

- the accommodation of the minor shall be separate from the adults in the establishment;

152 The 1987 Act, Section 16
153 *See* R.N. Saxena, The Mental Health Act, 1987 (2000)
154 The 2017 Act, Section 87
155 Or one psychiatrist and one mental health professional, or one psychiatrist and one medical practitioner

- the accommodation of the minor should be of the same quality that is provided to other minors admitted to hospitals for other treatments;
- the accommodation should cater to the needs of the minor, taking into account his/her needs, requirements and development; and
- the nominated representative should at all times be permitted to stay with the minor in the mental health establishment; and in case of a minor girl, if the nominated representative is a male, a female attendant has to be appointed by the nominated representative for the same.

In order to ensure that the minor is not forced into an admission into the mental health establishment, each time a minor is admitted to a mental health establishment, the concerned Board has to be apprised of the same within 72 hours. The Board reserves the right to visit the minor, interview him/her and review and analyse his/her medical records. If a minor has been in the mental health establishment for a month, on the completion of thirty days, the Board should be informed about the same. The Board shall review the admission and treatment of all minors admitted for thirty days and on completion of every thirty days period, within seven days of being informed about the same.

Discharge:

Under the **Mental Health Act, 1987,** a voluntary patient shall be discharged from the establishment within 24 hours of an application by him to be so discharged. However, the discharge may not be issued if the same is not in the interest of the person. Within 72 hours of such an application, the medical officer shall constitute a Board comprising two medical officers to examine whether the person needs further treatment in the mental health establishment and shall act according to the findings of the board.

An independent patient, under the **Mental Healthcare Act, 2017**,[156] shall be immediately discharged on a request so made by the person. However, a mental health professional may prevent such a discharge for a period of up to 24 hours and proceed with necessary assessment

156 The 2017 Act, Section 88

within those 24 hours, to ascertain whether the independent patient will require admission as a patient with support needs, if the former has reason to believe that such patient:

- is unable to decipher the purpose, nature and significance of his/her decisions, which requires him/her to get substantial or high support from his/her nominated representative; or
- has recently been threatening to cause bodily harm to himself/herself or has attempted or attempting to cause bodily harm to himself/herself; or
- has recently been acting violently towards any other person; or
- shows signs of inability to take basic care for himself/herself, which places him in a position of individual risk of harm to himself.

If any of the above criteria is fulfilled, the voluntary patient shall, within a period of 24 hours of his/her request to be discharged as an independent patient, be admitted as supported patient under Section 89 of the 2017 Act. If any of the above criteria is not fulfilled, the independent patient shall be discharged within a period of 24 hours of his/her request to be discharged.

If a minor who is admitted in a mental health establishment, attains the age of 18 years while he/she is still in the establishment, he/she shall be classified as an independent patient by the medical officer at the establishment, and the provisions of the Act shall apply to him/her accordingly.

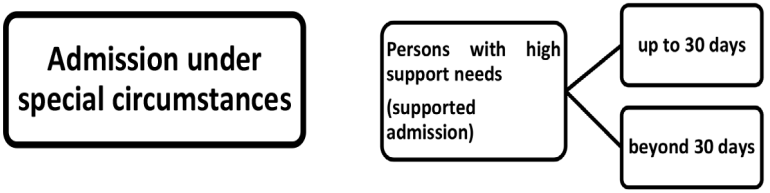
Section 98 of the 2017 Act lays down the provisions pertaining to discharge planning, which apply to all discharges from mental health establishments governed by this Act. Discharge planning is incumbent whenever the person undergoing the treatment for mental illness in a mental health establishment:

- Is to be discharged into the community; or
- Is to be discharged into a different mental health establishment; or
- A new psychiatrist is to undertake the care and treatment of the person.

Discharge planning would involve the participation of the psychiatrist, who was till date responsible for the person's care and treatment, in consultation with the person with mental illness, his/her nominated representative and/or family member/care-giver and the psychiatrist who will be responsible for the care and treatment of the person in the near future, in the planning pertaining to what treatment or services would be apt for the person and, also, in the drawing of a detailed plan for the treatment and care.

ii. Admission under ***"special circumstances"*** under the 1987 Act; Admission and treatment in mental health establishments of persons with mental illness who have ***"high support needs"*** under 2017 Act.

Mental Health Act, 1987 **Mental Healthcare Act, 2017**



Admission under special circumstances under the Mental Health Act, 1987:

Mentally ill persons may be admitted under certain special circumstances[157] under the 1987 Act. Any mentally ill person who is not willing to express his/her willingness to be admitted as a voluntary patient or is unable to express willingness to be admitted as a voluntary patient in a psychiatric hospital or psychiatric nursing home can be admitted if an application with respect to the same is made by his/her relative or friend, and the medical officer in charge is satisfied that it is in the interest of the person to admit him/her in the psychiatric hospital or psychiatric nursing home, as the case may be.

Involuntary admission under special circumstances is only viable when the patient is mentally ill and the medical professionals have reached a satisfaction to that effect. Admission under special circumstances for

157 The 1987 Act, Section 19

the mere observation of the patient amounts to a violation of the right to life, liberty and dignity of the person so admitted.[158]

No person so admitted as an inpatient shall be kept in the psychiatric hospital or psychiatric nursing home as an inpatient for a period exceeding ninety days, except in accordance with the other provisions of this Act.

The application should be accompanied by the certificates of two medical practitioners, with a minimum of one of them being a medical practitioner in a Government service. The certificates should certify *inter alia* that the mentally ill person is in such a condition, that he/she should be kept as an inpatient in a psychiatric hospital or psychiatric nursing home. The medical officer in charge of the concerned hospital or nursing home, as the case maybe, may, however, get the medically ill person examined by two medical practitioners working in the hospital, rather than requiring certificates. A mentally ill person so admitted, or any other person on his/her behalf, may apply to the Magistrate for his/her discharge from the hospital or nursing home. The Magistrate may, after making such necessary inquiry as he/she may deem fit, allow the application and discharge the mentally ill person, or may dismiss the application. A person admitted as an inpatient under special circumstances cannot be so kept for more than 90 days, subject to the other provisions of the 1987 Act.

Supported admission under the Mental Healthcare Act, 2017

Supported admission under the Mental Healthcare Act, 2017, is subject to various time bound brackets to ensure that no person with mental illness languishes in a mental health establishment beyond the necessary time. Examining the patient to ensure that the situation demands a supported admission is mandated by various requirements under the 2017 Act, thereby minimizing the scope of calculated and manipulated admissions of persons with mental illness.

- **Up to 30 days**

A person with mental illness may be admitted to a mental health establishment through supported admission for a period of 30 days,[159]

158 Dr. Sangamitra Acharya & Anr. v. State (NCT of Delhi) & Ors., W.P. (CRL.) 1804/2017 & CM No. 9963/2017

159 The 2017 Act, Section 89

if the medical officer of the concerned mental health establishment receives an application from the nominated representative in this regard. Following are the pre-requisites for such an admission to take place:

- The person with mental illness should be examined on the day of admission or within 7 days preceding the date of the admission, independently by one psychiatrist and a mental health professional/ medical practitioner, to find that the concerned person has a mental illness of such a nature that:
  - o He/she has attempted or threatened to cause harm to himself/ herself or his/her body; or
  - o He/she has been behaving violently towards others or has threatened to cause harm to others; or
  - o He/she is showing incapability to take care of himself/herself thereby putting himself/herself at the brink of harm.
- The mental health professional/medical practitioner should certify, after taking into account any psychiatric advance directive, that in the circumstances, admission to the mental health establishment is the least restrictive care option possible;
- The person is unable to take decisions or decipher them and, therefore, it is not possible to admit him/her independently.

For supported admission, the informed consent of the person or his nominated representative (if he/she is unable to understand the implications of his/her decisions for the time being) should be obtained, and any advance directive of the person should also be considered. If an admission of this nature takes place, the medical officer/ mental health professional has to report to the concerned Board about such admission within 3 days of the admission in the case of a woman or a minor; and within 7 days of the admission in any other case. The provisions of the Act are considerate towards the sensitivity and the plausibility of misuse of such a provision, in the case of a minor and a woman and, therefore, require the reporting to the concerned Board to be made as soon as possible. Application can be made to the Board for reviewing the decision of such an admission of the person with mental illness

by the person with mental illness, or his/her nominated representative or a representative from a registered non-governmental organization. The Board should review the application within 7 days of receiving an application for review.

The conditions and progress of the person admitted with support shall be timely reviewed, and if the person is better and the requisite criteria are no longer being fulfilled because of his/her improvement, he/she shall be discharged or be admitted as an independent patient. If the person is discharged, such a person is not eligible for re-admission as a supported patient till 7 days have elapsed from the date of his/her discharge.

After the expiry of 30 days from the date of admission, if the patient does not fulfill the afore-discussed criteria any more, he/she shall no longer remain in the establishment. However, if any of the afore-mentioned situations continue, the patient may continue to remain in the mental health establishment for more than 30 days on the fulfillment of the below-mentioned criteria.

- **Beyond 30 days**

If a person with mental illness admitted to a mental health establishment through supported admission requires continuous admission and treatment beyond 30 days,[160] or requires a re-admission within 7 days of discharge, he may be admitted on the fulfillment of certain conditions. Following are the pre-requisites for such an admission to take place:

- The person with mental illness should be examined on the day of admission or within 7 days preceding the date of the admission independently by one psychiatrist and a mental health professional/ medical practitioner that the concerned person has a mental illness of such a nature that:
  - He/she has attempted or threatened to cause harm to himself/ herself or his/her body; or
  - He/she has been behaving violently towards others or has threatened to cause harm to others; or

160 The 2017 Act, Section 90

- He/she is showing incapability to take care of himself/herself thereby putting himself/herself at the brink of harm.

- The mental health professional/medical practitioner should certify, after taking into account any advance directive that, in the circumstances, admission to the mental health establishment is the least restrictive care option possible;
- The person is unable to take decisions or decipher them and, therefore, it is not possible to admit him/her independently.

For supported admission, the informed consent of the person or his nominated representative (if he/she is unable to understand the implications of his/her decisions for the time being) should be obtained and any advance directive of the person should also be considered. If an admission of this nature takes place, the medical officer/ mental health professional has to report to the concerned Board about such admission within 7 days of the admission. The Board may within 21 days of such an intimation either permit the re-admission or may order for discharge of the patient. While taking the decision, the Board shall examine whether there is a need for the institutional care of such person, and whether an environment less restrictive than a mental health establishment can be provided in the community. The Board may also require the medical officer or psychiatrist in charge to come up with a plan for community based treatment and the progress that can be made by following the plan. Mere absence or paucity of community based services in a place of treatment cannot be the reason for re-admission beyond the period of 30 days.

The conditions and progress of the person admitted with support shall be reviewed, timely, and if the person is better and the requisite criteria are no longer being fulfilled because of his/her improvement, he/she shall be discharged or be admitted as an independent patient. If a person with mental illness admitted to a mental health establishment through supported admission is permitted continuous admission and treatment beyond 30 days, further extension of time may be facilitated on the fulfillment of the afore-discussed conditions, but subject to the following time limits wherein the review process has to be repeated.

a. Time period extension in the first instance → up to 90 days

b. Time period extension in the second instance → up to 120 days

c. Time period extension from the third instance onwards → up to 180 days each time.

iii. Reception orders under the Mental Health Act, 1987, and Orders by Magistrate under the Mental Healthcare Act, 2017

A. Reception Orders under the Mental Health Act, 1987

A reception order is an order issued by the Magistrate, under this Act, for the admission and detention of a mentally ill person in a psychiatric nursing home or hospital.[161]

On Application: An application for a reception order can be made by the medical officer in charge of the psychiatric hospital or psychiatric nursing home or by the husband/wife or any other relative of the person with mental illness, to the Magistrate in whose local jurisdiction the psychiatric hospital or nursing home is situated. If the Magistrate is satisfied that it is in the interest of the health and safety of the person with mental illness, the Magistrate may pass a reception order.[162]

On production before the Magistrate:

Under the 1987 Act, every officer in charge of a police station may take into protection a person found wandering about who seems to be mentally ill and unable to take care of himself/herself and/or maybe dangerous to the society because of his/her mental illness.[163] Every person who is detained or taken into protection and detained has to be produced before the nearest Magistrate within a period of twenty-four hours and shall not be detained beyond twenty-four hours without the permission of the Magistrate. If the Magistrate is satisfied that it is in the interest of the health and safety of the person with mental illness to be admitted in a psychiatric hospital or nursing home, the Magistrate may pass a reception order.[164]

161 The 1987 Act, Section 2(s)
162 *See* the 1987 Act, Section 22
163 The 1987 Act, Section 23
164 The 1987 Act, Section 24

B. Orders by Magistrate under the Mental Healthcare Act, 2017

It is the duty of the officer in-charge of a police station, if he has sufficient reason to believe that there is a person residing within the police station's local limits and he/she is being ill-treated or neglected, the former shall report the same before the Magistrate.[165] It is also the duty of any person who has reason to believe that a person has mental illness and is being ill-treated or neglected, to report the same before the officer-in-charge of the local police station. The Magistrate shall cause such person with mental illness to be produced before him and take necessary action therewith.[166]

Under the 2017 Act when any person is brought before the local Magistrate, and the person is mentally ill or appears to be so, the Magistrate may, through an order in writing, convey the person to a public mental health establishment for assessment and/or treatment, as the case may be.[167] The Magistrate may also authorize the admission for a period not exceeding ten days of the person with mental illness in a mental health establishment for his/her assessment and necessary treatment, after which the mental health professional in charge of the health establishment has to submit a report to the Magistrate for necessary action.[168]

Role of officer in-charge of the local police station: The 2017 Act also imposes a duty on the officer-in-charge of every police station in the country to take under his/her protection any person found wandering in the local limits of the station, if the officer is of the opinion that the person has mental illness and he/she is, thereby, incapable of taking care of himself/herself or because of his/her mental illness could be of risk to himself/herself or to others.[169] Before taking into his/her protection, the police officer concerned shall apprise the person of the grounds for taking him/her under protection. The person taken into protection has to be taken to the nearest public health establishment within twenty-four

165 The 2017 Act, Section 101
166 *Id.*
167 The 2017 Act, Section 102
168 *Id.*
169 The 2017 Act, Section 100

hours, and under no circumstances should be put in a police lock-up or prison.[170] In the public health establishment, the medical officer in-charge has to arrange for the check-up and assessment of the person taken under protection, so that proper treatment can be meted out to the latter in consonance with the provisions of the Act. Every officer-in-charge of a police station is also required to report to the Magistrate about any person with mental illness in his/her private residence who is neglected or ill-treated.[171]

2. Specific provisions pertaining to TREATMENT under the Mental Healthcare Act, 2017

Informed consent is defined for the first time pertaining to persons with mental illness in India. It becomes vital for the sheer fact that determining factors for informed consent of the person with mental illness are complicated and need to be addressed very sensitively. The 2017 Act defines ***"informed consent"***[172] as consent given for a specific intervention and which adheres to the following conditions:

- Consent given without any force/threat/fraud/mistake/ misrepresentation/undue influence of any kind;
- Consent in order to be 'informed' must be obtained after providing sufficient information pertaining to the risks and benefits of the specific treatment and the existent alternatives to it;
- The information so provided should be in a language that the person giving the consent understands and should be made in a manner conducive for him to understand the implications of the same.

The Act also defines **a *"least restrictive"* alternative/environment/ option** as one which aptly addresses the treatment needs of the person and imposes the least possible restrictions on the person's rights.[173] These provisions are important for the protection of patients with mental illness, especially women with mental illness, who are facilitated protection from exploitation and abuse, because of these protective

170 *Id.*
171 The 2017 Act, Section 101
172 The 2017 Act, Section 2(i)
173 The 2017 Act, Section 2(j)

mandates imposed by the law.

The 2017 Act also lays down restrictions pertaining to ***"emergency treatment"***[174] of the person with mental illness in certain exceptional situations. It is stated that any medical treatment, including treatment pertaining to mental healthcare, can be given to a person with mental illness in the establishment/community (after obtaining the informed consent of the nominated representative, when the latter is available). An emergency treatment is administered where the same is immediately and urgently necessary to prevent:

- death or irreversible harm to the person with mental illness;
- the person with mental illness inflicting serious harm to himself/herself or to others and/or to property belonging to himself/herself or others as the case maybe, where the same is a consequence of the mental illness of the person.

However, the medical officer in-charge or the psychiatrist in-charge is not allowed to administer any medical treatment to the person with mental illness which is not directly related to the emergency treatment, or to administer electro-convulsive therapy. The emergency treatment should not ordinarily continue for a period longer than seventy-two hours or as soon as the person is assessed at a mental health establishment.

The 2017 Act also lays down certain restrictions pertaining to **electro-convulsive therapy** as a form of treatment for persons with mental illness in India.[175] It is stated that electro-convulsive therapy should not be performed on persons without the use of anesthesia or muscle relaxants. Electro-convulsive therapy should not be performed on minors with mental illness. However, if in the opinion of the treating psychiatrist, the therapy is required, informed consent of the guardian of the minor should be obtained before proceeding with the treatment.[176] **Sterilization** should never be done to men/women with mental illness as a way of treatment of those persons. Moreover, **chaining** in any manner is also prohibited under the Act.[177]

174 The 2017 Act, Section 94
175 The 2017 Act, Section 95
176 *Id.*
177 *Id.*

The 2017 Act also lays down essential conditions to be fulfilled before **psychosurgery** is performed as a treatment for the person with mental illness.[178] It is stated that psychosurgery shall not be performed on a person with mental illness till the informed consent of the person on whom the surgery is being performed is obtained, and approval to perform the same has been obtained from the concerned Board.[179]

Treating with dignity is one of the most important principles that should be adhered to in the mental healthcare of persons with mental illness. To be as much in touch with humanity as possible is vital for recovery from any form of mental illness. Therefore, the Act clearly states that nobody shall be subjected to **solitary confinement or seclusion**.[180] The Act also forbids usage of physical restraint on the person with mental illness, except when usage of **physical restraint** is the only way to avert imminent harm to the person with mental illness or to others and the usage is authorized by the psychiatrist in-charge of person with mental illness in the hospital. The restraint shall not be continued beyond the time that is absolutely necessary in the situation. The reason for the restraint, the manner and duration of the same should be recorded in the medical records of the person with mental illness by the medical officer or the mental health officer in charge of the hospital, and the nominated representative of the person should be informed about the restraint within twenty-four hours of the same. The restraint shall not in any case be administered as a punishment or as a deterrent to any person with mental illness. A mental health establishment is required under the Act to maintain record of instances of restraints and send report of the same to the concerned Board.[181] It is important to note that a mental health professional or medical practitioner is forbidden to perform any function and discharge any duty which he/she is not authorized to perform under the 2017 Act and to recommend any medicine not so authorized in the field of his/her profession.[182]

178 *See* also Draft Central Regulations, 2017, Paragraph 13
179 The 2017 Act, Section 96
180 The 2017 Act, Section 97
181 *See* also Draft Central Regulations, 2017, Paragraph 14
182 The 2017 Act, Section 106

3. Authorities Under the Mental Healthcare Act, 2017

The Central Authority for Mental Health Services under the 1987 Act is succeeded by the **Central Mental Health Authority** under the Mental Healthcare Act, 2017. On establishment of the Central Mental Health Authority, all assets and liabilities of the Central Authority for Mental Health Services stand vested and transferred to the former.[183] Some of the important functions of the Central Mental Health Authority under the 2017 Act are discussed herein below[184]:

- Registering mental health establishments under the control of the Central Government, maintaining registers and providing information pertaining to the same;
- Developing norms for quality and service provided by mental health establishments under the Central Government;
- Supervising all mental health establishments under the control of the Central Government;
- Maintaining a national register of clinical psychologists, mental health nurses and psychiatric social workers;
- Training of law enforcement officials, mental health professionals and other health professionals about the provisions of the Act; and
- Advising the Central Government on matters pertaining to mental healthcare, etc.

The State Authority for Mental Health Services under the 1987 Act is succeeded by the State Mental Health Authority under the 2017 Act. All assets and liabilities of the State Authority for Mental Health Services stand vested and transferred to the **State Mental Health Authority**.[185] Some of the important functions of the State Mental Health Authority under the 2017 Act are discussed herein below[186]:

- Registering mental health establishments in the State except those registered with the Central Mental Health Authority[187] and

183 The 2017 Act, Section 42.
184 The 2017 Act, Section 43.
185 The 2017 Act, Section 54.
186 The 2017 Act, Section 55.
187 Hospitals registered with the Central Mental Health Authority under Section 43 of the 2017 Act.

maintaining and publishing a register of the establishments so registered;

- Developing norms for quality and service provided by mental health establishments in the State;
- Supervising all mental health establishments in the State;
- Maintaining a register of clinical psychologists, mental health nurses and psychiatric social workers;
- Training of law enforcement officials, mental health professionals and other health professionals about the provisions of the Act; etc.

The State Mental Health Authority has to constitute the **Mental Health Review Boards** for the purposes of the 2017 Act.[188] The constitution of the Boards by the State Authority for a particular district or group of districts will be such as will be prescribed by the Central Government.[189]

The powers and functions of the Mental Health Review Board, as enumerated in the Act are as follows[190]:

- Register, review, alter or cancel an advance directive of the person with mental illness;
- Appoint a nominated representative of the person with mental illness;
- To receive and decide upon applications pertaining to non-disclosure of information, deficiencies in care and services, etc.;
- To visit and inspect and thereby keep track of the health services in prisons and jails;
- To conduct inquiry, on receipt of a notice thereby, pertaining to violations of rights of persons with mental illness in a mental health establishment, and on non-compliance of the order or direction to impose penalty;
- Take steps to protect the rights of persons with mental illness;

188 The 2017 Act, Section 73.
189 *See* The 2017 Act, Section 74.
190 The 2017 Act, Section 82.

Any person aggrieved by the order of the Board may approach the High Court of the State where the Board is located, and prefer an appeal before the same.[191]

It is important to note that any contravention of the provisions of the 2017 Act is punishable at the first instance with a punishment of imprisonment up to six months and fine up to Rs.1,00,000/-, or both; and for every such contravention made subsequently, imprisonment up to two years and/or with a fine between Rs. 50,000/- and Rs. 5,00,000/-.[192] The 2017 Act also lays down penalties for establishing or maintaining of mental health establishment in contraventions of the Act.[193]

Summarizing: The Mental Healthcare Act, 2017, came into force very recently, that is, from 29th May, 2018[194] on which date the Mental Health Act, 1987, stood repealed. In order to address the present and future, it is important to analyse and draw a link with what was the situation in the past. This Chapter compared two major aspects of the 2017 Act and the 1987 Act, namely: (i) the procedures pertaining to admission, treatment and discharge under the two Acts; (ii) various Authorities under the two Acts. This Chapter holds significance because one cannot ignore the fact the 2017 Act has not been introduced in a vacuum, but is replacing a 31 year old legislation. Therefore, it was important to understand the major administrative changes in the law enforcement mechanism that will be brought about by the virtue of the new law. The 2017 Act which was introduced in the light of UNCRPD aims for just, equitable and holistic mental healthcare in India through its various provisions. It can be concluded by stating that, as compared to the 1987 Act, the 2017 Act is a progressive step for mental healthcare in India. The provisions of the 2017 Act are meticulously drafted and cater to minute details pertaining to admission, treatment and care of persons with mental illness in the country.

191 The 2017 Act, Section 83
192 The 2017 Act, Section 108
193 The 2017 Act, Section 107
194 Notification No.: S.O. 2173(E), Ministry of Health and Family Welfare, Government of India (29th May, 2018)

VII. ANALYSING THE DECISIONS OF INDIAN COURTS ON MATTERS RELATING TO MENTAL ILLNESS

The Courts in India have time and again dealt with issues pertaining to rights and healthcare of persons with mental illness. This Chapter aims to bring together all the pertinent judgements on this area to fore and analyse the same from the perspective of women with mental illness wherever relevant. The Mental Healthcare Act, 2017, came into force very recently, that is, from 29th May, 2018[195] on which date the Mental Health Act, 1987, stood repealed. Chapter VI of this book drew a comparison between the working of the Mental Health Act, 1987, and the Mental Healthcare Act, 2017. This Chapter also analyses the era of the Mental Health Act, 1987, and the time before that, by delving into the decisions of the Indian Courts pertaining to mental healthcare till date.

- **In Re: Death of 25 Chained Inmates In Asylum Fire In Tamil Nadu[196]**

The matter before the Hon'ble Supreme Court of India was pertaining to a gruesome news item published in the leading newspapers of the country, regarding the grave tragedy at a mental asylum in Eravadi, Tamil Nadu, where twenty-five inmates were charred to death when a fire had broken out because they were unable to escape, the reason for the same being that they were chained to poles or beds. The Hon'ble Supreme Court asked the respondents for the factual report in the first place.[197] The Court then required every State in the country to file an affidavit requiring *inter alia* the following details:[198]

  - When was the State Mental Health Authority set up in the State (If a State does not have a State Mental Health Authority, the reason for the same, and a date by when the State Mental Health Authority will be established and will become operational);

195 Notification No.: S.O. 2173(E), Ministry of Health and Family Welfare, Government of India (29th May, 2018)

196 AIR 2002 SC 3693

197 *See* In Re: Death of 25 Chained Inmates In Asylum Fire In Tamil Nadu v. Union of India & ors., 2001(5) Scale 64

198 *See* Re: Death of 25 Chained Inmates v. Union of India, AIR 2002 SC 979

- The dates of meetings of the State Mental Health Authority till date and a short summary of the decisions taken so far, since the inception of the Authority;
- Undertakings from the State that a meeting of the State Mental Health Authority be conducted at least once in every four months;
- The number of prosecutions undertaken and penalties or other punitive measures imposed by the State under the Mental Health Act, 1987.

The Supreme Court also required every State and Union Territory in the country to conduct an assessment survey and file a report pertaining to the following:[199]

- Average number of mental health resource personnel in the state;
- Bed strength, outpatient facilities and rehabilitation facilities in the public and private sector.

The Chief Secretary of each State was asked to file an affidavit whether any minimum standards had been set up for licensing Mental Health Institutions and whether the registered mental health institutions were adhering to the prescribed minimum standard. The Union of India was directed to file a policy to set up at least one Mental Health Hospital run by the Central Government in each State and to consider the viability of framing uniform rules setting standards of service for Mental Health Institutions. Section 43 of the Mental Health Act, 1987, states that a patient can apply to the Magistrate for discharge. A minimum of two members of the Legal Aid Board of every State are required to be appointed to visit the institutions monthly and assist the patients and their family members in applying for discharge from the Institution. The Supreme Court held that it is mandatory for the Judicial Officer concerned to explain to the patients their rights at the time of admission, and inform them about whom to approach in case any of those rights are violated.[200] The Court also recommended the setting up of rehabilitation

199 In Re: Death of 25 Chained Inmates In Asylum Fire In Tamil Nadu, AIR 2002 SC 3693

200 *Id.*

schemes for patients who do not have any support in the community, which would include the setting up of *"Supported Shared Home-like Accommodation."*[201]

- **Sheela Barse v. Union of India**[202]

The Supreme Court condemned the admission of non-criminal mentally ill persons in prisons and held that the same was illegal and unconstitutional. The Court directed the Judicial Magistrate to get any such person produced before him/her to be examined by a mental health professional and, thereafter, send such a person to the nearest place of treatment and care.

- **Binoo Sen v. State of West Bengal through the Principal Secretary, Department of Social Welfare and others**[203]

In this case, the Calcutta High Court directed that, whenever it is brought before the notice of a Court that a person produced before it suffers from any form of mental illness, before remanding such a person to a Home, the Court must send the person for a medical check-up at a hospital which is well-equipped to conduct such a test and provide mental healthcare to him/her.

- **Chandan Kumar Banik v. State of W.B.**[204]

This case came before the Supreme Court in the form of a PIL, wherein a letter addressing the court accompanied by a picture of a patient chained in the Mental Hospital located in Hooghly, West Bengal, was attached. After getting a reply pertaining to the situation from the Government of West Bengal, the Court also appointed a Committee to investigate into the issue. Taking due note of the condition of administration in the hospital, amenities available to and accessible by patients, the Supreme Court expressed its displeasure about the fact that the administration of the Hospital was under the charge of only a Sub-Divisional Officer. The Court observed that the head of the management at an institution

201 *Id.*

202 AIR 1993 SCW 2908; *See* also Sheela Barse v. Union of India, 1995(5) SCC 654; Sheela Barse v. Union of India, 1993(4) SCC 204 ; Sheela Barse v. Union of India, 1986(2) Scale 1

203 1999(2) Cal. H.C.N. 268

204 1995(Sup4) SCC 505

like this should be an official who is able to understand and appreciate the treatment and care of persons with mental illness. As several lapses and flaws in the functioning of the Hospital were enumerated in the Report submitted by the Investigating Committee, the Supreme Court directed that a copy of the Report be sent to the Chief Secretary to the Government of WB and, thereafter, be placed before the concerned Minister of the WB Government for necessary action in pursuance of the improvement of the conditions in the Hospital.

- **Chandigarh Administration v. Nemo,[205] and**
- **Suchita Srivastava and Another v. Chandigarh Administration[206]**

The Chandigarh Administration had come before the Punjab and Haryana High Court to seek permission to medically terminate the pregnancy of a mentally retarded girl. The High Court set up an Expert Body to look into the issue of whether the termination of the pregnancy would be in the best interest of the victim. The girl had been raped by one of the guards of the Nari Niketan. This brought into fore the lurking risk which girls at such institutions face - that of being vulnerable to sexual and physical attacks by the care-givers at the institution. The Punjab and Haryana High Court issued *inter alia* the following directions for the functioning of the Nari Niketan and similar institutions:

- o A Medical Board to visit fortnightly Nari Niketan, Ashreya and other similar institutions. The Medical Board to be notified and to comprise specialists, particularly a gynecologist, skin specialist and counsellor, and headed by the Director, Health Services, Chandigarh. The periodical examination to particularly take note of any form of sexual or other abuse of any inmate in such institution;
- o The Chandigarh Administration to provide the best medical treatment to all the inmates of such Government run or Government aided institutions;
- o The description and details of each inmate and their photographs, respectively, to be displayed in the website of the concerned

205 2009(3) R.C.R.(Civil) 766 (P&H) (DB)
206 AIR 2010 SC 235

Department and the said information to be updated on a regular basis;

- Chandigarh Administration to not keep or employ male staff members for the internal working of such institutions if there are any female inmates in the institution.

In furtherance of the matter, the Supreme Court held that the *"woman's right to privacy, dignity and bodily integrity should be respected"* which includes her reproductive choice to continue with the pregnancy.[207]

- **Tulshidas Kanolkar v. State of Goa[208]**

In this case, a woman with mental disability was repeatedly raped. The Supreme Court observed that, in such a case, apart from physical violence, there is also *"exploitation of her helplessness."* Justice Arijit Pasayat stated it was exigent to prescribe a higher penalty for the rape of a mentally challenged woman whose "*mental age may be less than 12 years*."

- **Chitta Ranjan Bhattacharjee v. State of Tripura[209]**

In this PIL, the petitioner requested the High Court of Guwahati to issue directions to the State Government to perform its duties with respect to mentally ill persons as mandated by the Mental Health Act, 1987. The Court issued *inter alia* the following directions to the State:

- Create awareness among the general public regarding the functioning of the Act;
- Ensure existence of necessary facilities for mental healthcare through mental hospitals, psychiatric hospital and other mental healthcare facilities;
- Issue guidelines in police stations, laying down points for awareness about respecting the rights of persons with mental illness; etc.

207 Suchita Srivastava and Another v. Chandigarh Administration, AIR 2010 SC 235
208 AIR 2004 SC 978.
209 2010(2) GauLT 514 (Gauhati) (Agartala Bench)

- **D.K. Basu v. State of WB[210]**

In this case, one of the issues before the Supreme Court was that of custodial violence, including deaths in the lock-ups. The Court issued directions pertaining to the same and required the directions to be put in the form of a notice in a conspicuous place in every police station in the country. The Court also took note of the failure by the authorities in the country to properly cater to the requirements of persons with mental illness, who are found loitering on the streets or other places. The Court noted that despite the existence of the Mental Health Act, 1987, because there is no awareness about the provisions of the legislation, the fundamental rights of persons with mental illness are being grossly hampered. The Court, therefore, issued directions to the State to create awareness about the provisions of the Mental Health Act, 1987, and facilitate the implementation of its provisions by taking necessary action. The Court also required setting up of a Scheme for rehabilitation of persons with mental illness who lack the capacity to take care of themselves or whose family members are unwilling to take care of them. State authorities were further directed to provide such persons with mental healthcare facilities. Directions were issued to create awareness through the All India Radio and other electronic media regarding the role of the society to protect the rights of persons with mental illness.

- **Court on its own motion v. Principal Secretary (Social Justice & Empowerment)[211]**

In this case, the High Court of Himachal Pradesh issued directions to the Government of Himachal Pradesh pertaining to mental healthcare and rehabilitation of persons with mental illness. Enumerated herein below are some of the directions issued by the Hon'ble High Court to various authorities of the State Government of Himachal Pradesh:

  - o The Principal Secretary (Health) was directed to fill up the posts of psychiatrists in all district hospitals in Himachal Pradesh;
  - o The Principal Secretary (Health) was directed to provide clothing and footwear to the patients at the Himachal Pradesh

210 (1997)1 SCC 416

211 2015(3) R.C.R.(Civil) 684 (HP) (DB)

Hospital for Mental Health and Rehabilitation four times in a year, depending on the change of weather;

- The Director, Women and Child Development, was directed to ensure that mentally ill patients are admitted in the Mental Health and Rehabilitation Centre, Boileauganj, Shimla;
- The rehabilitation grant for women with mental illness was increased to Rs. 50,000/-;
- Women with mental illness were not to be admitted to Nari Niketan, Mashobra. Such women were to be admitted to the psychiatric wards of general hospitals or in the Mental Health and Rehabilitation Centre, Boileauganj, Shimla;
- Steps to be taken to ensure that patients who have been cured can return to their homes;
- Enough number of posts to be approved, created and filled up within three months to assist and attend to the inmates at the H.H. Mental Health and Rehabilitation Centre, Shimla;

The High Court also directed the Superintendents of Police in the State to comply with the provisions of Section 23 of the Mental Health Act, 1987, and to produce within 24 hours before the Magistrate any person taken into protection and/or detained under Section 23.[212]

- **Joseph v. State of Kerala[213]**

In this case, the High Court of Kerala directed the Mental Health Centres under the control of the Government of Kerala to ensure that the provisions of the Mental Health Act, 1987, particularly Sections 15, 16 and 17 are adhered to. A mentally ill person who lacks the capacity to give consent for mental healthcare treatment can be admitted in a psychiatric hospital only if an application in furtherance of the same is made by a relative or friend of the person, and the medical officer in-charge at that point at that hospital must be satisfied that admitting the person as an in-patient is the only viable option.

212 *See* also Dr. Upendra Baxi v. State of U.P., 1998(9) SCC 388; and Upendra Baxi v. State of Uttar Pradesh, 1983(2) SCC 308

213 2014(5) R.C.R.(Civil) 457 (Kerala)

- **State of Gujarat v. Kanaiyalal Manilal[214]**

The High Court of Gujarat held in this case that the treatment and care of mentally ill persons in psychiatric hospitals and nursing homes is the statutory obligation of the State Government in a welfare State like India.

- **In Re: Illegal Detention of Machal Lalung v. ABC[215]**

The present writ petition was filed before the Supreme Court under Article 32 of the Constitution and was made pertaining to mentally challenged under-trial prisoners languishing in mental hospitals for years. The Supreme Court directed necessary steps to be taken to conclude the trials of these prisoners and/or release them to their family members, respectively.[216]

- **Nathalie Vandenbyvanghe v. The State of TN[217]**

A French national came as a tourist to India and lost his passport in India. He did not know English and was found loitering on the streets, lost. He was brought along with 114 other persons by the Police, and reception orders were issued against all the 114 of them including the French national. On contacting the French embassy, the French national's daughter was apprised that her father was at a psychiatric hospital in Chennai. She came to India and filed the instant habeas corpus petition before the High Court of Madras. The facts are that on 9th July, 2008, following persons were surrounded by the Police and declared by a team of doctors to be suffering from bipolar disorder mania, and a certificate to that affect had been issued, namely:

  - o Inspector of Police at Kottar Police Station brought fifty male persons;
  - o Inspector of Police at Nesamony Nagar Police Station brought forty-five male persons as well as twenty female persons.

214 1997(1) GujLH 560 (Gujarat)

215 2007(9) Scale 432; *See* also In Re: Illegal Detention of Machal Lalung, 2007(9) Scale 434; Re: Illegal Detention of Macha Llalung, 2007(9) Scale 435

216 *See* also Veena Sethi v. State of Bihar, 1982 SCC(Cri) 511; and S. Hariprakash v. Hon'ble Chief Justice, Madras High Court2014(4) MLJ (Criminal) 534

217 Habeas Corpus Petition No.1041 of 2008 (Madras)

They were then brought to and admitted at the Institute of Mental Health at Chennai. The Hon'ble High Court of Madras held that:

> *"This exposes the psycho-fever of the police to proceed against those who are wandering in the streets to be treated as mentally ill persons in disregard of their actual physical and mental condition. We must express our total dissatisfaction over the way in which the entire matter had been handled, not only by the police, but also at the level of the doctors and the learned Judicial Magistrate, as well."*[218]

The Court further held that persons with mental illness are not criminals, and the State owes its duty towards the protection of their human rights. The medical officers were not careful enough before certifying a person as mentally ill; and, that a person is not entitled to any less attention than others, just because he/she is found wandering about on the streets.

- **Rakesh Chand Narain v. State of Bihar**[219]

A letter was addressed to the Chief Justice of India in 1986[220] relating the plight of patients at the Mental Hospital at Kanke near Ranchi. The Supreme Court required the State Government of erstwhile Bihar to file a counter-affidavit and the Chief Judicial Magistrate of Ranchi to issue a report pertaining to the issue.[221] Three years later, in the present case, the Supreme Court observed that the Scheme which had been submitted before the Court had not been implemented properly. The Court held that India, being a welfare State, has a duty towards the health of every citizen including the mental healthcare of persons with mental illness. The Court constituted a Committee of Management for the Mental Hospital at Kanke to work towards the transformation of conditions in the said Hospital. The Court was of the concerted opinion that, if the conditions in the Mental Hospital at Kanke could reach the level of mental healthcare at NIMHANS, Bangalore, the quality of the Kanke Hospital would improve and the patients at the latter would be able to benefit from the modern scientific treatments available in

218 Nathalie Vandenbyvanghe v. The State Of Tamil Nadu, Habeas Corpus Petition No.1041 of 2008 (Madras)

219 AIR 1989 SC 348

220 *See* also Aman Hingorani v. Union of India and others, AIR 1995 SC 215

221 *See* Rakesh Chandra Narayan v. State of Bihar, 1986(2) Scale 739

mental healthcare. Later, in a Judgement in the year 1994, the Supreme Court directed that the Ranchi Manasik Arogyashala should be made an autonomous institution.[222]

- **Robert Heijkamp v. Bal Anand World Children Welfare Trust[223]**

The question before the Hon'ble Bombay High Court in this case was whether a child of a mentally ill person be considered as a child in need of care and protection under the Juvenile Justice Act, 1986. The Court was of the opinion that such a child would ordinarily be deemed to be abandoned under the JJ Act, 1986.[224] However, the determination of the mental illness of such a parent cannot be done by an authority under the JJ Act, 1986, and can only be done under the Mental Health Act, 1987. Therefore, only if a Court dealing with a matter under the Mental Health Act, 1987, is of the opinion that the parent/person is mentally ill could the Child Welfare Committee under the JJ Act, 1986, be justified in concluding that the child of such a parent is abandoned and, therefore, eligible for adoption under the relevant provisions of the Juvenile Justice Act, 1986.

- **Supreme Court Legal v. State of M.P.[225]**

In this case, the Supreme Court condemned the practice of chaining of patients with mental illness in the Gwalior Mental Asylum as a gross violation of right to life guaranteed under Article 21 of the Constitution. Some of the patients were found without a piece of clothing on them. The Supreme Court directed the authorities to take immediate action to remedy the deplorable situation.

- **Ravinder v. Government of NCT & Ors.[226]**

The Delhi High Court in this case directed the payment of Rs. 2 lakhs as compensation by the government to a 71 year old person for confining him in the Institute of Human Behaviour and Allied Sciences, Delhi (*IBHBAS), because he had lost his temper in Court. It is to be noted

222 Rakesh Chandra Narayan v. State of Bihar, 1994(3) Scale 1034
223 2008(1) BCR 719 (Bombay)
224 The Juvenile Justice Act, 1986, Section 41
225 1994(5) SCC 27
226 W.P. (CRL.) 3317/2017

that he was admitted without citing of any provision under the Mental Health Act, 1987. The Delhi High Court condemned this incident as an act of sheer negligence on the part of the doctors at IHBAS, Delhi, and an absolute violation of the fundamental rights of the person confined, including his right to life. The Court *inter alia* made reference to the judgement of the US Supreme Court in *O'Connor v. Donaldson*[227] wherein it was held that the sole finding of mental illness of a person cannot be a reason to keep him/her in confinement.

- **Dr. Sangamitra Acharya & Anr. v. State (NCT of Delhi) & Ors.[228]**

In this case, the High Court of Delhi held that involuntary admission under special circumstances under Section 19 of the Mental Health Act, 1987, is only viable when the patient is mentally ill and the medical officer in charge of the mental health institution has reached a satisfaction to that effect. Admission under special circumstances for the mere observation of the patient amounts to a violation of the right to life, liberty and dignity of the person so admitted. The fundamental criteria to be fulfilled, therefore, must be that the person so admitted should be unable to express his/her willingness to get admitted, and such an admission should be in the best interest of the person. To be satisfied with the existence of the above conditions, the medical officer in charge of the mental health institution should personally interact with the person and make observations regarding the condition of the person thereafter.

The Hon'ble High Court held that such a decision cannot be taken by a mere conversation on the phone or through a WhatsApp message, even if the person conveying the message was a qualified mental health professional. The Court reiterated the intent of the Parliament while framing such a law as being that when a person is brought by someone else, claiming that the person is mentally ill, the provisions of law entail a duty on the medical officer in charge of the mental health institution to be personally satisfied that the person is mentally ill and is, therefore, not in a position to express willingness to be admitted as an in-patient.

227 422 US 563 (1975)
228 W.P. (CRL.) 1804/2017 & CM No. 9963/2017

> *"A person brought to a mental health institution without her consent, and sought to be admitted, faces a serious infraction of her life and liberty. This dictates the mandatory nature of the safeguards under the MHA having to be scrupulously followed."*[229]

A violation of the above mandate, the Court observed, will not only cause irreparable harm to the person, but will also seriously violate his/her constitutional rights. The Court also recommended the setting up of a Code of Ethics for Psychiatrists to follow, a code which would reinforce the law, and directed the Delhi Police to prepare a manual stating in detail how to deal with cases under the Mental Health Act, 1987, and, thereafter, under the Mental Healthcare Act, 2017.

- **Dr. Ajay Verma v. Union of India**[230]

In this case before the Uttarakhand High Court, the petitioner had brought to the notice of the honorable court the *"plight of mentally disturbed ill children."*It was alleged that the mentally ill children, in particular females are sexually exploited. The petitioner had also made representations before the State for taking remedial measures to improve the conditions for children living with disability and mental illness. Some of the important directions given by the honorable High Court while deciding this issue were:

- State Government was directed to prepare a comprehensive policy for rehabilitating children and patients with mental illness.
- All the SSPs/SPs throughout the State were directed to ensure that such patients are not treated by Tantriks, Quacks, etc. They were to also ensure that the mentally disturbed patients are *"not chained/shackled/fettered/ill-treated or kept in solitary confinement, even in the private homes and institutions."*
- The State Government was directed to set up Centre for Human Rights, Ethics, Law and Mental Health; to constitute the State Authority under Section 45 of the Mental Healthcare Act, 2017; and thereafter also constitute the Mental Health Review Board as per Section 73 of the Act.

229 Dr. Sangamitra Acharya & Anr. v. State (NCT of Delhi) & Ors., W.P. (CRL.), Para. 123

230 Writ Petition (PIL) No. 17 of 2018. D/d. 1.6.2018

- The State Government was further directed to provide mental healthcare services and treatment to all the persons with mental illness *"at an affordable cost, of good quality, available in sufficient quantity, accessible geographically and without any discrimination."*
- Due publicity to the 2017 Act through various media was to be given and necessary steps for ensuring the same were to be taken by the State Government.
- No person or organization should be permitted to establish or run a mental health establishment, unless the same is registered with the authority constituted under the Act.
- No person with mental illness should be subjected to *"electro-seclusion or solitary confinement."*
- Quarterly reports to be sent by the Medical Officers of the Jails and Prisons to the Board, certifying therein that there no prisoners in the prison or jail suffering from mental illness.
- Person in-charge of the State-run custodial institutions were directed to ensure that any resident of the institution who has, or is likely to have, a mental illness shall be taken to the nearest mental health establishment, run or funded by the appropriate Government for assessment and treatment at the earliest.
- Every police officer was directed to take under protection any person found wandering at large within the limits of the police station *"whom the officer has reason to believe has mental illness and is incapable of taking care of himself. Every person taken into protection is ordered to be taken to the nearest public health establishment forthwith."* Further, it is the duty of every police officer to report to the Magistrate if any person suffering from mental illness is *"being ill-treated or neglected."*

- **Court on its own motion v. State of H.P.**[231]

In this case before the Himachal Pradesh High Court, the Court had taken suo motu cognizance on a letter petition addressed to this Court wherein attention of this Court was drawn towards *"the inaction on*

231 CWPIL No. 128 of 2018. D/d. 7.8.2018

the part of the authority in providing medical treatment to one Khem Raj, son of Hukmi Ram, resident of Village and P.O. Chalahal, Tehsil Sunni, District Shimla, H.P., who perhaps was suffering from chronic Psychotic Schizophrenia disorder." In compliance with the order passed by the Court, compliance affidavit was handed over, which admitted that the patient was, thereafter, now undergoing treatment at State Mental Health Rehabilitation Hospital, Shimla. The patient was now "being taken care of properly"; therefore, this petition was closed, as no further orders were necessary with respect to the same.

Matters pending before the Honorable Supreme Court of India:

- **Gaurav Kumar Bansal v. Union of India and Another**[232]

The Supreme Court in this case has issued notice to the Insurance Regulatory Development Authority of India and the Centre in response to a plea seeking directions under Section 21(4) of the Act which states that *"every insurer shall make provision for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness."* It has been stated in this petition before the Supreme Court that despite the existence of the aforesaid statutory provisions and a letter issued by the Insurance Regulatory Development Authority of India directing all insurance companies to adhere to the provisions of Section 21(4), there had been no follow up with respect to the same by the Authority, nor had any action been taken against the errant insurance companies which were not adhering to the said provisions.

- **Gaurav Kumar Bansal v. Union of India and Another**[233]

The Supreme Court in this case has issued notice to the Centre and State Governments in response to a public interest litigation which raised the issue of the increasing number of child suicides in the country. The present petition before the honorable Supreme Court prayed for directions to be issued to the Governments at the Central and State level

232 *See* https://www.livelaw.in/top-stories/sc-issues-notice-on-plea-to-direct-insurers-to-provide-medical-insurance-for-mental-illness-treatment-158402 (Last visited on June 18, 2020)

233 *See* https://www.livelaw.in/top-stories/sc-notice-pil-child-suicides-mental-health-act-146885 (Last visited on June 18, 2020)

to implement the public health programme to check and prevent the suicides in their respective jurisdiction in adherence to Sections 29 and 115 of the Mental Healthcare Act, 2017.

Summarizing: This Chapter is significant because it draws an insight into the decisions of the Supreme Court of India and the various High Courts in the country pertaining to mental healthcare issues. It can be concluded by stating that the Courts in India have time and again tried to draw a balance between the *"best interest"* of the person with mental illness involved, keeping in mind the gravity of the medical necessity in his/her mental healthcare. The Courts have also always upheld the right to life, dignity and equality of persons with mental illness at par with the other citizens of the country. It can be said that the 2017 Act upholds the ethos of these tenets and principles laid down by the Indian Courts.

VIII. India's National Mental Health Policy, 2014, and its Reflection in The Mental Healthcare Act, 2017

The aims and objectives of the National Mental Health Policy of India, 2014, and its recommendations find place in the provisions of the Mental Healthcare Act, 2017. Having discussed the 2017 Act and various judicial decisions of the Indian Courts pertaining to mental healthcare in India, it becomes very important to critically analyse the National Mental Health Policy of India, 2014, to comprehensively understand the existent legal framework.

1. Objectives of the National Mental health Policy of India, 2014:

A Policy Group to recommend a National Mental Health Policy was set up in 2011. The National Mental Health Policy was passed in 2014[234] and was made in consonance with WHO Resolution WHA 65.4 approved by the 65th World Health Assembly on *"The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level."*[235] The goals and objectives, which the National Mental Health Policy of India, 2014, aims to achieve are:

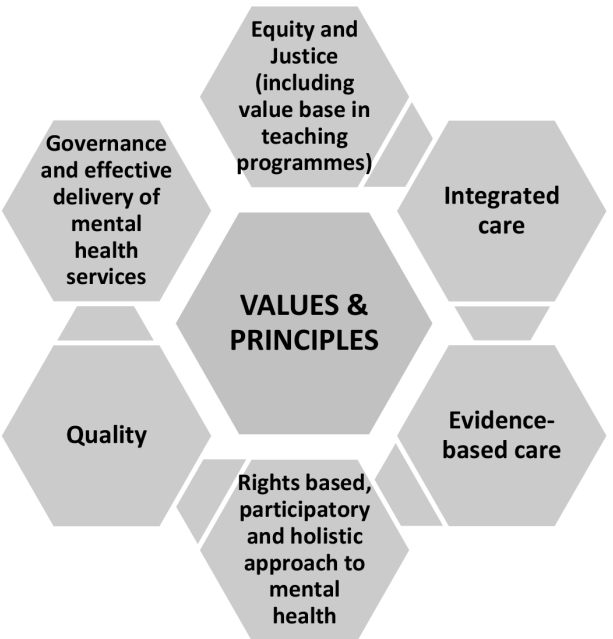
- Reduce the disability, distress, mortality, etc., relating to mental health issues;
- Create awareness and enhance the level of understanding pertaining to mental health in the country;
- Strengthen the leadership in the mental health sector at various levels, including Center, State and District;
- Enable universal access to mental health care in the country;
- Enhance and increase the capacity to utilize mental health services by persons with mental health problems (Such services would include preventive services, services for treatment, care and support);

234 National Mental Health Policy of India (2014), Available at https://www.nhp.gov.in/sites/default/files/pdf/national%20mental%20health%20policy%20of%20india%202014.pdf (Last visited on April 5, 2021)

235 WHO Resolution WHA 65.4, Available at http://apps.who.int/gb/DGNP/pdf_files/A65_REC1-en.pdf (Last visited on December 15, 2018)

- Increase access to mental health services for the vulnerable sections of the society (for example: homeless persons, socially/ economically/educationally backward sections of the Indian society);
- Reduce the occurrence of suicides and attempts to commit suicide;
- Reduce the stigma surrounding mental illness in the country;
- Reduce the prevalence of risk factors associated with mental health problems;
- Provide appropriate interventions by identifying the social, psychological and biological determinants of mental health issues, etc.

The fundamental principles to which the National Mental Health Policy of India adheres are enumerated in the chart below:



Fundamental values and principles of the 2014 Policy

The 2014 Policy emphasizes on the importance of proper funding and availability of the same across departments for the proper fulfillment of the vision envisaged in the Policy. It is vital that new activities relating to rehabilitation of persons with mental illness and continuance of mental healthcare facilities should be coupled with adequate amount of funding from the Government.

The 2014 Policy recognizes the role that families of persons with mental illness play. *"The emotional and social costs of providing care for a family member with mental illness cannot be quantified but exacts a huge toll on the family."*[236] The Policy recommends that the family members be provided:

- Access to information;
- Guidance in getting access to services for their family member with mental illness; and
- Support to carry on with their role as care-givers.

The Policy calls for inter-sectoral collaboration and acknowledges the fact that the Government and the non-government (private and non-profit organizations) sectors should work hand in hand for the proper redressal of justice.

The recommendations of the 2014 Policy have been broken down into seven broad categories, namely[237]:

236 The 2014 Policy, Para 4.5
237 The 2014 Policy, Para 5

Strategic Directions and Recommendations of Action (2014 Policy)

2. Analysing the Strategic Directions and Recommendations of the 2014 Policy:

i. Effective governance and accountability[238]:

One of first steps towards addressing the concerns of mental healthcare in India are developing relevant laws, policies and laws in consonance with the National Mental Health Policy, 2014, with proper implementation and mechanisms to monitor the implementation. The Mental Healthcare Act 2017 is very much in consonance with the spirit of the 2014 Policy and is a positive step towards the realization of the goals envisaged in the Policy. However, availability of sufficient funds and proper planning is another major necessity to ensure the proper implementation of the recommendations of the Policy.

ii. Promotion of mental health[239]:

The Policy recommends the redesigning of Anganwadi Centres to look

238 The 2014 Policy, Para 5.1
239 The 2014 Policy, Para 5.2

after the early child care, emotional and development needs of children below the age of six years. Life Skill Education should be provided to school children and college going students by skilled trainers and skilled teachers, catering to the context and the age of the students. Programmes should also be floated to assist adults in handling the stress in their lives, which can be done by counselling and appropriate workplace policies at the workplace. The Policy recommends the inclusion of Ayurveda and Yoga professionals to be included in the list of activists promoting mental health. Gender sensitization of healthcare providers is another important measure recommended by the Policy. Reducing poverty and decreasing disparity in incomes is recommended through sensitization of the policy makers of the Government, because alleviating these factors will be instrumental in improving the mental health results. These recommendations are vital for the proper implementation of the 2017 Act, too. The Act, being in consonance with the spirit of the Policy, demands proper promotion of mental health which can effectively nip the issue in the bud.

iii. Prevention of mental illness and reduction of suicides and attempts to commit suicide[240]:

("Addressing stigma, discrimination and exclusion"[241])

The 2014 Policy recommended the decriminalization of attempt to commit suicide,[242] which has been incorporated in Section 115 of the 2017 Act. The Act of 2017 requires the appropriate Government to design and plan public health programmes for reducing suicides and attempts to commit suicide.[243] The 2017 Act decriminalizes 'attempt to commit suicide.' It is stated that notwithstanding the provisions of Section 309 of the Indian Penal Code, any person who attempts to commit suicide should be presumed to be under severe stress and should not be tried or punished under the Indian Penal Code for the attempt to commit suicide.[244] The 2017 Act also makes it a duty of the Appropriate Government to provide care, treatment and rehabilitation

240 The 2014 Policy, Para 5.3
241 *Id.*
242 *Id.*
243 The 2017 Act, Section 29(2)
244 The 2017 Act, Section 115

to a person who attempts to commit suicide, the reason being that the person who so attempts is under severe stress, and care, treatment and rehabilitation are vital to reduce the chances of any further attempts to commit suicide by the person.[245]

The 2014 Policy recommends the encouragement of persons with mental illness to be actively involved in the social and economic walks of life, to create a conducive environment for their growth without discrimination of any kind. This finds its resonance in Chapter V of the Act of 2017, which enumerates the rights of persons with mental illness. Removal of discrimination is only possible through eradicating the stigma relating to mental illness in the country. Sensitizing various sections of society, particularly the police and the judicial officers, is a very vital step towards the fulfillment of the same. Section 30 of the 2017 Act requires the Appropriate Government to take all possible measures to ensure that various programmes to reduce stigma relating to mental illness should be planned, funded, enforced and implemented effectively. One of the major features of such programmes being, generating of awareness by disseminating information and making various sections of the society sensitive to the issue of mental illness.

iv. Access to mental healthcare to be universal:[246]

The 2014 Policy requires mental healthcare facilities to be universally accessible. Comprehensive services that address treatment, care and rehabilitation of persons with mental illness should be readily available to all sections of the society, across territories, communities, sections and strata. This right has been enumerated in Section 18 of the 2017 Act, which states that every person has the right to access to mental health services which are run by the government or are funded by it. The 2014 Policy also requires the development of standards and periodical improvisation of the quality of these facilities. Programmes should be implemented that facilitate the screening and early identification of symptoms of mental illness and provide treatment for the same.

The 2014 Policy also advocates the idea of *"Assisted Living Services"*[247] which is a form of domiciliary care for persons with long term or chronic

245 *Id.*
246 The 2014 Policy, Para 5.4
247 *Id.*

mental illnesses. A combination of the *'institutional', 'community'* and *'family'* care and rehabilitation dependent on the situation, nature of illness and requirements of the person with mental illness should be incorporated for every such person with mental illness to be able to stand when back in the society.

v. Increasing the availability of adequately trained mental health human resources[248]:

Mental health professionals for the purposes of this recommendation of the 2014 Policy include psychiatrists, psychologists, medical psychiatric social workers, counsellors, psychiatric nurses, etc. The same is reiterated in the definition of a mental health professional under the 2017 Act.[249] The Policy emphasizes upon the need to increase the availability of more and more mental health professionals in the country to facilitate universal access to mental healthcare. Integrating the training pertaining to mental health in other fields is necessary to facilitate the person with mental illness to be directed to a mental health professional from a general practitioner. The Policy recommends setting up of more psychiatric nursing courses or mental health courses and the skill upgradation of auxiliary nursing midwives in mental healthcare.

vi. Community participation[250]

The 2014 Policy requires the Government to promote the full participations of persons with mental illnesses in all aspects of life, which includes housing, education, employment, social welfare, etc. The Policy recommends the involvement of such persons in Village Health, Water and Nutrition Committees, Patient Welfare Committees, in order for them to be able to participate in the planning and the monitoring of the public health system in India.

vii. Research[251]

The National Health Policy of India, 2014, harps upon the importance of comprehensive and collaborative research to improve mental healthcare facilities in the country. It is recommended that the comprehensive

248 The 2014 Policy, Para 5.5
249 The 2017 Act, Section 2(s)
250 The 2014 Policy, Para 5.6
251 The 2014 Policy, Para 5.7

research agenda should also incorporate epidemiological, health and clinical research systems, along with sociological, ethnographic and other research methods, recognizing the important role of diverse methodologies and disciplines including that of participatory research method. It is recommended that Centres of Excellence for Mental Health should foster partnerships with the Medical Colleges of Psychiatry, District Mental Health Programmes and NGOs working in this arena and various research institutions. Research should, also, be conducted to evaluate the scope and potential of alternative therapies, traditional knowledge and practices in addressing mental health problems.

The WHO Resource Book on Mental Health, Human Rights and Legislation (2005) discusses about the significance of the coordinate interface between mental health legislation and mental health policy. It is stated that mental health legislation can help in achieving the goals laid down in the Policy, and sometimes the legislation can be instrumental in making the policy makers to formulate a Policy to further the cause of the legislation and facilitate the proper enforcement of the laws, and the same is true vice-versa.[252]

It can be concluded by saying that even though the National Health Policy of India, 2014, does not address the concerns of mental healthcare for women separately, the Policy is a progressive step towards better mental healthcare in the country, resultantly protecting the rights of women with mental illness, too. The recommendation for universal access to mental healthcare, community care and comprehensive research is a positive development in mental healthcare discourse. The beacon of the propositions of the Policy has been taken forward by the 2017 Act which, if properly implemented, can lead to the realization of the aims of the 2014 Policy and the protection of the rights of women with mental illness. The strategic recommendations and directions of the 2014 Policy can always act as the basic tenets to rely on for fulfilling the aims and objectives of the 2017 Act.

252 The WHO Resource Book on Mental Health, Human Rights and Legislation (2005)

IX. International Instruments

This Chapter analyses the various international instruments, declarations and standards pertaining to healthcare and rights of persons and women with mental illness. It is divided into two broad parts that are: International Instruments by UN and WHO; and the regional and organizational developments pertaining to mental healthcare worldwide. The aim of this Chapter is to test the 2017 Act on the anvil of International mental healthcare standards. This Chapter also gives a bird's eye view of mental healthcare globally, by analyzing the mental healthcare legal instruments and standards that are international, regional and organizational in nature.[253]

1. United Nations and the World Health Organization

i. Declarations and Conventions covering general rights

a. The Universal Declaration of Human Rights (1948) (UDHR)

UDHR[254] was proclaimed by the UN General Assembly on 10th December, 1948, which was also declared as the Human Rights Day to mark the occasion.

UDHR came into existence in the background and in the time of World War II and was based on the idea *"that there are a few common standards of decency that can and should be accepted by people of all nations and cultures."*[255] UDHR is a yardstick of measuring the progress of a nation in the true sense of the term.[256] The document describes itself as a *"common standard"* towards which *"every individual and every organ of society"* should *"strive."*

With respect to the basic character of UDHR, Eleanor Roosevelt,[257] stated, that:

253 *See* also Jean McHale, Et. al., Health Care Law: Text and Materials (2007)

254 UDHR, Available at http://www.un.org/en/udhrbook/pdf/udhr_booklet_en_web.pdf (Last visited on November 5, 2020)

255 Mary Ann Glendon, *The Rule of Law in the UDHR,* 2 Nw. J. Int'l Hum. Rts. 1 (2004)

256 *Id.*

257 Elena Roosevelt presided over the drafting process as chair of the U.N.'s first Human Rights Commission.

> *"In giving our approval to the declaration today, it is of primary importance that we keep clearly in mind the basic character of the document. It is not a treaty; it is not an international agreement. It is not and does not purport to be a statement of law or of legal obligation. It is a declaration of basic principles of human rights and freedoms, to be stamped with the approval of the General Assembly by formal vote of its members, and to serve as a common standard of achievement for all peoples of all nations."*

It is to be noted that even though UDHR as such is not binding, most of its rights had already received a significant degree of recognition by 1948 in the Constitutions of many nations[258]; and over the years most of its rights have been incorporated into the domestic legal systems of almost all countries.[259]

UDHR, being the foremost International instrument towards the protection of human rights of one and all, is relevant to the discussion pertaining to the international perspective of women with mental illness. Laying down provisions for equality and dignity, irrespective of status, sex, etc., UDHR can be said to be the international foundation to the protection of rights of one and all, which would include women with mental illness. The Preamble to UDHR begins by recognizing the need to protect the inherent dignity of all human beings and the inalienable and indispensable human rights. Equal rights of men and women, being one of the pillars towards the promotion of social progress and better standards of life at large, are pivotal for UDHR.[260] Enumerated herein in the table below are those provisions of UDHR which are pertinently relevant with respect to the rights of women with mental illness:

258 Mary Ann Glendon, *The Rule of Law in the UDHR,* 2 Nw. J. Int'l Hum. Rts. 1 (2004)

259 *Id.*

260 *See* Anita Abraham, National Law School of India University, Bangalore, Human Rights Law –Essential National and International Documents (2004)

Article of UDHR	Right
Article 1	Freedom and equality in dignity of rights; Spirit of brotherhood;
Article 2	Every person is entitled to the rights and freedoms enumerated in UDHR irrespective of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status;
Article 3	Right to life, liberty and security of person;
Article 5	No one to be subjected to torture or treatment which is cruel or degrading;
Article 6	Right to recognition everywhere as a 'person' before law;
Article 7	All are equal before the law and are, therefore, entitled to the equal protection of law;
Article 8	All have the right to effective remedy for the violation of the rights guaranteed to them;
Article 9	No one to be subjected to exile, detention or arrest which is arbitrary in nature;
Article 12	No one should be made arbitrarily subject to interference with his/her privacy, family, home or correspondence, or to any attack to his/her person, honour or reputation. The law should protect every person from any interference of this kind;
Article 16	Men and women of full age have the right to marry and to found a family. Everyone is entitled to equal rights pertaining to marriage, during marriage and at its dissolution;
Article 19	Every person has the right to freedom of opinion and expression;

Article 25	Right to a standard of living which is adequate not only for the well-being, but also the good health of the family, which includes clothing, food, medical care, etc. Motherhood and childhood being entitled to special care and assistance facilities.
Article 28	All persons are entitled to a social and international order in which the rights and freedoms in this Declaration can be fully realized;
Article 29	Exercise of one's rights entails the duty to respect and protect the rights of others. A person's rights can be subjected only to such further limitations as are necessary to protect the rights of others, public order, morality and the general welfare of the society at large.

b. The International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR)

After UDHR, the Human Rights Commission came up with two instrumental Covenants, both of which entered into force in the year 1976, namely: ICCPR[261] and ICESCR.[262]

UDHR, ICCPR and ICESCR together make the International Bill of Rights. Both ICCPR and ICESCR have their foundation in UDHR and comprise rights and duties of persons and the responsibilities of the State parties in furtherance of the provisions of UDHR. India acceded to ICCPR[263]and ICESCR[264] on 10th April, 1979. Most of the rights in

261 ICCPR, Available at http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx (Last visited on November 5, 2020)

262 ICESCR, Available at http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx (Last visited on November 20, 2020)

263 Some landmark Judgements of the Supreme Court of India that refer to the ICCPR:
PUCL v. Union of India, (1997) 1 SCC 301; D.C. Saxena (Dr.) v. Honourable Chief Justice of India, (1996) 5 SCC 216; Kirloskar Brothers Ltd., v. ESI Corpn., (1996) 2 SCC 682; Kubic Darusz v. Union of India, (1990) 1 SCC 568; Francis Coraile Mullin v. Administration, Union Territory of Delhi, (1981) 1 SCC 608.

264 Some landmark Judgements of the Supreme Court of India that refer to the ICESCR:
LIC of India v. Consumer Education Research Centre (1995) 5 SCC 482; Regional Director, ESI Corpn. v. Francis Decosta, 1993 Supp (94) SCC 100; CESC Ltd. v.

the Bill of Rights were already there in the provisions of the Indian Constitution, and some others have been recognized by the Courts in India while interpreting the fundamental rights in Part III of the Constitution of India.

Sr. No.	Rights	UDHR	ICCPR	ICESCR	Fundamental Right under the Constitution of India
i.	Right to life	Article 3	Article 6	-	Article 21
ii.	Right to personal liberty	Article 3	Article 9	-	Article 21
iii.	Right to health	Article 25	-	Article 12	Article 21 Parmanand Katra v. Union of India; Paschim Banga Khet Mazdoor Samity & ors v. State of West Bengal & ors.
iv.	Right against discri-mination	Article 2	Article 2 & Article 4	Article 2	Articles 14, 15, 23 and 30
v.	Right to privacy	Article 12	Article 17	-	Article 21 Justice K.S. Puttaswamy (Retd.) v. Union of India

Subhash Chandra Bose, (1992) 1 SCC 441.

vi.	Right to family	Article 16	Article 23	-	Article 21 Lata Singh v. state of Uttar Pradesh; Shakti Vahini v. Union of India and Ors.; Jasvir Singh and anr. v. State of Punjab and Ors.
vii.	Right to protection of: a. persons with disability b. women c. children	Article 25	Article 24	Article 12.2	Article 15
viii.	Right to equal protection before law	Article 7	Article 26	-	Article 14
ix.	Right to legal remedy	Article 8	Article 14	-	Article 14 and 32
x.	Right against torture, cruel, inhuman treatment or punishment	Article 5	Article 7	-	Articles 14, 17, 21 and 23
xi.	Right to work	Article 23	-	Article 6 & Article 7	Article 19(1)(g)

c. Convention on Elimination of Discrimination Against Women (CEDAW)

The need to protect the rights of women in particular was recognized by the United Nations Organization and enacted in the form of CEDAW.[265] India signed and ratified on 30th July, 1980, and 9th July, 1993, respectively.[266]

The basis of the Convention is to prevent discrimination on the ground of gender and thereby promote and protect equality between men and women alike. State parties to CEDAW undertake to take measures towards facilitating the exercise of rights and protection of freedoms of women in their country. This Convention is the only human rights treaty which not only protects the rights of women, but also targets to reform traditions and cultures which influence the gender roles and family relations in the society.[267] Article 1 of CEDAW defines *"discrimination against women"* and, thereby, elaborates upon the vices this Convention aims to address.[268] CEDAW condemns *"all forms of discrimination against women,"* in all degrees and forms and entails the State parties to take appropriate measures through policies and laws, thereby embodying the principle of the equality of men and women, including sanctions prohibiting any form of discrimination against women.[269] Legal protection of women should be on an equal basis with

265 CEDAW, Available at http://www.ohchr.org/Documents/ProfessionalInterest/cedaw.pdf (Last visited on January 10, 2020)

266 Some landmark Judgements of the Supreme Court of India that refer to provisions of CEDAW:
Gita Hariharan (Ms.) v. RBI, (1992) 2 SCC 228; Apparel Export Promotion Council v. A.K. Chopra (1999) 1 SCC 759; Vishaka v. State of Rajasthan, (1997) 6 SCC 241; C. Masilamani Mudaliar v. Idol of Sri Swaminathaswami Mudaliar Thirukoil (1996) 8 SCC 525; Madhu Kishwar v. State of Bihar, (1996) 5 SCC 125

267 UN Women, *United Nations Entity for Gender Equality and the Empowerment of Women, Convention on the Elimination of All forms of Discrimination Against Women,* Available at http://www.un.org/womenwatch/daw/cedaw/ (Last visited on January 10, 2020)

268 The term "*discrimination against women*" is defined in Article 1 of CEDAW to mean *"any distinction, exclusion or restriction made on the basis of sex, which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."*

269 CEDAW, Article 2

men. The parties to the Convention should take all appropriate steps to eliminate discrimination against women by any person, organization or enterprise.[270] State parties should work in all fields, including social, political, cultural, economic, to ensure through legislations and policies, the full advancement and development of women.[271] This includes appropriate measures to:

- Modify social and cultural patterns discriminating between men and women;
- Ensure family education, to facilitate a proper understanding of maternity as a social function and the need to acknowledge the common responsibilities of men and women[272];
- Eliminate discrimination against women in the field of education[273] and employment[274];
- Eliminate discrimination against women in the field of health care to facilitate equal access to health care services, including appropriate services pertaining to pregnancy[275];
- Eliminate discrimination against women in the economic and social life, which includes equal access to family benefits, bank loans, mortgages, recreational activities, sports, etc.[276];
- Eliminate discrimination against women in all family matters and decisions pertaining to marriage and its dissolution.[277]

CEDAW also requires the parties to address the particular problems of women in the rural areas and address the concerns with appropriate policy measures.[278] State parties should ensure that men and women are equal before law and have equal legal capacity, including in particular

270 *Id.*
271 CEDAW, Articles 3 and 5
272 CEDAW, Article 5
273 CEDAW, Article 10
274 CEDAW, Article 11
275 CEDAW, Article 12
276 CEDAW, Article 13
277 CEDAW, Article 16
278 CEDAW, Article 14

civil rights, enter into contracts, administer properties, etc.[279]

CEDAW is particularly relevant to the present research. Women with mental illness are more vulnerable as compared to men with mental illness, for the sheer existence of vulnerabilities of women, who are susceptible to discrimination in the society, family and in matters relating to healthcare. Elimination of discrimination also requires positive action towards empowering the women to be on an equal standing to exercise their rights just like men. Mentally ill women are discriminated not only on the ground of their incapacities caused by their illness, but also because of the patriarchal setup where the plights of women are often ignored. CEDAW therefore, is a guiding light towards making sure that mental healthcare laws are gender sensitive and eliminate discriminations of any form on the basis of gender, ensuring equality in access to mental healthcare facilities, treatment, care and exercise of rights.

d. Other important UN Conventions:

The Convention on the Rights of the Child (CRC)[280] is relevant to our discussion from the perspective of female children with mental illness. Proclaiming that childhood requires special care and assistance, CRC protects the rights and duties of all members of the human family, including the children.[281] State parties to the Convention recognize that every child has the inherent right to life and the maximum possible facilities for survival and development. Among myriad other rights, Article 24 of the Convention elaborates upon the right to healthcare of every child; that is, the right of every child to enjoy the highest attainable standards of health, treatment during illness and rehabilitation. Other relevant and important United Nations instrument is the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,[282] which requires the parties to the Convention to take

279 CEDAW, Article 15

280 CRC, Available at http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx (Last visited on January 10, 2020)

281 *'Child'* is defined for the purposes of the Convention of the Rights of the Child, Article 1 as "*every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier."*

282 Available at http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx (Last visited on January 3, 2020)

effective measures, legislative, administrative, judicial, etc., to prevent acts of torture in any territory under its jurisdiction.

ii. Declarations and Conventions covering rights of persons with mental illness in particular

a. Declaration on the Rights of Disabled Persons (1975)

This Declaration was adopted by the UN General Assembly in 1975 to protect the rights and ensure the welfare of persons who are physically and/or mentally disadvantaged and for their rehabilitation and integration to a normal life.[283] The term *"disabled person"* is defined to mean a person who is incapable, because of deficiency in his/her mental capabilities, of ensuring and living a normal individual and/or social life.

- Disabled persons have the *"inherent right to respect for their human dignity"* and to the equal exercise of the fundamental rights and the same civil and political rights as are available to others[284];
- They should be able to exercise as normal a life as possible and be enabled to become as self-reliant as feasible;
- They have the right to equal physical, mental and physiological treatment as others;
- The special needs of persons with disability should be borne in mind at every stage of social and economic planning;
- Disabled persons should be facilitated to be able to live with their families and foster parents;
- If the disabled person has to stay at a specialized establishment because of his/her condition, the conditions at the establishment should be as close to a normal lifestyle as possible;
- Disabled persons should be protected from exploitation, discriminatory and abusive treatment;

283 UN Declaration on the Rights of Disabled Persons (1975), Available at http://www.ohchr.org/EN/ProfessionalInterest/Pages/RightsOfDisabledPersons.aspx (Last visited on January 3, 2020)

284 *Id.*

- They should be entitled to and have access to qualified legal aid;
- Whenever the rights of disabled persons are being considered, organization of disabled persons should be consulted about the same;

This Declaration was one of the first international documents concerning persons with disabilities. Despite the fact that the principles in this Declaration are more generic in nature and are not limited to healthcare only, this Declaration has been a guiding light for such similar instruments that came about later.

b. UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991)

The UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care were adopted by the UN General Assembly in 1991 in its plenary meeting vide Resolution A/RES/46/119.[285]

The Principles recognize *"mental health care"* to include diagnosis and analysis of the mental condition of a person, and treatment, care and rehabilitation for a mental illness or a suspected mental illness. The twenty-five principles succinctly provide for equality and well-being in mental healthcare. Some of the pertinent points covered in the principles are discussed herein below:

- Referring to the basic rights and fundamental freedoms, it is stated that best available mental health care should be made available to all without discrimination.
- The need to be treated with respect upholding the dignity of the person, and protecting him/her from economic exploitation, sexual exploitation, physical abuse, etc., is also upheld by the principles.
- Determination of the mental illness of any person should be according to the medical standards internationally accepted.

285 UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991) Available at http://www.un.org/documents/ga/res/46/a46r119.htm (Last visited on December 15, 2017)

- Past medical history should never be considered the sole factor to determine the mental illness of a person.
- Classification of a person as a person with mental illness will never be made except for matters pertaining to mental healthcare.
- Except according to the respective domestic law, no person can be compelled to undergo medical examination to determine whether he/she has a mental illness.
- Confidentiality should be protected as a right to all the persons to whom these Principles apply.
- Every person in need of mental healthcare has the right to be first and as far as feasible to be treated in his/her community; and when the treatment is undergone at a mental health facility, the person shall be treated at a mental health facility nearest to his/her home.
- The environment of treatment in mental health care should be as less restrictive as possible. The patient should be protected from any form of unnecessary medication, abuse or harm by other patients or staff at the healthcare facility, and from any other acts or situations of discomfort.
- Treatment involved in mental healthcare should be patient centric, and should be based on a prescribed plan which is prepared for each patient individually. In pursuance of the treatment, international norms of medical ethics should be strictly adhered to.[286] The treatment of each patient should strive towards enhancing the personal autonomy of the person as far as possible.
- Medication should only be administered for treatment and therapeutic purposes and never in the form of a punishment or for the convenience of someone. Medication records of the patient should be maintained, and the treatment should be prescribed by a legally authorized mental health practitioner.
- The importance of informed consent for treatment in mental healthcare is also discussed in detail.

286 *See* Shaun D. Pattinson, Medical Law and Ethics (2009); J.K. Mason, Et. Al., Mason and McCall Smith's Law and Medical Ethics (2006)

- o Obtaining the informed consent of the patient is a pre-requisite for the treatment to commence.
- o Informed consent should be a free consent without any duress or fraud, and the information provided should be in the language in which the patient is conversant.
- o The information should include the diagnosis, purpose, duration and method of the treatment process, side effects and risks of the treatment. The patient should also be apprised of the alternative treatment.
- o The patient should be given the right to request the presence of person or persons of his/her choice while giving the informed consent. However, the obtaining of informed consent may become difficult in some cases, and the treatment can be proceeded with without obtaining the consent of the patient, under the following circumstances:

- The patient is an involuntary patient at the time of the treatment; or
- An independent authority decides that the concerned treatment is in the medical interest of the patient;

However, if the personal representative of the patient is there, he/she should be the one to give the consent to the treatment. In case of a medical emergency, the qualified mental health practitioner may proceed with the treatment without obtaining the patient's informed consent, if the treatment is vital to prevent immediate or plausible harm to the patient. However, as far as possible, every attempt should be made to explain to the patient about the details of the treatment administered during mental healthcare. The medical record of the patient has to be updated regularly and should specify whether a treatment has been administered voluntarily or involuntarily.

- Involuntary seclusion and physical restraint of the patient should never take place, except according to the officially approved procedures, and should be employed only as a means of last resort, and when it is the only way possible to prevent any harm to the patient or others. Some of the important points to be taken note of here are:

- The restraint shall not be continued beyond the period necessary;
- The personal representative of the patient should be given instant notice of such a restraint or confinement;
- The instances of such restraints, the reasons for the same, the nature and duration are to be mentioned in the patient's medical record;
- A patient in seclusion or under restraint shall be kept in conditions which are humane; and
- The patient shall be under the careful supervision of the qualified staff.

- It is forbidden to carry out sterilization as a treatment for mental illness.
- Psychosurgery or any other irreversible or intrusive treatments are not to be undertaken upon an involuntary patient. In case of a voluntary patient, informed consent of the patient is mandatory along with an approval of an independent external body that the said treatment is necessary and that the consent has been freely obtained.
- No major surgical or medical procedure shall be conducted on a person with mental illness if the same is not permitted by the domestic law of the country. The same can be undertaken only when the same is necessitated for the best interest of the person and he/she has given informed consent for the same. If the patient is not in a state to give an informed consent, the procedure will only be executed if approved by an independent review by a competent body.
- Experimental treatment and/or clinical trials cannot be undertaken without the informed consent of the patient for the same. If the patient is not in a state to give an informed consent, the procedure will only be executed if approved by an independent review by a competent body.

- If there is violation of any of the aforementioned mandates, the patient or his/her representative or any interested person, for that matter, will have the right to appeal against the treatment meted out to the patient before a judicial or other independent authority appointed for the purpose in the concerned country.

c. WHO, Mental Health Care Law: Ten Basic Principles (1996)

Based on a concerted and comparative analysis of the laws pertaining to mental health in forty-five countries and taking a cue from the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, 1991, WHO adopted the Ten Basic Principles of Mental Health Care Law in 1996.[287] These principles are ancillary to the basic principles of health care in general, like confidentiality, informed consent, etc.

The Principles are enumerated herein below:

i. Promotion of mental health of all and prevention of mental disorders;

ii. Accessibility to mental health care;

iii. Mental Health Assessments to adhere to the principles internationally accepted;

iv. Mental Healthcare to be least restrictive;

v. Right to self-determination;

vi. Right to be assisted to exercise one's self-determination;

vii. Availability and accessibility to review procedure;

viii. Periodical review mechanism which is automatic;

ix. Qualified decision maker; and

x. Respect of and adherence to Rule of Law.

287 WHO, Ten Basic Principles of Mental Health Care Law (1996), Available at http://www.who.int/mental_health/policy/legislation/ten_basic_principles.pdf (Last visited on April 1, 2020)

These Principles contain the basic tenets to which mental healthcare laws of countries should also adhere. Based on the legal system of each country, these principles might not find a place in one single compiled law, but in different legal instruments combined together. The 2017 Act of India does stand tested and passed under the anvil of this test.

d. UN Convention on Rights of Persons with Disability (2006) & Optional Protocol

UNCRPD was introduced with the intention to promote respect for the inherent dignity of all persons with disabilities, by making sure that they get equal access to enjoy all human rights and fundamental freedoms. The term *"persons with disability,"* for the purposes of UNCRPD includes *"those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others."*[288]

Article 3 enumerates the general principles or tenets to which UNCRPD adheres, namely:

- Autonomy of the individual, inherent dignity, freedom of choice;
- Non-discrimination;
- Inclusion in society and the opportunity for active and full participation in societal affairs;
- Respecting diversity and accepting human diversity as an inherent aspect of humanity;
- Equality of opportunity and accessibility;
- Respecting the evolving capacity of children with disabilities and respecting their right to preserve their identity; and
- Equality between men and women.

UNCRPD was instrumental in the coming into existence of the 2017 Act in India. The Preamble of the 2017 Act states *inter alia* that the Act was introduced to align and to harmonize the existent mental healthcare laws in the country to UNCRPD.

288 UNCRPD, Article 1

Women with Disability: UNCRPD is an exhaustive instrument covering various rights of persons with disabilities. It is stated that every person with disability is entitled to respect for his/her physical and mental integrity on an equal basis and at par with the others in the society. This was the first instrument of its kind pertaining to persons with disabilities which specifically mentions about women with disabilities, the vulnerabilities faced by them and directs the member states to take necessary steps to obviate such vulnerabilities and discrimination. UNCRPD recognizes the fact that women and girls who have disabilities are more often than not at a greater risk of injury or abuse, negligent treatment, violence, exploitation and maltreatment, both within their homes and outside. Article 6 of UNCRPD discusses about women with disabilities and the need to address the predicaments faced by them. It is stated that women and girls having disabilities face discriminations which are multiple in number and nature. State parties to UNCRPD should, therefore, work towards ensuring equal and full enjoyment by them of all fundamental freedoms and human rights. Appropriate measures should also be made in order to ensure the advancement, empowerment and development of women in order to guarantee their enjoyment of various human rights and fundamental freedoms. State parties are also directed to put into place effective and appropriate legislations and policies, including women-centric and women-focused laws and policies to ensure identification of instances of violence, exploitation and abuse of persons with disabilities, and ensure that such instances are investigated and prosecuted further, thereto. State parties are also directed to ensure access by persons with disabilities, in particular women and girls who have disabilities, to programmes for social protection and poverty reduction.

Rights and freedoms: Some of the other important points of concern addressed by UNCRPD include bringing about awareness pertaining to the rights of persons with disabilities, ensuring the equality and accessibility of persons with disabilities and equal recognition before the law. The right to life is recognized as an inherent right of every individual and all the required measures should be undertaken by the member states to ensure that the persons with disabilities are able to enjoy their right to life at par with others. The right to equal recognition before the law, access to justice, liberty of person and security of person

are some other important rights recognized in the UNCRPD. Apart from the above, UNCRPD recognizes the following rights and freedoms of persons with disability:

- Freedom from torture or degrading, inhuman or cruel punishment or treatment;
- Freedom from abuse, violence and exploitation;
- Integrity of person;
- Liberty of nationality;
- Liberty of movement;
- Freedom to live independently and the right to be included in the community;
- Freedom of speech, expression, opinion and access to information;
- Personal mobility in the time and manner of one's choice and at an affordable cost;

For the pursuance of the above, state parties to UNCRPD, have undertaken to collect information, both research data and statistical data to be able to formulate and implement policies to bring their legal framework in consonance with the principles laid down in UNCRPD. For the fulfillment of the said purpose, the importance of international cooperation is also recognized. UNCRPD also sets up a Committee on the Rights of Persons with Disabilities for the fulfillment of the aims and purposes of the Convention. It is to be noted that the 2017 Act of India was introduced with the aim to make the laws pertaining to mental healthcare in India in consonance and harmony with UNCRPD.

e. WHO Mental Health Action Plan 2013-2020[289]

The 65th World Health Assembly in its resolution WHA65.4, in May 2012, on addressing the global burden pertaining to mental disorders, recognized the need for a coordinated and comprehensive response from the social and health sectors of all member nations at the national level. On the basis of the resolution culminated the WHO Mental health Action

289 Available at http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf?ua=1 (Last visited on February 5, 2019)

Plan of 2013-2020 after exhaustive and comprehensive consultation with all the member states, the civil society and the international stake holders. The Action Plan aims towards multifarious factors pertaining to mental healthcare, namely, prevention, rehabilitation, promotion, recovery and care.

The background in which the Action Plan culminated is discussed at length in the Action Plan itself:

- Scarcity of resources to meet the needs of mental healthcare
- Inequitable distribution of resources
- Inefficient usage of available resources

Global Data by WHO:

1. **Globally: Annual spending on mental health < US$ 2**
2. **Low availability of basic medicines for mental healthcare in primary healthcare facilities and less usage of the same because of lack of trained medical professionals**
3. **Low-income countries: Annual spending on mental health < US$ 0.25;**
4. **Low income countries: only 36% covered by mental health legislation;**
5. **High income countries: 92% covered by mental health legislation**

The Mental Health Action Plan proceeds on six cross-cutting binding principles in the fulfillment of the goals of the Act, namely:

i. Universal Health Coverage

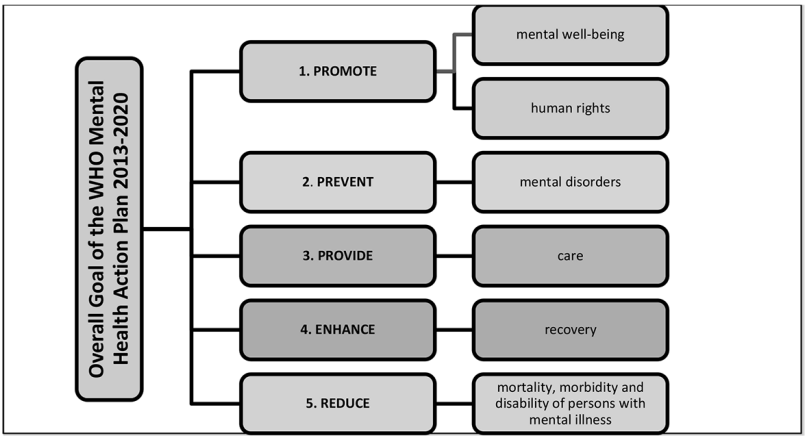
ii. Protection of Human Rights

iii. Evidence-based practice

iv. Life course approach

v. Multi-sectoral approach and

vi. Empowerment of persons with mental illness and psychological disabilities.



Overall Goal of the WHO Mental Health Action Plan 2013-2020

The WHO Action Plan aims to fulfill the following targets by the year 2020:

- 80% countries of the world to update/develop their policies pertaining to mental health and bring the same in consonance with various regional and international human rights instruments;
- 50% countries of the world to update/develop their laws relating to mental health and bring the same in consonance with various human rights instruments of regional and international nature;
- Increasing at least by 20% service coverage for severe mental disorders;
- 80% countries of the world to have at least two promotion and prevention programmes functioning at the national and multi-sectoral level pertaining to mental health;
- Reducing the world wide rate of suicides by 10%;
- 80% countries should be collecting and reporting regularly, a core set of mental health indicators at least every two years through their information systems.

The WHO Action Plan also elucidates upon the options for implementation of the afore-mentioned targets and plans in great detail.

With respect to universal health coverage pertaining to mental health, it is stated that persons with mental disorders should be in a position to access basic mental health care without running the risk of impoverishment and irrespective of differentiating factors like sex, age, race, sexual orientation, etc. Mental health treatment, strategies and inventions should be in compliance with the provisions of the United Nations Convention on Rights of Persons with Disabilities, and universally recognized best standards and practices. Apart from promoting the mental well-being, the WHO Action Plan targets towards prevention of mental disorders, providing adequate care, enhancing chances and scope for recovery, reducing the disability, morbidity and mortality of persons with mental illness and also protecting their human rights.

The WHO Action Plan takes the life course and the multi-sectoral approaches. As per the *"life course approach,"*[290] it is necessary for the policies, services and plans pertaining to mental health to take into account the social and healthcare needs at all the respective stages of life course, namely: infancy, childhood, adolescence, adulthood and old age. As per the *"multi-sectoral approach,"*[291] for a comprehensive fulfillment of mental healthcare requirements, there is a need of concerted cooperation among the public sectors pertaining to health, housing, social, education, employment and the private sector in pursuance with the specific requirements and situations of each of the member states, respectively. It is very important for the fulfillment of the above goals and the proper implementation of the mental health action plan that the persons with mental disorders or with psychological disabilities are empowered and are actively involved in mental health policy, legislation, services, advocacy, monitoring, evaluation and research.

f. Sixty-fifth World Health Assembly (Geneva, 2012): Resolution WHA 65.4

In the background of WHO Resolution WHA55.10[292] and the United Nations General Assembly Resolution 65/95,[293] and recalling the same,

290 *Id.*

291 *Id.*

292 Available at http://www.who.int/substance_abuse/en/WHA55.10.pdf (Last visited on December 15, 2020)

293 Available at http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/65/95&referer=http://www.un.org/en/ga/65/resolutions.shtml&Lang=E (Last visited on December 15, 2019)

WHO Resolution WHA 65.4[294] was passed after considering WHO Report of 2011[295] titled *"The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level."*

WHO Resolution WHA 65.4 passed in 2012 in Geneva on *"The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level"* urged its member states to take specific positive steps to alleviate the global burden of mental disorders. WHO Resolution WHA65.4 was passed taking into account the work already done and undertaken by WHO, particularly in pursuance of the Mental Health Gap Action Programme, 2008.[296] The Resolution suggested the increase in the investment in mental health for the well-being of its citizens. Investment should not only be limited to national investments, but also include multi-lateral treaties working towards the goal. The Resolution also acknowledges that mental illness culminates from attitudinal and behavioural impediments by the members of society and, therefore, need to facilitate equal participation of persons with mental illness with others in society in the background of the World Report on Disability 2011[297] which *inter alia* elaborates on the steps to facilitate the participation and the inclusion of persons with mental disabilities in society.[298]

294 Available at http://apps.who.int/gb/DGNP/pdf_files/A65_REC1-en.pdf (Last visited on December 15, 2020)

295 WHO, Report by the Secretariat, *The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level* (2011), Available at http://apps.who.int/iris/bitstream/handle/10665/23741/B130_9-en.pdf?sequence=1 (Last visited on December 15, 2020)

296 Available at http://www.mhinnovation.net/sites/default/files/downloads/resource/mhGAP%20Mental%20Health%20Gap%20Action%20Programme%20English.pdf (Last visited on April 6, 2018)

297 Available at https://www.ncbi.nlm.nih.gov/books/NBK304079/ (Last visited on April 6, 2020)

298 *See* also UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993), Available at https://www.un.org/development/desa/disabilities/standard-rules-on-the-equalization-of-opportunities-for-persons-with-disabilities.html (Last visited on January 1, 2018)

WHO Resolution WHA 65.4 urged its member states to collaborate with its Secretariat to work towards a comprehensive mental health action plan and *inter alia* to take the following specific positive steps:

- To develop policies and strategies to promote policies and strategies promoting mental health, early identification, support, care and treatment followed by recovery;
- To include in such policies the promotion and protection of the human rights of persons with mental illness particularly to tackle the issue of stigma surrounding this form of illness in the society;
- To address through these Policies, major risks pertaining to poverty and homelessness by promoting awareness among the general masses, creating opportunities for rehabilitation of persons with mental illness, enabling them to become self-sufficient by generating their own income and providing them with housing and such facilities to be able to be rehabilitated in the society;
- To identify through surveillance frameworks, various social determinants of health and, thereby, evaluate the existent trends in mental health issues in one's country;
- To give appropriate priority to mental health and to works towards streamlining mental health by:
    - o Promoting mental health;
    - o Prevention of mental disorders;
    - o Provision for support, care and treatment in programmes relating to health and development in the country; and
    - o Allocate appropriate funds to facilitate the same.

It is noteworthy that the National Mental Health Policy of India[299] was passed by the Government of India in 2014 in consonance with and in furtherance of WHO Resolution WHA 65.4.

299 National Mental Health Policy of India (2014)

2. Regional and Organizational developments pertaining to Mental Health

i. World Congress of Psychiatry - The Hawaii Declaration (1977)

The Hawaii Declaration was adopted by the 6th World Congress of Psychiatry which had assembled at Honolulu in Hawaii in 1977.[300] The Declaration was later amended by the 7th World Congress of Psychiatry in 1983 in Vienna, Italy.[301]

The Guidelines laid down in the Hawaii Declaration are considered as the minimum ethical standards which the psychiatrists across the countries should adhere to.[302] Some of the important guidelines enlisted in the Declaration are discussed herein below:

- It is the foremost duty of every psychiatrist to treat a patient to best of his/her capability, with the accepted latest scientific knowledge while adhering to the principles of ethical standards.
- Respecting the privacy and dignity of the patient is vital. The treatment should be based on mutual agreement, cooperation and trust. If establishing the same with the patient is difficult, the mutual understanding should be established with a relative or someone near to the patient.
- The patient should be informed about and presented with the opportunity to choose among the available options of treatment options and procedures.
- No treatment should be administered without the will and consent of the patient. However, if there is need for an immediate treatment to be administered to the patient and he is not in a condition to consent, then treatment can be proceeded with without the will of the patient. Whenever the conditions for compulsory treatment

300 World Psychiatric Association, The Declaration of Hawaii, Available at http://www.codex.vr.se/texts/hawaii.html (Last visited on April 6, 2018)

301 Available at http://www.wpanet.org/detail.php?section_id=5&content_id=27 (Last visited on April 6, 2018)

302 *See* also S.A.M. McLean and J.M. Mason, Legal and Ethical Aspects of Healthcare (2003); Sudhir Anand, Et. Al., Public Health, Ethics and Equity (2009)

cease to exist, such treatment should stop; and the psychiatrist is to proceed with any further kind of treatment only once the voluntary consent is obtained.

- The psychiatrist is supposed to respect and protect the dignity of his/her patients and their human rights and should not misuse this fiduciary relationship to cause harm to the patient or exploit him/her in any way.
- When a patient is presented before a class for research and analysis, informed consent of the patient is mandatory.
- All information divulged by the patient to the psychiatrist should be kept confidential by the latter, unless the disclosure of the same becomes necessary to prevent harm to the patient or someone else. The research subject/ patient should be free to withdraw the consent at any given point of time

ii. Latin America - The Caracas Declaration of Latin America (1990)[303]

In 1990, there was a Regional Conference on '*Restructuring of Psychiatric Care in Latin America within the Local Health Systems Model'* in Caracas. The Declaration states the importance of the consonance of the following approaches for psychiatric care for Latin America (countries which included Brazil, Colombia, Chile, Ecuador, Venezuela, and Panama), namely:

- Decentralized;
- Preventive, and
- Participative.

The Declaration states the significance of protecting the civil and human rights of persons in need of psychiatric care. Every attempt should be made to avoid relocation of such persons so that they can be treated and can live in their community or ordinary place of residence. The Declaration proposed reforming the laws pertaining to mental healthcare in various Latin American countries to bring them in consonance with the aims, objectives and principles of the Declaration.

303 Available at http://www1.paho.org/hq/dmdocuments/2008/DECLARATIONOFCARACAS.pdf (Last visited on February 10, 2018)

iii. Europe: The WHO European Region

The WHO European Region includes 53 member states comprising a population of around 900 million people. Majority of the member states have mental health laws and policies and have been making advancement towards community-based services in health.[304]

The WHO European Ministerial Conference on Mental Health held in Helsinki in 2005 addressed the challenges facing mental healthcare in Europe and passed the Mental Health Declaration, which was co-signed by the European Commission and the Council of Europe and endorsed by the Regional Committee. It was acknowledged that there is *"no health without mental health."* The member states of the WHO European Region, in this Ministerial Conference, passed the Mental Health Declaration for Europe in 2005, wherein it was committed to follow *inter alia* the below-mentioned measures, tailored to the needs and constitutional framework of the member states:

- Enforcing legislation and policies pertaining to mental health;
- Access impact of government's action on mental health;
- Eliminate stigma surrounding mental health;
- Affording people with mental health the choice to make decisions pertaining to their own care;
- Ensure that the legislations are anti-discrimination and sensitive;
- Aim at averting risk factors pertaining to mental health, for example by introducing sensitive and inclusive work environment;
- Enhance the role of primary healthcare in mental healthcare;
- Promote community based services;
- Provide for basic care facilities to persons with mental illness, for example, relating to health, education, employment, etc.;
- Promote development in specialized expertise in mental healthcare;

304 The European Mental Health Action Plan 2013-2020, Available at http://www.euro.who.int/__data/assets/pdf_file/0020/280604/WHO-Europe-Mental-Health-Acion-Plan-2013-2020.pdf (Last visited on April 15, 2020)

The Council of Europe and the European Commission was requested to support this Declaration passed in Helsinki.

Following is the list of various Policies and Declarations pertaining to mental health passed by European nations over the years:

- The European Pact for Mental Health and Well-being passed by the European Commission in 2008;
- Mental Health Gap Programme, 2008;
- European Union Health Programme funded Joint Action on Mental Health and Well-being in 2013;
- The European Mental Health Action Plan, 2013-2020.

It is important to analyse the European Mental Health Action Plan 2013-2020,[305] which holds immense importance for the present discussion. It adheres to the basic tenets of healthcare including gender and equity, social determinants, etc. It is further acknowledged that disorders relating to depression occur twice as commonly in women, than in men. The Action Plan emphasizes upon the need to respect the human rights of persons with mental illness and provide them with sufficient opportunities, giving them the scope to enjoy a quality life, free of discrimination and stigma. Effective, appropriate and safe treatment for mental illness is an entitlement to be available to one and all. The Plan acknowledges the need to work in close coordination with other sectors like education, research, etc.

iv. World Psychiatric Association (WPA)

WPA is an international organization of 140 psychiatric societies across 120 nations, representing more than two lakh psychiatrists.[306] The World Psychiatric Association works for the following missions[307]:

- Work towards attaining highest possible standards pertaining to clinical practice;

305 *Id.*

306 Available at http://www.wpanet.org/detail.php?section_id=5&content_id=4 (Last visited on February 5, 2018)

307 *Id.*

- Disseminate information, skills and knowledge pertaining to mental disorders, steps to prevent the same, values based practice and evidence-based therapy;
- Promote mental health for all;
- Promote the highest attainable ethical standards for psychiatric practices;
- To espouse the cause for protecting and upholding the rights of patients with mental illness, their families and psychiatrists;
- Reaching out to the isolated and impoverished sections of the society.

WPA organizes the World Congress of Psychiatry after a period of every three years. It is one of the major international scientific events in the field of psychiatry.[308] The World Congress of Psychiatry has been held by far at Madrid (1996), Hamburg (1999), Yokohama (2002), Cairo (2005), Prague (2008), Buenos Aires (2011), Spain (2014) and Berlin (2017).

v. World Federation of Mental Health (WFMH)[309]

WFMH is an international membership organization. It was founded in 1948 with the aim to promote among peoples and nations:

- The advancement of mental health;
- Prevention of mental and emotional disorders;
- Appropriate treatment and care of persons with such disorders and the promotion of mental health;
- Focus on best practices in mental healthcare globally;
- Disseminate public awareness and necessary information relating to mental healthcare among the people at large; and
- To improve the mental healthcare facilities and standards worldwide.

308 *Id.*

309 Available at https://wfmh.global/ (Last visited on February 5, 2018)

WFMH observed the World Mental Health Day for the first time on 10th October, 1992, as an annual event with the aim to promote *"mental health advocacy and education of the people on relevant issues."*[310] In the year 1996 when the fifth World Mental Health Day was celebrated, the theme was Women and Mental Health with the aim to address the concerns and vulnerabilities of women with mental illness. The World Mental Health Day, 2018, will be focusing on *"young people and mental health in a changing world."*[311]

Summarizing: This Chapter holds significance for this research work because it shows the global perspective pertaining to mental healthcare. International standards and regional and organizational developments relating to mental healthcare give the analysis of the 2017 Act a positive boost. The 2017 Act emerges from this Chapter as being globally viable, being abreast with the latest relevant legal developments world-wide, and an appropriate piece of legislation with larger aims which can be fulfilled on its implementation, if the same is done word for word.

310 World Mental Health Day, WFMH, Available at https://wfmh.global/world-mental-health-day/ (Last visited on February 5, 2018)

311 World Mental Health Day, 2018, WFMH, Available at https://wfmh.global/world-mental-health-day-2018/ (Last visited on May 5, 2018)

X. Delving into the Mental Healthcare Laws of Six other Countries

To be able to evaluate the Indian legal scenario it was very important to weigh the Indian legal framework with the World standards and requirements. This Chapter delves into the legal framework pertaining to mental healthcare and the position of women with mental illness in six countries, namely: United Kingdom, South Africa, Bangladesh, Indonesia, New Zealand and Brazil. It is a fair combination of developed and developing nations and, thereby, helps in drawing an analysis as to how the laws of countries with various socio-political and economic setups address mental healthcare in their territories, respectively. The ultimate aim of this Chapter is to widen the horizon of discussion and appreciate the Indian situation.

	Country	Mental Healthcare Legislation
1.	United Kingdom	The Mental Health Act, 1983, as amended by the Mental Health Act, 2007; and The Mental Capacity Act, 2005
2.	South Africa	The Mental Health Care Act, 2002
3.	Bangladesh	The Mental Health Act, 2014
4.	Indonesia	The Mental Health Law of 2014
5.	New Zealand	The Mental Health (Compulsory Assessment and Treatment) Act 1992
6.	Brazil	Ministerial Decrees of 1991, 1992, 1999, 2000, 2001 and Law No. 10.216 of 2001

1. United Kingdom

The United Kingdom, located in the northern part of Europe, comprises England, Scotland, Wales and the Northern Ireland. It is a Constitutional monarchy and is considered as one of the few largest economies in the world.

The Guardian, in an article titled *"Mental illness soars among young women in England,"*[312] blamed the drastic increase in chronic mental

312 Denis Campbell and Haroon Siddique, Mental illness soars among young women in

illness among women in England on sexual violence, peer pressures, childhood traumas and pressures from the social media. According to the Government funded Adult Psychiatric Morbidity survey, one in four women in England aged between 16 years to 24 years has harmed herself because she experiences mental health problems.[313] In the light of the same, the laws pertaining to mental healthcare in the United Kingdom are discussed herein below.[314]

The Mental Health Act, 2007,[315] introduced in 2007, amended the Mental Health Act 1983, the Domestic Violence, Crime and Victims Act 2004 and the Mental Capacity Act 2005.

"Mental disorder" is defined in the Mental Health Act, 2007, to mean *"any disorder or disability of the mind."* The main aim of the 1983 Act which the 2007 Act amends is to ensure that a person with mental disorder is not detained for treatment without his/her free consent. It also enumerates the safeguards to be in place and the procedures to be followed to ensure that proper treatment is meted out to the patients and that no treatment is proceeded with in the absence of his/her consent.[316] The Mental Health Act, 2007, was passed in response to the Bournewood Judgement[317] of the European Court of Human Rights where a man with autistic illness was kept in the Bournewood Hospital without his consent and against his wishes and the wishes of his caretakers. The Court held this as a violation of the principles of the European Convention on Human Rights.[318]

England – survey, The Guardian (Sep. 2016), Available at https://www.theguardian.com/lifeandstyle/2016/sep/29/self-harm-ptsd-and-mental-illness-soaring-among-young-women-in-england-survey (Last visited on October 14, 2019)

313 *Id.*;
See also Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England (2014), Available at http://webarchive.nationalarchives.gov.uk/20180328140249/http://digital.nhs.uk/catalogue/PUB21748(Last visited on October 14, 2017)

314 *See* Joan Raphael-Leff and Rosine Jozef Perelberg, Female Experience - Three Generations of British Women Psychoanalysts on Work with Women (1997)

315 The Mental Health Act, 2007, Available at http://www.legislation.gov.uk/ukpga/2007/12/pdfs/ukpga_20070012_en.pdf (Last visited on November 1, 2020)

316 *Id.*

317 HL v. UK (Application No.45508/99)

318 ECHR, Article 5

In order to address the issue of capacity/incapacity to give consent to medical treatment, the following legislations were passed[319]:

- Adults with Incapacity (Scotland) Act 2000
- Mental Capacity Act 2005 (England and Wales)
- Mental Capacity Act (Northern Ireland) 2016

It is to be noted that the Mental Health Act, 2007,[320] and the Mental Capacity Act, 2005, work in parity with each other, complementing each other in various aspects. Mental Health Act, 2007, is limited to treatment and assessment for mental disorder, whereas the Mental Capacity Act, 2005, addressed the concern of capacity to consent for treatment whether physical or mental.

The Mental Health Act, 1983,[321] as amended by the Mental Health Act, 2007, lays down the provisions pertaining to mental healthcare in the United Kingdom. Admission to hospital is categorized into compulsory admission to hospital and application for admission to hospital. Compulsory admission to hospital is further categorized into admission for the purpose of assessment, admission for the purpose of treatment, and admission for the purpose of assessment in cases of emergency. An application for admission to hospital may be made for the admission of a patient to a hospital under this Act. Permission granted in response to this application is considered as enough authority for the applicant, or any person authorised for this purpose by the applicant, to take the patient and convey him to the hospital if the situation so demands.

An application may be made in respect of a patient already in the hospital, and if the application is made, it shall be deemed that the admission has taken place from the date of the application. Any surgical operation pertaining to brain tissue, or such other form of treatment as may be prescribed by regulations, can be executed only on obtaining the consent of the person with mental illness and after getting a second

319 Tony Zigmond, Mental Health Law across the UK, 41(6) BJ Psych Bull. 305–307 (2017), Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5709677/#R5 (Last visited on March 3, 2021)

320 *See* Paul Bowen, Blackstone's Guide to the Mental Health Act, 2007 (2007)

321 The Mental Health Act, 1983, Available at https://www.legislation.gov.uk/ukpga/1983/20/contents (Last visited on March 3, 2020)

opinion of a medical practitioner for the said purpose. There is a Mental Health Review Tribunal to consider applications and references made by patients. An approved mental health professional may be appointed by a local social service authority, and the professional has the power to enter and inspect, at reasonable hours, premises in which a patient is living, if he/she has reason to believe that the patient is not being properly taken care of. Ill treatment of a patient under this Act is an offence. Any person, being an officer/staff/manager at a hospital or care home, who ill-treats or neglects a patient undergoing treatment is subject to, on summary conviction, imprisonment for a term not exceeding six months or to a fine not exceeding the statutory maximum, or to both, and on conviction on indictment, to imprisonment for a term up to 5 years or to a fine of any amount, or to both.

The laws pertaining to mental healthcare in UK are, therefore, abreast with time and are organized enough to cater to various issues relating to mental healthcare that arise or are likely to arise in the country.

2. The Republic of South Africa

The Republic of South Africa is situated in the southern-most tip of the African continent. The Constitution[322] of the Republic of South Africa prohibits unfair discrimination of people with mental or other disabilities.[323] The Mental Health Care Act, 2002,[324] is the principal statute governing mental healthcare in South Africa, which provides for treatment, care and rehabilitation of mentally ill persons.

The Mental Health Care Act, 2002, defines the term *"mental health status"* to mean *"the level of mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis."* The objects of the Act are:

- to regulate mental health care by

322 The Constitution of the Republic of South Africa, Available at http://www.justice.gov.za/legislation/constitution/SAConstitution-web-eng.pdf (Last visited on March 13, 2018)

323 The Constitution of the Republic of South Africa, Article 9(3)

324 Available at http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/legislations/acts/mental_health_care_act_17_of_2002.pdf(Last visited on March 13, 2018)

- providing for the best possible healthcare, treatment and rehabilitation facilities,
- ensuring access to mental healthcare, and
- integrating mental healthcare services into services available for general health;

- enumerating the rights and duties of mental health care users and the obligations of mental health care providers, respectively, and
- regulating matters pertaining to the property rights of persons with mental illness.

The Act requires various organs of the State to come together and ensure that mental healthcare and rehabilitation reaches at all levels of healthcare that are primary, tertiary and secondary. It promotes community based approach and aims towards protecting the rights of the mentally ill persons, thereby improving their mental health status. Mental health care is categorized into involuntary, voluntary and assisted mental healthcare, keeping in mind the facts and circumstances of each case. For the fulfillment of the aims of the Act, the Mental Health Review Boards have been set up at various levels.

The Act enumerates the following rights and duties pertaining to mental health care users:

1.	Respect human dignity and privacy	• Aiming towards improving mental capacity of the user; • Facilitate his/her reintegration into the community; • Intrusion by the healthcare to be proportionate to the mental status of the user.
2.	Consent by the mental health care user	• Care; • Treatment; • Rehabilitation services; • Admission to mental health establishment.

3.	No unfair discrimination	Receive health care, treatment and rehabilitation services according to the standard applicable to any other healthcare user.
4.	Not to be exploited and abused	Every person, organization or body providing mental health care should ensure: • that the users of mental healthcare are not exploited or abused, • that they are not subject to forced labour, and • are not punished for the convenience of others.
5.	Determining the mental health status	To be based on factors exclusively relevant for the mental health status of the user of mental healthcare.
6.	Non-disclosure of information	Non-disclosure of information which the mental health user is entitled to keep private and confidential
7.	Limitation to adult intimate relationship	Only if the ability to consent of the mental healthcare user is diminished due to mental illness
8.	Right to representation	The mental healthcare user is entitled to representation, including legal representation
9.	Right to get discharge report	The user has the right to get discharge report from the establishment where he/she was admitted for mental healthcare, treatment or for availing rehabilitation services.
10.	Knowing one's rights	A health care provider must inform the user of his/her rights under the Mental Health Care Act, 2002.

Rights and Duties pertaining to mental health care users under the Mental Health Care Act, 2002

The disparity in the letter of the law and the ground level situation is, however, humongous. Mental health is an impending and vital public health issue in the country.[325] A study reported in 2014 at a South African local newspaper stated that one-third of South Africa's population suffers from mental illness, and over seventy-five percent of them do not receive or have access to mental healthcare facilities.[326] Juveniles receiving treatment at these facilities have been raped or run the risk of being raped.[327] Establishments are under-staffed, and the facilities for rehabilitation of these patients are not strong enough for them to recoup into normal life.[328] Implementation of the law and proper enforcement mechanism, it is submitted, can help in obviating such a situation and in fulfilling the aims of the 2002 Act. Funding and support of the State in this regard is indispensable.

3. People's Republic of Bangladesh[329]

Bangladesh is a country located in southern part of Asia. It shares its geographical boundaries with India and Myanmar. There is a higher prevalence of mental disorders among the economically weaker sections of Bangladesh, particularly more in women than in men; more so because women are considered the more vulnerable sex of society.[330]

325 Catherine E Draper, et. al., *Mental Health Policy in South Africa: development process and content,* 24. 342-356 (2009)Health Policy and Planning, Available at https://academic.oup.com/heapol/article/24/5/342/586799 (Last visited on March 3, 2020)

326 SA's Sick State of Mental Health, Sunday Times (6th July, 2014), Available at http://www.sadag.org/index.php?option=com_content&view=article&id=2178:sa-s-sick-state-of-mental-health&catid=74&Itemid=132 (Last visited on March 3, 2020)

327 *Id.*

328 Catherine E Draper, et. al., *Mental Health Policy in South Africa: development process and content,* 24. 342-356 (2009) Health Policy and Planning, Available at https://academic.oup.com/heapol/article/24/5/342/586799 (Last visited on March 3, 2018)

329 *See* also WHO, *WHO-AIMS Report on Mental Health System in Bangladesh* (2007), Available at http://www.who.int/mental_health/bangladesh_who_aims_report.pdf (last visited on March 17, 2020)

330 *See* M.E.Karim, M.M. Zaman, National Institute of Mental Health & Hospital (Bangladesh), WHO Bangladesh: Prevalence, Medical Care, Awareness and Attitude Towards Mental Illness in Bangladesh (2007)

Social stigma attached to mental illness, many a time, prevents these women from coming out and accepting their mental illness and getting treated for the same.[331]

An article published in 2014 in BMC Psychiatry discusses *inter alia* how the mental healthcare dynamics in Bangladesh are very similar to that in its neighbouring countries, particularly India and Pakistan.[332] It also states that Bangladesh, being essentially a male dominated nation, the women with mental illness are more likely to remain neglected and, thereby, do not receive the required mental healthcare and treatment.[333] Despite having a three-tier healthcare system, inadequate mental health professionals, coupled with less infrastructural support in this sphere, comes in the way of the mental healthcare delivery.[334]

The Mental Health Act, 2014,[335] is the principal statute governing mental healthcare in Bangladesh which provides for treatment, care and rehabilitation of mentally ill persons. The Act repeals the Mental Health Act 1986.

The Mental Health Act, 2014, lays down the legislative scheme for the treatment of persons with mental illness and their assessment; establishes the Mental Health Tribunal and the Mental Health Complaints Commissioner; and appoints the chief psychiatrist. The term used in the Act is *'consumer'* for any person who has received or is receiving mental health services or has sought or is seeking such services. It aims towards providing treatment and care in the least restrictive way, thereby, respecting the rights of the persons receiving the treatment. Informing such persons of their rights is therefore of

331 *See* also A.K. Chowdhury, M.N. Alam, Dasherkandi Project Studies. *Demography, morbidity and mortality in a rural community of Bangladesh.* Chowdhury AK, Bangladesh Med Res Counc Bull. (1981)

332 M.D. Hossain, et. al., *Mental Disorders in Bangladesh: A Systematic Review,* BMC Psychiatry (2014), Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4149198/ (Last visited on March 5, 2020)

333 *See* also N.A. Jahan, *Women's Mental Health - their problems, their disorders,* Bang J Psychiatry (2001)

334 M.D. Hossain, et. al., *Mental Disorders in Bangladesh: A Systematic Review,* BMC Psychiatry (2014), Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4149198/ (Last visited on March 5, 2020)

335 The Mental Health Act, 2014, Available at http://www.astss.org.au/wp-content/uploads/2016/01/14-026aa-authorised.pdf (Last visited on March 13, 2020)

vital importance. Treatment is encouraged to be participative, so that the person undergoing treatment can exercise his/her decision making right.

The Act lays down the following *"mental health principles"* which the mental health care providers are duty-bound to adhere to when administering treatment/care under this Act:

- Treatment to be in the least restrictive way possible, respecting the rights, dignity and autonomy of the person receiving mental health services[336];
- Mental health services should aim towards bringing out the best possible therapeutic outcome for the person receiving mental health services;
- Active involvement in the decision-making process pertaining to treatment and healthcare by the person receiving mental health services and by his/her carers;
- The medical and other health needs and the individual needs of the persons receiving mental health services should be respected and protected;
- Particular care should be taken to address the interests of children or young persons receiving mental health services.

The Act introduces two concepts, namely that of "statement of rights" and "advance statements." A statement of rights is a document that lays down the rights of the person being assessed or receiving treatment under the Act and comprises the process of such assessment or treatment, as the case may be. It is the duty of an authorized psychiatrist to ensure that when the statement of rights is handed to such a person, he/she is given an oral explanation of what is contained in the statement of rights. An advance statement is a document that sets out a person's preferences with respect to treatment under the Act, in the event that he/she becomes a patient in need of mental healthcare in the future. An advance statement has to be in writing, signed by the person making the statement, should be dated,

336 *See* also The Daily Star, Draft Bangladesh Mental Health Act, 2014: Rights Perspective (2015), Available at http://www.thedailystar.net/draft-bangladesh-mental-health-act-2014-rights-perspective-51534 (Last visited on March 12, 2018)

and should also be signed by an authorized witness who attests to the fact that the person making the statement has the capacity to understand his/her statement *presently. An advance statement may be revoked by the person making the statement. Making of a new advance statement also has the effect of revoking the previous statement.

The 2014 Act is, therefore, a beacon of hope for the mental health delivery system in Bangladesh. By providing for consent, autonomy and active involvement in the decision-making process by the person receiving the mental health services, the 2014 Act gives scope for justice and equality in the mental healthcare system in Bangladesh.

4. Republic of Indonesia

Republic of Indonesia is a trans-continental sovereign island state located predominantly in South-East Asia having some territories in Oceania. It comprises over thirteen thousand islands.

In 2016, Human Rights Watch came out with a report titled, *"Indonesia: Treating Mental Health with Shackles"*[337] which tore open to the world the harsh reality of the mentally ill in Indonesia, who have been confined inside walls, shackled with chains, abused and treated worse than animals. This was followed by reports from the CNN,[338] Al Jazeera,[339] the Guardian,[340] TIME,[341] Huffpost[342] and multiple articles in various legal and health journals across the globe.

337 HRW, *Indonesia: Treating Mental Health with Shackles* (2016), Available at https://www.hrw.org/news/2016/03/20/indonesia-treating-mental-health-shackles (Last visited on February 10, 2020)

338 Kathy Quiano, *Living in chains: In Indonesia, mentally ill kept shackled in filthy cells* CNN (2016), Available at https://edition.cnn.com/2016/03/20/asia/indonesia-mental-health/index.html (Last visited on February 10, 2018)

339 Mentally ill in Indonesia shackled and locked up, Al Jazeera English (2016), Available at https://www.youtube.com/watch?v=-Vkvulgc2s4 (Last visited on December 12, 2020)

340 Sam Jones, *'Living in hell': mentally ill people in Indonesia chained and confined,* The Guardian (2016) Available at https://www.theguardian.com/global-development/2016/mar/21/living-in-hell-indonesia-mentally-ill-people-chained-confined-human-rights-watch-report (Last visited on December 12, 2017)

341 Thousands of Mentally Ill Indonesians Are Imprisoned in Shackles, Report Says, TIME, Available at http://time.com/4265623/indonesia-mental-illness-chains-pasung-hrw/ (Last visited on December 12, 2017)

342 Kathryn Snowdon, *Indonesia's 'Horrifying' Mental Health Services Exposed By Human Rights Watch* (2016) Available at http://www.huffingtonpost.co.uk/entry/indonesias-horrifying-mental-health-services-exposed-by-human-rights-watch_uk_56efeed6e4b0cc1ede8c53f2 (Last visited on December 12, 2020)

According to HRW, around 57000 people in Indonesia with mental illness or perceived mental illness had been confined and put into shackles at least once in their lifetime. Pasung, the practice of restraining or confining mentally ill persons, though banned in Indonesia in 1977, was found prevalent even now.[343] The entire country has only 48 mental health institutions and around 600-800 psychiatrists. Due to lack of access to mental health facilities, families land up shackling their relatives with mental illness within the confines of their homes.[344] Fear of stigma and embarrassment by the family, leads such confinements, most often, to be absolute in nature and perpetual in duration.[345]

There is over-crowding in the mental health institutions raising the risk of incidences of exploitation and sexual abuse, especially of women patients. Female wards are mostly open, and staff members, including the male staff, have access to the wards all 24 hours, thereby making female patients very vulnerable and victims of sexual perpetration and violence.[346] Patients are almost everywhere forced to eat, sleep, urinate and excrete in the same confined place, making life for them a living hell. Treatment administered ranges from that by *"magical herbs,"* religious recitations and involuntary electro-convulsive therapy without anesthesia.[347] Not a single patient present in these institutions claimed to be a voluntary patient; most of them had been dumped by their families or were found abandoned and were languishing in these institutions against their will.[348]

343 *See* Harry Minas & Hervita Diatri, Pasung: *Physical restraint and confinement of the mentally ill in the community,* International Journal of Mental Health Systems (2008) Available at https://ijmhs.biomedcentral.com/articles/10.1186/1752-4458-2-8 (Last visited on January 15, 2020)

344 Kriti Sharma, *Break the Shackles of Stigma on Mental Healthcare in Indonesia,* Human Rights Watch (2014) Available at https://www.hrw.org/news/2014/09/16/break-shackles-stigma-mental-health-care-indonesia (Last visited on October 19, 2017)

345 Human Rights Watch, *Indonesia: Treating Mental Health with Shackles* (2016), Available at https://www.hrw.org/news/2016/03/20/indonesia-treating-mental-health-shackles (Last visited on February 10, 2018)

346 *See* also Movement for Global Mental Health, *'Living in Hell'*: mentally ill people in Indonesia chained and confined, Available at http://www.globalmentalhealth.org/category/country/indonesia (Last visited on October 19, 2017)

347 HRW, *Indonesia: Treating Mental Health with Shackles* (2016)

348 *See* also The ASEAN Secretariat, *ASEAN Mental Health Systems* (2016), Available at http://asean.org/storage/2017/02/55.-December-2016-ASEAN-Mental-Health-System.pdf (Last visited on February 10, 2020)

The Mental Health Law of 2014 of Indonesia lays down a national mental health policy and various local mental health policies to address the concerns of mental healthcare of persons with mental illness and to protect their human rights. The promotion of mental health is aimed at:

- Improving the level of community health;
- Eliminating stigma, human rights violations;
- Improving understanding, awareness and community participation;
- Increasing public acceptance and participation towards mental healthcare.

The law requires preventive measures to be implemented in the family, community and various institutions, to have a holistic approach to the entire issue. The mental health curative efforts should aim towards recovery, reduction of suffering and controlling the disability. The law sets up the Mental Health Service system which includes basic mental health services and referral mental health services. Human resource planning should be conducted by the Government according to the law, through procurement of human resources in the field of mental health in the government and community level through education, training and sensitization.[349]

There is a dearth of literature analyzing the impact of the introduction of the 2014 Act in Indonesia. It can be stated that implementation of the law and proper redressal of justice still remain matters of concern pertaining to mental healthcare in the country.

5. New Zealand

New Zealand is an island nation located in the south-western Pacific Ocean. It includes the South Island, the North Island and six hundred small islands. New Zealand is very rich in biodiversity, being one of the last pieces of lands discovered by humans. It is a high-income economy.

349 Available at https://translate.google.co.in/translate?hl=en&sl=id&u=https://kabarlgbt.files.wordpress.com/2016/02/uu_no_18_2014-2.pdf&prev=search (Last visited on July 23, 2020)

The New Zealand Bill of Rights Act, 1990,[350] enumerates the rights of the people of New Zealand, including their right to life and security. The rights also include the right to refuse medical treatment. An exception to the same has been drawn with respect to persons with mental illness in need of treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992.[351]

The 1992 Act is the primary legislation pertaining to mental healthcare in New Zealand.[352] The main aims of the Act, as stated in the Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992, are[353]:

- defining the circumstances under which compulsory assessment and treatment may occur;
- ensuring that vulnerable persons are protected from any form of harm;
- ensuring that the public at large is protected from any harm;
- protecting the rights of patients and proposed patients;
- assessment and treatment should be done in the least restrictive manner possible;
- ensuring good clinical practice;
- ensuring accountability for actions taken by virtue of the Act.

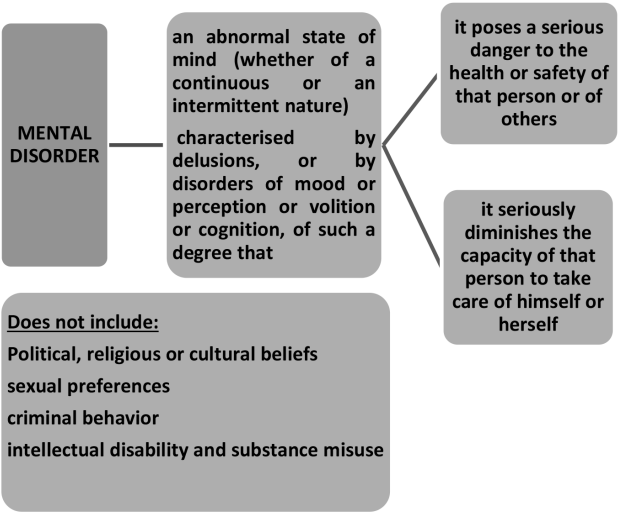
Section 2 of the Act defines mental disorder in relation to a person.

350 Available at http://www.legislation.govt.nz/act/public/1990/0109/latest/DLM224792.html (Last visited on April 3, 2020)

351 Available at http://www.legislation.govt.nz/act/public/1992/0046/latest/DLM262176.html (Last visited on January 3, 2020)

352 *See* also the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, Available at http://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/ (Last visited on April 5, 2018)

353 Available at https://www.health.govt.nz/system/files/documents/publications/guide-to-mental-health-act.pdf (Last visited on January 3, 2018)



Definition of "mental disorder" under the Mental Health (Compulsory Assessment and Treatment) Act 1992

A person can request a mental health assessment of any person under the Act. The same has to be supported by the recommendation of the registered medical practitioner and the person's general practitioner. A specialist psychiatrist must conduct the clinical assessment for the pursuance of the same. Registered Duly Appointed Officers oversee the functioning of this provision of this Act to avert any miscarriage of justice under the Act. Period of assessment may be for 5 days initially and then extended to a further period of 14, days if need be. Despite the provision for compulsory treatment it is mandatory to obtain the consent of the patient at the earliest if he has the ability to consent.[354] A patient may be declared as a restricted patient presenting special difficulties by a declaration by the Director of Mental Health Services on reference by the Judge before whom the matter is pending.

The Act lays down various rights of patients undergoing treatment under the Act, namely:

354 The Mental Health (Compulsory Assessment and Treatment) Act, 1992; and Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act, 1992

- General right to information;
- Respect for their cultural identity;
- Right to appropriate treatment;
- Right to be informed about the treatment;
- Right to get psychiatric advice which is independent;
- Right to get legal advice;
- Right to company and seclusion;
- Right to receive letters, postal articles and, also, visitors;
- Right to make phone calls; and
- Right to make complaints in case of breach of rights.

If a complaint is made by, or on behalf of, a patient that any of his/her rights under the Act have been breached, the matter has to be referred to a district inspector who will proceed with the investigation and arrive at a decision under this Act, accordingly.

In addition to the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996[355] protects the rights of persons with mental illness. It is mandatory to treat patients undergoing mental treatment with respect, dignity and independence. Such persons have the right to not be discriminated against, to get certain standards of care and to get the opportunity to make informed choices, etc.[356] Patients also enjoy the right to privacy including the privacy pertaining to one's medical information under the Privacy Act, 1993.[357] It can be concluded that the laws in New Zealand are well-placed and cater to various aspects of mental healthcare in the country quite aptly.

355 Available at http://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/ (Last visited on April 5, 2018)

356 Ian Soosay and Rob Kydd, *Mental Health Law in New Zealand,* BJPsych Int. 13(2): 43–45 (2016), Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5619622/ (Last visited on April 10, 2020)

357 The Privacy Act, 1993, Available at http://www.legislation.govt.nz/act/public/1993/0028/latest/DLM296639.html (Last visited on April 5, 2020)

6. Federative Republic of Brazil

Brazil is a country in the continent of South America, and spreads over an area of around 8.5 million kilometers square. It is a stark example of contrasts; reason being that it is one of the prospering economies in the world according to its GDP, and it is at the same time also classified as a lower middle income country by the World Bank on the basis of its HDI.[358]

In 1990, there was a Regional Conference on *"Restructuring of Psychiatric Care in Latin America within the Local Health Systems Model"* in Caracas.[359] The Declaration states the significance to protecting the civil and human rights of persons in need of psychiatric care. Following the Caracas Declaration, Brazil has since 1991 undertaken quite a few positive steps towards restructuring its psychiatric care regime.[360]

Discussed herein below are some of those significant legal reforms in Brazil[361]:

- **Ministerial Decree No. 189 (1991):** The Decree aimed at improving the quality of attention that was being meted out to persons with mental illness by funding instrumental mental health services and programmes including therapeutic workshops.
- **Ministerial Decree No. 224 (1992):** This Decree required psychiatric care to incorporate multi-professional teams, ensuring that service and healthcare is continuous and consistent at all stages.
- **Ministerial Decree No. 1077 (1999):** This Decree provides for access to basic drugs and facilities for mental healthcare, thereby

358 Mario D Mateus, *The mental health system in Brazil: Policies and future challenges,* International Journal of Mental Health Systems 2:12 (2008), Available at https://www.researchgate.net/publication/23241126_The_Mental_Health_System_in_Brazil_Policies_and_Future_Challenges (Last visited on July 23, 2020)

359 Available at http://www1.paho.org/hq/dmdocuments/2008/DECLARATIONOFCARACAS.pdf (Last visited on February 10, 2018)

360 Mónica Bolis, *The Impact of the Caracas Declaration on the Modernization of Mental Health Legislation in Latin America and the English-speaking Caribbean,* Available at http://citeseerx.ist.psu.edu/viewdoc/download? doi=10.1.1. 525.8287&rep=rep1&type=pdf (Last visited on December 5, 2017)

361 *Id.*

requiring the states and also authorities at the municipal level to have a permanent programme to make basic mental health drugs available at all times.

- **Ministerial Decree No. 106 (2000):** This Decree established the Residential Therapeutic Services for Mental Health under Brazil's National Health System. The Residential Therapeutic Services provides for houses in the premises of communities where the persons with mental illness who do not have a family to go back to can live, including persons who have been released from long-term stay at hospitals for mental healthcare treatment.
- **Ministerial Decree No. 799 (2000):** This decree establishes the mechanism for auditing of the various mental health services in the country, including regular supervision of mental healthcare facilities in hospitals.
- **Law No. 10.216 (2001):** This Law mandates the State to ensure the protection of the rights of persons with mental health *system/ issues and, also, reorients the mental healthcare regime in the country on the following lines, namely:
  - o Non-discrimination on the grounds of race, sex, colour, nationality, family, etc.;
  - o Rights of persons requiring mental healthcare and their families, including the access to best possible health care, protection from abuse, informed consent, therapeutic treatment involving less invasive treatment, etc.
  - o Role of the State to develop the national mental health policy and play a positive role in furtherance of the policy;
  - o Regulating involuntary admissions for mental healthcare in hospitals;
  - o Rehabilitation and psychological assistance to be provided to long-term patients of mental healthcare in hospitals;
  - o Psychiatric hospitalization should be preceded by well-researched findings;

- Regulating admission to hospitals for mental healthcare, respecting the decision-making power of the person and the opportunity of the family to play a role in the same, the need for hospitalization, etc.[362]

The *"return home programme*" existent in Brazil provides for rehabilitation of persons with mental illness and their social inclusion during and after recovery. Patients who have had a long stay at hospitals for mental healthcare are provided with a monthly benefit to rehabilitate them and facilitate them towards self-dependence over time.[363] It is submitted that the rehabilitation policy in Brazil is something that the Indian legal system could take a cue from.

7. Concluding

The Mental Healthcare Act, 2017 of India came into force very recently, that is, from 29th May, 2018,[364] in furtherance of the aims of the UNCRPD. After having delved into the legal framework of the afore-discussed six countries in this Chapter, and after having analysed the provisions of the Mental Healthcare Act, 2017, one is bound to appraise the provisions of the 2017 Act. It can therefore be concluded by stating that the 2017 Act is a compilation of the best practices pertaining to mental healthcare laws across the world, and it stands fairly passed on the anvil of juxtaposition to the laws on mental healthcare in the six countries that were discussed in this Chapter.

362 *See* also WHO-AIMS Report on Mental Health System in Brazil, Available at http://www.who.int/mental_health/evidence/who_aims_report_brazil.pdf (Last visited on July 23, 2020)

363 Mario D Mateus, *The mental health system in Brazil: Policies and future challenges,* International Journal of Mental Health Systems 2:12 (2008), Available at https://www.researchgate.net/publication/23241126_The_Mental_Health_System_in_Brazil_Policies_and_Future_Challenges (Last visited on July 23, 2020)
See also Sônia Barros and Mariana Salles, Mental health care management in the Brazilian National Health System, Rev. esc. enferm. USP vol.45 no.spe2 São Paulo Dec. (2011), Available at http://www.scielo.br/scielo.php?pid=S0080-62342011000800025&script=sci_arttext&tlng=en (Last visited on July 23, 2020)

364 Notification No.: S.O. 2173(E), Ministry of Health and Family Welfare, Government of India (29th May, 2018)

XI. Conclusion and Suggestions

1. The Constitution of India - the Constitutionality & Legality of the Mental Healthcare Act, 2017

The Preamble to the Constitution of India upholds the ethos of dignity, equality and justice, in the background of which is the indispensable right to life and personal liberty guaranteed under Article 21 of the Constitution of India. Right to life entails within its ambit the right to live with dignity, the right to healthcare,[365] the right to privacy, the right to a home and family, the right not to be ill-treated or tortured and the right to make one's own decisions, etc.[366] Right to equality includes not only the right to be treated equally and be given equal opportunity, but also the right not to be discriminated against arbitrarily. Equality includes equality of opportunity, of freedom, and an independent decision-making right in one's economic, social and cultural setup.

Persons with mental illness are the weaker sections of this society, sometimes requiring aid in decision-making and care-takers to address their needs.[367] This necessitates the need for the law to particularly protect the right to privacy of persons with mental illness and their right to autonomy to the extent exercisable.

The Hon'ble Supreme Court of India in the landmark Judgement of *Justice K.S. Puttaswamy (Retd.) v. Union of India*[368] upheld the right to privacy as a fundamental right, covered under the right to life guaranteed under Article 21 of the Constitution of India, and discussed privacy from the context of *"freedom of choice."* The Court held that the freedoms of an individual under Article 19(1) of the Constitution of India can only be fulfilled when the individual has the right to choose his/her preferences pertaining to those freedoms.[369] Read with Article 21, the freedom and

365 Andrew Clapham, Et. Al., Realizing the Right to Health (2009)

366 *See* Lata Singh v. State of Uttar Pradesh, AIR 2006 SC 2522; Shakti Vahini v. Union of India and Ors. W.P. Civil No. 231 of 2010 (Supreme Court of India); Paschim Bangal Khet Mazdoor Samity v. State of West Bengal, AIR 1996 SC 2426; Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1; State of Punjab v. Ram Labhaya Bagha, AIR 1998 SC 1703

367 *See* Marc Stauch MA, Et. al., Text, Cases and Materials on Medical Law and Ethics (2012)

368 (2017) 10 SCC 1

369 *See* Mary Donnelly, Healthcare Decision-Making and the Law – Autonomy, Capacity and the Limits of Liberalism (2010)

liberty envisaged in Article 19 of the Constitution of India entails with it the right of the person to choose factors pertaining to various facets of his/her life, including what to eat, where to live, how to live, who to live with, healthcare and various other vital life decisions. Right to privacy is indispensable for a person's dignity and, thereby, recognizes his/her autonomy to make choices that have the potential of affecting his/her life.[370] From the very crux of this Judgement of the Hon'ble Supreme Court in *Justice K.S. Puttaswamy (Retd.) v. Union of India,*[371] the constitutionality of psychiatric advance directives under the Mental Healthcare Act, 2017, can be seen to ensue. The right of a person with mental illness to decide the way he/she wants/does not want to be cared for and treated is very much his/her *"freedom of choice"* to decide upon the vital factors about treatment and care during mental illness, in which, because of the provision of psychiatric advance directive, he/she has the power and privilege to decide about the same in advance. The Hon'ble Supreme Court in its landmark Judgement *in Common Cause (A Regd. Society) v. Union of India and Another*[372] delivered this year, upheld the constitutionality of passive euthanasia and laid down guidelines for advance directive pertaining to the same. Even though such an advance directive is different from the psychiatric advance directive issued under the 2017 Act; nevertheless, they both are advance directives with respect to their basic feature (basic features being: issued by the person when he/she is of sound mind, to be executed when he/she is unable to give consent); which implies the approval to the constitutionality of the concept of advance directives in general, given by the Hon'ble Supreme Court of India.[373]

Rights of persons with mental illness are the same as that of any other persons, but the role of the State to respect and protect the rights of these persons is more active. The rights of persons with mental illness envisaged in Chapter V of the 2017 Act are in the reflection of the rights laid down in the United Nations Convention on Rights of Persons with Disabilities. It is also important to note that these rights take after the fundamental rights in Part III of the Constitution of India, either directly

370 Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1

371 (2017) 10 SCC 1

372 W.P. (CIVIL) NO. 215 OF 2005

373 Judgement Common Cause (A Regd. Society) v. Union of India and Another, W.P. (CIVIL) NO. 215 OF 2005

or through various landmark Judgements of the Hon'ble Courts in the country.[374]

The 2017 Act provides for the setting up of, and assigning of duties to, Mental Health Authorities at the Central[375] and State[376] level, Mental Health Boards.[377] It lays down the duties of the appropriate government;[378] and provides for registration, recognition and regulation of mental health establishments[379] for the purposes of this Act, and the admission, treatment and discharge of persons in need of mental healthcare.[380] Sections 107 to 109 of the Act provide for punishments and penalties for violation of various provisions of the Act, respectively. These provisions, it is submitted, have the capacity to pave the way for proper implementation of the rights guaranteed under the 2017 Act in time to come. However, it is pertinent to note that the successful implementation is possible only if it is accompanied by massive flow of fund from the Central Government to various State Governments which are already grappling with inadequate medical infrastructure at district levels.[381] The National Health Policy, 2017,[382] aims to raise the public healthcare expenditure from 1.4% to 2.5% of GDP. Public healthcare includes within its ambit mental healthcare, and the National Health Policy, 2017, aims to consider the provisions of the National Mental Health Policy of India, 2014. The National Health Policy, 2017, could, resultantly, prove to be pivotal in fulfilling the aims of the 2017 Act.

374 *See* Lata Singh v.State of Uttar Pradesh, AIR 2006 SC 2522; Shakti Vahini v. Union of India and Ors. W.P. Civil No. 231 of 2010 (Supreme Court of India); Paschim Bangal Khet Mazdoor Samity v. State of West Bengal, AIR 1996 SC 2426; Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1; State of Punjab v. Ram Labhaya Bagha, AIR 1998 SC 1703

375 The 2017 Act, Chapter VII

376 The 2017 Act, Chapter VIII

377 The 2017 Act, Chapter XI

378 The 2017 Act, Chapter VI

379 The 2017 Act, Chapter X

380 The 2017 Act, Chapter XII

381 Raghuraj Gagneja, *Mental Healthcare Bill: Despite the positive reform, a lot more needs to be done for the mentally ill,* FIRSTPOST (April 8, 2017), Available at http://www.firstpost.com/india/mental-healthcare-bill-despite-the-positive-reform-a-lot-more-needs-to-be-done-for-the-mentally-ill-3373156.html (Last visited on May 10, 2020)

382 The National Health Policy, 2017, Available at http://cdsco.nic.in/writereaddata/National-Health-Policy.pdf (Last visited on May 10, 2017)

When undergoing treatment, a woman with mental illness is in the most vulnerable of states. The2017 Act will play a pivotal role in ensuring that the vulnerabilities of such women requiring and undergoing mental healthcare are not exploited. The provisions of the Act are progressive and are a welcome change. Proper implementation of the legal provisions word for word will lead to the ultimate success of this legislation.[383]

2. Testing the Mental Healthcare Act, 2017, on the anvil of the WHO Checklist on Mental Health Legislation

Having tested the Mental Healthcare Act, 2017, on the anvil of the Constitution of India and the mandates of the United Nations Convention on the Rights of Persons with Disabilities, the final stage of critical evaluation of the new law was done in this research through evaluating its contents on the WHO Checklist on Mental Health Legislation[384] The WHO Resource Book on Mental Health, Human Rights and Legislation (2005)[385] comprises the WHO Checklist on Mental Health Legislation.[386] The Checklist is aimed at helping the law makers of various countries in evaluating the comprehensiveness of their mental health legislation and/or assists them in drafting a new legislation on the matter. The provisions of the Mental Health Care Act, 2017, were tested by the author through the checklist[387] and out of the 175 requirements mentioned in the checklist, the provisions of the 2017 Act cover 149 requirements. It is noteworthy that some of the requirements in the checklist, like reservation, education, etc., have been covered under the Rights of Persons with Disabilities Act, 2016, and hence do not find mention in the 2017 Act. As a whole, the mental healthcare legal framework in India presently covers the requirements specified in the WHO Checklist fairly well.

383 *See* Dr. Lily Srivastava, Law and Medicine (2010)

384 WHO Checklist on Mental Health Legislation, Annexure 1 of The WHO Resource Book on Mental Health, Human Rights and Legislation (2005), Available at https://ec.europa.eu/health/sites/health/files/mental_health/docs/who_resource_book_en.pdf (Last visited on April 5, 2020)

385 The WHO Resource Book on Mental Health, Human Rights and Legislation (2005), Available at https://ec.europa.eu/health/sites/health/files/mental_health/docs/who_resource_book_en.pdf (Last visited on April 5, 2020)

386 WHO Checklist on Mental Health Legislation, Annexure 1 of The WHO Resource Book on Mental Health, Human Rights and Legislation (2005), Available at https://ec.europa.eu/health/sites/health/files/mental_health/docs/who_resource_book_en.pdf (Last visited on April 5, 2020)

387 *See* Annexure 2

3. Addressing stigma, discrimination and exclusion[388] of women with mental illness in the country

Stigma is one of the worst aspects of mental illness that a woman faces because of her condition. Ostracizing, non-recognition, abandonment ensue from the stigma attached to mental illness in the society.[389] Paragraph 5.3.1 of the National Mental Health Policy of India, 2014, requires the government to address the stigma associated with mental illness in the Indian society and the discrimination and exclusion meted out to persons with mental illness. Section 30 of the 2017 Act requires the Appropriate Government to take all possible measures to ensure that various programmes to reduce stigma relating to mental illness should be planned, funded, enforced and implemented effectively. One of the major features of such programmes being, generating awareness by disseminating information and making various sections of the society sensitive to the issue of mental illness.

Each of the above provisions requires a positive and active role of the government and the implementation authorities. The 2017 Act imposes a duty on the appropriate government not only to plan and design, but also to implement programmes promoting mental health and preventing mental illness;[390] one of these programmes being those aiming at reducing suicides and attempted suicides in India.[391] In furtherance of the same, the Appropriate Government is required to take the following measures[392]:

- Giving wide publicity to the 2017 Act through public media at regular intervals, namely through television, radio, electronic and print media;

388 The 2014 Policy, Para 5.3.1

389 Christie Hunter, *Understanding and reducing the stigma of mental illness in women*, Women's Health Research Institute, Available at http://www.womenshealth.northwestern.edu/blog/understanding-and-reducing-stigma-mental-illness-women (Last visited on April 1, 2018)

390 The 2017 Act, Section 29(1)

391 The 2017 Act, Section 29(2);
It is to be noted that Section 115 of the 2017 Act decriminalizes attempt to commit suicide. It is stated that notwithstanding the provisions of Section 309 of the Indian Penal Code, any person who attempts to commit suicide should be presumed to be under severe stress and should not be tried or punished under the Indian Penal Code for the attempt to commit suicide.

392 The 2017 Act, Section 30

- Programmes to reduce stigma relating to mental illness to be planned, funded, enforced and implemented effectively;
- The Government officials including police officers and other officers to be periodically sensitized and be provided awareness and training on matters pertaining to this Act.

The 2017 Act, read with the National Mental Health Policy of India, 2014, therefore, addresses the socio-cultural vice of stigma surrounding mental illness by disseminating information and creating awareness; thereby, aiming towards clearing the cobwebs of stigma relating to mental illness in Indian society.

4. Positive role of the Appropriate Government under the Mental Healthcare Act, 2017

The Appropriate Government[393] is required by the 2017 Act to increase the human resources in mental health services by developing education and training programmes in coordination with institutions of higher education. It is also important to improve the skill of existent human resources by updating them with the latest developments and advancements made in the area of mental healthcare. The Appropriate Government has to take up the responsibility to train the medical officers in public healthcare establishments and the medical officers in prisons to be able to provide basic emergency mental healthcare services.[394] The Act requires the Appropriate Government to set up internationally acceptable guidelines within a period of ten years of the commencement of the Act.[395] The 2017 Act also acknowledges the coordinate role of various Ministries and Departments (including health, law, home affairs, employment, women, education, social justice, etc.) of the government, coordination of the same being instrumental in achieving the aim of the Act.[396]

393 The 2017 Act, Section 2(b)
394 The 2017 Act, Section 31
395 *Id.*
396 The 2017 Act, Section 32

5. The 2018 Rules

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

The Mental Healthcare (Rights of Persons with Mental Illness) Rules, 2018,[397] have been drafted by the Central Government in exercise of the powers conferred by Section 121 of the 2017 Act.[398] The 2018 Rules are in furtherance of the cause of the mandates of UNCRPD, taken up by the 2017 Act. The provisions of the 2018 Rules, if implemented completely, can be instrumental in addressing the concerns of women with mental illness in the country.

Mental healthcare includes not only the diagnosis and treatment of mental illness, but also the care and rehabilitation of the person back into society.[399] It is, therefore, very important to understand the various elements that constitute mental illness to gauge this phenomenon.

The Rules lay down provisions for the setting up of *"half-way homes," "sheltered accommodation," "supported accommodation," "hospital and community based rehabilitation establishment" and "hospital and community based rehabilitation service,"* respectively; thereby, recognizing the pertinent role of rehabilitation for complete mental healthcare. The provisions are not myopic, but rather look at mental healthcare holistically, with the ultimate aim of enabling the persons with mental illness to be able to get back to independent living and facilitate their reintegration into the society.

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397 Notification No.: G.S.R. 509(E), Ministry of Health and Family Welfare, Department of Health and Family Welfare, Government of India (29th May, 2018)

398 See also the Draft Central Regulations, 2017 under the 2017 Act, Available at https://mohfw.gov.in/sites/default/files/Final%20Draft%20Rules%20MHC%20Act%2C%202017%20%281%29.pdf (Last visited on April 27, 2018);
By virtue of the powers to make regulations under Section 122 of the 2017 Act, Central Government has drafted the Draft Central Regulations, 2017, on behalf of Central Mental Health Authority. It is important to note that these Draft Central Regulations are subject to the modifications that may be made by the Central Mental Authority once it is constituted.

399 The 2017 Act, Section 2(o)

Clarity on the concepts pertaining to rehabilitation of persons with mental illness is provided by the various definitions enumerated in the 2018 Rules. Discussed herein below are some of the important definitions given under the 2018 Rules:

Rule 2(c)	**Half-way home**	means: "a *transitional living facility for persons with mental illness who are discharged as inpatient from a mental health establishment, but are not fully ready to live independently on their own or with the family."*
Rule 2(d)	**Hospital and community based rehabilitation establishment**	means: *"an establishment providing hospital and community based rehabilitation services"*
Rule 2(e)	**Hospital and community based rehabilitation service**	means: *"rehabilitation services provided to a person with mental illness using existing community resources with an aim to promote his reintegration in the community and to make such person independent in all aspects of life including financial, social, relationship building and maintaining."*
Rule 2(h)	**Sheltered accommodation**	means: *"a safe and secure accommodation option for persons with mental illness, who want to live and manage their affairs independently, but need occasional help and support"*

Rule 2(i)	**Supported accommodation**	means: *"a living arrangement whereby a person in need of support, who has a rented or ownership accommodation, but has no live-in caregiver, gets domiciliary care and a range of support services from a caregiver from an agency to help him live independently and safely in the privacy of his home."*

The 2018 Rules require the Appropriate Government under the Act of 2017 to establish such number of half-way homes, sheltered accommodations, supported accommodations, hospital and community based rehabilitation establishment and services at such places as are necessary for providing services required by persons with mental illness and are to follow the required minimum standards specified in law.[400]

The Rules also elaborate in detail the *"right to access basic medical records."*[401] It is stated *inter alia* that a person with mental illness is entitled to receive the documented versions of his/her medical information relating to diagnosis, assessment, investigation and treatment as per the medical records.

After having discussed the essential features of the 2018 Rules, it can be said that these Rules are indeed a beacon of hope in fulfilling the aim of the 2017 Act. The rules pertaining to rehabilitation are meticulously framed. It is the implementation of these Rules and the positive action by the appropriate government and various authorities under the 2017 Act that can together facilitate the aims of the Act in the light of UNCRPD, to not only provide for the treatment of the person with mental illness, but also the reintegration and rehabilitation of the person into society to enable him/her to lead an independent life.

400 2018 Rules, Rules 3 and 4
401 *Id.,* Rule 6

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

The Mental Healthcare (Central Mental Health Authority and Mental Health Review Boards) Rules, 2018[402] lay down elaborate details about the composition, functioning, finance, accounts and audit of the Central Mental Health Authority. It also provides the rules for the provisional registration of mental health establishments by the Central Authority. The Rules also discuss about the composition of the Mental Health Review Boards. The power of the Central Authority to conduct audit, inspection and enquiry of mental health establishments is covered in Chapter VI of the Rules. Following are the five Forms provided for by the Rules which provide clarity with respect to many a technicality pertaining to the functioning of the Central Authority and the Review Boards:

- Form A - It provides for information on the activities of the Central authority/ State Authority/ Board.
- Form B - It provides for application for grant of provisional registration/ renewal of provisional registration for a mental health establishment.
- Form C - It provides for certificate of provisional registration/ renewal of provisional registration.
- Form D - Register of Mental Health Establishments
- Form E - Annual Report of Central Authority

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

The Mental Healthcare (State Mental Health Authority) Rules, 2018,[403] lay down elaborate details about the composition, functioning, finance,

402 Available at https://www.latestlaws.com/wp-content/uploads/2019/03/Mental-Health-Care-Central-Mental-Health-Authority-and-Mental-Health-Review-Boards-Rules-2018.pdf (Last visited on April 6, 2020); Notification No.: G.S.R. 507(E), Ministry of Health and Family Welfare, Department of Health and Family Welfare, Government of India (29th May, 2018)

403 Available at https://www.latestlaws.com/wp-content/uploads/2019/03/Mental-Healthcare-State-Mental-Health-Authority-Rules-2018.pdf (Last visited on April 6, 2020); Notification No.: G.S.R. 508(E), Ministry of Health and Family Welfare, Department of Health and Family Welfare, Government of India (29th May, 2018)

accounts and audit of the State Mental Health Authority. Chapter III provides for the provisional registration of mental health establishments by the State Mental Health Authority; and, Chapter V lays down detailed provisions pertaining to the audit, enquiry and inspection of mental health establishments in a State. The various forms to the Rules provide *inter alia* for the format of application for grant of provisional registration of mental health establishments, certificate of provisional registration, renewal of provisional registration, etc.

6. Need to incorporate the provisions of the detailed Draft Mental Healthcare Rules, 2017

The 2018 Rules which have been notified on 29th May, 2018,[404] were preceded by the Draft Mental Healthcare Rules, 2017. The Draft 2017 Rules were more elaborate and meticulously drafted. Many of the provisions of the Draft Rules have not been incorporated in the 2018 Rules. It is suggested that some of the essential provisions of the Draft 2017 Rules should be incorporated in the 2018 Rules as they provided detail and clarity. Discussed herein below are some of the relevant provisions of the Draft 2017 Rules:

Half-way homes: The Government is required to set up half-way homes for persons with mental illness. The half-way homes can function from within the community or outside the campus of any other mental health establishment. Half-way homes are to be registered as mental health establishments[405] and are to comply with the standards and requirements for the same. Admission to a half-way home can be taken by a person after his/her discharge from a mental health establishment or on advice by a mental health professional to be admitted in a half-way home instead of a mental health establishment. A half-way home runs programmes to help persons with mental illness in their transition journey while recuperating by learning life skills and moving towards an independent living and reintegration into society. Services to inmates at a half-way home are to include social services, psychiatric services, medical services, educational services and such other services as are required for the holistic welfare of the inmates, including individual

404 Notification No.: G.S.R. 509(E), Ministry of Health and Family Welfare, Department of Health and Family Welfare, Government of India (29th May, 2018)

405 The 2017 Act, Section 65(1)

counselling and group counselling. In order to prepare the inmates for independent living after being discharged from half-way homes, their stay at half-way homes should involve performance of various chores, remuneration for which is also paid to appreciate and recognize the work put in by them, engaging in various occupational activities, being trained in financial management and being provided with employment counselling. Movement inside a half-way home for the inmates should be free. Inmates are to be facilitated outings from the half-way home under supervision or subject to some conditions. This helps in gradually finding themselves reintegrated into society.

Sheltered accommodation: The sheltered accommodations, as stated in the Draft Rules, are to be owned, maintained, administered and run by a government agency. The persons with mental illness who are allotted admission in a sheltered accommodation can exercise the option of staying there with their parents, spouse or care-giver. The Draft Rules require a sheltered accommodation to have some of the following facilities, namely:

- Communal areas having sports facilities, library, garden, jogging track, etc.;
- Provision for common dining area and common laundry services;
- Visiting area facilitating visits from friends and relatives;
- Twenty-four hours emergency alarm in case of an emergency;
- A manager and other staff members to look after the housekeeping and attending to situations of emergency.

A sheltered accommodation should comprise accommodation facilities ranging from shared rooms, independent rooms with kitchen and bath, and apartments with private front door.

Supported accommodation: The concept of supported accommodation, as envisaged in the Draft Rules, entails structured assistance services from Government agencies for persons with mental illness who want to live in their own homes. This support is in addition to the unstructured support available to such a person from his/her friends and families and the treating mental health professional. These services should be

flexible enough to cater to the individual needs of each person with mental illness, respectively. Support services, which are a combination of some paid and some free services, may include assistance with respect to management of money, medical appointments, daily chores, etc.

Hospital & Community based Rehabilitation Services:[406] Hospital & Community Based Rehabilitation are to be made available to persons with mental illness at mental health establishments, community centres homes, including half-way homes. These services, depending on the needs of the persons with mental illness in that area, the local conditions and the availability of resources, are to include:

- Medical treatment facilities;
- Vocational rehabilitation services;
- Family counselling;
- Self-help groups;
- Support in the recovery process;
- Psychological interventions which include psycho-education, psychotherapy and counselling, etc.

For the fulfillment of the above goal, the State Government is required to take steps towards providing training to rehabilitation workers and primary health care workers in psychological care; training persons who have recovered from mental illness and their family members to become resource persons for workers working in the area of rehabilitation; creating an inclusive environment congenial to the overall development of the person with mental illness, ensuring the protection of his/her rights. The State Government is also required to arrange for awareness and sensitization drives in schools to alert students about the issue at a young age. Instilling awareness among the members of society about the sensitivity of the issue is an important role involved herein, along with making persons with mental illness and their care-givers aware of their rights.

406 The Draft 2017 Rules, Schedule B

Capacity to consent for treatment:[407] The expert committee appointed by Central Mental Health Authority has to determine the factors to be considered to evaluate the capacity of a person with mental illness to consent for treatment.

The right to access basic medical records:[408] A person with mental illness has the right to receive documented medical information relating to his/her diagnosis and treatment. The person may request for a copy of the basic medical record by making an application in writing.

The right to free legal aid:[409] All mental health establishments are to put up on display on their notice board at a prominent place in a local language about the right of persons with mental illness to get free legal aid and the contact information of the local Legal Services Authority.

The provisions in the Draft 2017 Rules pertaining to rehabilitation have been meticulously framed, providing detail, clarity and precision. These Draft Rules and the positive action by the appropriate government and various authorities under the 2017 Act can together facilitate the aims of the Act, in the light of UNCRPD, to not only provide for the treatment of the person with mental illness, but also the reintegration and rehabilitation of such persons into the society to enable them to lead an independent life. It is, therefore, suggested that the afore-discussed provisions of the Draft 2017 Rules should be incorporated in the 2018 Rules.

7. Putting forth some Suggestions

The Mental Healthcare Act, 2017, was introduced with the aim to bring the mental healthcare laws in India in consonance with the provisions of UNCRPD and other International Mental Healthcare Standards. It is important to note that the Mental Healthcare Act, 2017, came into force from 29th May, 2018,[410] on which date the Mental Health Act, 1987, stood repealed. The Mental Healthcare Act, 2017, is gender neutral; at the same time not gender biased. It propagates justice and equality in

407 The Draft 2017 Rules, Rule 16
408 The Draft 2017 Rules, Rule 19
409 The Draft 2017 Rules, Rule 20
410 Notification No.: S.O. 2173(E), Ministry of Health and Family Welfare, Government of India (29th May, 2018)

mental healthcare and gives the freedom to choose the treatment to be given to a person during his/her mental healthcare. Having analysed the 2017 Act, read with the National Mental Health Policy of India, 2014, it is humbly submitted that the proper implementation of the 2017 Act and the 2018 Rules in letter and spirit, read with the National Mental Health Policy of India, 2014, will proficiently improve the condition and status of women in need of mental healthcare in the country.

The NCW and NIMHANS Report (2016),[411] had put forth some important suggestions pertaining to mental healthcare of women with mental illness. Positive and constructive suggestions were also made by the persons interviewed and by the respondents to the questionnaires filled during the surveys conducted by the researcher.

Reliance has been on all these suggestions in addition to the analysis undertaken in the course of this research for the researcher to come forth with some suggestions of her own. Herein below are some suggestions to further the cause of the 2017 Act, particularly from the perspective of women with mental illness in India:

- The provisions of the Draft Mental Healthcare Rules, 2017, should be incorporated in the Mental Healthcare (Rights of Persons with Mental Illness) Rules, 2018, which have been notified on 29th May, 2018[412]; and, the Draft Central Regulations, 2017,[413]should be passed in their present form;
- Facilitating care-giver support: The 2017 Act provides for mental health services to provide for support to family with mental illness.[414] This support should include support at the financial,

411 Available at http://ncwapps.nic.in/pdfReports/Addressing_concerns_of_women_admitted_to_psychiatric_institutions_in_INDIA_An_in-depth_analysis.pdf (Last visited on October 10, 2020)

412 Notification No.: G.S.R. 509(E), Ministry of Health and Family Welfare, Department of Health and Family Welfare, Government of India (29th May, 2018)

413 Draft Central Regulations, 2017, made by the Central Government in exercise of the powers conferred under Section 122 of the 2017 Act on behalf of the Central Mental Health Authority subject to modification by the Central Mental Authority on its constitution. Draft Central Regulations, 2017, Available at https://mohfw.gov.in/sites/default/files/Final%20Draft%20Rules%20MHC%20Act%2C%202017%20%281%29.pdf (Last visited on April 27, 2018)

414 The 2017 Act, Section 18(4)(c)

medical and emotional level to the care-giver of the person with mental illness;

- The 2017 Act should ensure that women with mental illness in a mental health institution should be provided with appropriate and adequate privacy, including separate sleeping facilities from men;[415]
- Increase the number of women personnel in mental healthcare in India;
- Training health-care providers at the primary healthcare level to identify mental illness in a patient who comes for treatment before them. The health-care providers should be also trained about the basics of mental healthcare for them to be able to prescribe temporary treatment and medicine in case of mental illness of a patient when access to a psychiatrist, in case of an emergency, is not possible. Training Anganwadi and ASHA workers to identify traits of mental illness in a person and create awareness about mental healthcare and rights of persons with mental illness in the rural pockets of society;
- Providing digital access to psychiatrists on a regular basis in remote areas;[416]
- It should be ensured that every person with mental illness should be treated and provided with healthcare facilities at par with persons with physical illness, and medical insurance for treatment of patients with mental illness should be made available by health insurers in the same manner as is made available for treatment of physical illness[417];
- Gender sensitization and regular and appropriate training, pertaining to special needs and healthcare of women with mental illness, of

415 *See* the WHO Checklist on Mental Health Legislation (Annexure 1 to the WHO Resource Book on Mental Health, Human Rights and Legislation, 2005), Available at https://ec.europa.eu/health/sites/health/files/mental_health/docs/who_resource_book_en.pdf (Last visited on April 5, 2020)

416 *See* The National Health Policy, 2017, Available at https://www.nhp.gov.in/nhpfiles/national_health_policy_2017.pdf (Last visited on April 5, 2020)

417 *See* the 2017 Act, Section 21

healthcare professionals, mental healthcare professionals, police, judiciary, educationists, government authorities, etc. Training sessions to be interactional once in every six months for the various sectors to come together and discuss their experiences and concerns[418];

- Integration of 'inter-sectoral liaisons'[419] among various sectors involved in the care, treatment, welfare and rehabilitation of women with mental illness, including health, social justice, rehabilitation, housing, law, home affairs, police, education, etc.[420]
- Sensitizing women in general about their rights in society, to be able to accept and acknowledge their right to decision making pertaining to their life, irrespective of their mental illness;
- Disseminating information in various sectors of the society about the provisions of the 2017 Act by the Authorities under the 2017 Act, thereby creating awareness pertaining to rights of persons with mental illness and creating awareness among the general masses about the option of psychiatric advance directives. The Indian media can play a pivotal role in ensuring that the ultimate aim of equity in mental healthcare can be reached. Awareness pertaining to the 2017 Act can be brought about through the media by discussions in the mainstream news, advertisements by the Government in primetime news television, radio channels, magazines, newsletters and newspapers;
- Visits to women with mental illness in mental health establishments by outsiders should be supervised;
- Absolute transparency in the process of determining the status of mental illness of a person;
- The Policy makers and law makers should always ask the "woman question"[421] while addressing mental healthcare issues in the country and while making plans and improving plans relating to mental healthcare;

418 *Id.*

419 NCW and NIMHANS Report(2016), Page 244

420 *Id.*

421 *See* Katherine T. Barlett, *Feminist Legal Methods,* 103 (4) Harvard Law Review 829 (1990)

- Inspections of the likes of the one conducted by NCW and NIMHANS in coming out with its 2016 Report should be made a practice to be repeated once in every six years;[422]
- The provisions relating to shelter homes, supported accommodation and half-way homes in the 2018 Rules to be implemented, the same to be backed by sufficient funding by the Government of India. There should be proper monitoring of these homes and accommodations, including regular inspections, to avert situations of exploitation or abuse[423] and, also, to ensure that the purpose of setting up these homes and accommodation is fulfilled
- Applying the principle of *"best interest"* of the person with mental illness and the principle of *"medical necessity"* by the person taking mental healthcare decisions for himself/herself or by anyone taking the decision on his/her behalf, keeping in mind that the *"least restrictive"* methods of treatment for mental healthcare should be incorporated[424];
- Increasing the funding allotment towards mental healthcare in the Annual Budget of India;
- Creating Sexual Harassment Redressal Centres in all mental health establishments;
- Discouraging the practice of long-stay patients in mental hospitals, and making all efforts to locate the family and residence of abandoned women with mental illness;
- Vocational and occupational training of women with mental illness. At the same time, confidence boosting sessions of counselling and character building is vital to rehabilitate the women and help them in leading an independent life[425]; and,

422 *See* also the 2017 Act, Section 67(1)

423 *See* Himanshi Dhawan, *What the Deoria story tells you about India's unwanted girls,* Times of India (August 12, 2018), Available at https://m.timesofindia.com/home/sunday-times/what-the-deoria-story-tells-you-about-indias-unwanted-girls/amp_articleshow/65369502.cms (Last visited on August 13, 2020)

424 *See* Ravinder v. Government of NCT of Delhi and Ors., W.P. (CRL) 3317/2017

425 *See* also UN, Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993), Available at https://www.un.org/development/desa/

- Follow-up with rehabilitated women by the authorities and psychiatric social workers under the 2017 Act is also necessary to avert relapse of the illness.

Finally, it is suggested that educating society in general about mental healthcare, and clearing the cobwebs of stigma that many sections of the society associate with mental illness is very important for the complete fulfilment of this goal. Taking refuge with faith healers for cure of mental illness should be discouraged, and the importance of timely medication and mental healthcare should be discussed and highlighted. Gender sensitization across all sections of society, that is, across geographical, social, gender, cultural, economic, ethnic, regional boundaries and differences, is the most vital of all steps that needs to be taken for a holistic solution to this issue.

disabilities/standard-rules-on-the-equalization-of-opportunities-for-persons-with-disabilities.html (Last visited on January 1, 2018)

Annexure 1 - Empirical Research

As the Secondary Empirical Data relied upon as a part of this research comprises the NCW and NIMHANS Report (2016) and HRW Report (2014), both of which have been discussed in detail and analysed in the previous section of this book, this is only a compilation and analysis of the primary empirical data collected by the author herself. It is noteworthy that the primary empirical research undertaken is not claimed as representative of the entire country. It is only to compliment the data collected in the 2016 and the 2014 Reports, respectively, and thereby further authenticate the viability of these two well-researched and comprehensive reports.

1. Aim of the Empirical Research undertaken

The empirical work taken up in the pursuance of this research is aimed at gauging the situation at the ground level. Being a student of law, the author was not well-equipped enough to understand the intricacies of a mental health establishment or the mental healthcare from the medicinal perspective. It was also necessary to analyse the general understanding of the people at large relating to the issue of mental healthcare, especially the situation of women with mental illness. Awareness about the 2017 Act and the concepts introduced by the Act among the general public was also something that had intrigued the researcher in the pursuance of this research.[426]

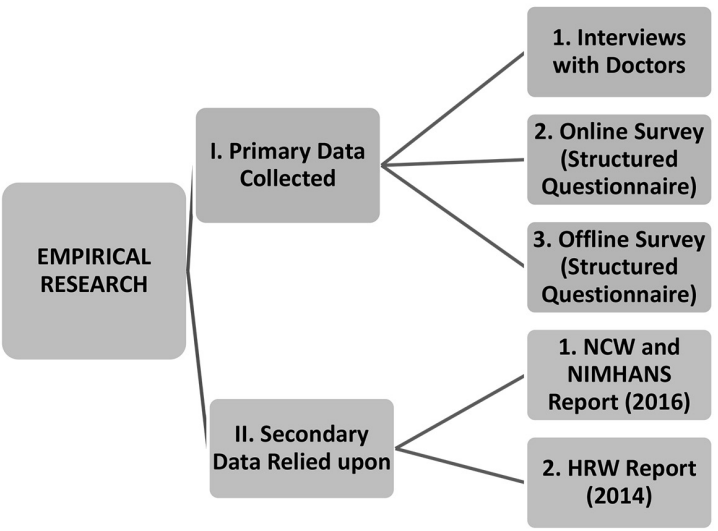
During the course of the research, the author was provided with the most authentic data possible pertaining to women with mental illness in India, that is, the NCW and NIMHANS Report on *"Addressing concerns of women admitted to psychiatric institutions in India: An in-depth analysis"* published in 2016. The report was exhaustive, elaborate and was performed by a team of skilled researchers and professionals with adequate resources, thereby forming an important source of secondary data of empirical nature for this research.[427] The research also refers to a report by a renowned NGO, Human Rights Watch, titled "*Treated Worse than Animals - Abuses against Women and Girls with*

426 *See* Roberta Morris, Et. al., Doing Legal Research- A Guide for Social Scientists and Mental Health Professionals (1997)

427 *See* Chapter III

Psychological and Intellectual Disabilities in Institutions in India" published in 2014,[428] which was instrumental in NCW and NIMHANS coming together to pursue its research culminating in their 2016 Report mentioned above. These two Reports have been analysed in detail in the book; nevertheless, it is important to acknowledge the same as vital sources of secondary empirical data relied upon by the researcher.

The Empirical Research Work which forms a part of this research can be categorized as follows:



Categories of Empirical Research undertaken or relied upon

A. PRIMARY DATA Collected:

a. Interviews with Doctors

b. Online Survey (Structured Questionnaire)

c. Offline Survey (Structured Questionnaire)

B. SECONDARY DATA Relied upon:

1. Report by NCW and NIMHANS published in 2016, titled: *"Addressing concerns of women admitted to psychiatric institutions in India: An in-depth analysis"*[429]

428 *See* Chapter II.

429 Available at http://ncwapps.nic.in/pdfReports/Addressing_concerns_of_women_

2. Report by HRW published in 2014, titled: "*Treated Worse than Animals - Abuses against Women and Girls with Psychological and Intellectual Disabilities in Institutions in India*"[430]

As the Secondary Empirical Data relied upon as a part of this Research comprises the NCW and NIMHANS Report (2016) and HRW Report (2014), both of which have been discussed in detail and analysed in the previous section of this research, this Chapter is only a compilation and analysis of the primary empirical data collected by the researcher herself. It is noteworthy, that the primary empirical research undertaken by the researcher is not claimed as representative of the entire country. It is to compliment the data collected in the 2016 and the 2014 Reports, respectively, and thereby further authenticate the viability of these two well-researched and comprehensive reports.

2. Interview with Psychiatrists

As part of the research, the author had the opportunity to interview five psychiatrists, each of whom has had multiple years of experience in the practice of psychiatry. All the interviews were focused interviews, and the questions asked were open-ended. The discussion revolved around one or more of the following areas:

- General analysis of the Mental Healthcare Act, 2017;
- Stigma pertaining to mental illness of women;
- Psychiatric advance directives;
- Vulnerabilities of women with mental illness;
- De-criminalization of attempt to commit suicide;
- Human Rights of persons with mental illness, etc.

admitted_to_psychiatric_institutions_in_INDIA_An_in-depth_analysis.pdf (Last visited on October 10, 2020)

430 Available at https://www.hrw.org/report/2014/12/03/treated-worse-animals/abuses-against-women-and-girls-psychosocial-or-intellectual (Last visited on April 5, 2020)

Psychiatrist 1

Summary of the interview:

- "India is not prepared as a country to go for advance directives." Since there is no concept of advance directive for any major physical illness, how can the same be introduced for mental illness. India lacks in infrastructure to maintain records of psychiatric advance directives for the treating doctor to have access to the advance directives of all his/her patients, respectively. It increases the burden on the Psychiatrist because he/she will have to delve into whether the advance directive is good for the well-being of the patient or not. A blanket ban on any kind of treatment through an advance directive, for example, could prove to be very harmful to the patient in need of treatment. While making the advance directive, the patient cannot be sure what kind of treatment will be available when the advance directive becomes enforceable; for example, 5 years down the line, there could be improvements in mental healthcare which one would not be aware of while making the advance directive. Therefore, rather than treating the patient, recourse to fulfilling the formalities of the advance directive will become an unnecessary concern for the treating doctor. Psychiatric advance directive doesn't matter. *"It will not change much. Hardly any people are going to make advance directives."* Now that there is the concept of nominated representative (relative), he/she can give consent on behalf of the patient. That is better than advance directive.

Psychiatrist 2

Summary of the interview:

- *"Influence of stigma is more for women than men. Prevalence of stigma is much higher in our society amongst women."* Though the level of stigma has reduced to a great extent and more people are coming to Doctors for treatment, yet the stigma is still very much prevalent for women. Most of the women, when they get victimized in any form, don't want to disclose it to their near and dear ones. They think that if they disclose, then they might be stigmatized or may be isolated totally. That is one of the main

causes why so many women do not seek psychiatric help. Stigma is prevalent across all sections of society for women with mental illness, even in the western world, particularly United States and Japan. Psychiatrists need to be more aware of this stigmatization. Psychiatrists generally listen to their symptoms and prescribe medicine; the patients are not counselled. Counselling has to go hand in hand with psychiatric treatment. Government should also have more of a role to play, and there should be anti-stigma campaign. Celebrities should endorse the cause and help in creating awareness about mental illness. Psychiatrists and psychologists should be more careful about this stigmatization.

- Most of the patients in the Medical College come from village areas. Many of them are illiterate and have no idea of what mental illness is. First of all they go to the local faith healers and local quacks; only after that, they come to the doctors. Awareness programmes should be in all strata of society, particularly in village areas.

- Both the ideas of psychiatric advance directives and of nominated representatives are very good, but in a country like ours where there is illiteracy, most of our patients do not have any idea about psychiatric illness, so how would they predict a future mental illness' course. If awareness is brought about, then maybe implementation of the advance directive will be more rational in such a case.

- If a person is brought from the streets by the police, stating that he/she suffers from mental illness, the first thing that the psychiatric team does is the Mental Status Examination (MSE) of the person. If as per the MSE the patient is fine, the doctors inform the police that the person does not need any treatment. The Police then try to locate the family or home of the person and send him/her back to the family.

- Patients are abandoned in hospitals by the family. Even after their recovery, when the patient is ready for discharge, nobody is willing to take the patients back. Some of these patients are absolutely okay, but because no one is coming to take them back, they occupy a bed in the hospital. *"We try to get them involved in psychiatric rehabilitation."*

- "Bio-psycho-social-spiritual." Psychiatric rehabilitation is a major concern. In a psychiatric hospital or a psychiatric unit, the treatment part is given much attention. Rehabilitation is mainly done by NGOs. *"I think in any psychiatric hospital or any psychiatric unit in any general hospital itself, there must be the provision for psychiatric rehabilitation…For complete cure of a psychiatric patient, holistic approach is always mandatory."* Medicine can remedy to some extent. Psycho-therapy, psychiatric rehabilitation, care-givers all have to come together for complete cure of the psychiatric patient. *"In our country, only the medicine part is taken care of, but all other parts are neglected." A* bio-psycho-social-spiritual model should be taken up. This is the holistic approach that is required for a complete cure of the patient.

- Psychiatrist to patient ratio is very low in our country. *"Not only psychiatrists, psychiatric social workers, psychologists and nurses trained in psychiatry, there is deficit everywhere."* Training the general physician in basic psychiatry in remote village areas in India where psychiatrists are not available can be an important step to address this concern. Integration of mental healthcare with primary healthcare and decentralization of mental healthcare is the way ahead.

Psychiatrist 3

Summary of the interview:

- Law has generally been very gender neutral. Apart from mention of reproductive rights, the provisions of the mental healthcare law are gender neutral.

- The concept of psychiatric advance directives can be compared to a will. The provision of making a will exists in the country, yet very few people make a will, because nobody apprehends death. Similarly, with respect to psychiatric advance directive, it would be very rare when an individual would come up and say how they want to be treated when they become mentally ill. An advance directive should be a tri-partite agreement involving the patient, the family member or care giver and the treating psychiatrist. The treating psychiatrist should be able to decide whether the advance

directive would be good or bad for the health of the patient making the directive. Admission of the patient to a hospital for mental healthcare should be for his/her benefit and should be valid, based on the consent of the legal guardian/care giver/family member of the patient. If the practice of advance directive comes to fore, every hospital will require a legal team to look into the legality of each advance directive before it.

- 90% of the patients that we treat are difficult patients, who are unable to gauge what is good for them at that point of time. Compulsory treatment in such situations should be accommodated. The family members/ care givers should be given the right by law to get such a person treated and cured.
- Many of the patients are not capable of differentiating what is good for them from what is bad for them. They don't want to bathe or keep themselves clean. Bed bugs and lice would develop, and various dermatological issues would become prevalent if some force is not used to make them clean and tidy and if proper hygiene is not maintained.
- The stigma surrounding mental illness is waning because of awareness among people and the generation of sensitivity in the society about mental illness. More and more people are coming to hospitals and psychiatrists for psychiatric treatment.
- The Act is completely silent about the rights of the care-givers. The care-givers receive the brunt of the violence and incapacity of the patient when he/she is unable to differentiate his/her good from his/her bad.
- Referring to the vulnerability of women, it can be said that when a husband falls sick, the wife is more accepting. This is not always the case when the wife falls sick. Husbands, sometimes, on their own accord and, sometimes, under the influence of parents, want to go for a divorce from a woman who develops mental illness.
- Every time there is an attempt to commit suicide, a psychiatrist should be made to get involved to find out the causes which led to such an attempt by the person. Through counselling and proper

treatment the person should be helped to recover. If the attempt to commit suicide is repeated, there should be a compulsory treatment, if need be through admission in a psychiatric hospital or in the psychiatric unit of a general hospital. Decriminalization of attempt to commit suicide is a welcome change to help such a person to get back to a normal state of mind and live a normal life as a member of society.

- Hysterectomy does not take away the physical aspect of sex. It only disables the woman from bearing a child. A woman with mental illness who is unable to take care of herself; how can one expect her to mother a child? So, hysterectomy, in extreme situations, should be allowed.

Psychiatrist 4

Summary of the interview:

- Most of the patients that come are with family members. Advance directive might antagonize the caring family by making the situation anti-family, leading to hostility or abandonment of the patient itself. This may lead to multiple litigations, unnecessarily. Psychiatric advance directives could be viable twenty years down the line when the country has the capacity to set up the infrastructure for the same. It will unnecessarily create impediments for the treating psychiatrist for whom the treatment of the ailing patient is a matter of primary concern at this point of time.

- Autonomy of the patient is difficult to gauge here, because the patient is not in a fit state of mind. Scope of misuse is there in every circumstance. Just because of the 2% chance of misuse by a care-giver in mental healthcare decision making for a person with mental illness, we cannot stop the 98% good work that is being done for the welfare of the patients.

- Under the new law, there is provision for registration of hospitals. There are checks which can be put in place to ensure that torture is not meted out. However, one cannot ignore the fact that there are dargahs and temples where faith healing goes on, and law enforcement agencies cannot enter such places to check for violation of any law because these are sensitive zones and the

question of culture and religion comes into the picture.

- The rights introduced in the new law are a welcome change. However, these rights need to be accompanied with duties, and for fulfilling the same, India requires funding and infrastructure.

Psychiatrist 5

Summary of the interview:

- Psychiatric advance directive is not feasible in India presently. India does not have the infrastructure for psychiatric advance directive to operate smoothly.
- The human rights aspect of the 2017 Act is a welcome change. Proper implementation of the provisions can go a long way in promoting and protecting the interests and welfare of patients with mental illness.
- Women with mental illness are more vulnerable than men with mental illness. Mental illnesses that are more common in women than in men are depression, particularly unipolar depression and Alzheimer's disease.
- The process of recovery of a patient should go through four main phases, namely:

i) Identification of the mental illness

ii) Acceptance of the fact of the mental illness

iii) Medical Treatment

iv) Reformative action and rehabilitation.

Mere treatment does not solve the issue. Helping the patient stand independently and become an active part of the society should be the ultimate aim.

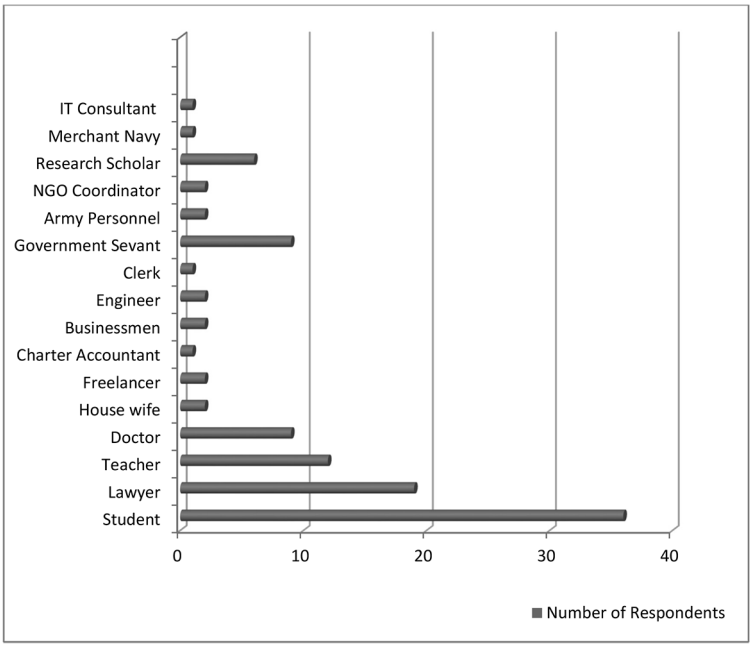
Comparing and Analysing All The Five Interviews:

There was an acknowledgement among all the five psychiatrists interviewed in the pursuance of this research of the comparative

vulnerability of women with mental illness in the country. They all acknowledged the prevalence of stigma and the tendency to go to traditional faith healers before approaching the psychiatric professionals. Abandonment of patients in mental hospitals was also a common phenomenon reported by them. Decriminalizing attempt to commit suicide was considered a necessary change. There was, however, difference of opinion about the viability of introducing psychiatric advance directives. Four of the psychiatrists interviewed were of the opinion that introduction of psychiatric advance directives would be a hassle for the family members and care-givers, would unnecessarily add complications for the mental healthcare team and would open the window for unnecessary litigations. Awareness regarding psychiatric advance directives and proper implementation would result in a positive change, according to one psychiatrist. The concerted opinion of all the psychiatrists was, therefore, that the societal and legal setup of India was not yet conducive for the introduction of psychiatric advance directives. Concern over rehabilitation for the holistic treatment and care of persons with mental illness was recognized and emphasized upon by all the five psychiatrists interviewed.

3. Online Survey

The researcher conducted an online survey by circulating a structured questionnaire. The questionnaire comprised twelve questions, out of which six questions were close-ended and six questions were open-ended. The questionnaire was circulated online and received a total of a hundred and ten responses.



Designations of the 110 respondents to the online survey

Questions in the online survey:

The questionnaire comprised twelve questions, out of which six questions were close-ended, and six questions were open-ended.

Close-ended questions:

i) Is there a stigma surrounding mental illness in the Indian society? (Yes/No)

ii) Are you aware of the Mental Healthcare Act, 2017? (Yes/No)

iii) Are women with mental illness more vulnerable than their male counterparts? (Yes/No)

iv) Is India ready for the concept of psychiatric "advance directives"? (Yes/No)

v) Do many Indians still believe in traditional forms of healing for mental illness? (Yes/No/Maybe)

vi) Are the provisions pertaining to admission, treatment and discharge under the Mental Healthcare Act, 2017, an improvement on the relevant provisions from the Mental Health Act, 1987? (Yes/No/ No comments)

Open-ended questions:

i) Chapter V of the Mental Healthcare Act, 2017, enumerates the rights of persons with mental illness. What steps can be taken to protect these rights of women with mental illness?

ii) What would be the implications of introducing psychiatric advance directives on women in need of mental healthcare?

iii) What, according to you, are the parameters that should be kept in mind to determine the free and informed consent for mental healthcare of women with mental illness?

iv) What, according to you, can be done to ensure that mental healthcare is sensitive to the vulnerabilities of women with mental illness?

v) What role can psychiatric institutions and the psychiatric fraternity play to ensure that mental healthcare is gender sensitive?

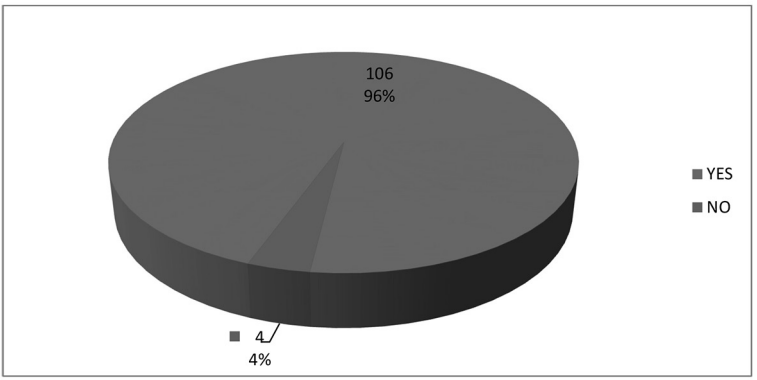
vi) What role can the law play in ensuring the rehabilitation of women with mental illness into society?

In addition to the above questions, there was also space allotted for any additional comments by the respondents of the questionnaire. The 110 responses received included Indians from all walks of life who have access to the internet. They were either minimum graduates or were pursuing their studies.

Analysis of the Responses to the Questions in the online survey:

It is important to note that the online link to the Mental Healthcare Act, 2017, was given in the beginning of the questionnaire for the respondents to make references to it while answering the online questionnaire. Herein, next, is the question-wise analysis of the 110 responses received to the online survey:

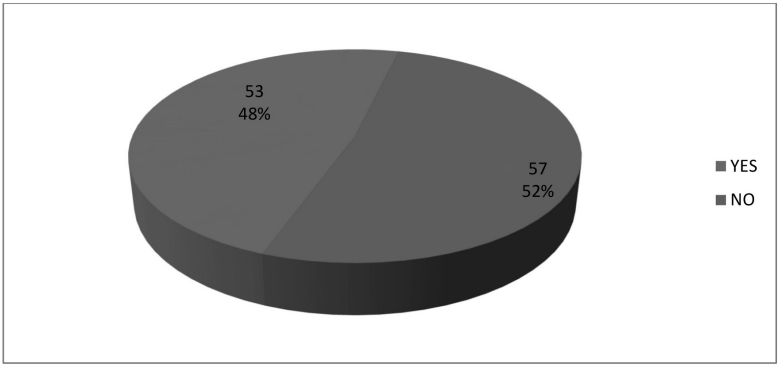
Question 1: Is there a stigma surrounding mental illness in the Indian society? (Yes/No)



	YES	NO
Number of respondents	**106**	**4**
Percentage	**96%**	**4%**

Out of the 110 respondents who filled the questionnaire, a thumping majority of 106 persons, that is, 96% of the respondents agreed that there is stigma pertaining to mental illness in the country. Reasons associated with the stigma are manifold, including inconvenience and danger caused to others by persons with mental illness, association of mental illness with sins or evil spirits, and the general perception that persons with mental illness become an obligation and a monetary burden on the family. Name calling, branding, general ostracizing and abandonment are some of the resultant effects of associating stigma to mental illness in India.

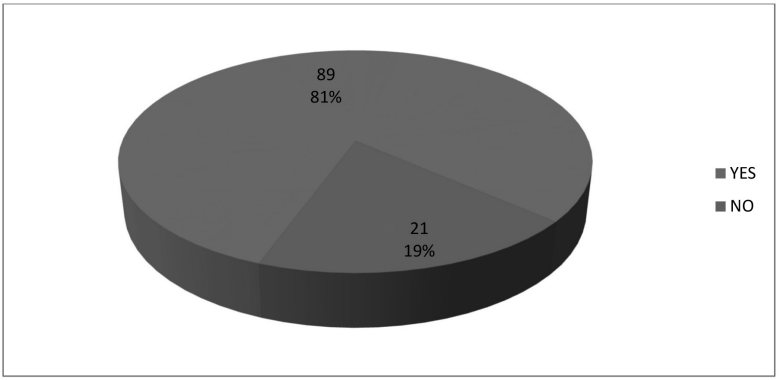
Question 2: Are you aware of the Mental Healthcare Act, 2017? (Yes/No)



	YES	NO
Number of respondents	**53**	**57**
Percentage	**48%**	**52%**

Only half (53) of the 110 respondents who filled the questionnaire were aware of the Mental Healthcare Act, 2017, and a little more than half (57) were not aware of the new 2017 Act. The new Act has multifarious facets that have the potential to change mental healthcare in India drastically. The respondents of the online survey were all educated professionals and students. Lack of awareness among more than half of them about the 2017 Act is a matter of great concern. Disseminating awareness is a vital step which should precede the implementation of the Act for the process of implementation to be smooth and successful.

Question 3: Are women with mental illness more vulnerable than their male counterparts? (Yes/No)



	YES	NO
Number of respondents	**89**	**21**
Percentage	**81%**	**19%**

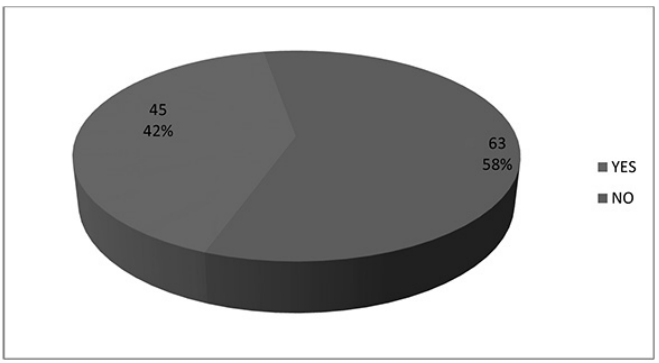
Out of the 110 respondents who filled the questionnaire, a majority of 89 persons that is 81% of the respondents agreed that women with mental illness more vulnerable than their male counterparts. This justifies the asking of the *"woman question"* pertaining to mental healthcare. In the social-economic setup prevalent in the country, it is a known fact that women happen to be the vulnerable section of society. Women with mental illness sometimes become victims of twin disabilities, that of *'gender'* and *'mental illness.'* The gravity of the same has been addressed in the NCW Report (2016) and HRW Report (2014).

Question 4: Chapter V of the Mental Healthcare Act, 2017, enumerates the rights of persons with mental illness. What steps can be taken to protect these rights of women with mental illness?

The responses to this question were manifold, however all of them recommended steps that can be taken by the Government towards the protection of the rights of women with mental illness in the country. Herein below are some of the primary responses received to this question:

- Generate awareness;
- Set up special homes;
- Sensitization of mental healthcare professionals;
- Justice redressal system should be cheaper;
- Setting up of guidelines to protect the rights of women with mental illness;
- Ensuring the support of the family; and
- Proper implementation of the provisions of the law.

Question 5: Is India ready for the concept of psychiatric "advance directives"? (Yes/No)



	YES	NO
Number of respondents (108)	**45**	**63**
Percentage	**42%**	**58%**

There was a difference of opinion regarding the viability of introducing the concept of psychiatric advance directives in India. Two respondents chose not to answer this question. 45 out of the 108 respondents said yes, whereas 63 of them said no. The apprehensions addressed by some of the respondents whom the researcher met in person were relating to awareness about the concept and that this concept would introduce unnecessary formalities in healthcare when the imminent requirement

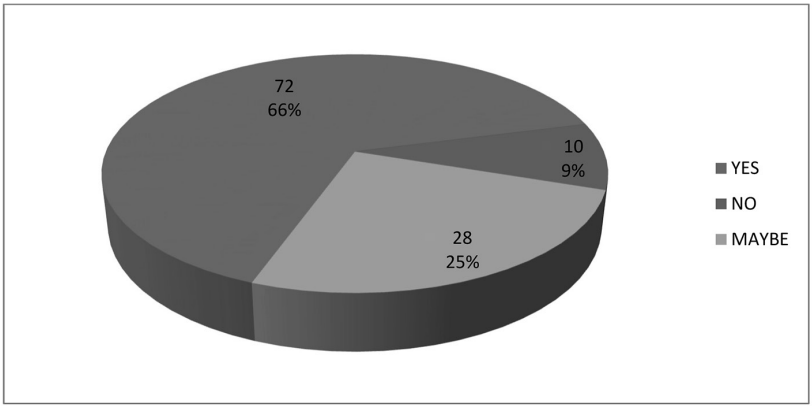
is the treatment of the patient. However, the ones in support of the concept of psychiatric advance directives considered it a welcome change, which will give the persons with mental illness the freedom of choice and the right to exercise their autonomy over their own body. It is important to note that the online link to the 2017 Act was given in the beginning of the questionnaire for the respondents to make reference to while answering the online questionnaire. Therefore, the respondents were well-informed in advance about the concept of psychiatric advance directive before answering the questionnaire.

Question 6: What would be the implications of introducing psychiatric advance directives for women in need of mental healthcare?

42% of the respondents had stated that India is ready for the concept of psychiatric advance directive, and 58% had said no. The online link to the 2017 Act was given in the beginning of the questionnaire for the respondents to make reference to while answering the online questionnaire. Therefore, the respondents were well-informed in advance about the concept of psychiatric advance directive before answering the questionnaire. The responses to this question were mixed. Herein below are some of the pertinent responses received to this question:

- Psychiatric advance directives will give more autonomy to the patient with mental illness about his/her treatment;
- Chances of misuse;
- Lack of awareness about the concept;
- Unnecessary complications for the treating Doctor;
- A patient with mental illness may not differentiate between what is good and what is bad for him/her; and
- Opening gates for unnecessary litigations.

Question 7: Do many Indians still believe in traditional forms of healing for mental illness? (Yes/No/Maybe)



	YES	NO	May be
Number of respondents	**72**	**10**	**28**
Percentage	**66%**	**9%**	**25%**

66% of the respondents to this question agreed to the fact that many Indians still believe in traditional forms of healing for mental illness. 25% of the respondents were not sure, and only 9% disagreed to the proposition. Traditional forms of healing include faith healers, visits to dargahs and temples, and other forms of religious and cultural activities associated with a cure for mental illness in the country. It is relevant to note that the psychiatrists interviewed by the researcher had also acknowledged the fact that many of the patients who come to them already try traditional healing methods for mental healthcare before approaching them for mental healthcare and treatment.

Question 8: What, according to you, are the parameters that should be kept in mind to determine the free and informed consent for mental healthcare of women with mental illness?

All the respondents were in favour of ensuring the obtaining of informed consent of the person with mental illness before proceeding with any form of treatment. The respondents recommended that the information provided before obtaining the consent should be communicated in the

language and manner which the patient can decipher. If the patient is unable to understand and is not in a state to give consent, the same information should be provided to and consent be obtained from the nominated representative/guardian/family member of the patient. It is important to ensure that the consent obtained is free and that there is no fraud/force/coercion/misrepresentation involved in obtaining the same.

Question 9: What, according to you, can be done to ensure that mental healthcare is sensitive to the vulnerabilities of women with mental illness?[431]

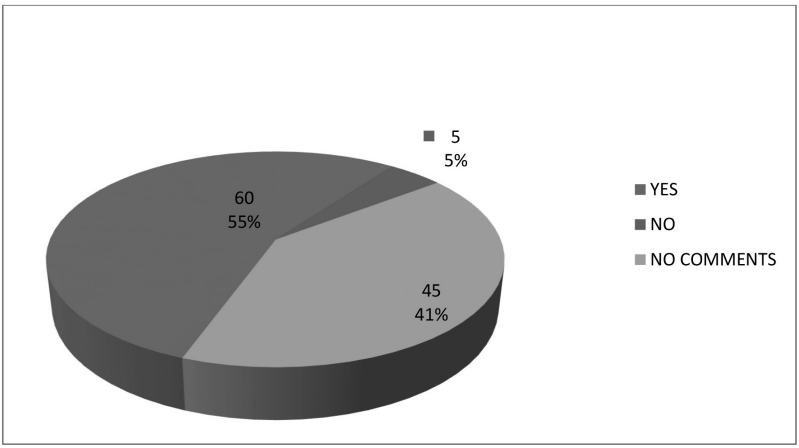
Question 10: What role can psychiatric institutions and the psychiatric fraternity play to ensure that mental healthcare is gender sensitive?

81% of the respondents had agreed to the proposition that women with mental illness are more vulnerable than men with mental illness in this country. The responses to questions 9 and 10 were almost same and, therefore, have been clubbed together for the purpose of analysis and compilation. While answering these two questions, the respondents proposed multiple suggestions. The list herein below exhaustively enumerates the suggestions put forth by the respondents while answering this question:

- Increasing the number of women personnel in mental health care;
- Sensitization of mental health care providers;
- Making women with mental illness aware of their rights; and
- Making family members sensitive to the situation and rights of women with mental illness in the country.

Question 11: Are the provisions pertaining to admission, treatment and discharge under the Mental Healthcare Act, 2017, an improvement from the relevant provisions from the Mental Health Act, 1987? (Yes/No/No Comments)

431 The analysis of the responses to Question 9 and Question 10 have been combined and written together herein below Question 10.



	YES	NO	NO COMMENTS
Number of respondents	**60**	**5**	**45**
Percentage	**55%**	**5%**	**41%**

Answering this question with a *'yes'* or a *'no'* was not mandatory because a third option of *"no comments"* was also provided for. The same was done knowing that it would be impractical to expect all the respondents to the survey to be aware of the provisions of both the 2017 Act and the Mental Health Act, 1987. It is noteworthy that the persons who responded were, therefore, aware of the provisions of both the legislations and their implications. According to 55% of the respondents the provisions pertaining to admission, treatment and discharge under the 2017 Act are an improvement on the relvant provisions of the Mental Health Act, 1987.

Question 12: What role can the law play in ensuring the rehabilitation of women with mental illness in society?

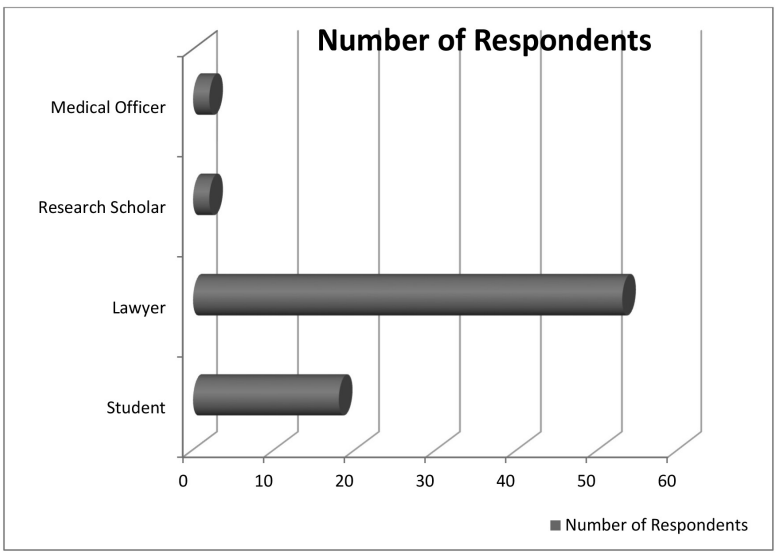
This question received many positive responses from the respondents with suggestions that are very much viable. The pertinent suggestions put forth in the responses were:

- Setting up of more shelter homes and half-way homes;

- Making mental healthcare a journey towards independence;
- Ensuring the financial independence of the women with mental illness;
- Support from the family and care-givers;
- Educating society;
- Gender sensitization; and
- Vocational and occupational training.

4. Offline Survey

The researcher conducted an offline survey by circulating a structured questionnaire. The questionnaire comprised nine questions, out of which five questions were both close-ended and open-ended in nature; and four questions were open-ended only. There was the option of "Any additional comments" at the end of the questionnaire. The questionnaire received a total of seventy-five responses. The respondents comprised 53 lawyers, 18 students, 2 research scholars and 2 medical officers.



Designations of the 75 respondents to the offline survey

Herein below are the questions asked in the questionnaire of this offline survey:

1. Are you aware of the following developments in law pertaining to mental healthcare?

The Mental Healthcare Act, 2017	❑ Yes	❑ No
The National Mental Health Policy, 2014	❑ Yes	❑ No
The Mental Health Act, 1987	❑ Yes	❑ No
The United Nations Convention on Rights of Persons with Disability	❑ Yes	❑ No

2. Is there a stigma surrounding mental illness in the Indian society?

❑ Yes ❑ No

Reasons for the same (comments, if any): _____

_____

_____

_____

_____

_____

_____

_____

_____

3. Are women with mental illness more vulnerable than their male counterparts?

❑ Yes ❑ No

Reasons for the same (comments, if any): _____

_____

_____

_____

_____

_____

_____

Chapter III of the Act introduces the concept of **psychiatric advance directives,** and Chapter IV comprises provisions pertaining to the nominated representative of the person with mental illness. The Act states that any person, not being a minor, has the right to make an **advance directive in writing, specifying the way the person wishes to be cared for and treated for a mental illness**; and, the individual or individuals, in order of precedence, he wants to appoint as nominated representatives.

4. Is India ready for the concept of psychiatric *"advance directives"*?

❑ Yes ❑ No

Comments, if any: _____

5. Do many Indians still believe in traditional forms of healing for mental illness?

❑ Yes ❑ No

Comments, if any: _____

The 2017 Act defines '**informed consent'** to mean "consent given for a specific intervention, without any force, undue influence, fraud, threat, mistake or misrepresentation, and obtained after disclosing to a person adequate information including risks and benefits of, and alternatives to, the specific intervention in a language and manner understood by the person."

6. What, according to you, are the parameters that should be kept in mind to determine the free and informed consent for mental healthcare of women with mental illness?

Rights of persons with Mental Illness (Chapter V of the 2017 Act):

i. Right to access mental healthcare
ii. Right to community living
iii. Right to protection from cruel, inhuman and degrading treatment
iv. Right to equality and non-discrimination
v. Right to information
vi. Right to confidentiality
vii. Restriction on release of information in respect of mental illness
viii. Right to access medical records
ix. Right to personal contacts and communication
x. Right to legal aid
xi. Right to make complaints about deficiencies in provision of services.

7. Chapter V of the Mental Healthcare Act, 2017, enumerates the rights of persons with mental illness. What steps can be taken to protect these rights of women with mental illness?

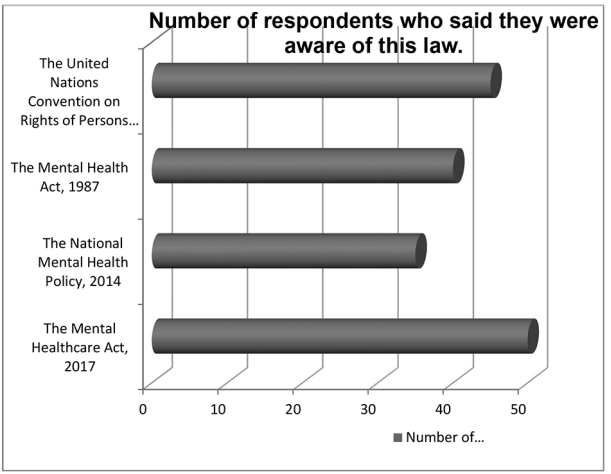
8. What, according to you, can be done to ensure that mental healthcare is sensitive to the vulnerabilities of women with mental illness?

9. What role can psychiatric institutions and the psychiatric fraternity play to ensure that mental healthcare is gender sensitive?

10. Any additional comments:

2. Are you aware of the following developments in law pertaining to mental healthcare?

The Mental Healthcare Act, 2017	❑ Yes	❑ No
The National Mental Health Policy, 2014	❑ Yes	❑ No
The Mental Health Act, 1987	❑ Yes	❑ No
The United Nations Convention on Rights of Persons with Disability	❑ Yes	❑ No

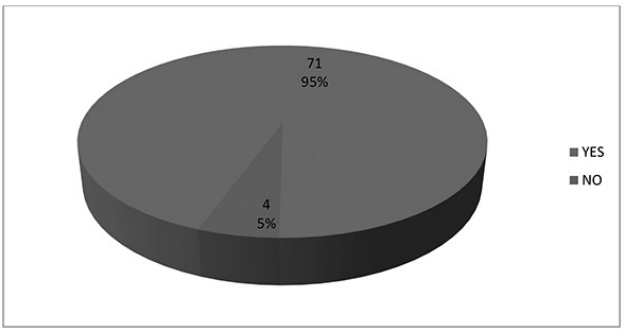


Legal instrument	Yes	No
1. The Mental Healthcare Act, 2017	50	25
2. The National Mental Health Policy of India, 2014	35	40
3. The Mental Health Act, 1987	40	35
4. United Nations Convention on Rights of Persons with Disability	45	30

3. Is there a stigma surrounding mental illness in the Indian society?

❑ Yes ❑ No

Reasons for the same (comments, if any):



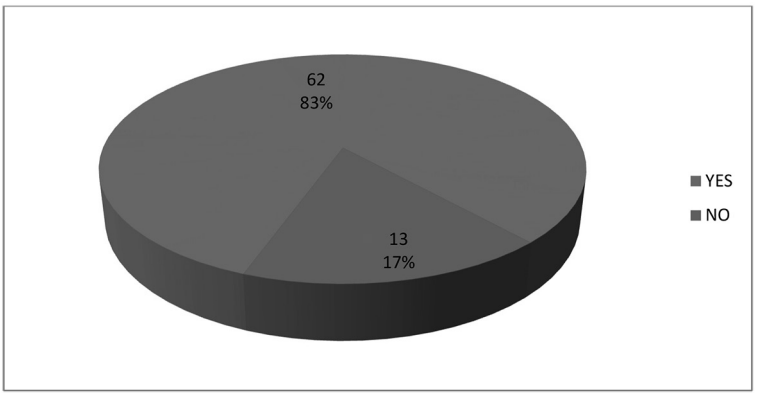
	YES	NO
Number of respondents	71	4
Percentage	95%	5%

Out of the **75** respondents who filled the questionnaire, a thumping majority of 71 respondents, that is, 95% of the respondents agreed that there is a stigma pertaining to mental illness in the country. Reasons associated with the stigma are manifold, including inconvenience and danger to others caused by persons with mental illness, association of mental illness with sins or evil spirits, and general perception that persons with mental illness become an obligation and a monetary burden to the family. Name calling, branding, general ostracizing and abandonment are some of the resultant effects of associating stigma to mental illness in India.

4. Are women with mental illness more vulnerable than their male counterparts?

❑ Yes ❑ No

Reasons for the same (comments, if any):



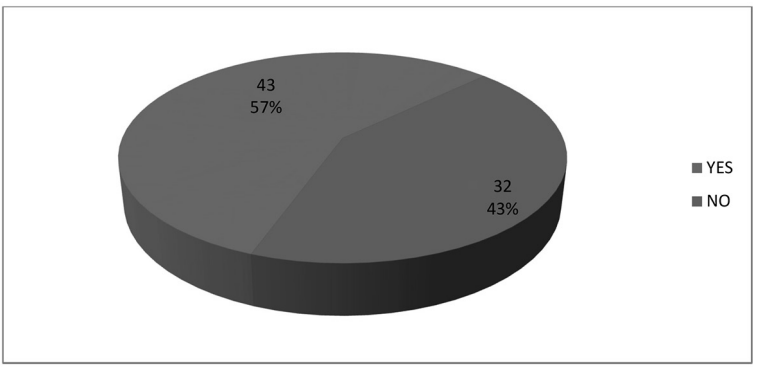
	YES	NO
Number of respondents	**62**	**13**
Percentage	**83%**	**17%**

Out of the 75 respondents who filled the questionnaire, a majority of 62 respondents, that is, 83% of the respondents agreed that women with mental illness more vulnerable than their male counterparts. This justifies the asking of the *"woman question"* pertaining to mental healthcare. In the social-economic setup prevalent in the country. It is a known fact that women happen to be the vulnerable sections of the society. Women with mental illness sometimes become victims of twin disabilities, that of *'gender'* and *'mental illness'*. The gravity of the same has been addressed in the NCW Report (2016) and HRW Report (2014).

5. Is India ready for the concept of psychiatric "advance directives"?

❑ Yes ❑ No

Reasons for the same (comments, if any):



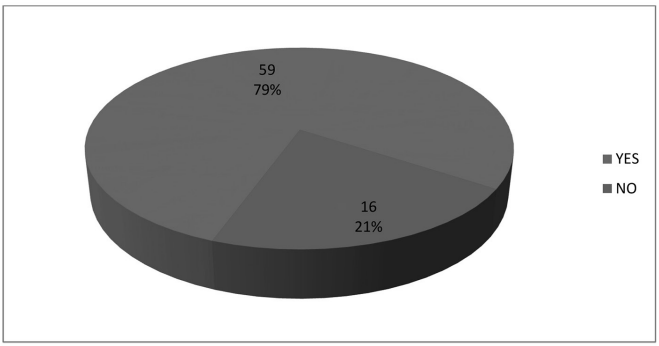
	YES	NO
Number of respondents	**43**	**32**
Percentage	**57%**	**43%**

There was a difference of opinion regarding the viability of introducing the concept of psychiatric advance directives in India. 43 out of the 75 respondents said 'yes,' whereas 32 of them said 'no.'

6. Do many Indians still believe in traditional forms of healing for mental illness?

	YES	NO
Number of respondents	**43**	**32**
Percentage	**57%**	**43%**

Reasons for the same (comments, if any):



	YES	NO
Number of respondents	**59**	**16**
Percentage	**79%**	**21%**

79% of the respondents to this question agreed to the fact that many Indians still believe in traditional forms of healing for mental illness. 21% of the respondents disagreed with the proposition. Traditional forms of healing include faith healers, visits to dargahs, temples and other forms of religious and cultural activities associated with a cure for mental illness in the country. It is relevant to note that the psychiatrists interviewed by the researcher had also acknowledged the fact that many of the patients who come to them already try traditional healing methods for mental healthcare before approaching them for mental healthcare and treatment.

7. What, according to you, are the parameters that should be kept in mind to determine the free and informed consent for mental healthcare of women with mental illness?

The responses to this question in the offline survey were very similar to the responses to this question in the online survey. All the respondents were in favour of ensuring the obtaining of informed consent of the person with mental illness before proceeding with any form of treatment. The respondents recommended that the information provided before obtaining the consent should be communicated in the language and manner which the patient can decipher. If the patient is unable to understand and is not in a state to give consent, the same information should be provided to, and consent be obtained from the nominated representative/guardian/family member of the patient. It is important to ensure that the consent obtained is free and that there is no fraud involved in obtaining the same.

8. Chapter V of the Mental Healthcare Act, 2017, enumerates the rights of persons with mental illness. What steps can be taken to protect these rights of women with mental illness?

The responses to this question in the offline survey were very similar to the responses to the question in the online survey. Like the online survey, all the respondents to the question in the offline survey made recommendations towards the protection of the rights of women with mental illness in the country. Herein below are some of the primary responses received to this question:

- Generate awareness among the general public;
- Ensure that they are not abandoned in mental healthcare facilities;
- Rehabilitation;
- Sensitization of police, judiciary, mental healthcare professionals;
- Sensitization of the society;
- Proper enforcement mechanism should be in place;
- Support of the family;
- Vocational training of women with mental illness during their recovery;

9. What according to you, can be done to ensure that mental healthcare is sensitive to the vulnerabilities of women with mental illness?

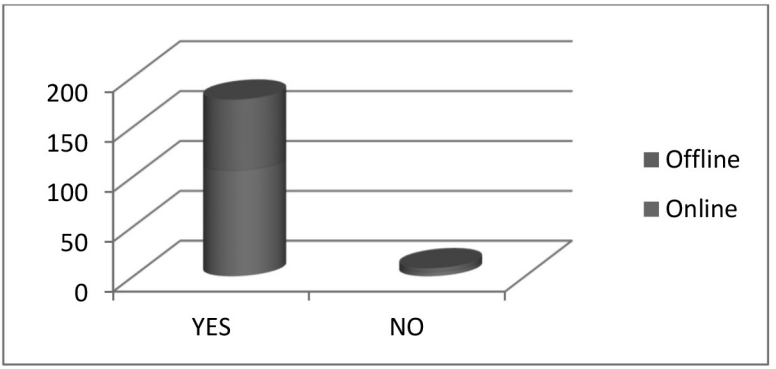
10. What role can psychiatric institutions and the psychiatric fraternity play to ensure that mental healthcare is gender sensitive?

83% of the respondents had agreed to the proposition that women with mental illness are more vulnerable than men with mental illness in this country. The responses to questions 8 and 9 were almost same and, therefore, have been clubbed together for the purpose of analysis and compilation. While answering the two questions, the respondents proposed multiple suggestions. The list, herein below, exhaustively enumerates the suggestions put forth by the respondents while answering this question:

- Increasing the number of women personnel in mental health care;
- Sensitization of mental healthcare providers;
- Making it mandatory for the mental healthcare providers to obtain the informed consent of women with mental illness before administering any treatment to them;
- Making women with mental illness aware of their rights;
- Ensuring that only female staff should be present in women's wards at mental healthcare units and that no male member of the staff should visit the women's wards without the supervision of, and in the absence of, a female staff member; and,
- Making family members sensitive to the situation and rights of women with mental illness in the country.

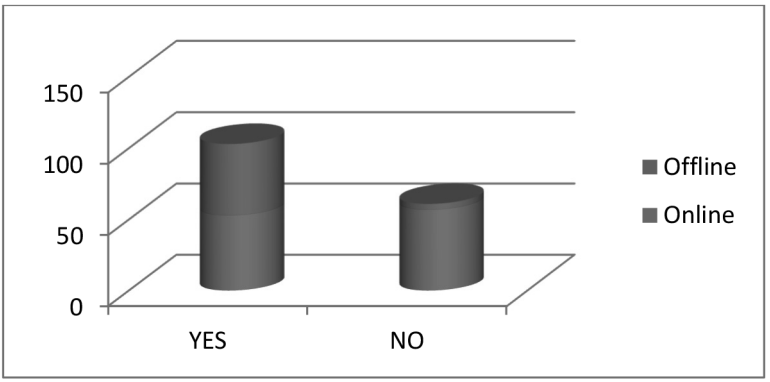
5. Compiling the Results of the Close-Ended Questions of the Online and Offline Survey

Question 1: Is there a stigma surrounding mental illness in the Indian society?



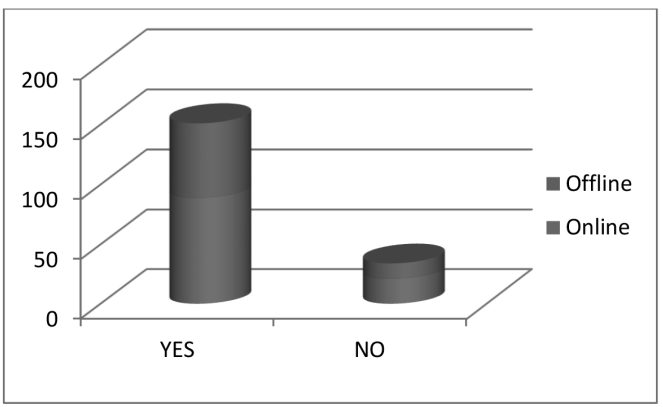
Question 2: Are you aware of the Mental Healthcare Act, 2017?

	YES	NO
Online survey (110)	53	57
Offline Survey (75)	50	25
TOTAL (185)	103	82
PERCENTAGE	55.6%	44.3%



Question 3: Are women with mental illness more vulnerable than their male counterparts?

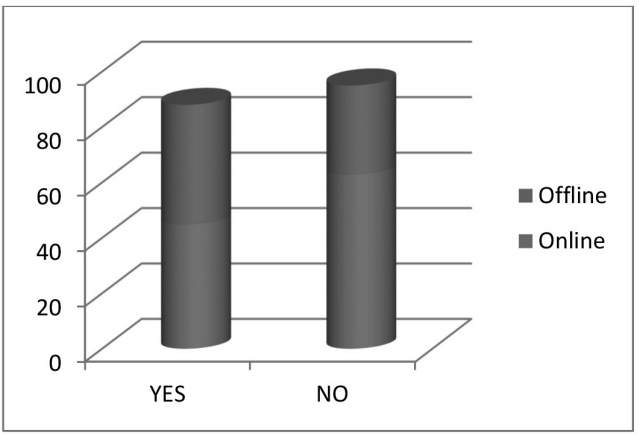
	YES	NO
Online survey (110)	89	21
Offline Survey (75)	62	13
TOTAL (185)	151	34
PERCENTAGE	81.6%	18.3%



Question 4: Is India ready for the concept of psychiatric "advance directives"?

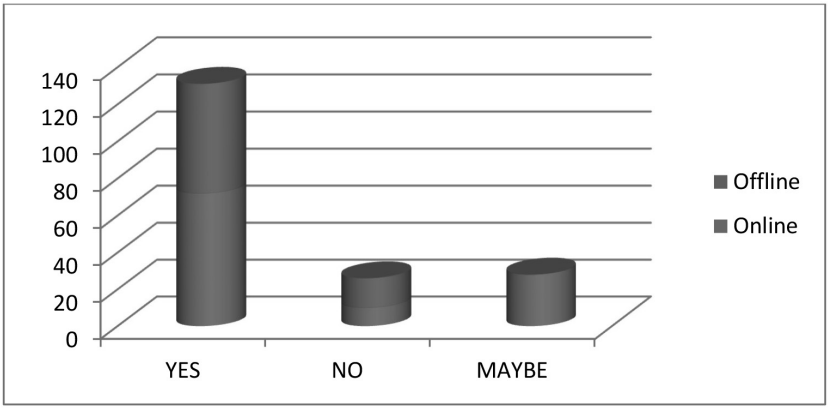
	YES	NO
Online survey (108)	**45**	**63**
Offline Survey (75)	**43**	**32**
TOTAL (183)	**88**	**95**
PERCENTAGE	**48.1%**	**51.9%**

1 Two respondents to the online survey chose not to answer this question.



Question 5: Do many Indians still believe in traditional forms of healing for mental illness?

	YES	NO	May be
Online survey (110)	**72**	**10**	**28**
Offline Survey (75)	**59**	**16**	**--**
TOTAL (185)	**131**	**26**	**28**
PERCENTAGE	**70.8%**	**14.1%**	**15.1%**



6. Decoding the Empirical Research

The responses to the questions in both the online and offline survey were headed in the same direction. It can be discerned that the result of both the surveys is reliable because of the similarity in the answering trend evident in both of them. It is important to note that the results of the surveys, the interviews with the psychiatrists, the visits to NGOs are all in consonance with the findings of the NCW and NIMHANS Report (2016)[432] and HRW Report (2014),[433] which is the secondary source of empirical data relied upon in the pursuance of this research.

The results of the empirical research undertaken by the researcher also fulfil the aim of drawing a picture of the various aspects of mental healthcare and that of getting a better understanding of the roles of various personnel involved in mental healthcare in the country. Getting an idea of the temperament of the general public was also facilitated by the small exercise of the two surveys (online and offline) conducted by the researcher.

432 Available at: http://ncwapps.nic.in/pdfReports/Addressing_concerns_of_women_admitted_to_psychiatric_institutions_in_INDIA_An_in-depth_analysis.pdf (Last visited on October 10, 2020)

433 Available at https://www.hrw.org/report/2014/12/03/treated-worse-animals/abuses-against-women-and-girls-psychosocial-or-intellectual (Last visited on April 5, 2020)

Annexure 2 - Testing the Mental Healthcare Act, 2017, on the Anvil of the WHO Checklist on Mental Health Legislation

S. No.	LEGISLATIVE ISSUE	Extent to which covered in the Mental Healthcare Act, 2017*
A. PREAMBLE		
1.	Does the legislation have a Preamble which emphasizes the human rights of people with mental disorders?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
2.	Does the legislation have a Preamble which emphasizes the importance of accessible mental health services for all?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
3.	Does the legislation specify that the objectives to be achieved include non-discrimination against people with mental disorders?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
4.	Does the legislation specify that the objectives to be achieved include protection and promotion of rights of people with mental disorders?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
5.	Does the legislation specify that the objectives to be achieved include improved access to mental health services?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
6.	Does the legislation specify that the objectives to be achieved include a community-based approach?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

* See also Richard M. Dufy and Brendan D. Kelly, Concordance of the Indian Mental Healthcare Act 2017 with the World Health Organization's Checklist on Mental Health Legislation, International Journal of Mental Health Systems (2017); Richard M. Dufy and Brendan D. Kelly, India's Mental Healthcare Act, 2017 and the World Health Organization's Checklist on Mental Health Legislation, INDIA'S MENTAL HEALTHCARE ACT, 2017 (2020)

	B. Definitions	
7.	Is there a clear definition of mental illness/mental disorder/ mental disability/mental incapacity?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
8.	Is it evident from the legislation why the particular term (above) has been chosen?	❑ Covered Adequately ☑ Covered Partially ❑ Not Covered
9.	Is the legislation clear on whether or not mental retardation/ intellectual disability, personality disorders and substance abuse are being covered in the legislation?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
10.	Are all key terms used consistently in the legislation?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
11.	Are all the key terms used consistently throughout the legislation (i.e., not interchanged with other similar terms with similar meanings)?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
12.	Are all 'interpretable' terms (i.e., terms that may have several possible interpretations or meanings or may be ambiguous in terms of their meaning) in the legislation defined?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
	C. Access to Mental Healthcare	
13.	Does the legislation provide for financing of mental health services?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
14.	Does the legislation state that mental health services should be provided on an equal basis with physical health care?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

15.	Does the legislation ensure allocation of resources to underserved populations and specify that these services should be culturally appropriate?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
16.	Does the legislation promote mental health within primary health care?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
17.	Does the legislation promote access to psychotropic drugs?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
18.	Does the legislation promote a psychosocial, rehabilitative approach?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
19.	Does the legislation promote access to health insurance in the private and public health sector for people with mental disorders?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
20.	Does the legislation promote community care and de-institutionalization?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
D. Rights of Users of Mental Health Services		
21.	Does the legislation include the right to respect, dignity, and being treated in a humane way?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
22.	Is the right to patients' confidentiality regarding information about themselves, their illness and their treatment included?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
23.	Are there sanctions and penalties for people who contravene patients' confidentiality?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

24.	Does the legislation lay down exceptional circumstances when confidentiality may be legally breached?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
25.	Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to release information?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
26.	Does the legislation provide patients free and full access to information about themselves (including access to their clinical records)?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
27.	Are circumstances in which such access can be denied outlined?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
28.	Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to withhold information?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
29.	Does the law specify the right to be protected from cruel, inhuman and degrading treatment?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
30.	Does the legislation set out the minimal conditions to be maintained in mental health facilities for a safe, therapeutic and hygienic environment?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
31.	Does the law insist on the privacy of people with mental disorders?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

32.	Is the law clear on minimal levels of privacy to be respected?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
33.	Does the legislation outlaw forced or inadequately remunerated labour within mental health institutions?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
34.	Does the law make provision for educational activities; vocational training; leisure and recreational activities; and religious or cultural needs of people with mental disorders?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
35.	Are the health authorities compelled by the law to inform patients of their rights?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
36.	Does legislation ensure that users of mental health services are involved in mental health policy, legislation development and service planning?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
E. Rights of Families or Other Carers		
37.	Does the law entitle families or other primary carers to information about the person with a mental disorder (unless the patient refuses the divulging of such information)?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
38.	Are family members or other primary carers encouraged to become involved in the formulation and implementation of the patient's individualised treatment plan?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered

39.	Do families or other primary carers have the right to appeal involuntary admission and treatment decisions?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
40.	Do families or other primary carers have the right to apply for the discharge of mentally ill offenders?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
41.	Does legislation ensure that family members or other carers are involved in the development of mental health policy, legislation and service planning?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
F. Competence, Capacity and Guardianship		
42.	Does legislation make provision for the management of the affairs of people with mental disorders if they are unable to do so?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
43.	Does the law define "competence" and "capacity"?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
44.	Does the law lay down a procedure and criteria for determining a person's incapacity/ incompetence with respect to issues such as treatment decisions, selection of a substitute decision-maker, or making financial decisions?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
45.	Are procedures laid down for appeals against decisions of incapacity/incompetence and for periodic reviews of decisions?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered

46.	Does the law lay down procedures for the appointment, duration, duties and responsibilities of a guardian to act on behalf of a patient?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
47.	Does the law determine a process for establishing in which areas a guardian may take decisions on behalf of a patient?	❑ Covered Adequately ☑ Covered Partially ❑ Not Covered
48.	Does the law make provision for a systematic review of the need for a guardian?	❑ Covered Adequately ☑ Covered Partially ❑ Not Covered
49.	Does the law make provision for a patient to appeal against the appointment of a guardian?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
G. Voluntary Admission and Treatment		
50.	Does the law promote voluntary admission and treatment as a preferred alternative to involuntary admission and treatment?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
51.	Does the law state that all voluntary patients can only be treated after obtaining informed consent?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
52.	Does the law state that people admitted as voluntary mental health users should be cared for in a way that is equitable with patients with physical health problems?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

53.	Does the law state that voluntary admission and treatment also implies the right to voluntary discharge/refusal of treatment?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
54.	Does the law state that voluntary patients should be informed at the time of admission that they may only be denied the right to leave if they meet the conditions for involuntary care?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
H. Non-Protesting Patients		
55.	Does the law make provision for patients who are incapable of making informed decisions about admission or treatment, but who do not refuse admission or treatment?	❑ Covered Adequately ☑ Covered Partially ❑ Not Covered
56.	Are the conditions under which a non-protesting patient may be admitted and treated specified?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
57.	Does the law state that if users admitted or treated under this provision object to their admission or treatment, they must be discharged or treatment stopped unless the criteria for involuntary admission are met?	❑ Covered Adequately ☑ Covered Partially ❑ Not Covered
I. Involuntary Admission (when separate from treatment) and Involuntary treatment (where admission and treatment are combined)		
58.	Does the law state that involuntary admission may only be allowed if there is evidence of mental disorder of specified severity?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

59.	Does the law state that involuntary admission may only be allowed if there is serious likelihood of harm to self or others and/or substantial likelihood of serious deterioration in the patient's condition, if treatment is not given?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
60.	Does the law state that involuntary admission may only be allowed if admission is for a therapeutic purpose?	❑ Covered Adequately ☑ Covered Partially ❑ Not Covered
61.	Does the law state that two accredited mental health care practitioners must certify that the criteria for involuntary admission have been met?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
62.	Does the law insist on accreditation of a facility before it can admit involuntary patients?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
63.	Is the principle of the least restrictive environment applied to involuntary admissions?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
64.	Does the law make provision for an independent authority (e.g., review body or tribunal) to authorise all involuntary admissions?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
65.	Are speedy time frames laid down within which the independent authority must make a decision?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
66.	Does the law insist that patients, families and legal representatives be informed of the reasons for admission and of their rights of appeal?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered

67.	Does the law provide for a right to appeal an involuntary admission?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
68.	Does the law include a provision for time-bound periodic reviews of involuntary (and long-term "voluntary") admission by an independent authority?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
69.	Does the law specify that patients must be discharged from involuntary admission as soon as they no longer fulfill the criteria for involuntary admission?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
J. Involuntary Treatment (when separate from involuntary admission)		
70.	Does the law set out the criteria that must be met for involuntary treatment, including: Patient suffers from a mental disorder?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
71.	Does the law set out the criteria that must be met for involuntary treatment, including: Patient lacks the capacity to make informed treatment decisions?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
72.	Does the law set out the criteria that must be met for involuntary treatment, including: Treatment is necessary to bring about an improvement in the patient's condition, and/or restore the capacity to make treatment decisions, and/or prevent serious deterioration, and/or prevent injury or harm to self or others?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

73.	Does the law ensure that a treatment plan is proposed by an accredited practitioner with expertise and knowledge to provide the treatment?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
74.	Does the law make provision for a second practitioner to agree on the treatment plan?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
75.	Has an independent body been set up to authorise involuntary treatment?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
76.	Does the law ensure that treatment is for a limited time period only?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
77.	Does the law provide for a right to appeal involuntary treatment?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
78.	Are there speedy, time-bound, periodic reviews of involuntary treatment in the legislation?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
	K. Proxy Consent for Treatment	
79.	Does the law provide for a person to consent to treatment on a patient's behalf if that patient has been found incapable of consenting?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
80.	Is the patient given the right to appeal a treatment decision to which a proxy consent has been given?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
81.	Does the law provide for use of "advance directives" and, if so, is the term clearly defined?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

L. Involuntary Treatment in Community Settings		
82.	Does the law provide for involuntary treatment in the community as a "less restrictive" alternative to an inpatient mental health facility?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
83.	Are all the criteria and safeguards required for involuntary inpatient treatment also included for involuntary community-based treatment?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
M. Emergency Situations		
84.	Are the criteria for emergency admission/treatment limited to situations where there is a high probability of immediate and imminent danger or harm to self and/or others?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
85.	Is there a clear procedure in the law for admission and treatment in emergency situations?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
86.	Does the law allow any qualified and accredited medical or mental health practitioner to admit and treat emergency cases?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
87.	Does the law specify a time limit for emergency admission (usually no longer than 72 hours)?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
88.	Does the law specify the need to initiate procedures for involuntary admission and treatment, if needed, as soon as possible after the emergency situation has ended?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

89.	Are treatments such as ECT, psychosurgery and sterilization, as well as participation in clinical or experimental trials outlawed for people held as emergency cases?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
90.	Do patients, family members and personal representatives have the right to appeal against emergency admission/treatment?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
N. Determination of Mental Disorder		
91.	Does the legislation define the level of skills required to determine mental disorder?	❑ Covered Adequately ☑ Covered Partially ❑ Not Covered
92.	Does the legislation specify the categories of professionals who may assess a person to determine the existence of a mental disorder?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
93.	Is the accreditation of practitioners codified in law and does this ensure that accreditation is operated by an independent body?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
O. Special Treatments		
94.	Does the law prohibit sterilization as a treatment for mental disorder?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
95.	Does the law specify that the mere fact of having a mental disorder should not be a reason for sterilization or abortion without informed consent?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
96.	Does the law require informed consent for major medical and surgical procedures on persons with mental disorders?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

97.	Does the law allow medical and surgical procedures without informed consent, if waiting for informed consent would put the patient's life at risk?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
98.	In cases where inability to consent is likely to be long term, does the law allow authorization for medical and surgical procedures from an independent review body or by proxy consent of a guardian?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
99.	Are psychosurgery and other irreversible treatments outlawed on involuntary patients?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
100.	Is there an independent body that makes sure there is indeed informed consent for psychosurgery or other irreversible treatments on involuntary patients?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
101.	Does the law specify the need for informed consent when using ECT?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
102.	Does the law prohibit the use of unmodified ECT?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
103.	Does the law prohibit the use of ECT in minors?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
P. Seclusion and Restraint		
104.	Does the law state that seclusion and restraint should only be utilized in exceptional cases to prevent immediate or imminent harm to self or others?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

105.	Does the law state that seclusion and restraint should never be used as a means of punishment or for the convenience of staff?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
106.	Does the law specify a restricted maximum time period for which seclusion and restraints can be used?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
107.	Does the law ensure that one period of seclusion and restraint is not followed immediately by another?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
108.	Does the law encourage the development of appropriate structural and human resource requirements that minimize the need to use seclusion and restraints in mental health facilities?	☑ Covered Adequately ❑ Covered Partially ***Not covered?**
109.	Does the law lay down adequate procedures for the use of seclusion and restraints, including: who should authorise it; that the facility should be accredited; that the reasons and duration of each incident be recorded in a database and made available to a review board; and that family members/ carers and personal representatives be immediately informed when the patient is subject to seclusion and/or restraint?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

Q. Clinical and Experimental Research		
110.	Does the law state that informed consent must be obtained for participation in clinical or experimental research from both voluntary and involuntary patients who have the ability to consent?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
111.	Where a person is unable to give informed consent (and where a decision has been made that research can be conducted): Does the law ensure that proxy consent is obtained from either the legally appointed guardian or family member, or from an independent authority constituted for this purpose?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
112.	Where a person is unable to give informed consent (and where a decision has been made that research can be conducted): Does the law state that the research cannot be conducted if the same research could be conducted on people capable of consenting, and that the research is necessary to promote the health of the individual and that of the population represented?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
R. Oversight and Review Mechanisms		
113.	Does the law set up a judicial or quasi-judicial body to review processes related to involuntary admission or treatment and other restrictions of rights?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

114.	Does the above body: Assess each involuntary admission/treatment?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
115.	Does the above body entertain appeals against involuntary admission and/or involuntary treatment?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
116.	Does the above body review the cases of patients admitted on an involuntary basis (and long-term voluntary patients)?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
117.	Does the above body regularly monitor patients receiving treatment against their will?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
118.	Does the above body authorise or prohibit intrusive and irreversible treatments (such as psychosurgery and ECT)?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
119.	Does the composition of this body include an experienced legal practitioner and an experienced health care practitioner, and a "wise person" reflecting the "community" perspective?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
120.	Does the law allow for appeal of this body's decisions to a higher court?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
121.	Does the law set up a regulatory and oversight body to protect the rights of people with mental disorders within and outside mental health facilities?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

122.	Does the above body conduct regular inspections of mental health facilities?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
123.	Does the above body provide guidance on minimizing intrusive treatments?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
124.	Does the above body maintain statistics on, for example, the use of intrusive and irreversible treatments, seclusion and restraints?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
125.	Does the above body maintain registers of accredited facilities and professionals?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
126.	Does the above body report and make recommendations directly to the appropriate government minister?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
127.	Does the above body publish findings on a regular a basis?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
128.	Does the composition of the body include professionals (in mental health, legal, social work), representatives of users of mental health facilities, members representing families of people with mental disorders, advocates and lay persons?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
129.	Is this body's authority clearly stated in the legislation?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

130.	Does the legislation outline procedures for submissions, investigations and resolutions of complaints?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
131.	Does the law stipulate the time period from the occurrence of the incident within which the complaint should be made?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
132.	Does the law stipulate a maximum time period within which the complaint should be responded to, by whom and how?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
133.	Does the law stipulate the right of patients to choose and appoint a personal representative and/or legal counsel to represent them in any appeals or complaints procedures?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
134.	Does the law stipulate the right of patients to an interpreter during the proceedings, if necessary?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
135.	Does the law stipulate the right of patients and their counsel to access copies of their medical records and any other relevant reports and documents during the complaints or appeals procedures?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
136.	Does the law stipulate the right of patients and their counsel to attend and participate in complaints and appeals procedures?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

S. Police Responsibilities		
137.	Does the law place restrictions on the activities of the police to ensure that persons with mental disorders are protected against unlawful arrest and detention and are directed towards the appropriate health care services?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
138.	Does the legislation allow family members, carers or health professionals to obtain police assistance in situations where a patient is highly aggressive or is showing out-of-control behaviour?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
139.	Does the law allow for persons arrested for criminal acts, and in police custody, to be promptly assessed for mental disorder, if there is suspicion of mental disorder?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
140.	Does the law make provision for the police to assist in taking a person to a mental health facility who has been involuntarily admitted to the facility?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
141.	Does the legislation make provision for the police to find an involuntarily committed person who has absconded and return him/her to the mental health facility?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

	T. Mentally Ill Offenders	
142.	Does the legislation allow for diverting an alleged offender with a mental disorder to the mental health system in lieu of prosecuting him/her, taking into account the gravity of the offence, the person's psychiatric history, mental health state at the time of the offence, the likelihood of detriment to the person's health and the community's interest in prosecution?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
143.	Does the law make adequate provision for people who are not fit to stand trial to be assessed, and for charges to be dropped or stayed while they undergo treatment?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
144.	Are people undergoing such treatment given the same rights in the law as other involuntarily admitted persons, including the right to judicial review by an independent body?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
145.	Does the law allow for people who are found by the courts to be "not responsible due to mental disability" to be treated in a mental health facility and to be discharged once their mental disorder sufficiently improves?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

146.	Does the law allow, at the sentencing stage, for persons with mental disorders to be given probation or hospital orders, rather than being sentenced to prison?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
147.	Does the law allow for the transfer of a convicted prisoner to a mental health facility, if he/she becomes mentally ill while serving a sentence?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
148.	Does the law prohibit keeping a prisoner in the mental health facility for longer than the sentence, unless involuntary admission procedures are followed?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
149.	Does the legislation provide for secure mental health facilities for mentally ill offenders?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
	U. Discrimination	
150.	Does the law include provisions aimed at stopping discrimination against people with mental disorders?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
	V. Housing	
151.	Does the law ensure non-discrimination of people with mental disorders in the allocation of housing?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
152.	Does the law make provision for housing of people with mental disorders in state housing schemes or through subsidized housing?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

153.	Does the legislation make provision for housing in halfway homes and long stay, supported homes for people with mental disorders?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
	W. Employment	
154.	Does the law make provision for the protection of persons with mental disorders from discrimination and exploitation in the work place?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
155.	Does the law provide for "reasonable accommodation" for employees with mental disorders, for example by providing for a degree of flexibility in working hours to enable those employees to seek mental health treatment?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
156.	Does the law provide for equal employment opportunities for people with mental disorders?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
157.	Does the law make provision for the establishment of vocational rehabilitation programmes and other programmes that provide jobs and employment in the community for people with mental disorders?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
	X. Social Security	
158.	Does legislation provide for disability grants and pensions for people with mental disabilities?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered

159.	Does the law provide for disability grants and pensions for people with mental disorders at similar rates as those for people with physical disabilities?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
Y. Civil Issues		
160.	Does the law uphold the rights of people with mental disorders to the full range of civil, political, economic, social and cultural rights to which all people are entitled?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
Z. Protection of Vulnerable Groups		
Protection of Minors		
161.	Does the law limit the involuntary placement of minors in mental health facilities to instances where all feasible community alternatives have been tried?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
162.	If minors are placed in mental health facilities, does the legislation stipulate that they should have a separate living area from adults?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
163.	If minors are placed in mental health facilities, does the legislation stipulate that the environment is age appropriate and takes into consideration the developmental needs of minors?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
164.	Does the law ensure that all minors have an adult to represent them in all matters affecting them, including consenting to treatment?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

165.	Does the law stipulate the need to take the opinions of minors into consideration on all issues affecting them (including consent to treatment), depending on their age and maturity?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
166.	Does legislation ban all irreversible treatments for children?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
<u>Protection of Women</u>		
167.	Does legislation allow women with mental disorders equal rights with men in all matters relating to civil, political, economic, social and cultural rights?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
168.	Does the law ensure that women in mental health facilities have adequate privacy?	❑ Covered Adequately ☑ Covered Partially ❑ Not Covered
169.	Does the law ensure that women in mental health facilities are provided with separate sleeping facilities from men?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
170.	Does legislation state that women with mental disorders should receive equal mental health treatment and care as men, including access to mental health services and care in the community, and in relation to voluntary and involuntary admission and treatment?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

Protection of Minorities		
171.	Does legislation specifically state that persons with mental disorders should not be discriminated against on the grounds of race, colour, language, religion, political or other opinions, national, ethnic or social origin, legal or social status?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
172.	Does the legislation provide for a review body to monitor involuntary admission and treatment of minorities and ensure non-discrimination on all matters?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
173.	Does the law stipulate that refugees and asylum seekers are entitled to the same mental health treatment as other citizens of the host country?	❑ Covered Adequately ❑ Covered Partially ☑ Not Covered
AA. Offences and Penalties		
174.	Does the law have a section dealing with offences and appropriate penalties?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered
175.	Does the law provide appropriate sanctions against individuals who violate any of the rights of patients as established in law?	☑ Covered Adequately ❑ Covered Partially ❑ Not Covered

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