CHAPTER - VII

CONCLUSION AND SUGGESTIONS

“What are we having this liberty for? We are having this liberty in order to reform our social system, which is full of inequality, discrimination and other things, which conflict with our fundamental rights.”

B.R. Ambedkar

People with mental illness encountering human rights violations in meeting their basic needs are a reality to be found in every corner of the globe. The inherent vulnerability of those with mental health issues and the stigma of being a burden on society, it is essential that human rights are acknowledged for this population. The reports show that individuals with mental health issues are maltreated and marginalized due to the nature of their illness. This trend is attributed to a number of factors including culture, ethnicity, religion, language, and poverty. Although there are ongoing discourses over the treatment of individuals diagnosed with mental illness and those exhibiting mental health symptoms around the world, it is important to note that the severity of abuse varies from one culture to another based on inherent beliefs. For instance, just as in certain cultures, women are not accorded equal rights and are relegated to the background; some cultures perceive the mentally ill as not being part of normal society and hence, those with mental illness are subjected to varying forms of abuse. The maltreatment and abuse of the mentally ill have been widely captured in literature. Furthermore, India’s dismal record of rights violations of the mentally ill was glaringly exposed with the death of twenty-five patients at an asylum in Tamil Nadu. The lack of human rights or their violations, as seen in the Erwadi tragedy and

---

4On 6 August, 2001, in Erwady in the Ramanathapuram district of Tamil Nadu, 26 mentally ill patients kept chained in a thatched shed in a dargah were charred to death in a fire. Following this shocking incident, the Supreme Court took suo moto notice of the incident in the form of a Public Interest Litigation, quoted in NHRC, Mental Health Care and Human Rights, 71 (2008) available at: http://www.bhrc.bih.nic.in/Docs/Mental-HealthCare-and-Human-Rights.pdf (Visited on June 7, 2017).
similar cases\textsuperscript{5}, does not stem from a shortcoming in existing Indian or international law \textit{per se}; but is the result of social stigma, prejudice, and other social and economic factors linked with mental illness.\textsuperscript{6} Every human body and mind has an integrity which is inviolable.

Every human being has certain irreducible barest minimum needs such as right to air, potable water, food, clothing, health, medical care and treatment, clean and hygienic conditions for living accommodation, environmental sanitation, personal hygiene and so on. Deprivation of any one of these amounts to violence to the person.\textsuperscript{7}

The term mental disorder has been defined under various Indian legislations. Mental health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the WHO’s definition of health: “A state of complete physical, mental and social well-being, and not merely the absence of disease.” It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.\textsuperscript{8} The expression \textit{mental disorder} under the Hindu Marriage Act, 1955, means mental illness, arrested or incomplete development of mind, psychopathic disorder or any other disorder or disability of mind and includes schizophrenia.\textsuperscript{9} The word \textit{Mental illness} under Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1955, means any mental disorder other than mental retardation.\textsuperscript{10} \textit{Mental Illness} under the Mental Healthcare Act, 2017 means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the

\textsuperscript{5}The Delhi-based NGO ‘Saarthak’ filed a Public Interest Litigation in October 2001, calling for a ban on the practice of physical restraint and administering ‘unmodified’ or ‘direct’ Electro Convulsive Therapy, i.e. ECT without anaesthesia. ACMI, an advocacy organisation for families caring for family members with mental illness, filed another Public Interest Litigation before the court emphasising the importance of family members and their underrepresentation in decisions regarding the care of the mentally ill, quoted in NHRC, Mental Health Care and Human Rights, 71-72 (2008) available at: \url{http://www.bhrc.bih.nic.in/Docs/Mental-HealthCare-and-Human-Rights.pdf} (Visited on June 7, 2017).

\textsuperscript{6}Supra note 2.


\textsuperscript{9}The Hindu Marriage Act, 1955, s. 13(1).

ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub-normality of intelligence person who is in need of treatment by reason of any mental disorder other than mental retardation.\textsuperscript{11} The expression \textit{psychopathic disorder} means persistent disorder or disability of mind, whether or not including sub-normality of intelligence which results in an abnormally aggressive or seriously irresponsible conduct on the part of the other party, and whether or not it requires or is susceptible to medical treatment.\textsuperscript{12} A term \textit{psychotic disorder} involves distorted awareness and thinking. Two of the most common symptoms of psychotic disorders are hallucinations (the experience of images or sounds that are not real, such as hearing voices) and delusions, which are false beliefs that the ill person accepts as true, despite evidence to the contrary. Schizophrenia is an example of a psychotic disorder.\textsuperscript{13} The term \textit{Depression} is a clinical disorder which may be caused by various social factors. Most experts agree that while depression disorders decrease with age, depression symptoms decrease. The relationship between age and depression symptoms is curvilinear: younger and older people have the highest number of depression symptoms whereas middle aged people have the lowest.\textsuperscript{14} \textit{Lunatic} had been defined under the Indian Lunacy Act, 1912 an idiot or person of unsound mind.\textsuperscript{15}

In \textit{Smt. Anima Roy v. Probodh Mohan Roy},\textsuperscript{16} the Court observed, that the definition thus says that \textit{lunatic} means (it does not say includes) an idiot or a person of unsound mind. It is, therefore, a hard and fast definition and we cannot give any other meaning to the word lunatic than that which is mentioned in the definition itself. Hence, going by the language of the Hindu Marriage Act, it is not possible to make room for different degrees of lunacy. No doubt, while Section 5, Clause (ii) of the Hindu Marriage Act, 1955, makes a difference between an idiot and a lunatic, Section 3 clause (5), of the lunacy Act, 1912 regards an idiot as much a lunatic as a person of unsound mind. In a decree for annulment, by a decree of nullity, of a marriage on the

\begin{footnotesize}
\begin{enumerate}
\item The Mental Healthcare Act, 2017, s. 2(s).
\item The Hindu Marriage Act, 1955, s. 13(1).
\item Joseph Goldberg, "Types of Mental Illness" available at: http://www.webmd.com/mental-health/mental-health-types-illness (Visited on April 18, 2013).
\item Sumita Saha and Ruby Sain, \textit{Depression among the Elderly} 39 (2012).
\item Indian Lunacy Act, 1912, 3(5).
\item AIR 1969 Cal. 304.
\end{enumerate}
\end{footnotesize}
ground of lunacy of the spouse, the burden to prove lunacy at the time of marriage lies on the petitioner.

Mental Infirmity and Mental Unsoundness of mind has been discussed in Jai Prakash Goel v. State, the Court observed that a person may not be adjudged as of unsound mind yet the court may nevertheless consider it appropriate to appoint a guardian ad litem under Order xxxii Rule 15. However, the Court is not bound to make a rigorous or formal enquiry as contemplated by the Lunacy Act, 1912 and is competent to pass an order as soon as it is satisfied as to the party’s mental competence. The Court further observed that there is a vast difference between mental unsoundness and incapacity by reason of mental infirmity, the latter being of a lesser degree. The Collins English Dictionary and Cobuild English Dictionary defines infirm as weak or ill and usually old. The Concise Oxford Dictionary states that infirm refers to a person who is not physically strong, especially through age. In Black’s Law Dictionary “infirm” has been defined as weak, feeble, lacking moral character or weak of health. Incapacity has been defined in the same treatise as want of legal ability of act. A person suffering from a low intellectual quotient (IQ) may not be viewable as of unsound mind, but there can be no gainsaying that he would be incapable of protecting his interests in litigation. The Mental Health Act, 1987, in Section 2(1) defines mentally ill person as one who is in need of treatment by reason of any mental disorder other than retardation, thereby drawing a distinction between these states of health. There is no manner of doubt that Respondent, Shri Brahm Prakash is incapable of protecting his interests in the litigation by reason of his infirmity and infliction of an abnormally low IQ. Accordingly, the Court appointed Mrs. Meena Goel, Wife of Shri Brahm Prakash, as his guardian ad litem.

Mental health has been hidden behind a curtain of stigma and discrimination for too long. It is time to bring it out into the open. The magnitude, suffering and burden in terms of disability and costs for individuals, families and societies are staggering. In the last few years, the world has become more aware of this enormous burden and the potential for mental health gains. According to World Health Organisation, it is estimated that approximately 500 million individuals globally are

---

17AIR 2005 Delhi 83.
18Id.at 84 and 87.
affected by mental illness, alcoholism and drug addiction. However, at any given time, it is estimated that approximately 20% of the adult population have a mental health problem. In India, neuropsychiatric disorders are estimated to contribute to 11.6% of the global burden of disease. In Canada, it is believed that mental illness will affect approximately 20% of the population in their lifetime. The increase in the incidence of depression, in particular, is alarming. Depression is a common illness worldwide, with an estimated 350 million people affected. One out of ten people suffer from major depression and almost one out of five persons has suffered from this disorder during his or her lifetime. By 2020, depression will be the second leading cause of world disability and by 2030; it is expected to be the largest contributor to disease burden. Suicidal behaviours have been associated with depressive symptoms. Every year over 800,000 people die by suicide according to the World Health Organisation. Moreover, suicide is the 10th leading cause of death in the United States, accounting for the deaths of approximately 43,000 Americans in 2014. According to a report the global cost of mental illness estimates at nearly $2.5 Trillion in 2010, with a projected increase to over $6Trillion by 2030. Depression was estimated to cost at least US$ 800 billion in 2010 in lost economic output, a sum expected to more than double by 2030. In India, according to World Health

23 Magnus Mfoafo-M’Carthy and Stephanie Huls, Supra note 3.
24 ILO, Supra note 21.
28 Ibid.
Organisation the burden of mental health problems is of the tune of 2,443 DALYs per 100,000 population, and the age-adjusted suicide rate per 100,000 population is 21.1. It is estimated that, in India, the economic loss, due to mental health conditions, between 2012-2030, is 1.03 trillions of 2010 dollars. Mental health workforce in India (per 100,000 population) include psychiatrists (0.3), nurses (0.12), psychologists (0.07) and social workers (0.07).  

Today, the mental disorders are among one of the leading causes of the diseases and disability in the world, it has become necessary to generate the awareness of mental health especially in countries like India where too many misconceptions are existing. For example the most common misconception is that the India has low percentage of the population suffering from mental disorder and needs to be handled first so that the approachability to mental health services can be enhanced. The concept of mental health in India encompasses only the treatment of seriously mentally ill person admitted in the mental hospital, otherwise it has no implications to them. Though, the morbidity rate of mental disorders is surprisingly high in India. In India, there has been a very recent change that few people have started acknowledging the relevance of general mental health.

Vignettes of depression and dementia were widely recognized. However, neither condition was thought to constitute a health condition. Dementia was construed as a normal part of ageing and was not perceived as requiring medical care. Thus, primary health physicians rarely saw this condition in their clinical work, but community health workers frequently recognized individuals with dementia. Depression was a common presentation in primary care, but infrequently diagnosed. Both late-life mental disorders were attributed to abuse, neglect, or lack of love on the part of children towards a parent. There was evidence that the system of family care and support for older persons was less reliable than has been claimed. Care was often conditional upon the child’s expectation of inheriting the parent’s property. Care for those with dependency needs was almost entirely family-based with little or no formal

services. Unsurprisingly, fear for the future, and in particular dependency anxiety was common place among elderly.34

The problem is not prevalent in adults but is also emerging in the children. Despite the strong commitment to child protection enshrined in the Indian Constitution and child related policies; the country’s progeny is at profound risk. The mental health problems cause great suffering to the child, their families, and communities and great loss to the society and nation. A healthy childhood lays the foundation for a healthy adulthood. Children and adolescents are valuable assets to families and nations and thus their overall wellbeing is a matter of a grave concern.35

The competence of the psychiatrist to fill the role of mental hygienist raises additional questions. Within the field of mental hygiene, psychiatrists face new functions and goals; occasionally they assume or are assigned responsibilities which they are poorly equipped to fulfill. They have been trained as medical practitioners, but they are moving from their therapeutic role to invade such areas as education, social science and community organization. Indeed many of the weaknesses in the mental hygiene movement reflect the deficiencies that psychiatrists have brought to it.36 The crux of the problem here is that our model of medical education and training is not adequate to meet the demands of the rising burden. The psychiatrist community is aware of the problem, but the problem has not been addressed seriously.37

International human rights instruments are important in the context of mental health because they are the only source of law that legitimizes international scrutiny of mental health policies and practices within a sovereign country and also because they provide fundamental protections that cannot be taken away by the ordinary political process. Mental health and human rights are inextricably linked. They are complementary approaches to the betterment of human beings. Some measure of mental health is indispensable for human rights because only those who possess some reasonable level of functioning can engage in political and social life. On the other

36George Rosen, Madness in Society: Chapters in the Historical Sociology of Mental Illness 326 (1968).
hand, human rights are indispensable for mental health as they provide security from harm or restraint and the freedom to form and express beliefs that are essential to mental well-being.\textsuperscript{38} In accordance with the objectives of the United Nations Charter and international agreements, a fundamental basis for mental health legislation is human rights. Key rights and principles include equality and non-discrimination, the right to privacy and individual autonomy, freedom from inhuman and degrading treatment, the principle of the least restrictive environment, and the rights to information and participation.\textsuperscript{39} The United Nations has defined human rights to mean generally as “those rights, which are inherent in our nature and without which we cannot live as human beings. Section 2 (d) of the Protection of Human Rights Act, 1993 has defined the human rights to mean the rights relating to life, liberty, equality and dignity of the individual guaranteed under the Constitution or embodied in the international covenants and enforceable by the courts in India.\textsuperscript{40} Mental health legislation is a powerful tool for codifying and consolidating these fundamental values and principles. Equally, being unable to access care is an infringement of a person’s right to health, and access can be included in legislation.\textsuperscript{41} Therefore, international and regional systems have addressed the human rights of persons with mental illnesses through treaties, declarations and thematic resolutions.\textsuperscript{42} A person with mental illness is entitled to treatment with the same dignity and decency as any other human being. A mentally ill person does not become a non person merely on account of certain disabilities.\textsuperscript{43} Mentally ill persons have to be treated at par with all human beings. All international documents, be it the Universal Declaration of Human Rights, U.N. Declarations on the Rights of Disabled and Mentally Retarded Persons or the Principles for the Protection of persons with Mental Illness and the Improvement of Mental Health Care, proclaimed or adopted, as the case may be, by the General Assembly, provide that such persons shall be treated at par with all other

\textsuperscript{38}Carla A. Arena Ventura, “International Law, Mental Health and Human Rights”, available at: https://humanrights.nd.edu/assets/134859/venturamentalhealth.pdf (Visited on June 10, 2016).


\textsuperscript{41}Supra note 39.

\textsuperscript{42}Supra note 38.

persons. In 1948, the United Nations through its Declaration of Human Rights affirmed the basic principle that a mentally ill person should at all times be treated with humanity and respect for the inherent dignity of the person. Every person with a mental illness should have the right to exercise all civil, political, social and cultural rights. The Declaration of the Rights of the disable, which includes person with mental illness, was adopted by the United Nations in 1975.

The United Nations Charter affirms the essentiality of “a universal respect for, and observance of, human rights and fundamental freedoms for all without distinction…” The rights of individuals with disabilities are grounded in a human rights framework based on the United Nations Charter, the Universal Declaration of Human Rights, international covenants on human rights and related human rights instruments. Persons with disabilities are entitled to exercise their civil, political, social, economic and cultural rights on an equal basis with others under all the international treaties. The full participation of persons with disabilities benefits society as their individual contributions enrich all spheres of life and this is an integral part of individual’s and society’s well-being and progress for a society for all - with or without disabilities. In the context of mentally ill persons, it not only refers to their privileges but remedial right of protection against infringement of their human and other statutory rights. The first human rights legal resolutions, such as Universal Declaration of Human Rights, did not specifically address the rights of mental health consumers. They codified more general, but still relevant rights, like right to life and liberty and right to be free from inhuman, degrading treatment. Later resolutions such as the Declaration on the Rights of Mentally Retarded Persons, 1971 and the Declaration on the Rights of The Disabled Persons, 1975, began the process of establishing international minimum standards for the treatment of persons with mental disabilities.

The United Nations Charter, adopted as a binding treaty in 1945, requires member states to advocate and to observe the human rights of all individuals,

---

45Supra note 40.
regardless of their racial, gender, ethnic, or religious differences.\textsuperscript{48} India was among the original members of the United Nations that signed the Declaration by United Nations at Washington on 1 January 1942 and also participated in the historic United Nations Conference of International Organization at San Francisco from 25 April to 26 June 1945. As a founding member of the United Nations, India strongly supports the purposes and principles of the United Nations and has made significant contributions to implementing the goals of the Charter, and the evolution of the United Nations specialized programmes and agencies.\textsuperscript{49}

The Universal Declaration of human rights was drafted by representatives of all regions of the world and encompassed all legal traditions. Formally adopted by the United Nations on December 10, 1948, it is the most universal human rights document in existence, delineating the thirty fundamental rights that form the basis for a democratic society.\textsuperscript{50} Forty eight countries came together at the United Nations held in Paris; they are the Universal Declaration of Human Rights signatories.\textsuperscript{51} In addition, India is one of the founding signatories of Universal Declaration of Human Rights. Notable is the fact that signatory states have legal obligations to protect, promote and fulfill concerned human rights treaties.\textsuperscript{52} The Universal Declaration of Human Rights contains a comprehensive listing of key civil, political, economic, social, and cultural rights.\textsuperscript{53} While this declaration articulated the core elements of public health concerns, it did not create any binding obligations on the members of the United Nations.\textsuperscript{54} The document’s non binding status was initially perceived as

one of its major weaknesses.\textsuperscript{55} Though not legally binding, a declaration may by custom become recognized as laying down rules binding upon States.\textsuperscript{56} Today, the Declaration is a living document that has been accepted as a contract between a government and its people throughout the world. According to the Guinness Book of World Records, it is the most translated document in the world.\textsuperscript{57} Many of these rights, in various forms, are today part of the constitutional laws of democratic nations.\textsuperscript{58} Further, the Universal Declaration has given rise to a range of other international agreements which are legally binding on the countries that ratify them. These include the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights.\textsuperscript{59}

The International Covenant on Civil and Political Rights was adopted by the United Nations General Assembly on 16 December 1966. The ICCPR was to take effect ten years later in all nations that had become state parties. A sufficient number of states had become parties so the ICCPR took effect as planned in 1976.\textsuperscript{60} India acceded to the Convention on 10 April 1979.\textsuperscript{61}In accordance with the Universal Declaration, the Covenants recognize that “... the ideal of free human beings enjoying civil and political freedom and freedom from fear and want can be achieved only if conditions are created whereby everyone may enjoy his civil and political rights, as well as his economic, social and cultural rights.”\textsuperscript{62} In subsequent years, the right to health came to be incorporated in the International Covenant on Economic, Social and Cultural Rights which was presented before the UN General Assembly in 1966 and

\textsuperscript{55}Supra note 53.


\textsuperscript{57}Supra note 50.


adopted in 1976.\textsuperscript{63} India also acceded to the Convention on 10 April 1979.\textsuperscript{64} The rights enumerated in the International Covenant on Economic, Social & Cultural Rights were subject to ‘progressive realisation’ and further contingent on the ability of State parties to muster adequate material resources for fulfilling the same. This condition was at the heart of the difference between rights enumerated in the International Covenant on Economic, Social & Cultural Rights and those enumerated in the International Covenant on Civil and Political Rights which could be specifically enforced against State parties. The hierarchy between the rights enumerated in the two covenants reflected the cold-war politics over the prioritization of the same. Some of the rights enumerated in the International Covenant on Civil and Political Rights were given a ‘non-derogable’ status and individual complaints mechanisms have been created for the protection of the same. In comparison, the economic, social and cultural rights were not made the subject of any means of specific enforcement at the international level and have retained an aspirational character, in a manner akin to the Directive principles in the Constitution of India.\textsuperscript{65}

In addition to the covenants in the International Bill of Human Rights,\textsuperscript{66} the United Nations has adopted more than twenty principal treaties further elaborating human rights. These include conventions to prevent and prohibit specific abuses such as torture and genocide and to protect specific vulnerable populations such as women (Convention on the Elimination of All Forms of Discrimination Against Women, 1979\textsuperscript{67}) and children (Convention on the Rights of the Child, 1989\textsuperscript{68}). Other conventions cover racial discrimination, prevention of genocide, political rights of women, prohibition of slavery and torture. Each of these treaties has established a

\textsuperscript{63}Supra note 54.
\textsuperscript{64}Supra note 61.
\textsuperscript{65}Supra note 54.
\textsuperscript{67}India signed the Convention on 30 July 1980 and ratified it on 9 July 1993 with certain reservations, Quoted in Supra note 61.
\textsuperscript{68}India acceded to the Convention on 11 December 1992, Quoted in Supra note 61.
committee of experts to monitor implementation of the treaty provisions by its State parties.  

In addition, in 1993, the Vienna Declaration, established during the World Conference on Human Rights meeting in Vienna, reemphasized the fact that people with mental and physical disabilities are protected by international human rights law and that governments must establish domestic legislation to realize these rights.  

The International Labour Organization deals with the whole range of labour issues. It attaches particular importance to basic economic and social as well as civil and political rights, as an essential element to improve the conditions of workers. It endeavours to implement these principles by adopting standards on subjects of concern. These International Labour Organization standards take the form of international labour conventions and recommendations. International Labour Organization’s Conventions are international treaties, subject to ratification by International Labour Organization Member States, whereas recommendations are non-binding. The International Labour Organization, adopted in 1998, makes it clear that these rights are universal, and that they apply to all people in all States - regardless of the level of economic development. It particularly mentions groups with special needs, including the unemployed and migrant workers. It recognizes that economic growth alone is not enough to ensure equity, social progress and to eradicate poverty. Everyone has the right to decent and productive work in conditions of freedom, equity, security, and human dignity. For people with mental health problems, achieving this right is particularly challenging. The right of people with disabilities to decent work, however, is frequently denied. People with disabilities, particularly women with disabilities, face enormous attitudinal, physical and informational barriers to equal opportunities in the world of work. Compared to non-disabled persons, they experience higher rates of unemployment and economic inactivity and are at greater risk of insufficient social protection that is a key to

70 Supra note 38.
73 Supra note 21 at 1.
reducing extreme poverty. The International Labour Organization has a longstanding commitment to promoting social justice and achieving decent work for people with disabilities.\textsuperscript{74} The International Labour Organisation’s mandate on disability issues is laid down in the International Labour Organization Convention concerning Vocational Rehabilitation and Employment of Disabled Persons No. 159 (1983).\textsuperscript{75} The International Labour Organization adopted Convention No. 159 on Vocational Rehabilitation and Employment (Disabled Persons) to urge countries to formulate, implement, and review national policies on vocational rehabilitation and employment of persons with disabilities based on the principle of equal opportunity.\textsuperscript{76} The convention defines a disabled person as an individual whose prospects of securing, retaining, and advancing in suitable employment are substantially reduced as a result of a duly recognized physical or mental impairment.\textsuperscript{77}

The Declaration on the Rights of Disabled Persons, proclaimed by General Assembly resolution 3447 (XXX) of 9 December 1975, reiterates the commitments and principles established in earlier United Nations instruments, and reaffirms the rights of persons with disabilities, set forth in the Declaration, without discrimination on any basis. It also reiterates the necessity of preventing physical and mental disabilities and of assisting persons with disabilities to develop their abilities in the most varied fields of activities and of promoting their integration as far as possible in normal life.\textsuperscript{78} In essence, the Declaration on the Rights of Disabled Persons states that all persons with disabilities have the same rights as other persons.\textsuperscript{79}

The binding treaties discussed above establish the underpinnings of the United Nations system of human rights. The norms and principles they contain, however, do not specifically address the rights of persons with mental disabilities. Traditionally,

\textsuperscript{75} Supra note 21 at 1.
\textsuperscript{77} Supra note 21 at 1.
monitoring bodies operating under the treaties have not adequately enforced them. Consequently, further guidance, development, and explanation have been necessary to ensure that member states can effectively apply the rights contained in these instruments to protect and promote mental health. Beginning in the 1970s, the United Nations developed a number of comments, declarations, resolutions, and guidance documents that have elaborated on the application of general rights to persons with mental disabilities. This evolution has occurred gradually, incrementally, and often inconsistently. General Comments to the International Covenants, General Assembly resolutions, Special Rapporteur reports on health and disability rights, and other related initiatives, some of which are ongoing as of this writing, have clarified the rights of persons with mental disabilities. Most significantly, the United Nations has approved principles that directly apply to the rights of persons with mental disabilities.80

In 1971, the General Assembly of the United Nations, in its resolution 2856 (XXVI), proclaimed the Declaration on the Rights of Mentally Retarded Persons. Bearing in mind the necessity of assisting persons with mental disabilities to develop their full abilities and of promoting their integration, the General Assembly calls for national and international action to ensure that the Declaration is used as a common basis and frame of reference for the protection of their rights.81 The Declaration proclaims that the mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings.82

In 1991 the United Nations General Assembly adopted Resolution 46/119, comprising principles for protecting the human rights of persons with mental disorders. The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care bring together a set of basic rights that the international community regards as inviolable in community and treatment settings. The 25 principles cover the definition of mental illness; protection of confidentiality; standards of care and treatment, including involuntary admission and consent to treatment; rights of persons with mental disorders in mental health facilities;

---

80Supra note 48.
81Supra note 78.
protection of minors; provision of resources for mental health facilities; role of
community and culture; review mechanisms providing for the protection of the rights
of offenders with mental disorders; procedural safeguards protecting the rights of
persons with mental disorders.\textsuperscript{83}

In order to facilitate the understanding and implementation of the United
Nations Principles, WHO published guidelines to the human rights of persons with
mental disorders. The guidelines include a checklist to facilitate the rapid assessment
of human rights conditions at the local and regional levels. A further document that
aids the implementation of the United Nations Principles is entitled \textit{Mental Health
Care Law: Ten Basic Principles}. It is based on a comparative analysis of national
mental health laws and describes ten basic principles for mental health legislation
irrespective of the cultural or legal context. There are annotations on the
implementation of the principles.\textsuperscript{84} The ten basic principles are promotion of mental
health and prevention of mental disorders, access to basic mental health care, Mental
health assessment in accordance with internationally accepted principles, provision of
the least restrictive type of mental health care, self-determination, right to be assisted
in the exercise of self-determination, availability of review procedures, automatic
periodic review mechanism, Qualified decision-makers and respect for the rule of
law.\textsuperscript{85}

WHO supports governments in the goal of strengthening and promoting
mental health. WHO has evaluated evidence for promoting mental health and is
working with governments to disseminate this information and to integrate effective
strategies into policies and plans. In 2013, the World Health Assembly approved a
Comprehensive Mental Health Action Plan for 2013-2020. The Plan is a commitment
by all WHO’s Member States to take specific actions to improve mental health and to
contribute to the attainment of a set of global targets. The Action Plan’s overall goal is
to promote mental well-being, prevent mental disorders, provide care, enhance
recovery, promote human rights and reduce the mortality, morbidity and disability for
persons with mental disorders. It focuses on 4 key objectives to strengthen effective
leadership and governance for mental health; provide comprehensive, integrated and

\textsuperscript{83}WHO, Mental Health Legislation & Human Rights, 17 (2003), available at:
\textsuperscript{84}Ibid.
\textsuperscript{85}Id. at 18.
responsive mental health and social care services in community-based settings; implement strategies for promotion and prevention in mental health; and strengthen information systems, evidence and research for mental health. Particular emphasis is given in the Action Plan to the protection and promotion of human rights, the strengthening and empowering of civil society and to the central place of community-based care. In order to achieve its objectives, the Action Plan proposes and requires clear actions for governments, international partners and for WHO. Ministries of health will need to take a leadership role and WHO will work with them and with international and national partners, including civil society, to implement the plan. As there is no action that fits all countries, each government will need to adapt the Action Plan to its specific national circumstances. Implementation of the Action Plan will enable persons with mental disorders to find it easier to access mental health and social care services; be offered treatment by appropriately skilled health workers in general health care settings; WHO’s Mental Health Gap Action Programme and its evidence-based tools can facilitate this process; participate in the reorganization, delivery and evaluation of services so that care and treatment becomes more responsive to their needs; gain greater access to government disability benefits, housing and livelihood programmes, and better participate in work and community life and civic affairs.86

Apart from the various international systems for monitoring human rights, there are also a number of regional conventions for the protection of human rights. These are87 European Convention on Human Rights, 1950,88 European Social Charter, 1961,89 European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 1987,90 American Declaration of the Rights and Duties of Man, 1948,91 Inter–American Convention on the Elimination of All Forms of Discrimination against Person with Disabilities and 1999 Inter–American

87Supra note 39 at 11.
88Supra note 83 at 15.
89Supra note 39 at 13.

While the basis for recognizing economic, social, and cultural mental health rights exists in international and regional instruments, institutions at the international, regional, and domestic levels have been reluctant to pursue, define, or enforce such positive rights. The right to health, however, has undergone a significant evolution in recent years through the adoption of several significant instruments and reports at the international and regional levels. Concurrently, an expanding body of scholarly writing has examined the scope and application of the right to health. The idea of affirmative mental health rights can fundamentally advance the dignity and welfare of persons with mental disabilities. International human rights law, of course, leaves domestic governments with a wide range of discretion in relation to each of these rights and freedoms. Nevertheless, this body of international law opens each of these areas to serious external scrutiny and may provoke domestic governments to recognize and respect these rights and freedoms.\(^{92}\)

In India, The Mental Health Care Act, 2017 and The Rights of Persons with Disabilities Act, 2016 are the two major legislations currently in force regulating health and disability rights of Persons Mental Illness.\(^{93}\) In 2008, India ratified United Nations Convention on Rights of Persons with Disabilities which mandates that all existing laws of the land must be in sync with the international United Nations treaty for disabled persons in India. The principle features of Convention on Rights of Persons with Disabilities that called for amendment of the Indian laws viz., Mental Health Act, 1987 and Person with Disabilities Act, 1995 were on the question of free legal capacity of the Persons with Mental Illness and his/her capacity to manage their own financial matters. In other words, the rights of legal guardian for Persons with Mental Illness in Mental Health Act, 1987 replaced by self-rights with or without support from others.\(^{94}\) The Union government has recently launched the National Health Policy, 2017, which focuses on providing better treatment, rights, and legal remedies for patients. It separately focuses on treatment for mentally challenged patients. So, the parliament has recently passed the Mental Healthcare Bill, which

---

\(^{92}\) *Supra* note 48.
\(^{94}\) *Ibid.*
repeals and replaces the Mental Health Act, 1987. It was published on 7th April 2017 in the Official Gazette of India. It provides for protecting and restoring property rights of mentally ill persons. The Mental Healthcare Act, 2017 provides statutory rights to mentally challenged and psychic patients in the form of a right to access mental healthcare and treatment. It also provides for procedure and process of admission, treatment and discharge of patients.\textsuperscript{95}

In addition to the specific mental health legislation, there are other areas where legislations are improving the mental health of persons with mental illness and protecting their rights in several ways. Most of the earlier legislations in respect of persons with mental illness were concerned with the determination of competency, dangerousness, diminished responsibility and the welfare of society. However, legislations drafted after eighties tend to give some stress on the rights of persons with mental illness also.\textsuperscript{96} The researcher has analysed the legislative framework in relation to mental health. The Constitution of India ensures equality, freedom, justice and dignity of all individuals and implicitly mandates an inclusive society for all including persons with disabilities.\textsuperscript{97} As citizens of India, the mentally ill are entitled to all those human and fundamental rights\textsuperscript{98} which are guaranteed to each and every citizen by the constitution of India, to the extent their disability do not prevent them from enjoying those rights or their enjoyment expressly or impliedly barred by the constitution by any other Statutory law.\textsuperscript{99} The framers of the Constitution of India seemed to have been aware of the problems of the weaker sections of the society and the disabled persons. Ensuring social and economic equality and justice also would require that some constitutional provisions should be made for the physically and mentally disabled. We find that such provisions have indeed, been made which are found scattered in different parts of the Constitution. Although according to Entry 9 in the List II of Schedule 7 of the Constitution, the subject of “Relief to the disabled and

\textsuperscript{98}Preamble, to the Constitution of India, 1950, Article 14, 15, 16, 21, 37, 38(2), 39(b), (c) and (e),41 and 46. The Constitution of India, 1950.
\textsuperscript{99}Supra note 47.
"unemployable" is the responsibility of the State Governments, in practice, the Central Government also has a major role to play in this field. The Ministry of Welfare has been identified as the nodal Ministry by the Government for the welfare of the disabled.\textsuperscript{100}

In India, The Mental Health Care Act, 2017 and The Rights of Persons with Disabilities Act, 2016 are the two major legislations currently in force regulating health and disability rights of Persons Mental Illness.\textsuperscript{101} The Parliament has now enacted the Mental Healthcare Act, 2017, which repeals and replaces the Mental Health Act, 1987.\textsuperscript{102} The Mental Healthcare Act, 2017 is passed with the object to align and harmonise with the United Nations Convention on the Rights of Persons with Disabilities which was ratified by the government in 2007. The new Act is passed as the Mental Health Act, 1987 did not adequately protect the rights of persons with mental illness nor promote their access to mental health care.\textsuperscript{103} The government has passed the Rights of Persons with Disabilities Bill, 2016 replacing the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995.\textsuperscript{104} Under the Act, the types of disabilities have been increased from the existing seven to 21. The newly added types include mental illness, autism spectrum disorder, cerebral palsy, muscular dystrophy, chronic neurological conditions, specific learning disabilities, multiple sclerosis, speech and language disability, thalassemia, haemophilia, sickle cell disease, multiple disabilities including deafblindness, acid attack victims and parkinson’s disease. Disability has also been defined based on an evolving and dynamic concept and government will have the power to add more types of disabilities.\textsuperscript{105}

\textsuperscript{101} FACEMI, “Law and Mental Illness”, available at: https://facemindia.org.in/law-and-mental-illness/ (Visited on May 9, 2016).
\textsuperscript{102} Supra note 95.
7.1 SUGGESTIONS

7.1.1 Mental Health Legislations to be implemented properly

The Act has an over-inclusive definition of “mental illness”. According to Dr. J.T Antony,\textsuperscript{106} actually the very idea of going for a definition of “mental illness” rather than defining persons with mental illness is itself not a desirable approach. Illness being a non-tangible concept, could be useful only in a clinical situation. In a law, various enforcement agencies as well as others have to locate the right candidates and deal with them as per the provisions that are laid down. To make their task easy, it would have been better to pinpoint persons with mental illness by having a good definition for it.\textsuperscript{107} Even while defining mentally ill persons in a restrictive manner, thereby excluding as many persons as possible, it is essential to ensure a legal umbrella for two clear-cut sub-groups of major psychotics. The legal cover is needed for acute psychotics who refuse treatment, even while being a threat to themselves or others and law with protective provisions is needed for chronic psychotics, who face the risk of being neglected, ill-treated, or exploited, sometimes even by their close relatives.\textsuperscript{108} The definition of “mental health establishment” is also very wide and it needs to be amended. Any one running establishment can be fined for not obtaining licence.\textsuperscript{109} One aspect which would worry everyone with some understanding about the existing mental health scenario in India is that the proposed law, with its provisions such as advance directive and nominated representative assumes that patients including paranoid psychotics have the wisdom to make right treatment decisions for themselves. Another equally dangerous aspect is that the law delegates to a lay body, namely the District Mental Health Board, the authority to intervene when disputes arise and decide on its own about what is wrong with the patient and decide on management. The Board should obtain an expert opinion of a psychiatrist, in this kind of decision-making. Forcible admission without a patient’s consent also has to be done at least on some rare occasions. A psychiatrist is required to do it, taking into consideration, the various genuine concerns expressed by a patient’s family, and also making judicious application of his mind. It would be quite gracious

\textsuperscript{106}Department of Psychiatry, Jubilee Mission Medical College and Research Institute, Thrissur, Kerala, India.
\textsuperscript{108}\textit{Ibid}.
\textsuperscript{109}The Mental Healthcare Act, 2017, ss. 2(p), 107.
on the part of our lawmakers if they care to understand that psychiatrists too are as concerned as anybody else, about human rights issues.\textsuperscript{110} The Act also decriminalizes suicide and prohibits electro convulsive therapy for minors. If some of the past year’s reports are seen, suicides are committed by students of schools and colleges. The former are higher in number, may be due to peer pressure, or academics. Mental childcare homes need to be cautious while giving treatment, advance directive should be provided to the children, or to their guardians. This challenge needs to be met. Electro convulsive therapy should be absolutely banned. There are remedies and treatments available in Ayurveda and other traditional methods of India, which are safer than electro convulsive therapy and other modern techniques.\textsuperscript{111} In the countries like England and Australia, they do have mental health tribunals. In India also, mental health tribunals should be established for the adjudication of disputes relating to treatment of persons with mental illness. In the near future, we hope that the law will be implemented properly to meet the obligations of the Mental Healthcare Act, 2017.

7.1.2 Need to Create Awareness in the Society

Society must stop treating people with mental illness as outcasts.\textsuperscript{112} In the empirical study the researcher has found that majority of the respondents agree that people with mental illness experience stigma and discrimination nowadays, because of their mental health problems. Majority of the people have a favourable attitude towards mentally ill people. Majority of the respondents were of the view that mental illness is an illness like any other, anyone can become mentally ill, people with mental illness deserve our sympathy, we need to adopt a far more tolerant attitude towards the people with mental illness in our society, people with mental illness are a burden on society and people with mental illness are not a danger for the society. Majority of the people do not feel frightening to think of people with mental problems living in residential neighborhoods. They would be willing to continue a relationship with a friend who developed a mental health problem. Mental health-related stigma and discrimination has changed in the past few years yet it is prevalent in some or the


\textsuperscript{111}\textit{Supra} note 95.

other form. Bengaluru is the mental health capital of the country because of NIMHANS, but still awareness is poor if not distorted. Citizens run for the rights of lakes, trees and animals.\textsuperscript{113} It is requested that volunteers from corporates, schools and colleges to display banners and campaigns that rip the stigma away. User patients and families display courage by doing the marathon for the cause. Suffering from a mental illness does not mean that the individual is sick or insane. There is a difference between a person with mental illness and a person of an unsound mind. Even the Law supports it. Equally important is the fact that unsoundness of mind is not a permanent everlasting phenomenon. Visiting a psychiatrist doesn’t necessarily mean that a person is insane. Even professional or counsellors do not make much of a difference.\textsuperscript{114} It is difficult to predict the progress over time of a variety of existing anti-stigma initiatives. Media coverage of these interventions will be essential to disseminate positive mental health messages, while challenging current misrepresentations.\textsuperscript{115}

In India, instructional activity regarding the topic of stigma and discrimination has been found to be ineffective during training programs of health workers. Instead, randomized control trials have found that face to face interactions with individuals affected by mental illness effective in stigma reduction.\textsuperscript{116} The health workers can also directly engage with these people, ask questions, and alleviate any concerns and beliefs they may have about a person with mental illness. However, in India, where people may be reluctant to share their stories about mental disorders, face to face interactions are difficult to organize at service provider’s trainings. Instead vignettes, audio-recordings, and films depicting stories of people with mental illness have been shown to have similar stigma reduction outcomes as face to face interactions. More practical and cost-effective for service provider trainings, indirect interactions do not need a person to be present. These videos also allow for the freedom of incorporating material and messages within the videos to raise the effectiveness of treatments.\textsuperscript{117}

\textsuperscript{114} Ibid.
\textsuperscript{115} Ibid.
\textsuperscript{116} Peter Byrne, “Stigma of Mental Illness and Ways of Diminishing It,” Advances in Psychiatric Treatment Jan 2000, 6 (1) 65-72, available at: http://apt.rcpsych.org/content/6/1/65 (Visited on August 8, 2017).
\textsuperscript{117} Ibid.
During trainings of service providers and awareness sessions in the community, showing examples of people with mental illness is an excellent use of evidence-based interventions to reduce stigma and discrimination. Behaviour change often requires going below the surface and modifying embedded belief systems. Through direct and indirect interactions with the mentally ill people, the stigma and discrimination held by health service providers in rural and urban settings can be addressed during trainings. These culturally relevant and cost effective solutions can help reduce the stigma surrounding highly stigmatized illnesses and disorders.118

7.1.3 Prevention of Mental Illness

7.1.3.1 Primary Health Care needs to be Strengthen for Early Detection

It is acknowledged that the only way of handling mental health problems is through including it into the primary health care arrangements implying trained screening and counseling at primary levels for early detection.119 Primary health care is about providing ‘essential health care’ which is universally accessible to individuals and families in the community and provided as close as possible to where people live and work. It refers to care which is based on the needs of the population. It is decentralized and requires the active participation of the community and family. Providing mental health services in primary health care involves diagnosing and treating people with mental disorders; putting in place strategies to prevent mental disorders and ensuring that primary health care workers are able to apply key psychosocial and behavioural science skills, for example, interviewing, counselling and interpersonal skills, in their day to day work in order to improve overall health outcomes in primary health care.120

Over the last two decades, there has been an increasing interest in the concept of early intervention in psychotic disorders, notably schizophrenia. Several lines of research underlie this emerging paradigm shift: (a) an increasingly well-established association between the duration of prolonged untreated illness and poor outcome; (b) evidence of progressive neurobiological changes in the early course of schizophrenia

118 Ibid.
both in the pre-psychotic and psychotic phases, as evidenced by brain imaging studies in schizophrenia; and (c) emerging data, albeit preliminary, suggesting the efficacy and effectiveness of early intervention programs in improving the outcome in these patients. Mental health service systems across the globe, including Asian countries, have been incorporating specialized early intervention programs. However, literature on early intervention in the Indian setting is relatively sparse. Early interventions represent an important paradigm shift in the management of schizophrenia. For early intervention efforts to be successful, the following elements need to be present: Early Initiation and Proven Effectiveness, Phase-specific, Integrated (psychosocial and pharmacological), and Continuity of Implementation. Early intervention programs will hopefully enhance the smooth transition between child and adult services for serious psychotic illness. Early intervention programs will offer a great opportunity to set in motion a life-cycle approach to management of these illnesses, and not just for the first two to three years.

7.1.3.2 Prevention and Promotion

Prevention is concerned with avoiding disease while promotion is about improving health and well being. By identifying the positive aspects of mental health, one can highlight or target the areas to promote and the goals to be attained. It is important to target the positive aspects of mental health, together with targeting the illness.

There are a number of advantages for integrating promotion and prevention in the field of mental health. Preventing mental disorders not only involves targeting risk factors and early symptoms of the disease, but can also involve promoting associated activities that improve the overall quality of life of people and their society. For example, child abuse, sexual abuse and substance use have been found to be associated with a number of mental disorders. Promotional and preventive activities

---

122 Ibid.
aimed at teaching parenting in secondary schools and supporting families can reduce child abuse and neglect and prevent future mental health problems.\textsuperscript{124}

7.1.3 Hospitals need to be updated

The analysis of survey which was related to the hospitals for mentally ill revealed that mental hospitals are an outdated means of treating people with mental illness. Mental hospitals, with all their inherent flaws and drawbacks, are powerful institution for proper care of a subset of mentally ill persons especially those with severe forms of illness and poor social supports. The future, therefore, probably lies in improving the structural and functional aspects of mental hospitals in India. These might include increasing the budgetary provisions for hospitals and an attempt at changing the bureaucratic attitude towards mental hospitals in general. Greater administrative autonomy would be one of the steps to be taken to improve functioning of mental hospitals by reducing bureaucratic and procedural delays. Also, there is a need for ‘need based decision making’ strategies, thereby cutting down on administrative delays. These would themselves result in improvements in the hospital infrastructure and facilities provided for patients.\textsuperscript{125} Although the use of institutions for long term care can be minimised by providing alternatives in the community, they will continue to be necessary. The quality of the institutional environment is a major determinant of the way the patients function. It is, therefore, important to subject institutions to regular evaluation and to improve their architectural design and the content of work programs where necessary.\textsuperscript{126}

7.1.3.1 General Hospital Psychiatry

Psychiatry departments need to be present in General Hospitals also. This gives scope for learning General Hospital Psychiatry and liaison.\textsuperscript{127} The analysis of survey which revealed that mental health services are not easily accessible and the services are to be integrated into general health services. A substantial number of patients with physical complaints attending general Hospital in fact have underlying psychiatric illness. Also the psychiatric co-morbidity with physical illnesses is very

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{124}Ibid.
\item \textsuperscript{125}K. Krishnamurthy, D. Venugopal and A.K. Alimchandani, “Mental Hospitals in India”, \textit{Indian J Psychiatry}, 2000, 42 (2), 125-132.
\item \textsuperscript{126}Ibid.
\end{itemize}
\end{footnotesize}
high. For example, up to 63% of HIV positive people, 20% with Myocardial Infarction, 33% with cancer, 25% with diabetes and 29% with Hypertension had co-morbid depression. Many neurological disorders have psychiatric co-morbidity. Pain management is a multi-disciplinary condition where psychiatrist has a pivotal role. Psychological factors have so much interplay with soma and no specialist can do away without a basic knowledge in psychiatry. High co-morbidity also has treatment implications. The deficiency of psychiatric specialists is very high. Most of the psychiatric patients attend a basic doctor first. If the psychiatric facilities are within the general hospital itself there is less stigma and greater scope for mutual learning and liaison. Hence adequately staffed and equipped psychiatric departments are a must in General Hospitals. 128

7.1.3.2 Psychiatrists

The estimated deficit of psychiatrists in India is 77% as per 2001 census. 17 Indian states and UTs are below this average. 129 Emigration of doctors and nurses could be reduced if they are provided better financial and non-financial incentives. We should not turn out to be a nation using its scarce resources to supply skilled health manpower to the rest of the world jeopardising our own health care system. 130 The long-term solution would be a strong training in psychiatry at the undergraduate level. However, it could take several decades to see the effect of such a measure. The short-term solutions would include either or both of two measures, namely the training of practicing non-psychiatrist physicians and the implementation of strict policies to enforce guideline-oriented examination of all patients to look for psychiatric problems leading to mandatory patient notification and psychiatrist referral. The best, most effective, fool-proof and long-lasting solution, would be the education of the general public. 131

128 Ibid.
129 Ibid.
131 Supra note 37.
7.1.3.3 Psychiatric Education and Training

There is an urgent need to reform the psychiatric medical education, both at the UG and PG level in the country.\textsuperscript{132} There is no even distribution of Medical colleges offering Psychiatry degree/diploma courses. Only few medical colleges offer Post Graduate course in psychiatry.\textsuperscript{133} Many of the courses in Private institutions are yet to be recognized. There should be constant quality check in Private centres.\textsuperscript{134} The quality in the Private centres which are business oriented is always dubious. During the recent examinations most of the private institutions are supplied with patients from Government colleges. We need improvement in the quality as well. Just having mere numbers is not enough. We need to have adequate training, research and treatment facilities in these Institutions.\textsuperscript{135} There is a great disparity between the required number of qualified psychiatrists as per MCI norms/Mental Health Act provisions and the sanctioned posts in Government institutions. In most places the sanctioned posts are also vacant. In private institutions faculty in full strength is seen only at the time of MCI inspections.\textsuperscript{136} The teaching staff must be adequate and qualified.\textsuperscript{137} Measures should be taken to recruit qualified teaching faculty at all psychiatric training centres. There should be a time-bound recruitment policy. The pay and incentives of the faculty should be adequate with good working conditions. Promotions should be time bound. These will hold the doctors from leaving to other places of the world.\textsuperscript{138} The student to teacher ratio must be satisfactory, normally one postgraduate student (MD) per teacher per year—recently this ratio has been changed to two MDs for one teacher from 2010. The ratio of student to number of patients he handles must be satisfactory. Each postgraduate teacher must have at least 40 in. patients with out-patient, follow-up and adequate laboratory facilities, and a library for research, in the unit.\textsuperscript{139} Updating of the knowledge of the faculty is very important. Training of the teachers should take place on a regular basis. But unfortunately there are very few such training programs except for pharma-sponsored ones which are likely to be biased for commercial reasons. The incentives to the teachers and

\textsuperscript{132}Ibid.
\textsuperscript{133}Supra note 127.
\textsuperscript{134}Ibid.
\textsuperscript{135}Ibid.
\textsuperscript{136}Ibid.
\textsuperscript{137}Ibid.
\textsuperscript{139}Supra note 37.

334
facilities provided for them need to improve if quality services are expected of them. Research work needs to be encouraged. Psychiatrists need to generate interest among medical graduates in the field of psychiatry. We should sensitize our medical brethren, health administrators and regulatory body office bearers, policy makers about the significance of undergraduate Psychiatric education. The selection of MD students must be strictly on merit, and in some institutions credit must be given to their work in rural areas. The duration of a postgraduate degree course must be for a minimum of three years and for the diplomas two years, after one year of compulsory rotatory internship in a recognized medical institution. This period of three years training has to be full-time, and every postgraduate student must be either a full-time resident or a full-time scholar. With regard to the content and method of training, the main purpose must be to expose the student, by graded residency posts, to all branches of clinical psychiatry and also neurology. The student must participate in the care and management of patients, and must be given increasing responsibility as his experience develops. By the time he is in his last year of training, he must be able to diagnose and initiate treatment independently. He has to become conversant with the allied subjects such as, neuroanatomy, neurophysiology, neurobiochemistry including electro-encephalography, neuroradiology, psychology, and social work, during his training. At present, no separate examination in psychiatry is required to get a MBBS degree. Thus, the undergraduate training in psychiatry needs to undergo drastic changes in the curriculum, which is not easy as MBBS curriculum is already known to be one of the most overburdened ones, due to the ever-expanding demands of each medical specialty. This pressure should, however, in no way hamper training and neglect important disciplines such as psychiatry. The medical curriculum may be modified by integrating the mental health issues with every existing subject in the present curriculum, in addition to increases in theory hours and the training period. A separate examination in psychiatry in the final year is a must as this would ensure that an undergraduate student gets through with sufficient knowledge and skill

\(^{140}\) Supra note 127.  
\(^{141}\) Ibid.  
\(^{142}\) Ibid  
\(^{143}\) Supra note 137.  
to deal with mental health issues.\textsuperscript{145} The WHO, whose primary mission is that of directing and coordinating International Health Work, must take vigorous steps to develop the standards of medical education at the undergraduate and postgraduate levels and strengthen the accreditation process. This will certainly improve the quality of health care.\textsuperscript{146}

\textbf{7.1.3.4 Infrastructure and Manpower}

No warrior, however strong he is, can fight without weapons. A well equipped psychiatric unit is the need of the hour. But the situation pathetic in many centres with poorly equipped hospitals which lack basic medicines, emergency life saving equipment, drugs, and grossly inadequate supporting staff. NHRC has critically commented upon the absence of these facilities and deficiency in the manpower.\textsuperscript{147} The government of India’s health care budget for the fiscal year 2010-2011 has gone up by 1,253 crore from the previous year doubling the budget for the national mental health programmes, from 50 crore to 103 crore. But it may not be enough to upgrade the mental health infrastructure and manpower. The government-run hospitals to care for the mentally ill, and the rehabilitation and long-term care centers to care for the mentally challenged are in fact not enough to help the patients timely with compassion. An example is the availability of one trained psychiatrist for every 100,000 people with a mental illness and the vast majority live in villages with no access to basic health care. There are only 25,000 psychiatric beds in the country, and 80 per cent of them are in mental hospitals where the quality has been questioned. According to WHO-AIMS Report on Mental Health System, India continues to lag behind other developing countries on key health indicators.\textsuperscript{148} The analysis of the data which is received under Right to Information from the PGIMER, Chandigarh, GMCH, Chandigarh and GMSH, Chandigarh it is revealed that in these hospitals there is a shortage infrastructure. There are very few doctors who are Senior Residents and permanent doctors. Most of them are Junior Residents. Doctors who are pursuing M.D in psychiatry are attending the patients. There is a shortage of beds, clean drinking water, chairs, proper ventilation etc. To solve this often ignored social and

\textsuperscript{145}\textit{Ibid.}
\textsuperscript{146}\textit{Supra} note 137.
\textsuperscript{147}\textit{Supra} note 127.
health issue, India would require at least USD 20 billion (One lakh crore Rupees) for the next five years. Given the fact that the government alone cannot solve crisis involving mental health infrastructure and manpower, it is essential to reform policy so that meaningful tri-sector partnership involving government, NGOs and private corporations could be established to ease the crisis cost-effectively at the grassroots. Qualified mental health, rehabilitation and social work-oriented NGOs with better credentials can be incorporated in the tri-sector partnership to raise funds, build shelters, train staff, bring awareness, and indentify the mentally challenged and those with mental illnesses at local levels via outreach services before it is too late. Without it, the voiceless minority may continue to remain insecure in India.\textsuperscript{149} The annual budget allocation for the disabled should specify the amount earmarked for mental patients. Actual spending for mental patients is almost zero. Indians donate generously to religious institutions but rarely if ever to organisations doing work for mental patients. Therefore, at least 25 per cent of the Government budget for the disabled should be earmarked for mental patients.\textsuperscript{150} Recommending that mental health financing needs to be streamlined, there is a need to constitute a national commission on mental health comprising professionals from mental health, public health, social sciences and the judiciary to oversee, facilitate support and monitor and review mental health policies.\textsuperscript{151}

7.1.4 Prevention of Suicide and Attempted Suicide

Mental Healthcare Act, 2017 decriminalizes attempt to suicide. The analysis of question in the questionnaire which was related to the decriminalization of attempt to suicide shows that majority of the people are in favour of decriminalization of attempt to suicide and they think that a person who attempts suicide shall be presumed to be suffering from mental illness at that time and will not be punished under the Indian Penal Code. Some of the major types of mental disorders may increase the risk of suicidal behaviour in persons with these disorders. In this the principal disorders

\textsuperscript{149} Ibid.
are depression, bipolar disorder, and schizophrenia.\textsuperscript{152} Organising services for suicide prevention has the double advantage of preventing premature loss of lives as well as the sensitization of the community to mental health issues as being relevant to all of the population. Experience in other countries have shown that following measures would be effective in addressing the problems of attempted suicide and suicide: recognition of the ‘normalcy’ of suicidal ideation in specific adverse life situation, increasing intra-Family communication to share feelings, experiences and mutual support, life skills education to children and adolescents, early recognition and treatment of mental disorders by general physicians, support for acute crisis support through volunteers in crisis centres; support to persons who have attempted suicide to prevent repetition, support to families where suicide has occurred and use of religious centres for mental health education. Voluntary organizations working with small communities can address these needs effectively.\textsuperscript{153}

7.1.5 Treatment of Mental Illness Associated with Substance Abuse

Mental illness is common amongst a population suffering from substance abuse and addiction as diagnosed mental illness patients often take medication that has unpleasant side effects and few drugs can also cause mental illness after years of chronic abuse.\textsuperscript{154} Survey study also reveals that majority of the people agree that drug addiction is also a type of mental illness. The abuse includes use of alcohol, drugs of intoxication, prescription drugs. There is evidence that the prescription drugs are occupying a greater role in substance abuse in the country.\textsuperscript{155} When there is a dual diagnosis of both a mental health disorder and a substance abuse issue, it is important that the patient should be enrolled in a treatment program that addresses both


\textsuperscript{155}Supra note 153.
problems at the same time.\textsuperscript{156} The public health costs are enormous. Interventions need to be addressed both at prevention, early identification, care and rehabilitation.\textsuperscript{157}

7.1.6 Community-Based Care

Rehabilitation is an important part of mental health services for a number of reasons. Firstly, in a number of severe mental disorders like schizophrenia, bipolar disorder and substance abuse, there is a proportion of persons who do not fully recover and have limitations in their functioning resulting in disability that needs to be addressed through rehabilitation. Secondly, chiefly due to the paucity of services, in India, large proportion of the severely ill persons are not under treatment till late in the illness, when there is associated disability along with the symptoms of illness, the disability alleviation requires rehabilitation. Thirdly, at different stages of the treatment rehabilitation in the form of intervention like activities of daily living, living in a therapeutic community to learn social skills, day care centres, vocational training, sheltered workshops where ill individuals can do productive work under support and supervision and community care facilities for long term stay when there are no family members to support the ill person. At present in India, the rehabilitation facilities are very limited and largely the result of efforts of individual persons and voluntary organisations.\textsuperscript{158}

The current treatment and rehabilitation practice should be substantially improved in the light of the rehabilitation research available and it should be made readily available for every disabled person.\textsuperscript{159} Assessment of needs in mental illness is an essential step in planning, developing and evaluation of mental health services should also be made in order to provide requirements of mental health services, to provide requirements of persons with mental illness and to enable them to achieve, maintain or restore an acceptable or optimal level of social independence or quality of life. The persons with serious mental illness constitute an incredibly diverse population, numbering in millions, shares needs unique to themselves in the areas of


\textsuperscript{157}Supra note 153.

\textsuperscript{158}Ibid.

treatment, rehabilitation, and environmental support. In recent years assessing the needs are given more importance in order to give proper care to the persons with mental illness.\textsuperscript{160}

Community based mental health care is the most appropriate step for future development of mental health services for many countries as community based care is superior to psychiatry based care, scarcity of qualified mental health professionals, their inability to meet all the needs of the community, problems in transportation of patients from their homes to tertiary care hospitals and preference of people to seek health care locally in the community.\textsuperscript{161} Survey study revealed that majority of the respondents in favour of community based care and for making legislative provisions relating to community based care. Community mental health service should be integrated into primary health care system. The staff at the primary health care level should be taken not to overburden in particular the primary health care staff with too many details which are not essential at the primary health care level. Mental health care is closely linked to the culture of the community, therefore, culturally sensitive programs should be developed, e.g. deeply religious beliefs, strong family ties with regional countries, etc. Community mental health care services should meet all the mental health needs of the community, including promotion of mental health, prevention of mental illness, psychosocial needs of the community, needs of special groups like adolescents, elderly, women, refugees, etc. and prevention of harm from substance abuse.\textsuperscript{162} Responsible persons in the local community have to be identified to act as nodal persons for the activities. It may be prudent to entrust the responsibility to a family member, whose interest may be more tenacious. A definite link with a medical service providing mental health care also seems critical.\textsuperscript{163}

\textsuperscript{160}R.R. Pillai, K. K. Sahu , V. Matthew , S. Hazra , P. Chandran and D. Ram, “Rehabilitation Needs of Persons with Major Mental Illness in India”, \textit{IJPR}, Vol. 14(2) 95-104.

\textsuperscript{161}B.S. Chavan, Nitin Gupta, et. al.,\textit{Community Mental Health in India}, 390 (2012).

\textsuperscript{162}Ibid.

7.1.7 Others

7.1.7.1 Vulnerable Group of the Society

Though the research is not specifically on the vulnerable group of the society but their needs cannot be ignored and protection of rights of these groups is the need of the hour:

- **Women**

  When it comes to health care, government policies, and rehabilitation projects in India, the mentally challenged women are often been marginalized. Besides, social stigma and poverty further aggravate their survival in the society. A recent report has confirmed the painful ordeal in Orissa where 25 per cent of the mentally challenged women were subjected to rape, while an additional 19 per cent faced other forms of sexual abuse.\(^{164}\) The vulnerability of the mentally challenged women towards terrorism, deadly diseases, and incest is rarely discussed in India. If they are not protected by the Indian society, they may become easier prey for domestic terrorism. Data on HIV or AIDS impacting these women in India are not available, therefore, surveys are needed. Problems related to incest involving them are not publicly discussed. But, the growing demand from the parents of the mentally challenged daughters opting for sterilization shows the invisible threat.\(^{165}\) Hence health and social work non-government organizations could lend a helping hand in assisting the government to tackle the thorny social issue.\(^{166}\) For female mental patients the issue of “Guardianship” is extremely important. Non-government organizations under strict supervision of a Disability Commissioner should be allowed to take up the responsibility at the expressed wish of the families. The arrangement should be made between families and organisations and given proper legal sanction without any hurdle. Model holistic rehabilitation-cum permanent homes should be established as a joint venture of the Government, non-government organizations and families of chronic schizophrenic women.\(^{167}\) Mental health needs of women are greater, of special nature and need interventions that are sensitive to their needs. Specific measures to care of this group would include the following strategies: greater number

\[^{164}\text{Supra note 148.}\]
\[^{165}\text{Ibid.}\]
\[^{166}\text{Ibid.}\]
\[^{167}\text{Supra note 150.}\]
of women health personnel, specific training to health personnel on gender issues, mental health education about self-care for mental health, support to women to form self-help groups, emotional support at individual and family levels and income generating activities.\textsuperscript{168}

- **Elderly**

Elderly people suffer from the dual medical problems of both communicable as well as degenerative diseases. The two commonest mental disorders are depression and dementia. There is need for prevention (control of diabetes, hypertension etc), early identification, treatment and rehabilitation. As over 70\% of elderly in urban areas and 34\% in rural areas are economically dependent on their families and almost all the elderly live with their families, support programmes for the families is an important area for intervention.\textsuperscript{169} A better approach may be to design a social security system, including financial products such as pension schemes and reverse mortgages that enable the elderly to live a dignified life.\textsuperscript{170} Despite all these attempts, there is need to impress upon the elderly about the need to adjust to the changing circumstances in life and try to live harmoniously with the younger generation as far as possible.\textsuperscript{171} Certain strategies and approaches at different levels of policy making, planning and programming etc. will have to be adopted in order to harness this vast human resource for promoting the involvement and participation of senior citizens in socio-economic development process on a much larger scale. This participation must result in an end to their social isolation and an increase in their general satisfaction with their life.\textsuperscript{172} If the senior citizen has transferred by way of gift or otherwise, his property, subject to the condition that the relative shall provide the basic amenities and basic physical needs to the senior citizen and such relative refuses or fails to provide such amenities and physical needs, Clause 23(1) says the said transfer of property shall be declared void by the Tribunal, if the senior citizen so desires. This is a welcome provision since it protects naïve senior citizens from exploitation by

\textsuperscript{168}Supra note 153.
\textsuperscript{169}Ibid.
\textsuperscript{172}Ibid.
relatives who intend to renege on their promise subsequently. Older people may be supported to “adjust” to the circumstances that they are in. It is necessary to focus on “need” while understanding assessment of people rather than the strengths and the contribution that an individual can make. Service development for families of people with dementia in India should keep in mind that the service should be home based, address the diverse medical and psychosocial health needs of the affected persons and their caregivers and be provided at a cost that the family can afford (therefore use public and low-cost service providers). Interventions that should not be pursued include the use of multiple medications, which can be detrimental in older age groups, particularly unproven medications such as cerebral activators and neurotropic agents. It is important to prepare health providers and societies to meet the specific needs of older populations, including training for health professionals in old-age care; preventing and managing age-associated chronic diseases including mental, neurological and substance use disorders; designing sustainable policies on long-term and palliative care; and developing age-friendly services and settings. Promoting mental health depends largely on strategies which ensure the elderly have the necessary resources to meet their basic needs, such as providing security and freedom; adequate housing through supportive housing policy; social support for elderly populations and their caregivers; health and social programmes targeted at vulnerable groups such as those who live alone, rural populations or who suffer from a chronic or relapsing mental or physical illness; violence or older adults maltreatment prevention programmes; and community development programmes. There is no medication currently available to cure dementia but much can be done to support and improve the lives of people with dementia and their caregivers and families, such as early diagnosis, in order to promote early and optimal management; optimizing physical and psychological health, including identifying and treating; accompanying physical illness, increasing physical and cognitive activity and

optimizing well-being; detecting and managing challenging behavioural and psychological symptoms; providing information and long-term support to caregivers. Effective, community-level primary mental health care for older people is crucial. An appropriate and supportive legislative environment based on internationally accepted human rights standards is required to ensure the highest quality of services to people with mental illness and their caregivers.

- Children

Another issue involving them is the ritual burying in mud. In July 2009, 60 children in Karnataka State had been buried up to their necks during a solar eclipse. The ritual was performed in the belief of a cure, but the children only suffered through a torturous ordeal in mud. Also, some families abandon the mentally challenged children because of the taboo deeply rooted in shame. The most important goal would be to restore childhood to all children; create conditions for optimal development at home and society; provide healthy adult contacts; facilitate life skills education; crisis support; friendly non institutional mental health services and create an atmosphere of security and hopeful future. Empowerment of children and adolescents is very essential in the context prevailing today in India as there is rapid globalization and urbanization with breaking up of joint families and dwindling traditional social support systems. School-based interventions can reduce risk factors to promote the mental health and well-being of children and adolescents.

- Special groups-refugees, disaster affected populations

It is well recognized that refugees, disaster affected population represent a group of persons with special emotional needs. This is because of the extreme disruption that they have experienced and the lost opportunity for normal life. All of these groups need opportunity to rebuild their lives and reorganize their life goals. Some of the well recognized strategies are: recognition of the special needs by

---

179 Ibid.
180 Ibid.
181 Ibid.
182 Supra note 148.
183 Supra note 153.
185 Ibid.
community and health personnel; community based and ambulant mental health care; opportunities to share the trauma; formation of self-help groups with common needs; crisis support and rehabilitative efforts for vocational and social life. Social programs for refugees have the potential to revive a sense of connectedness, re-establish social networks, and promote self-help activities. Strategies that foster community initiatives encourage a sense of control and engagement in the task of self-directed recovery, counteracting the inertia, dependency, and inter-group divisions that characterize many transitional refugee settings. There are compelling theoretical, economic, and strategic reasons, therefore, to give priority to social interventions in the array of strategies aimed at relieving distress and promoting well-being amongst refugees.

7.1.7.2 Role of NGO’s

Countless Non-Government Organisations and government agencies around the country are implementing exciting projects that seek to alleviate mental illness, as well as surrounding factors of gender based violence, homelessness, and drug abuse. However, in order for these projects to make a lasting difference, they need be implemented on a larger scale. The Banyan, a Chennai based mental health Non-Government Organisations, is leading the way in this space, with both its innovative service delivery in working with vulnerable women experiencing mental illness but equally, in its commitment to scale through establishing partnerships with universities in other parts of India and government agencies to increase the organisation’s reach. By the very same token, it is indeed the role of the government to evaluate, to encourage, and extend the full potential of these initiatives. There is a pressing need to build a bank of evidence-based solutions for tackling this health issue.

7.1.7.3 Government

Social and health workers argue that government should pay more attention in caring for the mentally challenged across India. The Government should seriously consider issuing of special India Relief Bonds bearing at least 12 per cent interest to

---

186 Supra note 153.
189 Supra note 148.
NGOs working with mental patients. Here psychiatrists have a key role to play in influencing the government to increase the priority afforded to mental health, to develop well tailored mental health policies and to support their implementation and fine tuning.

7.1.7.4 Increase Research Initiative

There is a real need to do research on mental illnesses in order to support these patients with appropriate treatments and post-treatment benefits to help them to reintegrate into society. Mental health researchers must strive to design ethical and scientifically sound research that does not ignore populations or kinds of research merely because of the difficulties involved. If mental health researchers continue to allow risks to discourage research, certain groups that could benefit from research will continue to be harmed by being understudied. Groups perceived as high risk deserve scientifically rigorous study as well. Continued research is required to advance researcher’s and institutional review boards understanding of how best to identify, define, effectively communicate and manage risks. Such efforts are essential to facilitating much needed mental health research.

7.1.7.5 Rural

There are no outreach services to identify the mental health problems at village level. While there are some facilities for diagnosis and treatment exist in major cities there is no access whatever in rural areas. To ensure that rural areas also benefit from private investment, the incentives given to invest in rural areas could be greater than those given for investment in urban areas. Another way in which the presence of mental health facilities in rural areas can be increased is by proper implementation of the District Mental Health Program which was initiated by the Government of India in 1996. Currently, the program is under implementation in only

190 Ibid.
192 Supra note 150.
194 Ibid.
195 Supra note 148.
123 of the total 657 districts of the country. A proper implementation of the program would go a long way towards ensuring that rural areas have adequate mental care facilities in near vicinity.\footnote{Aditya Ayachit, “Mental Health Law Reform: Challenges Ahead”, available at: \url{https://jilsblognujs.wordpress.com/2012/12/23/mental-health-law-reform-challenges-ahead/} (Visited on Dec. 25, 2017).} The analysis of survey also revealed that mental health services are not easily accessible, the services are to be integrated into general health services and are to be made available in each district and the basic and emergency mental health care is to be made available at all community health centre’s levels.

In brief, Psychiatry has indeed travelled a long way, along the dark corridors of the mental institutions of the forties and fifties, through the open doors of the general hospital psychiatry units of the sixties and seventies, and finally, out into the fresh air of the ever expanding rural mental health clinics of today.\footnote{D. Seshi Kumar, “The Community Psychiatry Movement: Pros and Cons”, \textit{AP J Psychol Med} 2011; 12(2):73–8.} Although mental health legislation has existed in India since the mid-19th century, it has gone through various changes over the years and the Mental Healthcare Act, 2017 has generated a lot of debate and criticism. Despite its shortcomings, the general expectation is that this Act will usher in a new era of proper care and allow people with mental disorders to lead a dignified life.\footnote{Muhammad Mudasir Firdosi and Zulkarnain Z. Ahmad, “Mental health law in India: Origins and Proposed Reforms”, \textit{BJ Psych International} Volume 13 Number 3 August 2016.}