

**India's Mental Healthcare Act, 2017
- Evaluation of the Act, its Context and
Initial Implementation**



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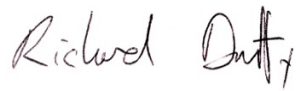
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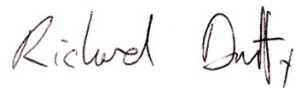
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Richard Duffy

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VI. List of Abbreviations

BCE	Before common era
CE	Common era
CRPD	Convention on the Rights of Persons with Disabilities
CMHA	Central Mental Health Authority
ECT	Electroconvulsive therapy
IPS	Indian Psychiatric Society
MHA	Mental Health Act 1987
MHCA	Mental Healthcare Act 2017
MHRB	Mental Health Review Board
NGO	Non-governmental organisation
PWDA	Persons with Disabilities Act, 1995
RPWDA	Rights of Persons with Disability Act, 2016
SMHA	State Mental Health Authorities
UK	United Kingdom
UN	United Nations
USA	United States of America
WHO	World Health Organization
WHO-RB	World Health Organization resource book on mental health, human rights and legislation

VII. Abstract

The United Nations has initiated a paradigmatic shift in mental healthcare through the United Nations Convention on the Rights of Persons with Disabilities (CRPD), in addition to this the WHO has identified legislation as a key tool for improving healthcare. In 2016, India adopted the Rights of Persons with Disabilities Act (RPWDA), closely followed in 2017 by the Mental Healthcare Act (MHCA). These Acts are pioneering pieces of legislation, both were explicitly written to bring Indian legislation in line with the CRPD. This research evaluated the concordance of India's Mental Health legislation with international standards and explored the views of psychiatrists in India.

To examine this, a black letter analysis was conducted comparing the RPWDA and the MHCA with the CRPD and the World Health Organization's Checklist on Mental Health Legislation from the WHO Resource Book (WHO-RB). Thirteen focus groups were conducted and included 93 mental health professionals, in 4 Indian states, over a two-year period. This was done to compliment and inform the blackletter analysis. In depth thematic analysis was also carried out on data in relation to two key topics: electroconvulsive therapy and assisted decision making. Themes and sub-themes relating to these topics were identified and discussed.

The black letter analysis highlighted a number of areas of non-concordance in the Indian legislation and identified the complexities of simultaneously protecting competing rights. Many potentially non-concordant areas stemmed from the interpretation of the Committee on the Rights of Persons with Disabilities rather than the text of the CRPD itself.

The focus groups revealed that the concerns of psychiatrists were often divergent or at odds with the international standards. They also highlighted that resource limitation and cultural differences will need to be overcome to adequately implement the new legislation. The complexity of using international standards and conventions as a mechanism for realising human rights for individuals with mental health problems was discussed.

VIII. Lay Abstract

The manner in which mental health care is being provided is being drastically changed by the United Nations Convention on the Rights of Persons with Disabilities (CRPD), this is reducing involuntary treatment and improving patient autonomy. To realise the CRPD, India passed two pieces of legislation the Rights of Persons with Disabilities Act (RPWDA), 2016 and the Mental Healthcare Act (MHCA), 2017. These Acts are pioneering pieces of legislation, both explicitly written to bring Indian law in line with the UNCRPD. This research aims to evaluate the concordance of India's Mental Health legislation with international standards.

To examine this, we looked at how the content of these two pieces of legislation compares to the CRPD and the World Health Organization's Checklist on Mental Health Legislation from the WHO Resource Book (WHO-RB). This did not consider the realisation of the legislation just the content.

To compliment this, thirteen focus groups were conducted in 4 Indian states, with 93 mental health professionals, over a two-year period. This helped us understand the legislation and the context it was written in. We used the results from these groups to describe the perspectives these mental health professionals had in relation to electroconvulsive therapy and assisted decision making. These topics were chosen as they are both strongly impacted by the CRPD.

Our review of the legislation highlighted several areas of non-concordance in the Indian legislation but also demonstrated how complex it can be to protect the wide range of rights that people have. Our analysis also demonstrated the additional challenges that have come about through the interpretation of the CRPD by the Committee on the Rights of Persons with Disabilities. This has prohibited all involuntary care.

The focus groups revealed that the concerns of psychiatrists were often at odds with the international standards. They also highlighted that resource limitation and cultural differences will need to be overcome to adequately implement the new legislation. The complexity of using international standards and conventions as a mechanism for realising human rights for individuals with mental health problems was discussed.

IX. Aims and hypothesis of the Project

The aims of this study are to examine the Indian MHCA from a legal perspective and to evaluate the opinions of Indian Psychiatrist's before, during and after implementation.

To achieve this aim, the following objectives have been identified.

1. The concordance of the MHCA with the WHO-RB will be evaluated
2. The concordance of the MHCA with the CRPD will be evaluated
3. A systematic examination of the relationship between the CRPD and the WHO-RB will be conducted.
4. Focus groups will be conducted with Indian psychiatrists to evaluate their views of the MHCA and its implementation.

X. Value of Research

This research provides a comprehensive analysis of the concordance of India's Mental Healthcare Act, 2017 with the United Nations' Convention on the Rights of Persons with Disabilities. This is relevant to many other countries seeking to bring their legislation in line with the convention. This is also the only review of this kind that the authors have identified.

This study is the only study internationally to compare India's legislation to the checklist contained in the World Health Organization's resource book on mental health, human rights and legislation. Of particular interest this examines the protections that are in place for people receiving treatment against their will.

This is the only study we are aware of that captures the perspectives of Indian psychiatrists during this dramatic shift in mental healthcare in India. We have presented findings in relation to two key topics: electroconvulsive therapy and assisted decision making.

XI. Outputs

Original research (peer reviewed)

- Duffy, R.M., Kelly, B.D. (2017). Rights, laws and tensions: A comparative analysis of the Convention on the Rights of Persons with Disabilities and the WHO Resource Book on Mental Health, Human Rights and Legislation. *International Journal of Law and Psychiatry*, 54, 26-35.
- Duffy, R.M., Kelly, B.D. (2017). Concordance of the Indian Mental Healthcare Act 2017 with the World Health Organization's Checklist on Mental Health Legislation. *International Journal of Mental Health Systems*, 11(1), 48.
- Duffy, R.M., Kelly, B.D. (2017). Privacy, confidentiality and carers: India's harmonisation of national guidelines and international mental health law. *Ethics, Medicine and Public Health*, 3(1), 98-106.
- Duffy, R.M., Narayan, C.L., Goyal, N., Kelly, B.D. (2018). New legislation, new frontiers: Indian psychiatrists' perspective of the mental healthcare act 2017 prior to implementation. *Indian Journal of Psychiatry*, 60(3), 351-354.
- Duffy, R.M., Kelly, B.D. (2019). India's Mental Healthcare Act, 2017: content, context, controversy. *International Journal of Law and Psychiatry*, 62, 169-178.
- Duffy, R.M., Gulati, G., Kasar, N., Paralikar, V., Narayan, C.L., Desousa, A., Goyal, N., Kelly, B.D. (2019). Stigma, inclusion and India's Mental Healthcare Act 2017, *Journal of Public Mental Health*, 18(3), 199-205.
- Duffy, R.M., Gulati, G., Paralikar, V., Kasar, N., Goyal, N., Desousa, A., Goyal, N., Kelly, B.D. (2019). A focus group study of Indian psychiatrists' views on electroconvulsive therapy under India's Mental Healthcare Act 2017: 'the ground reality is different'. *Indian Journal of Psychological Medicine*, 41, 507-515.

Books

- Duffy, R.M., Kelly, B.D. (2020). *India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights*. Cham: Springer.

Chapters

- Duffy, R.M., Sidhu, D.S., Kelly, B.D. (in press). Optimizing Patient Care in Psychiatry with Autonomy and Choice. In: *Optimizing Patient Care in Psychiatry*. Eds A Srivastava, N Shah, A Desousa. Routledge/Taylor and Francis, USA
- Kelly, B.D., Gulati, G., Duffy, R.M. (in press). Optimizing Patient Care in Psychiatry with Sound Mental Health Legislation. In: *Optimizing Patient Care in Psychiatry*. Eds A Srivastava, N Shah, A Desousa. Routledge/Taylor and Francis, USA

Oral Presentations

- Presented at the XXXVIth International Congress on Law and Mental Health. Rome 2019: *India's Mental Healthcare Act 2017 and the United Nations' Convention on the Rights of Persons with Disabilities in session.*

Editorials (peer reviewed)

- Duffy, R.M., Kelly, B.D. (2019). The right to mental healthcare: India moves forward. *British Journal of Psychiatry*, 214(2), 59-60.
- Duffy, R.M., Kelly, B.D. (2020). Can the World Health Organisation's 'QualityRights' Initiative help reduce coercive practices in psychiatry in Ireland? *Irish Journal of Psychological Medicine*, 1-4.
- Hoare, F., Duffy, R.M. (2021). The World Health Organisations' QualityRights materials for training, guidance and transformation: preventing coercion but marginalising psychiatry. *British Journal of Psychiatry*, 218(5), 240-242

Letters and correspondence

- Duffy, R.M., Kelly, B.D. (2017). Can psychiatry lead the way in legislating for health and wellbeing? *Irish Medical Journal*, 110(6), 591.
- Duffy, R.M., Kelly, B.D. (2019). Authors' reply. *British Journal of Psychiatry*, 215(2), 504.
- Duffy, R.M., Kelly, B.D. (2019). Global mental health. *Lancet*, 394(10193), 118-119.

- Duffy, R.M. (2019). Letter to the Editor. *Irish Journal of Psychological Medicine*, 36, 235-236.
- Duffy, R.M. (2020). Letter to the Editor, The Limitations of the MHC's report on seclusion and restraint, and suggestions for future reports. *Irish Journal of Psychological Medicine*, 1-2.

Submitted

- Duffy, R.M., Gulati, G., Paralikar, V., Kasar, N., Narayan, C.L., Goyal, N., Desousa, A., Goyal, N., Kelly, B.D. A Focus Group Study of Indian Mental Health Professionals' Views on Supported Decision Making under India's Mental Healthcare Act, 2017. *International Journal of Mental Health and Capacity Law*

XII. Output integration into the thesis

The contents of this thesis are heavily based on the published works of the author and large sections are taken directly from these works for clarity below I have indicated which published works each chapter is drawn from

Chapter 1

- Duffy, R. M., Kelly, B. D. (2020). Background to Mental Health Law. In: *India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights* (pp. 3-20). Springer: Cham.
- Duffy, R. M., Kelly, B. D. (2020). The United Nations and Mental Health Law. In: *India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights* (pp. 21-33). Springer: Cham.
- Duffy, R. M., Kelly, B. D. (2020). The World Health Organization and Mental Health Law. In: *India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights*. (pp. 25-48). Springer: Cham.

Chapter 2

- Duffy, R.M., Kelly, B.D. (2017). Rights, laws and tensions: A comparative analysis of the Convention on the Rights of Persons with Disabilities and the WHO Resource Book on Mental Health, Human Rights and Legislation. *International Journal of Law and Psychiatry*, 54, 26-35.
- Duffy, R.M., Kelly, B.D. (2019). India's Mental Healthcare Act, 2017: content, context, controversy. *International Journal of Law and Psychiatry*, 62, 169-178.
- Duffy, R. M., Kelly, B. D. (2020). History of Mental Health Legislation in India. In: *India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights* (pp. 51-60). Springer: Cham.
- Duffy, R. M., Kelly, B. D. (2020). India's Rights of Persons with Disabilities Act, 2016. In: *India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights* (pp. 61-80). Springer: Cham.

- Duffy, R. M., Kelly, B. D. (2020). India's Mental Healthcare Act, 2017. In: *India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights*. (pp. 81-106). Springer: Cham.

Chapter 3

- Duffy, R.M., Kelly, B.D. (2017). Concordance of the Indian Mental Healthcare Act 2017 with the World Health Organization's Checklist on Mental Health Legislation. *International Journal of Mental Health Systems*, 11(1), 48.
- Duffy, R. M., Kelly, B. D. (2020). India's Mental Healthcare Act, 2017 and the World Health Organization's Checklist on Mental Health Legislation. In: *India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights* (pp. 109-140). Springer: Cham.

Chapter 4

- Duffy, R. M., Kelly, B. D. (2020). Incorporation of the United Nations' Convention on the Rights of Persons with Disabilities into Indian Law Through the Rights of persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017. In: *India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights* (pp. 141-208). Springer: Cham.
- Duffy, R. M., Kelly, B. D. (2020). Compliance of India's Mental Healthcare Act, 2017 with the United Nations' Convention on the Rights of Persons with Disabilities. In: *India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights* (pp. 209-226). Springer: Cham.
- Duffy, R. M., Kelly, B. D. (2020). Adhering to Conventions: Intentional Grey Areas or Shirking Responsibility. In: *India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights* (pp. 227-249). Springer: Cham.

Chapter 5

- Duffy, R.M., Narayan, C.L., Goyal, N., Kelly, B.D. (2018). New legislation, new frontiers: Indian psychiatrists' perspective of the mental healthcare act 2017 prior to implementation. *Indian Journal of Psychiatry*, 60(3), 351-354.

- Duffy, R.M., Gulati, G., Paralikar, V., Kasar, N., Goyal, N., Desousa, A., Goyal, N., Kelly, B.D. (2019). A focus group study of Indian psychiatrists' views on electroconvulsive therapy under India's Mental Healthcare Act 2017: 'the ground reality is different'. *Indian Journal of Psychological Medicine*, 41, 507-515.
- Duffy, R.M., Gulati, G., Paralikar, V., Kasar, N., Narayan, C.L., Goyal, N., Desousa, A., Goyal, N., Kelly, B.D. (submitted) A Focus Group Study of Indian Mental Health Professionals' Views on Supported Decision Making under India's Mental Healthcare Act, 2017. *International Journal of Mental Health and Capacity Law*

A. Introduction

1. Mental health legislation

'To be obliged to confess this to oneself: infallibility is not infallible, there may exist error in the dogma, all has not been said when a code speaks, society is not perfect, authority is complicated with vacillation, a crack is possible in the immutable, judges are but men, the law may err, tribunals may make a mistake! to behold a rift in the immense blue pane of the firmament!' - Javert (Hugo, 1862).

The World Health Organisation (WHO) have recently commented on the importance of legislation to enhance the delivery of healthcare (2017). While this may be a relatively new concept in many medical specialities, psychiatry have a long, and often chequered history, of employing legislation to support the treatment of individuals. Mental health law has evolved in an iterative process, many jurisdictions retain legislative remnants of former abuses, societal demands, or cultural practices. Many well intended laws were often abused or their implementation underfunded with dire consequences for vulnerable individuals.

The last two decades have seen some dramatic shifts in the emphasis and content of mental health law, however internationally laws vary widely. Some jurisdiction's legislation focuses primarily on involuntary treatment (e.g. Ireland), while others attempt to address all areas of mental healthcare (e.g. India). There are jurisdictions that have never had mental health legislation (e.g. Laos) and those that are attempting to remove mental health specific law (e.g. Northern Ireland).

In 2017, 111 of 175 countries reported having standalone mental health law, only 53% of countries without standalone legislation addressed mental health in other legislation (WHO, 2018). Only 40% (66/175) had revised their legislation in the five years preceding the report. This legal heterogeneity has been brought into focus through the work of the WHO and the United Nations (UN). Through their resources, guidelines and conventions described below, there has been an emerging consensus of *how* people with mental illness should be treated. *What* should be included in

legislation to best facilitate this, is less clear. The potential of negative unintended consequences brought about by potential change is important to examine.

This chapter explores the evolution of mental health legislation with a particular focus on the role played by the UN and WHO. An understanding of this evolution provides valuable context for examining the content of modern mental health law and some of the tensions that exist within it.

1.1 The early history of mental health legislation

Mental health legislation has held a very prominent place in society and informed the treatment of individuals with mental illness for approximately the last two hundred years (Duffy and Kelly, 2020a). The treatment of those with mental illness goes back much further, descriptions of trepanning to treat depression have been found in the Ebers papyrus, a document approximately 3500 years old (Bou Khalil and Richa, 2014). The origins of the societal rules and laws concerning mental illness is obscure, but evidence exists from a wide range of cultures that indicate ritualised, legal or religious norms relating to the treatment of mental illness.

In approximately 1000 BCE, Israel's King David feigned mental illness in the belief that this would result in him being treated differently. His ruse was successful (1 Samuel 21:10-15). In Buddhism, around 500 BCE, Buddha treated people with mental illness in a compassionate manner that contrasted starkly with how they were commonly treated in the community (Somasundaram and Murthy, 2018). The Buddha's approach also drastically differed from the Twelve Tables of Rome, from the 5th century BCE, a set of laws inscribed on bronze tablets, which adopted a much less humane approach to children with disabilities (Berkson, 2006).

The rise of treatment for mental illness seen in the Islamic world from the eight century, and the later appearance of hospitals like Bethlehem Royal Hospital in London (1247) and the Pitié-Salpêtrière Hospital in Paris (1656) had little connection to formal legislation. In much of Europe the authority underpinning treatment came from Canon Law, which predated civil law, and it was often highly inconsistent in how it dealt with mental illness. It restricted access to sacraments like marriage and baptism for people with mental illness (Trenery and Horden, 2017) and delivered

judgements in relation to suicide, which prevented individuals from receiving a Christian burial. Church law also dealt with major crimes and showed some leniency towards mentally ill offenders. However, this leniency was not universal, as mental illness was also seen by some as punishment for sin or a spiritual affliction (Restak, 2000). The best-preserved records from the medieval period are from England and relate mostly to management of the property of the mentally ill and insanity as a defence in court (Trenery and Horden, 2017). Overall, the treatment of people with mental illness was highly variable prior to formal legislation. While there is historical evidence that mental illness sometimes elicited compassion, treatment, support and special legal consideration, there is much greater evidence that it was generally met with stigma, neglect, and marginalisation.

1.2 The history of formal mental health legislation

Religious traditions, cultural norms and Cannon law gave way to more formal iterations of mental health law. This begun with Edward II of England's *Praerogativa Regis*, dating from 1324 (Somasundaram, 1987). The influence on mental health law of different time periods are summarised in Table 1.1 and the impact of underpinning political and ideological themes are summarised in Table 2.1. These factors are also discussed in detail below.

1.2.1 Key time periods in mental health legislation

1.2.1.1 Poor Laws and the Protection of Property

Edward II of England's *Praerogativa Regis* gave the King wardship over the lands of 'idiots' and, later, 'lunatics'. These were referred to as 'Chancery' idiots or lunatics because it was the responsibility of the Lord Chancellor to take charge of their property.

Under the influence of this, prior to the late eighteenth century, the majority of mental health legislation dealt with the estates of people with mental illness (Parry-Jones, 1972). Other legislative measures that concerned the mentally ill dealt with criminals, the homeless and the unemployed. In England and Wales, these were

generally addressed in the Poor Law system. Overall, little attention was devoted to the needs of people with mental illness who did not have significant wealth. The first piece of legislation to relate to 'pauper lunatics' was the Vagrancy Act, 1744 which allowed for the incarceration of the 'furiously mad' (Hamilton, 1983). Scotland had similar legislation, the Scottish Poor Law, 1845 (Farquharson, 2017).

1.2.1.2 Early Residential Care

The Poor Law system led to the expansion of 'madhouses'. These private homes for individuals with mental illness, had been in existence since the 1600s and acted as precursors of the later, larger asylums. In England, these establishments were regulated in 1774 by the Madhouses Act. Private institutions for the mentally ill also existed outside the United Kingdom, with a diverse array of institutions in countries ranging from India (Somasundaram, 2008) to Germany (Schmideler and Steinberg, 2004). Initially, these establishments were not regulated by legislation, although with increasing rates of detention, legislative protections began to appear (e.g. the County Asylums Act, 1808 in England and Wales).

1.2.1.3 The Asylum Era

In many ways, the rise of the asylums in the nineteenth century began in England, the first country to legislate for the large-scale building of public asylums. These replaced and upscaled the 'madhouses' of the 1700s. This process began in earnest with the County Asylums Act, 1808 and France followed suit with the Law of 1838 (Shorter, 1997; Shorter, 2007). In 1845, England replaced the 1808 Act with the County Asylums Act, 1845 and the Lunacy Act, 1845, which provided a place of refuge for 'pauper lunatics' and mentally ill offenders. Other relevant legislation included the Lunatic Asylums Act, 1853 and the Lunacy Act, 1890.

Other countries in the British Empire developed legislation that mirrored that of England. Australia, Ireland, Scotland, Nigeria and India all had similar pieces of legislation (Porter and Wright, 2003). Canada did not incorporate the English Poor Law system when it gained independence and consequently many people with mental illness ended up in prison (Wright et al., 2003).

Porter and Wright (2003) highlight how the asylum movement became prominent outside of the British Empire. They describe developments in South Africa, Switzerland, France, Germany, Argentina and Mexico. Norway, too, enacted its Insane Act in 1848. Japan's legislation came much later, with the Mental Patients' Custody Act, 1900 and inpatient care was further embedded into law with the Mental Hospitals Act, 1919 (Suzuki, 2003). Despite trailing 100 years behind other jurisdictions, the Japanese institutionalised care of individuals with mental illness had many parallels with the English system.

Generally speaking, these asylums were built with the intention of helping people with mental illness who could not afford private care (Miller, 2007). These institutions were, however, soon both overcrowded and underfunded (Piddock, 2004); grounds for admission were often unclear; and if discharge occurred, it was a highly protracted process (Luchins, 1988). The asylums were also rife with medical illness and many patients died from infectious diseases (Anonymous, 1902).

1.2.1.4 Deinstitutionalisation

The advent of effective treatments for mental illness heralded a major shift in mental health legislation, they expanded the scope of mental health laws from, the management of property and containment of people, to the provision of care and treatment. This led to the dismantling of many asylums and efforts to move care to out-patient settings.

The most direct approach was taken in Italy where the Mental Health Act, 1978 (the 'Basaglia Law') aimed to eliminate asylum-based care entirely (Crepet and De Plato, 1983). In America, the Community Mental Health Act was passed in 1963 and resulted in a reduction in the numbers in asylums and expansion of community-based services. Reform in the UK was more gradual, following the Mental Health Act, 1959. While many psychiatric hospitals remained operational into the 1980s, the adoption of more progressive, less coercive laws to facilitate treatment undoubtedly contributed to the decline of institutional care (Rachlin, 1983).

Over this period, the evolution of mental health legislation was, however, shaped by a number of disparate factors, including not only new treatments but also

contemporary social and political events. For example, the libertarian and anti-establishment perspectives common in the 1960s and 1970s, combined with the rising costs of inpatient care, called into serious question the appropriateness of long-term psychiatric admissions and provided people with more protections during involuntary care (Appelbaum, 1996). While this process of change was generally positive, it also led to the criminalisation of some people with mental illness. The number of mentally ill people in prisons increased following the failure of the mental health system to provide a sufficient range of inpatient and outpatient treatments and interventions (Lamb and Weinberger, 2020).

1.2.1.5 Rights-Based Mental Health Law

Following the end of the Second World War, increased emphasis was placed on human rights, as reflected in the United Nations' (UN) Universal Declaration of Human Rights (UDHR), the rise of increasingly democratic forms of government, and the establishment of bodies such as the European Court of Human Rights. In psychiatry, the advent of effective treatments and the emergence of the anti-psychiatry and 'survivors of psychiatry' movements further increased recognition of the rights of people with mental illness.

Against this background, many countries revised their mental health legislation in parallel with psychiatric deinstitutionalisation. They sought to legislate for better mental healthcare rather than simply address legal matters concerning involuntary detention. For example, Western Australia introduced the Mental Health Act, 1996 which explicitly protected the rights of patients, promoted the least restrictive forms of treatment and stated that mental illness alone could not be grounds for involuntary detention. Some of the legislation of this era also removed stigmatising terminology and provided enhanced reviews of coercive practices, as described by the World Health Organization in its *Resource Book on Mental Health, Human Rights and Legislation* (WHO-RB) (2005).

The single-most significant force driving rights-based mental health legislation today is the UN Convention on the Rights of Persons with Disabilities (CRPD) (2006). The European Union (EU) Agency for Fundamental Rights (2015), for example,

highlighted many of the policy and legislative changes that have occurred in the EU as a result of the CRPD. The Convention has triggered a number of fundamental paradigm shifts, including replacing substitute decision-making with supported decision-making, strongly affirming capacity and autonomy, and, according to the most authoritative interpretation, banning all coercive treatments (UN Committee on the Rights of Persons with Disabilities, 2014).

The CRPD places patients at the centre of all mental health legislation and makes protecting rights the key driving principle. Good examples of legislation attempting to realise the CRPD include Mental Health Law 29889 in Peru (Toyama et al., 2017) and the Mental Healthcare Act, 2017 in India (Duffy and Kelly, 2020b). The latter is an example of legislation written explicitly to concord with the CRPD and is the chief focus of this thesis.

Despite all these developments, however, more than one third of countries still have no formal mental health law, and many others have highly out-dated legislation that is not rights-based and primarily defines involuntary treatment rather than articulating a more positive vision of mental healthcare (WHO, 2018a).

Table 1.1 Key time-periods and driving forces in mental health legislation (Duffy and Kelly, 2020a)

Driving force behind legislation	Positive consequences of legislation	Negative consequences of legislation	Examples	Time-period
Protection of property	Dealt with the property of people with mental illness	Made no provisions for people without money or property. Based on Common Law	Chancery Regulation Act, 1862 (England) Lunacy Regulation (Ireland) Act, 1871	1324 - present

		with limited safeguards.		
Asylum-based care	Provided care for poor and homeless people with mental illness First access to care for people with mental illness	Large scale institutionalisation Often inhumane condition in asylums	The Lunatic Asylums (Ireland) Act, 1875. Mental Patients' Custody Act, 1900 (Japan) The Law of 1838 (France)	1800 – 1960s
Advent of effective pharmacological treatments and the end of the asylum era	Deinstitutionalisation Promotion of autonomy Development of community services	Insufficient bed numbers and deprivation of treatment for those needing inpatient care Community-based services often underdeveloped	Mental Retardation and Community Mental Health Centers Construction Act, 1963 (USA) Italian Mental Health Act, 1978 (Italy)	1960s - 1980s

Patient-centred, de-stigmatising legislation pre-CRPD	Enhanced dignity and shift away from coercive treatments Enhanced protections when coercive measures are used	Patient advocacy groups felt reforms did not go far enough Excessive coercive measures remained in place Often worked from a substitute decision-making paradigm	Mental Health Care Act, 2002 (South Africa) Mental Health Ordinance, 2001 (Pakistan)	1990s - 2006
CRPD-informed, rights based mental health legislation	Affirms multiple rights especially dignity and autonomy Moves away from substitute decision-making to supported decision-making	Potentially limits people with severe illness from accessing treatment Criminalisation of people with mental illness could occur if their capacity cannot be questioned, with resulting stigmatisation	Law 29973, the General Law on People with Disabilities, 2012 (Peru) Mental Healthcare Act, 2017 (India)	2006 - present

1.2.2 Political and Ideologically Driven Legislation Relating to Mental Illness

Over past decades, various laws have emerged that are not explicitly pieces of mental health legislation but that nonetheless significantly impact on people with mental illness. These laws are often politically or ideologically driven. These are often reactive pieces of legislation passed following issues that have arisen in different contexts. Indicative examples are summarised in Table 1.2 and discussed in more detail below.

1.2.2.1 Military Psychiatry

Legislation relating to military psychiatry has had a significant influence on the field of mental health more generally. American military psychiatry has been particularly influential. One of the key motivations behind the creation of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (APA, 1952) was to facilitate the treatment of veterans of World War II (Houts, 2000). While the 'Medical 203' was not strictly speaking a law, it served a similar purpose, leading to the creation of the original DSM and greatly influencing the inclusion of mental disorders in what would later become the WHO's *International Classification of Mental and Behavioural Disorders (Volume 10)* (1992).

Military psychiatry has also had an impact on how conditions that are common in the military are perceived when they occur in the general population. It has been suggested that the use of PTSD in American legislation impacts on how the condition is perceived more broadly, leading to the minimisation of non-combat-related PTSD (Purtle, 2016).

1.2.2.2 Eugenics

In parts of North America, Poland and Germany, the evolution of psychiatry occurred in parallel with the emergence of eugenics, at the turn of the nineteenth century (Stahnisch, 2014; Gawin, 2007). As a result, many countries enacted legislation permitting eugenics and limiting the reproductive rights of the mentally ill.

Fourteen countries explicitly legislated for involuntary sterilisation (Amy and Rowlands, 2018a). In 1907, the US was the first country to introduce laws allowing the forced sterilization of people with intellectual disabilities (Diekema, 2003). In total, 30 US states enacted such laws and over 20,000 people were sterilised on the basis of mental illness.

In 1934, the British Brock Report recommended introducing legislation that would allow for the sterilisation of people who might 'transmit mental disorder or deficit' (Amy and Rowlands, 2018a). In 1940, Japan introduced a National Eugenics Law that permitted the forced sterilisation of people with 'inherited' mental illness. Switzerland was the first European country to introduce such laws in 1928 and they remained in force up until the 1990s (Amy and Rowlands, 2018b).

The most infamous eugenics legislation was in Germany where, in 1933, the 'Law for the Prevention of Hereditarily Diseased Offspring' was passed, based heavily on the US legislation. The German law was applied to a wide range of people with mental health conditions. Germany used sterilisation more frequently than other countries, sterilising almost 400,000 people between 1933 and 1939 (Proctor, 1988). After 1939, Germany adopted a 'euthanasia' program in which it killed up to 85% of its people with severe mental illness (Wyszinski, 1998). Other countries that enacted eugenics laws include Austria, Canada, Denmark, Estonia, Finland, Iceland, Japan, Mexico, Norway and Sweden. As recently as the 1990s, China introduced legislation that allowed for the sterilisation of people with a history of mental illness (Pearson, 1995).

Some have argued that current US legislation is more inclined to fund incarceration rather than the treatment for the mentally ill and therefore facilitates a form of *de facto* eugenics (Appleman, 2018). Eugenics is a tragic episode in the history of psychiatry that must be borne in mind when considering the history of the discipline and the necessity for a clear focus on human rights.

1.2.2.3 Key Events and the Protection of Society

From time to time, social and political events lead to rapid changes in legislation. This can be particularly relevant in jurisdictions that place a strong emphasis on case-law, such as England and Wales. In 1843, for example, Daniel M'Naughten killed the British prime minister's secretary, while suffering from paranoid delusions. This led to the M'Naughten rule which has been highly influential internationally in defining the verdict of 'not guilty by reason of insanity' (Arboleda-Florez, 1978). In another

example from the US, Anfang and Appelbaum (1996) describe how the Tarasoff case impacted legislation for decades.

Other recent examples of laws reacting to recent events include Laura's Law (California State) and Kendra's Law (New York State), both of which provide for court ordered out-patient treatment for people with mental illness. These pieces of legislation are named in memory of two people who were killed by persons with mental illness (Kass, 2014). Rushed legislation always runs the risk of unintended consequences and new limitations on the rights of the mentally ill.

Contemporary politics can also influence mental health laws. One of the clearest examples of this occurred in the former Soviet Union, where mental health legislation facilitated the silencing of political opposition (Thompson, 1990).

1.2.2.4 Legislation Relating to Suicide

The legal prohibition on suicide dates back to ancient Greece (Papadimitriou et al., 2007) and continued into the modern era through Church law: the Catholic Church refused to bury people who died by suicide from the sixth century onward (Dine, 2019). For this reason, establishing instances of suicide was important in medieval Europe and such cases often came before the courts (Trenery and Horden, 2017). On occasions, the family of a person who had died by suicide were punished (Behere et al., 2015).

Germany was the first country to decriminalise suicide attempts in 1751 (Kazarian and Persad, 2001). Other countries in Europe and North America began to follow suit (Behere et al., 2015). Some took a considerable period of time to make this change in legislation; Ireland, for example, passed its Criminal Law (Suicide) Act in 1993 (Osman et al., 2017). A 2016 review of legislation across 192 countries identified 25 countries where suicide is currently illegal and 20 others where, under Islamic or Sharia law, suicide attempts may result in jail sentences (Mishara and Weisstub, 2016).

1.2.2.5 Forensic Psychiatry

In its early iterations, forensic psychiatry legislation had broad powers and formed a key element of general asylum systems in many countries, such as Great Britain

(through its Criminal Lunatics Act, 1800). Such legislation generally addressed the evaluation of a person's fitness to plead and the insanity defence, as well as how people with mental illness progress through the criminal justice system, how prisoners with mental illness are treated, and how mental illness can lead to some degree of mitigation following offending behaviour.

Laws relating to fitness to be tried in court have been in existence for centuries (Mudathikundan et al., 2014). As early as 1583, juries were asked to determine if a defendant was 'mute of malice or by visitation of God' (Walker, 1968). Legislation concerning fitness to plead was formalised during the nineteenth century with legislation like the Criminal Lunatics Act, 1800 and the Prison Act, 1865 (Mudathikundan et al., 2014). Outside of Great Britain, other countries also identified that many defendants had unmet mental health needs (Konrad and Völlm, 2014). Many countries now have formal prerequisites relating to mental health and being tried (e.g. Section 4 of Ireland's Criminal law (Insanity) Act, 2006).

As trial by jury replaced trial by ordeal in twelfth-century England, pardon started to be given to people with mental illness (Higgins, 1986). Insanity defences were heavily influenced by a number of English cases in the eighteenth and nineteenth centuries, of which the best known was the 1843 M'Naughten case (Higgins, 1986). The impact of this case influenced judges and legislators across the world (Allnut et al., 2007; Weiss and Gupta, 2018). As the field of forensic psychiatry continues to evolve, future legislation will need to take account of the CRPD and its strong affirmation of legal capacity. Concerns have been raised that an overly dogmatic approach to this in the area of mental health could result in the criminalisation of people with mental illness (Freeman et al., 2015.)

1.2.2.6 Marriage Laws

From medieval times, the ability of people with mental illness to marry has been debated in court (Trenery and Horden, 2017). Positions on this issue have often been formalised in law, including, for example, Malaysia's Law Reform (Marriage and Divorce) Act 164, 1976 (Reddy, 1995). In India, the Special Marriage Act, 1954 and Hindu Marriage Act, 1955 both limited the ability of people with mental illness to

marry (Narayan et al., 2015; Sharma et al., 2015). Such laws remain a major problem today and may represent a continuation of the eugenics ideology of a century earlier. One 2016 analysis of 193 countries found that 37% prohibited people with mental illness from marrying and 11% stated that mental health problems were grounds for declaring a marriage void (Bhugra et al., 2016).

Table 1.2 Political and ideologically driven legislation that has impacted on people with mental illness

Driving force behind legislation	Positive consequences of legislation	Negative consequences of legislation	Examples of legislation
Concerns about the mental health of soldiers	Development of psychometric testing Development of treatments, especially for post-traumatic stress disorder (PTSD) and substance misuse	Interventions and legislation often not based on medical evidence but on the needs of the military Over-emphasis of combat as the main cause for PTSD	Medical 203 (1943) (USA) Federal Framework on Post-Traumatic Stress Disorder, 2018 (Canada)
Eugenics	Nil	Serialisation of hundreds of thousands of people with mental illness Mass euthanasia programs	Law for the Prevention of Genetically Diseased Offspring, 1933 (Germany) Sexual Sterilization Act, 1933 (British Columbia, Canada)

		Propagation of racist ideology	Maternal and Infant Health Care Law, 1994 (China).
Events interpreted as indicating a need to protect society	Supporters of such legislation believe it reduces risk.	Reduced personal autonomy, dignity and justice; increased stigma Rushed legislation Non-evidence-based reforms	Mental Health Act, 1973 (South Africa) Proposition 63 (2004) (California) Section 9.60 of New York State Mental Health Law, 1999
Legislation relating to suicide	Some have argued it creates a moral and social barrier that reduces risk of suicide	Can criminalise and stigmatise people who die by suicide and their families Can prevent people with suicidal ideation from seeking help Obstructs the collection of data related to suicide through underreporting	Section 327 of the Criminal Code Act, 1990 (Nigeria) Section 309 of Singapore Penal Code (Singapore)
Forensic psychiatry	Decriminalisation of people with mental illness who	May be seen to limit the legal capacity of people with mental illness	Homicide Act, 1957 (England)

	engage in offending behaviour		Penal Law (Article 34) (Greece)
	Protections for people with mental illness		
Marriage laws	May provide some protections for people who do not have the mental capacity to consent to marriage	Stigmatises people with mental illness, reducing their reproductive rights and right to a family Legislation often spuriously used against women with no mental illness	The Special Marriage Act, 1954 (India) Law Reform (Marriage and Divorce) Act 164, 1976 (Malaysia)

1.3 The United Nations and mental health law

With so many factors influencing the development of mental health law it has been important to establish consensus between countries, in this regard the UN and the WHO have provided much needed guidance (Duffy and Kelly, 2020c; Duffy and Kelly, 2020d).

Founded in 1945, with the purpose of maintaining international peace and security in the wake of the Second World War, the UN has done much to shape the latter half of the twentieth century. The organisation currently comprises 193 member states. In 1948, the UN published the UDHR, laying out a common standard of fundamental human rights (UN General Assembly, 1948). Many of these rights would later be articulated in the context of people with disabilities and incorporated into the CRPD (UN, 2006).

Many of the 30 articles of the UDHR have direct relevance for people with mental illness. Article 3, for example, gives people the right to life, liberty and security

of person. Article 6 protects an individual's right to recognition everywhere as a person before the law. Article 7 states that all persons are equal before the law. Article 9 prohibits arbitrary detention. Liberty and equal status before the law were especially important to individuals with mental illness at the time the Declaration was published because the asylum era was only beginning to come to an end. Article 5 gives people protection from torture and from cruel, inhuman or degrading treatment. Special Rapporteurs within the UN have since described the use of non-consensual treatment as a form of torture (UN Human Rights Council, 2013). Article 16 protects the equal right to marriage, which is still not available to many people with mental illness around the world (Bhugra et al., 2016).

The UN Human Rights Office of the High Commissioner recognises nine core international human rights instruments, each with its own monitoring body. These fundamental documents have a much greater legal footing than other UN documents and have consequently had significant impact. While not all of them are directly relevant to mental illness, they have broad applications for people with mental health problems.

Many of these conventions support the provision of healthcare in a general sense, although the International Covenant on Civil and Political Rights (UN General Assembly, 1966a) repeatedly gives 'the protection of public health or morals' as grounds for *limitation* of rights. Article 12 of the International Covenant on Economic, Social and Cultural Rights addresses mental health directly, stating:

'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (UN General Assembly, 1966b).

Other conventions promote the delivery of healthcare, including mental healthcare, and identify the impact of psychological trauma, but the Convention on the Rights of the Child (UN General Assembly, 1989) was the first of the core instruments to give detailed consideration to mental health. Article 17 gives a child a right to access media material promoting '*his or her social, spiritual and moral well-*

being and physical and mental health'. Article 19 protects children from 'mental violence'. Article 23 states:

'States Parties recognise that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.'

It continues by advocating for free assistance, training and education for carers. Article 25 gives children who have been placed in care due to their mental health a right to periodic review. Articles 27 and 29 promote the mental development of the child. Finally, Article 32 identifies the potential for economic exploitation to lead to mental harm. Following the Convention on the Rights of the Child (1989), the CRPD (2006) gave further consideration to mental health (below).

In recent years, many psychiatrists were disappointed that the UN did not include a consideration of mental health in its Millennium Development Goals (Thornicroft and Votruba, 2016). There were only minor improvements in the Sustainable Development Goals of the UN's 2030 Agenda for Sustainable Development (Cratsley and Mackey, 2018; UN, 2015). Bass and colleagues (2012) appealed to the UN to do more to address mental, neurological, and substance use disorders.

In 2016, the UN General Assembly had a special session on drugs which addressed the needs of people with substance misuse disorders and will hopefully be instrumental in shifting the emphasis away from criminalisation and punishment towards rehabilitation, treatment and prevention (UN General Assembly Special Session on Drugs, 2016). Encouragingly, this initiative also drew heavily on research in the area and was not defined by ideological views on substance misuse. This has been described as a positive and unprecedented step (Volkow et al., 2016).

1.3.1 The United Nations' Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991)

The UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (UN General Assembly, 1991) were initially

developed by the Subcommission on the Prevention of Discrimination and Protection of Minorities in 1988, after which input was received from governmental and non-governmental organisations (Moncada, 1994). The completed document was adopted by the General Assembly in 1991 and laid out basic standards for mental healthcare. The 25 principles are not legally binding and do not articulate new rights but, rather, set existing rights from the UDHR in the context of mental illness.

These rights include, *inter alia*, a right to life and a role in the community (Principles 3 and 7), protections from spurious, unfounded or malicious diagnoses (Principle 4), freedom from arbitrary medical examinations (Principle 5), confidentiality (Principle 6), the right to high quality, individualised care, delivered in the least restrictive manner (Principles 8-10), and a requirement for consent to treatment, albeit with certain exceptions (Principle 11). There is also a prohibition on sterilisation as a treatment for mental illness. This was an especially important step because eugenics legislation for people with mental health conditions existed into the 1990s (Amy and Rowlands, 2018a; Amy and Rowlands, 2018b).

The general limitation clause set out in the preamble arguably undermines impact of the entire document, it states:

'The exercise of the rights set forth in these Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others.'

While it is both well established and logically necessary that there are certain contexts in which some rights may be limited (UN Economic and Social Council, 1985), this clause is too general. The impact of the document is further muted by the fact that the General Assembly resolutions are not legally binding (Moncada, 1994).

Despite their limitations, however, it was believed that the 1991 Principles could improve human rights monitoring, prompt legislative change and even be directly applied at a domestic and international level (Rosenthal and Rubenstein, 1993). They were used to advocate for legislative change in, for example, Uruguay

(Moncada, 1994) and Australia (Zifcak, 1996), but, overall, their effect has been incremental rather than transformative.

1.3.2 The United Nations' Convention on the Rights of Persons with Disabilities

The CRPD has been the driving force behind the latest iterations of mental health law internationally (European Union Agency for Fundamental Rights, 2015). Some of the rights articulated in the CRPD are elaborations of those affirmed in 1991 Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. The 1991 Principles are, however, noticeably absent from the preamble to the CRPD and do not feature strongly in the history of the convention (Schulze, 2010). The social rights articulated in the 1991 Principles are, however, considered in some detail in the CRPD. By contrast, the 1991 Principles that relate to admission, coercive treatments and limitations of rights, and those that are ostensibly rooted in the 'biomedical model' of mental illness, are either not considered in the CRPD or have their validity called into question. The variation between the two documents, published fifteen years apart, highlight how dramatic the shift in emphasis in mental health law has been. The dissonance between the two documents is, in many ways, an overture to the tensions that currently exist in modern mental health law.

The CRPD does not create any new rights, instead, it contextualises existing rights for people with disabilities (Schulze, 2010). The convention was drafted between 2002 and 2006 in collaboration with non-governmental organisations representing the views of persons with disabilities. The General Assembly adopted the convention in 2006 and it came into force in 2008 (Steinert et al., 2016). The CRPD contains 50 articles; the first four address general principles, and Articles 31 to 50 focus on the implementation of the convention, the remaining 26 articles directly address specific rights. While the CRPD is framed to address the needs of all people with disabilities, it explicitly includes people with long-term mental illness under its remit; Article 1 states that:

‘Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.’

This inclusion of mental health under the remit of disability rights will have many positive outcomes (Morrissey, 2012), although there are also likely to be unintended negative consequences. The amalgamation of all disability under the one umbrella has, for example, diminished focused consideration of the position of people with mental illness. For example, the detailed discussion seen in Principle 11 of the Principles for the Protection of Persons with Mental Illness (UN, 1991), is absent in the CRPD.

Human rights institutions and organisations played a bigger role in the development of the UN-CRPD than in any prior international human rights treaty (Byrnes, 2014). Throughout the development of the UN-CRPD, Disability Rights international (DRI) and the International Disability Caucus (IDC) were vocal in affirming the retention of legal capacity in all contexts and strongly lobbied for deinstitutionalisation (Melish, 2014). DRI are an organisation that promote human rights for people with disabilities and advocate for their full participation in society, it had been involved in the development of many previous regional and international human rights treaties. The IDC is made up of disabled people's and non-governmental organisations, it was the strongest non-governmental voice in the development of the UN-CRPD (Schulze, 2010). The World Network of Users and Survivors of Psychiatry was part of the steering committee of the IDC (Degener and Begg, 2017). It's position on capacity and institutionalisation were non-negotiable (Melish, 2014). The World Network of Users and Survivors of Psychiatry represent the lived experience of many people who have received treatment for mental health conditions. However, they are not a representative sample. As a result, they reflect the views of individuals with a common experience or agenda rather than those of all individuals who have attended mental health services. They have a clear position statement on involuntary treatment:

‘Every user/survivor shall have the right to refuse any and all "treatments or procedures"' (World Network of Users and Survivors of Psychiatry, 2001)

In relation to capacity, forced interventions and independent living, there was a very wide range of perspectives; the UN-CRPD required agreement from all parties and as such numerous compromises had to be made. The positions on capacity and community living were not universally seen as positive by all organisations representing persons with disabilities (MacQuarrie and Laurin-Bowie, 2014). Article 12, which relates to capacity, was only agreed upon in the last few hours of the final meeting and was seen as a compromise. Towards the end of negotiation, there was growing support for forced interventions to be allowed in extreme circumstances. However, time ran out before all delegates could agree and this provision was omitted (Degener and Begg, 2017).

This debate has continued to evolve, as the UN Committee on the Rights of Persons with Disabilities (2014), who are responsible for interpreting the CRPD, state that ‘forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law’ (p.11). This further elaboration of the CRPD is seen by some as a step beyond what was intended in the CRPD and has raised many concerns.

The convention poses one of the central questions of this thesis, is India’s mental health and disability legislation concordant with the CRPD? India’s legislators took the bold step of explicitly attempting to align their Mental Health Act, 2017 and their Rights of Persons with Disabilities Act, 2016 with the UN convention. In chapter two India’s legislation is examined in more detail and in chapter 4 the CRPD is examined in more detail and the concordance of India’s legislation with it, is evaluated.

1.3.3 The United Nations’ Human Rights Council

The UN General Assembly established the UN Human Rights Council in 2006 to replace the Commission on Human Rights. This council regularly hears from Special Rapporteurs who report on a range of topics. The rapporteur on torture has identified

the treatment of people with mental illness as torture, on a number of occasions (UN Human Rights Council, 2016). They have also expressed concern about coercive treatments. For example, in 2018 they stated:

‘The risk is particularly high in the context of forced institutionalization and treatment of persons with psychosocial disabilities, who are often stripped of their legal capacity and not, or only inadequately, involved in decisions taken with regard to their treatment’ (UN General Assembly, 2018).

The inclusion of mental health treatments under the heading of torture is of particular concern because freedom from torture is a non-derogable right (UN Economic and Social Council, 1985). While contexts may exist where liberty or freedom of speech may need to be limited, the UN acknowledges no context in which torture is permissible.

The UN Human Rights Council also hears from the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. These reports have often expressed concerns at current mental health practices. In 2017, the report criticised psychiatry for an over-reliance on the ‘biomedical model’ and called for a paradigm shift in the treatment of mental health conditions (UN Human Rights Council, 2017a).

The UN Human Rights Council also has a working group on arbitrary detention that has reported that people with psychosocial and intellectual disabilities are often deprived of their liberty. They have, *inter alia*, identified the difficulties experienced by elderly people, highlighted forced treatments by religious organisations (UN Human Rights Council, 2017b), described the mental health consequences of detention during migration proceedings (UN Human Rights Council, 2018) and drawn attention to the involuntary detention of people who are dependent on illicit drugs (UN Human Rights Council, 2015). These reports have an impact on the ground. For example, through the work of the UN Human Rights Council, other UN bodies and human rights groups, pressure is being applied to reduce the arbitrary detention of people with substance misuse problems, although much more still needs to be done to protect rights in this

complex, contested area (Amon et al., 2014). The work of this council adds further weight to the case to end coercive practices in mental healthcare.

1.4 The WHO and mental health law

The WHO is a specialised agency of the UN. It was established in 1948 and it works with the 193 member states of the UN. The WHO seeks to create a world where everyone can live healthy, productive lives, it aims to place health at the center of the global agenda and seeks to work in partnership with countries to realize these goals. The WHO has recently acknowledged the importance of legislation in promoting health (2017). However, long before this it has had a major role in shaping mental health law. Initially this influence was indirect but since the 1990's the WHO has adopted an increasingly direct approach to influencing mental health law. The WHO is encouraging countries to update their mental health legislation in line with international guidelines, it aimed to have 50% of countries will achieve this by 2020 (WHO, 2013a).

1.4.1 The International Classification of Disease

The WHO took over responsibility for the International Classification of Diseases (ICD) shortly after its establishment. The earliest iterations of the ICD dealt only with causes of mortality. ICD 6, in 1949, was the first classification document to deal with morbidity and consequently it was also the first to consider mental illness (WHO, 1949; Hirsch et al., 2016). ICD 6 included a chapter entitled 'Mental, Psychoneurotic, and Personality Disorders'. It presented a list of diseases but did not include descriptions or diagnostic criteria. As a result, many of the conditions described lacked objectivity. There was no change between ICD 6 and ICD 7 (WHO, 1957).

Extensive revisions were included in ICD 8 with a large expansion in the number of conditions recognized (WHO, 1965). ICD 9 (WHO, 1977) produced a fundamental paradigm shift as descriptions and diagnostic features were included, greatly enhancing reliability and strengthening the use of ICD-based terminology in legislation. ICD 10 represented a significantly more detailed classification system with the number of codes increasing to over 155,000 (WHO, 1994; Topaz et al., 2013). In

2018, a version of ICD 11 was released after over a decade in development, with another extensive revision of diagnostic criteria in mental health, particularly in the area of personality disorders (WHO, 2018a). It is anticipated to come into operation in 2022.

While these documents may not directly shape legislation, they clarify who can be treated and how they can be treated under the law. Increasing the objectivity of diagnosis of mental health conditions helps to protect against some of the abuses seen in psychiatry in the past (Feighner et al., 1972; Telles Correia, 2017).

The benefits, challenges and limitations of creating an internationally standardized diagnostic schedule, particularly in psychiatry, have been long recognized (Sartorius, 1976). While debates concerning validity and content continue to this day (Schroeder et al., 2010), making diagnosis in psychiatry more objective has broad, and generally positive, implications for treatment and, consequently, for the consistent application of legislation in relation to mental disorder.

1.4.2 The World Health Organization Resource Book on Mental Health, Human Rights and Legislation (2005)

Published in 2005, the WHO's Resource Book on Mental Health, Human Rights and Legislation (WHO-RB) sought to provide guidance to governments on the development of human rights-centred mental health law (2005). The WHO-RB had a wide range of contributors, including medical and legal professionals, groups representing service users and their families, and both, governmental and nongovernmental organisations. The two principle authors are Melvyn Freeman (whose 2006 article is discussed at various points in this thesis) and Soumitra Pathare. Dr Pathare was heavily involved in drafting India's Mental Health and Disability legislation, this likely influenced India's concordance with the WHO-RB. Michelle Funk is also one of the named writers, her recent work on the QualityRights initiative has done much the WHO policy in line with the CRPD.

The WHO checklist is explicitly informed by the UDHR (United Nations, 1948). However, it is not a set of absolute rules and it is not legally binding. The WHO-RB checklist is, instead, designed to work by influencing states as they redraft and

implement national mental health laws. Given the checklist's close links with the UDHR, the authors make the assumption that its standards will be accepted by the international community (Kelly, 2015).

The WHO-RB provides detailed consideration of how legislation can be aligned with the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (UN, 1991) and provides examples of legislative approaches in different jurisdictions. Careful consideration is given to competing ethical principles, local resources and complex, nuanced situations. The WHO-RB provides detailed exploration of the rights of persons with mental illness and elaborates on numerous social and economic rights including housing, employment and social security. Where coercive measures are legislated for, the WHO-RB recommends the inclusion of extensive review processes. The largest single section of the document identifies and discusses the key legal issues that should be addressed in mental health legislation or policy. This is summarised in Annex One as the 'Checklist on mental health legislation'. The WHO checklist contains 175 items, divided into 27 sections, covering all key areas of mental health law. This checklist has been previously used to evaluate national mental health legislation in Ireland, India, England and Wales (Duffy and Kelly, 2017a; Kelly 2011).

The WHO-RB was a significant but incremental shift towards more humane person centred mental health law, it build upon the progress that had been made in earlier WHO documents. However, the paradigmatic shift caused by publication of the CRPD, only a year later, made much of the WHO-RB appear obsolete. The WHO-RB retains provisions for involuntary treatment, substitute decision-making, community treatment orders, seclusion and restraint, all of these are, arguably, prohibited under the CRPD, at least according to the UN Committee on the Rights of Persons with Disabilities (2014). The WHO-RB also uses a 'best interests' paradigm, although it gives significant weight to individual preference, albeit mostly in the context of advance directives. This is at odds with the shift that occurred with the CRPD, towards 'rights, will and preference' and supported decision-making frameworks. This resulted in the WHO's withdrawal of the resource book. Despite the impact of the CRPD, the vast majority of jurisdictions have retained legislative provisions that are not concordant with it, these laws permit some degree of substitute decision making and involuntary

treatment. Consequently the WHO-RB remains the most comprehensive, pragmatic and nuanced exploration of the necessary legal protections that should be in place. This leads to the second major question of this thesis, how does the Indian Legislation align with the WHO-RB. This is examined in detail in Chapter 3.

1.4.3 The QualityRights initiative

The WHO-RB appears to have been replaced by the publications relating to the WHO QualityRights initiative. This is the WHO's response to the challenges of making mental healthcare concordant with the CRPD and other international human rights standards (Funk and Drew, 2017). One of the stated objectives of this organization is to '*reform national policies and legislation in line with best practice, the CRPD and other international human rights standards.*' (WHO, 2019a). QualityRights have developed a toolkit that can be used to evaluate mental health practice in given jurisdictions (WHO, 2012). This toolkit identifies five themes that are each divided into standards, and each standard is subdivided into criteria, resulting in a total of 116 criteria.

These standards and criteria have already been deployed in a variety of countries, particularly in Europe (WHO Regional Office for Europe, 2018). The resultant reports are very thorough and highly informative, but are also problematic in a few regards. For example, they often place practices that are unjustifiable in any context alongside practices that are permitted by legislation, implicitly creating the impression that these practices are somehow equivalent. For example:

At one group of facilities, service users felt pressured by their psychiatrist to take medications. Sexual abuse of many female service users was described in another group of facilities, which had not been formally investigated and therefore not prosecuted (WHO Regional Office for Europe, 2018; p.27).

There are other examples; e.g.:

Service users are informed of and have access to procedures to file appeals and complaints, on a confidential basis, to an outside, independent legal body on

issues related to neglect, abuse, seclusion or restraint, admission or treatment without informed consent and other relevant matters (WHO, 2012; p.84).

QualityRights have also published extensive training and advocacy resources. The steps to reduce coercive treatments are greatly to be welcomed and need to be embraced widely (Duffy and Kelly, 2020e; Hoare and Duffy, 2021). The finding of abuses that have occurred in mental health facilities are highly disturbing and clearly must be addressed (Fawzy, 2015).

The training resources on capacity (WHO, 2019b) and supported decision-making (WHO, 2019c) provide numerous examples of well thought-through, rights-based approaches to supporting people with mental illness. They also highlight many gross violations of human rights that people with psychosocial disabilities often experience.

However, these documents also present multiple scenarios that describe psychiatric treatments as ineffectual, administered in an abusive manner and resulting in major side effects. By way of contrast, psychosocial interventions and attempts to deescalate situations by listening to the person's concerns are portrayed as universally effective. There is limited discussion of remedies that should be employed when such non coercive non pharmacological measures prove ineffective.

The capacity training module highlights that *'binding advance planning documents in countries have not been fully compliant with the CRPD'* (p.22), as they are either, non-binding when people come under mental health legislation or are invoked when someone is deemed too lose capacity rather than at a time of the person's choosing. There is a good discussion of a 'Ulysses clause', whereby people at risk of developing an acute episode of mental illness can make advance decisions that they cannot overrule during a period of illness (WHO, 2019c; Sarin, 2012). This is of particular importance as without such a clause rights-based legislation may actually deprive individuals of treatment.

As Freeman and colleagues (2015) highlight, however, many aspects of this kind of work that incorporate extreme interpretations of the CRPD run the risk of criminalizing people with mental illness. The module alludes to this indirectly in two places. It states that *'people with disabilities can only be detained on the same basis*

(or for the same reasons) as all other citizens (e.g. following a criminal sentence)’ (WHO, 2019b) (p 29). This statement may prove to be the norm if people with mental illness are not able to receive treatment at times where they lack capacity and refuse treatment.

The WHO material also highlights that, with regard to detention on the basis of risk, ‘other groups at higher risk of violence (e.g. gang members, persons drinking alcohol with a history of domestic violence) cannot be detained on the basis of increased violence risk’. However, these are groups that are over-represented in prison populations and, if dogmatically implemented, the CRPD may have a similar effect on people with mental illness.

In the QualityRights training document that relates to seclusion and restraint (WHO, 2019d), there is direct acknowledgement that there may be criminalization of people with mental illness; it states:

When someone is acting in a way which is very dangerous to others, this person should be stopped in the same manner as you would stop anyone, with or without a disability – such as by involving a specially trained group who are equipped with the skills to manage the situation (e.g. a response team, see topic 10) or alternatively in some instances law enforcement bodies (e.g. the police force) to guarantee the security of all (p.21).

This will result in many acute mental health episodes being dealt with by law enforcement staff, with minimal training in mental illness. This may lead to increased levels of harm, as restraint and seclusion will still occur, albeit in a forensic rather than a therapeutic setting.

Overall, the QualityRights documents bring WHO policy more in line with the interpretation of the CRPD provided by the UN Committee on the Rights of Persons with Disabilities (2014). This is most starkly seen in the training modules relating to Freedom from violence, coercion and abuse (WHO, 2019e), Supported decision-making and advance planning (WHO, 2019c) and Seclusion and restraint (WHO, 2019d). These documents describe how legislation permitting coercive treatments may amount to torture and may violate the CRPD – and they suggest that there is ‘a

lack of sanctions and remedies from the courts' for this (WHO, 2019e; p. 17). While there has undoubtedly been a CRPD-driven paradigm shift in recent years, this last statement seems like an excessive and very sudden departure from previous WHO publications, which until recently supported a degree of involuntary treatment (WHO, 2005).

The QualityRights initiative is not directly examined in this thesis though it is referenced in relevant sections throughout. This occurred for a number of reasons. First, India's legislation appears to have made an attempt to align with a less literal and dogmatic interpretation of the CRPD. Second, this has been the approach taken by many other countries, many of whom have expressed reservations in relation to Article 12 of the CRPD. Third, the WHO QualityRights specialized training course guide were only published in 2019 and have not been widely used to date. The criteria described in the QualityRights tool kit (WHO, 2012) are the logical and necessary focus of future research.

1.5 Comparative analysis of the Convention on the Rights of Persons with Disabilities and the WHO checklist on mental health legislation

The primary sections of this thesis comprise a black letter analysis of the concordance of India's legislation with the CRPD and the WHO-RB. Consequently, the areas of agreement and conflict between these two documents provide important background to these analyses. As highlighted above, the WHO-RB was published in 2005 a year before the release of the CRPD. Consequently, there are many areas of disagreement and dissonance between the two documents (Duffy and Kelly, 2017b). It was not possible for the authors of the WHO-RB to anticipate and incorporate the principles of the CRPD, as the provisions relating to capacity and involuntary treatment were only confirmed in the final days of negotiations (Degener and Begg, 2017).

1.5.1 The conceptualisation of mental illness as a disability

The role of the CRPD is to affirm the pre-existing rights of individuals with disabilities, of which mental illness is one of many. By contrast, the WHO-RB is solely focused on

individuals with mental illness. Hence it is important to consider the implications of including mental illness under the umbrella of disability, and examine how this has impacted the two documents.

Article 1 of the CRPD includes individuals with long-term mental impairments as persons with disabilities. The UN-CRPD is a strong and significant step away from the medical or welfare model towards social and rights-based models of disability. Harpur (2011, p1290.) describe it as an *'international norm for government policies that replaces the medical and social models with a human rights paradigm'*.

The Social model of disability has been around for over 35 years (Oliver, 1983) and has done much to advance the rights of individuals with disabilities. Where the medical or biopsychosocial models focus on an individual's limitation and pathology, the social model identifies barriers that reduce participation in society for individual's with certain physical or mental attributes. This subsequently led to more rights based models. It *'redirects analysis from the individual to processes of social oppression, discrimination and exclusion'* (Mulvany, 2000, p.582). Even before the development of the social model of disability, mental illness was often considered under the umbrella of disability. For Example, in 1974, England and Wales's National Assistance Act 1948 was expanded to include *'persons suffering from a mental disorder of any kind'*. Despite this, disability theorists throughout the twentieth century gave little consideration to mental illness (Shakespeare and Watson, 1997; Mulvany, 2000). The importance of the social model of disability is increasingly recognised in other medical specialities that were traditionally bastions of the medical model, for example rheumatology (Goering, 2015). However, in psychiatry this appears to be happening at the expense of the medical knowledge rather than in parallel with it.

The significance of the differences between persons with varying disabilities has long been debated (Mulvany, 2001). While there are many common areas of social oppression (Oliver, 1996), the consideration of disability as a single concept has the potential to be dangerously reductionistic.

A disability or rights based model focuses more on the treatment individuals receive over the course of their lives. This may stem from the fact that the nature of many disabilities is generally static or progressive, mental illness by contrast is often episodic with periods of acute exacerbation and remission. The definition of disability

in Article 1 includes '*long-term ... mental ... impairments*'. By contrast, the WHO-RB, dedicates more of its attention to acute periods of mental illness. An important related factor is that the illness process is modifiable with psychological and pharmacological interventions. While this may be the case with other disabilities, many individuals with mental impairments can achieve complete remission from the illness causing disability with appropriate treatment.

In addition to the episodic nature of psychiatric conditions, a second factor that complicates the classification of mental impairments as disabilities, is that during episodes of illness the level of support that an individual may need to exercise their capacity can vary greatly. Under the medical model this would have been described as an individual having impairments of mental capacity. This terminology is still reflected in the legislation of many jurisdictions, and based on this a significant proportion of inpatients have impaired capacity (Okai et al., 2007; Curley et al. 2019).

Finally, another major difference between individuals with mental-impairment-based-disabilities and other disabilities, is that there is an association between risk and episodes of illness. Individuals with mental health conditions have increased rates of suicide and self-harm (World Health Organisation, 2014). In addition, higher rates of violence are seen with in certain populations of people with mental illnesses (Senior et al., 2020). This association has been greatly overestimated in the past and has disproportionally influenced mental healthcare. However, even after controlling for other relevant factors, like criminal history, substance misuse and demographic profile, positive psychotic symptoms increase the risk of violence (Witt et al., 2013).

The fluctuant, but modifiable, nature of mental illness, the impact that episodes of illness can have on decision making ability and the association with risk, all complicate the description of mental impairments as disabilities.

1.5.2 International law, national law and policy

The CRPD is an international human rights convention, written as a legal document, by contrast the WHO-RB is a document that aims to shape and inform mental health legislation and policy. Consequently, the CRPD has to be both precise and direct; as its

provisions have to cover all individuals with disabilities they necessarily have to be more general.

International laws are often somewhat aspirational, laying out ideals, and leaving it to countries to attempt to implement their principles. This is due to the fact that many jurisdictions have protections that prevent external parties from imposing laws on them. Consequently, not only do international treaties have to be signed and ratified, but in the vast majority of jurisdictions they need to be incorporated into legislation. Different legal mechanisms are employed to allow countries to make legal arrangements that are appropriate for their particular cultural and economic position. For example the European Convention on Human Rights allows for a margin of appreciation. This is a:

‘realm of discretion left to national authorities in fulfilling certain state obligations under the ECHR.... The boundaries of the margin of appreciation cannot be precisely defined.’ (Broderick, 2018, p.205)

The CRPD, employs a different mechanism, it allows jurisdictions to make reservations provided they are compatible with *‘the object and purpose’* of the Convention (Article 46). As a result many countries have adopted the CRPD with reservations or declarations pertaining to the treatment of individuals with mental illness. For example, Australia included a declaration that stated:

‘Australia declares its understanding that the Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards. ...

Australia further declares its understanding that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards;’ (United Nations Treaty Collection, 2020).

Canada also retained a provision that allows for substitute decision making, Estonia permits curtailment of legal capacity in contexts where a person has an

impaired *'ability to understand and direct his or her actions'*. France interprets Article 15 in such a manner as to facilitate the participation in research of *'persons who are not able to give their consent'*. France also included a declaration which has implications for voting rights. The Netherlands, Norway and Poland are among the other countries that submitted reservations, concerning mental illness, in relation to articles 12, 14 and 15 (United Nations Treaty Collection, 2020). Irelands reservations include the statements:

'Ireland declares its understanding that the Convention permits supported and substitute decision- making arrangements which provide for decisions to be made on behalf of a person, where such arrangements are necessary, in accordance with the law, and subject to appropriate and effective safeguards.'

'To the extent article 12 may be interpreted as requiring the elimination of all substitute decision making arrangements, Ireland reserves the right to permit such arrangements in appropriate circumstances and subject to appropriate and effective safeguards.'

and

'Furthermore, Ireland declares its understanding that the Convention allows for compulsory care or treatment of persons, including measures to treat mental disorders, when circumstances render treatment of this kind necessary as a last resort, and the treatment is subject to legal safeguards.'

India made no declarations or reservations on signing the CRPD (United Nations Treaty Collection, 2020).

By contrast, the nature of the WHO-RB allows a deeper consideration of legislative implementation, and permits an examination of steps that can be tried in a variety of settings. As the content of the WHO-RB does not have any legal footing, there is a freedom to engage in nuanced discussion, to examine policies and laws that have worked in specific settings and to provide extensive discussion around the topics it raises. Countries are free to accept or ignore any of its recommendations.

1.5.3 Inclusive or exclusive definitions

Definitions are vital in relation to mental healthcare, due to the level of diagnostic subjectivity. As mentioned above one of the main achievements of the WHO was the increased reliability of diagnosis introduced by ICD 9 (WHO, 1977). The WHO-RB has continued to highlight this, the second topic addressed in its checklist is, '*Definitions*'. This sections seeks to clarify the definition of mental illness and mental capacity, ensure that the terms are consistently and appropriately used and establish if intellectual disability, substance misuse and personality disorders are included under the definition.

By contrast, the definitions are intentionally obscure in the CRPD, as it aims to have space to evolve and include a wider range of disabilities (Kafer, 2013). The CRPD has been criticized for a lack of clear definitions concerning other key terms (Byrne, 2013). Extending protections to broader groups of individuals with a wider range of disabilities is important in addressing the barriers present in society. However, an over inclusive definition runs the risk of undermining the objective of the CRPD. Some disability theorists attempt to avoid the distinction between disabled and non-disabled altogether (Erevelles and Kafer, 2010), and even where the distinction remains some scholars resist fixed definitions in an attempt to cast a wide net (Kafer, 2013). Pothier and Devlin deconstruct the definition of disability further and conceptualise disability as a question of 'politics and power' (2006).

While, the ambiguity of Article 1 may be inclusive and mitigate against legal debate related to more precise terms, it leaves unanswered questions for individual's with a first presentation of a mental illness or an acute exacerbation of a chronic condition. By contrast the WHO-RB is highly cognisant of the importance of clear definition. This is a natural difference that stems from the fact that the WHO-RB is considering contexts in which rights can be limited and consequently precise definition is vital. As Mulvany (2001) observes '*These diagnostic categories, though problematic, do enable a distinction between serious psychiatric disorders and other milder mental health problems*'. When affirming rights, broad definitions are very helpful, but when discussing the limitation of rights, precise and narrow definitions become important.

1.5.4 The balancing of ethical principles

The practice of medicine involves holding many ethical principles in tension. This is often a tightrope of compromise where no ethical principle can be fully realised and emphasising one inherently detracts from the others. In relation to mental healthcare different principles have been given hegemony in the CRPD and the WHO-RB, this has shaped the respective documents.

As both documents aim to shape global legislation and policy, the ethical principles they prioritise do not give full consideration to particular cultural contexts (Bayettia et al., 2016). Indian society does not give individualism the same degree of importance many other countries do (Alden et al., 2018). This collectivistic orientation may be protective of mental health (Bhullar et al., 2012). Healthcare in India often has a strong family involvement, families and clinicians may emphasise the 'right to' or even 'need for' medical treatment over an individual's treatment preference (Avasthi, 2010; Chavan et al., 2018). Families and occasionally authorities are often centrally involved in the process of health seeking for an individual (Alden et al., 2018). Consequently, the right to individual autonomy often receives less priority and programs that fail to integrate with families and communities struggle (Thara et al., 2008). There is also a deferential acceptance of medical opinions that in other countries could be seen as paternalistic (Shields, et al., 2013).

1.5.4.1 Autonomy and dignity

Occasionally in the provision of mental healthcare an individual's freedom may appear to be in conflict with their dignity. In many countries, autonomy is sometimes limited in the hope of maintaining dignity (Delmar, 2013; Delmar et al., 2011; Smebye et al., 2016). For example, when a patient is admitted on an involuntary basis with severe self-neglect secondary to psychosis. Wexler (1996) has highlighted that there is not a dyadic opposition between autonomy and dignity but rather they are connected as complementary and supportive values.

In this balance the WHO-RB seeks to protect dignity (as it perceives it) and on occasions it permits autonomy to be limited. To do this the resource book lays out criteria for coercive measures including involuntary mental healthcare, seclusion and restraint. It promotes voluntary engagement with services and acknowledges the need

to exhaust all non-restrictive measures before considering involuntary treatment. However, even in the document's section on autonomy and liberty, there is extensive consideration given to the protections around coercive treatments.

Personal autonomy is the hegemonic principle in the CRPD. As mentioned above this may be at odds with societies that tend towards a collectivist orientation rather than an individualistic one (Verma, 1999). At best, this is a failure of global organisations to account for local or national priorities, but, alternatively, it could be seen as the imposition of individualistic ethical principles on a collectivist society. Chandrasekhar (2018), discussing the Indian context, highlighted how the realisation of autonomy at all costs can 'support non-intervention or poor care, leaving vulnerable adults exposed to the risk of harm'.

The CRPD appears to hold an individual's rights to health, autonomy and liberty in tension. The right to personal liberty in Article 14 of the CRPD reflects the language of Section 21 of the Constitution of India, these documents both envisage contexts in which liberty can be limited. However, the balance is unambiguously shifted to autonomy by the United Nations Committee on the Rights of Persons with Disabilities (2014). This is most clearly elaborated in the QualityRights material, which are vociferous in denouncing all forms of involuntary treatment (World Health Organization, 2012), thus placing individual liberty and autonomy above health or dignity.

For many reasons the emphasis on autonomy may not align well with the needs of service users in India. First, India is a more collectivist society, although this is something that is changing (Chadda and Deb, 2013), consequently autonomy may not be valued to the same degree that it is in the CRPD.

Second, mental health literacy is often limited in India. While, this is improving, there is still significant levels of stigma and misinformation regarding mental health (Mehrotra et al., 2018; Mukherjee and Mukhopadhyay, 2018). This could hinder individuals with mental illness or their carers from seeking help and may justify a lower threshold for limiting autonomy to preserve health, dignity or safety.

Third, resource and funding limitations are significant in relation to mental healthcare in India. Chadda and Deb (2013) suggest that the paucity of mental health professionals is one of the reasons that enhanced involvement of the family is to be

permitted, this could justify autonomy not being the predominate principle. Although they acknowledge that the family can also significantly hinder mental health, many of the protections of the MHCA address this. Saya et al. (2019) also highlight that in contexts where mental health resources are greatly limited, such as India, there may be a need for the family to have an enhanced role and this may on occasions lead to the limitation of autonomy. Saya et al. (2019) also describe the challenges in realising care, dignity, and rights in a context of economic deprivation.

However, Shields et al. (2013), demonstrated that, even in the context of limited resources and limited mental health literacy, steps can enhance mental healthcare and this may reduce coercive practices. India's attempt to realise rights based mental health law despite its financial and infrastructural limitation is one of the key motivators for this research.

1.5.4.2 Families and caregivers' rights and an individual's privacy

The contrasting approach to a carers' rights to be involved in an individual's care, in the two documents is striking, it highlights the very difficult balance that clinicians must hold (Duffy and Kelly, 2017b). Family involvement is often central to mental healthcare (Pharoah et al., 2010), families are often involved in the involuntary admission process in psychiatry (O'Donoghue et al., 2010) and lack of discussion with relatives is often mentioned as a concern among families (The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2017). The individual receiving treatment, however, has a right to privacy. Though this privacy has limits, especially in cases where the patient poses a risk to themselves or others (Johnson et al., 2014), but establishing the correct balance is one of the most challenging areas in psychiatry (Rugkåsa and Canvin, 2017). These perspectives are affirmed in the WHO-RB, and careful consideration is given to the balance between confidentiality and carers' rights to information and involvement.

The CRPD adopts a very different consideration of family and caregivers, the discussion of family in the convention is focused on an individual with a disability's right to marry and make decisions about having a family. While the CRPD suggests the family play a role in situations where individuals are unable to care for a child with

disabilities they offer the carers little protection or entitlement to involvement in ongoing care. A robust application of Article 22 which addresses 'respect for privacy', could see families and carers marginalised.

1.5.4.3 Society and the individual

There has always been a balance in mental healthcare between the interests of the individual and the interests of society, historically the needs of the individual were often neglected (Shorter, 1997; Shorter, 2007). Thankfully, much has been done to address this, with reforms like patient centred care, the recovery model and deinstitutionalisation; but situations still arise where the interests of society have to be considered. The primary domain where this persists is in relation to risk, especially risks posed to others.

The UN-CRPD is firmly focused on the individual, their rights and needs. It often considers the responsibilities of society but generally does not highlight any rights society may have. The WHO-RB, on the other hand, has a broader focus, considering implications for society at large. This is a particularly important debate in the fields of forensic and addiction psychiatry, where the levels of risk are elevated. If the broader impact of mental illness is not considered in mental healthcare, there is the danger that this consideration will occur in a criminal justice setting (Freeman, 2015). To explore this carefully balanced area, the WHO-RB discusses in detail criteria for involuntary admission and treatment, oversight and review mechanisms, police responsibilities and special legislative provisions for mentally ill offenders.

The Committee on the Rights of Persons with Disabilities interpretation of the CRPD would conceptualise many of these measures as discrimination or torture (United Nations Committee on the Rights of Persons with Disabilities, 2014).

This is a very contentious topic, requiring highly nuanced debate. The link between violence and mental illness has often been over emphasised and this false portrayal has been used to justify the use of coercive measures on individuals with mental illness (Stuart, 2003; da Silva et al., 2020). Reviews of published data continue to identify confounders of the association between mental illness and violence, like substance misuse, and social factors (Witt et al., 2013). While relatively small, and

inflated by the media, the societal impact of violence perpetrated by individuals with mental illness is significant (Senior et al., 2020). Organisations like hundredfamilies.org often feel that the rights of families effected by violence, carried out by individuals with mental illness, are not protected (Hundred families, 2015).

The CRPD promotes individual autonomy as the hegemonic principle in this area of mental healthcare. In the context of psychiatry's history of stigmatization and coercion this is to be welcomed. However, the WHO-RB's detailed consideration of protections for individuals who may put others at risk due to mental illness is of value. The extrapolation of article 12 by the Committee on the Rights of Persons with Disabilities would prohibit coercive measures but this could potentially negatively impact individuals with mental illness and society at large. Holding the tension between the individual's rights and those of society remains vital in mental healthcare (Johnson et al., 2014). Admittedly it is a balance that has sadly erred on the side of coercion for too long. However, erring on the side of autonomy may prove just as harmful.

1.6 Summary

The role of legislation is set to become increasingly important in healthcare. Mental healthcare has historically been the area of medicine most dependent on legislative provisions. The UN and the WHO have done much to shape mental health legislation and have greatly assisted in ending the asylum era and transitioning towards patient centred, rights based, voluntary services. Documents and conventions published by these respective bodies have helped standardise diagnosis and treatment, and have attempted to limit coercive measures. Mental health legislation continues to evolve, with the UN CRPD currently being the primary driving force. Recent iterations have enhanced the protections of the rights of individuals receiving treatment, however, high degrees of controversy still remain.

The primary current tension that exists centres around capacity and whether or not there are any circumstances in which an individual's autonomy can be limited on the basis of their mental health. The CRPD, which could be read in such a manner as to

permit involuntary care, has been interpreted by the Committee on the Rights of Persons with Disabilities as a total prohibition on such practices. However, the WHO-RB, despite being withdrawn by the WHO, better reflects the current legislative position in the majority of jurisdictions. This thesis seeks to examine India's recent mental health legislation through the lens of these documents and the legal and ethical issues they raise.

2. India's mental health legislation

This chapter examines the mental health law of India. It begins by exploring the history of Indian legislation that has guided the treatment of those with mental illness and then focuses in detail on the two most recent pieces of relevant legislation, the RPWDA, 2016 and the MHCA, 2017.

2.1 History of India's mental health legislation

2.1.1 Early Mental Healthcare in India

Like all medical traditions worldwide, Indian medicine has long had an awareness of mental illness. In Unani medicine, from the thirteenth century CE, many different mental illnesses were described by one of its key practitioners Najabuddin Unhammad (c. 1222) (Nizamie and Goyal, 2010). Ayurveda (Somasundaram, 1984) and Siddha-based medicine also presented descriptions of mental illness (Somasundaram et al., 1985).

Even prior to the introduction of formal legislation, there was an increasing awareness of the European approach to treating mental illness in India from as early as the sixteenth century (Sanjeev, 2003). Mental hospitals initially arrived in India from the Muslim world (Sharma and Varma, 1984). Prior to British rule, there were no large institutions housing people with mental illness, families cared for the mentally ill (Sharma, 2006). Large-scale modern psychiatry in India, when it developed, mirrored the British asylum system (Mishra et al., 2018), although it is debated to what extent these 'madhouses', asylums and hospitals were used by native Indians (Verma, 1995).

The first asylum in India opened in Bombay in 1745, when a ward in a Bombay hospital was set aside for 'lunatics' (Crawford, 1914). This was followed by developments in Calcutta, where a hospital for the treatment of people with mental illness was opened in 1784 (Kumar and Kumar, 2008). Few additional asylums were constructed until the Lunatic Asylum Act, 1858 which led to the opening of multiple facilities across India (e.g. in Agra, in 1859). By 1900, 26 asylums were being run by the Indian government (Mills, 2001).

Until the middle of the nineteenth century, the treatment of people with mental illness in India occurred without formal legislative provisions. From 1851 on, however, legislation was gradually introduced, and its evolution has continued right up until today. This process has been shaped by key political events (Table 2.1) and has led to what is arguably one of the most progressive mental health laws internationally: The MHCA, 2017.

Table 2.1: Timeline of key developments in Indian mental health legislation and their political context

Year	Key events	Legislation
1745	First asylum founded in Bombay	-
1757	Beginning of 'Company Rule' in India	-
1851	-	Lunatic Removal Act
1858	Start of British rule in India	Lunacy (Supreme Courts) Act, Lunacy (District Courts) Act, Indian Lunatic Asylum Act
1860	Criminalization of suicide	Penal Code
1877	-	Military Lunatic Act
1898	-	Code of Criminal Procedure (Chapter 34)
1900	-	Prisoners Act
1912	-	Indian Lunacy Act
1947	Indian Independence	-
1949	-	Constitution of India
1987	-	Mental Health Act
1995	-	Persons with Disabilities Act
1999	-	National Trust Act
2007	Ratification of the United Nations' Convention on the	-

	Rights of Persons with Disabilities by India	
2012	-	Protection of Children from Sexual Offences Act
2014	New mental health policy	-
2016	-	Rights of Persons with Disabilities Act
2017	-	Mental Healthcare Act

2.1.2 Early Mental Health Legislation in India

English legislation was introduced during the period of 'Company Rule' in India before 'Direct Crown Rule' came into place in 1858. The first piece of mental health legislation introduced was the Lunatic Removal Act, 1851 (Firdosi and Ahmad, 2016). This facilitated the removal of mentally ill offenders from India to England at the expense of the East India Company.

The Lunatic Removal Act, 1851 was a short piece of legislation, comprising just seven sections. People of 'European birth' who committed crimes but were found to be of 'unsound mind' could be removed to 'any part of the United Kingdom' (Section 1). The Act gave the Government of India 'sufficient warrant and authority for the purpose of removal' and, on return to the UK, the person fell under the Criminal Lunacy Act, 1800 (Section 2). The cost of removal and treatment fell to the East Indian Company (Section 3), but this cost became a debt that the removed person then owed (Section 4).

When the English government implemented direct rule in 1858, they attempted to reduce costs by limiting transfers to England (Weiss, 1983). This was facilitated by increasing the number of asylums in India (Ernst, 1987). Even so, the Lunatic Removal Act had widespread use beyond India, with sections being applied in China and Korea (Hong Kong Daily Press Office, 1912). It was only repealed through the British Statutes (application to India) Repeal Act, 1960, after India gained independence.

In 1858, the year that the rule of India passed from the British East India Company to the British Crown, three mental health laws were enacted. First, the Lunacy (Supreme Courts) Act dealt with the judicial evaluation of mental health in presidency-towns. These towns were the initial trading ports found by the British East India Company: Madras, Calcutta and Bombay. Second, the Lunacy (District Courts) Act, 1858 provided similar legal framework for cases outside of presidency-towns. Third, the Indian Lunatic Asylum Act, 1858 governed detention in asylums (Nambi et al., 2016).

These laws primarily dealt with the detention of the mentally ill, the disposal of their estates, and the management of 'pauper lunatics' (people with mental illness without the means to pay for treatment). These were the matters commonly dealt with in mental health legislation of that era in many other countries. The Indian legislation was heavily based on the English law of the time, including the Lunatics Act, 1845 and the County Asylums Act, 1845 (Somasundaram, 1987). These Indian Acts were used with regularity and quickly entered common parlance in the relevant communities (Bhattacharyya, 2013). The Indian Lunatic Asylum Act was amended in 1886 and 1889 and a fourth act, the Military Lunatic Act, added in 1877 (Firdosi and Ahmad, 2016).

In 1860, the Indian Penal code, criminalized suicide, stating that 'whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both' (Section 309). While this provision was rarely used, it remains in place today and has been employed from time to time, even in recent decades. There was, however, a noted shift in perceptions concerning the criminalization of suicide in the years leading up to the MHCA (Vadlamani and Gowda, 2019).

From a historical perspective, two other Acts also related to people with mental illness: Chapter 34 the Code of Criminal Procedure, 1898 and Section 30 of the Prisoners Act, 1900 (Somasundaram, 1987). The Code of Criminal Procedure made extensive provisions for the management of people with mental illness accused of breaking the law. This included fitness to stand trial, acquittal on the grounds of

insanity and matters relating to disposal. Section 30 of the Prisoners Act, 1900 dealt with the management of prisoners with mental illnesses, including transfer to asylums.

2.1.3 Indian Lunacy Act, 1912

The Indian Lunacy Act, 1912 amended, consolidated, revised and replaced existing mental health legislation in an attempt to bring Indian legislation in line with the English Lunacy Act, 1890 (amended in 1891) (Somasundaram, 1987). The 1912 Act brought an end to the idea of the diverse asylum, where Indian and European ideas could co-exist, and so the asylums in India became archetypal colonial institutions (Bhattacharyya, 2013). This revision of the legislation was motivated by a general outcry at the conditions in which people with mental illness were being kept (Narayan and Shikha, 2013). The 1912 Act was a substantial document with 101 sections covering a vast array of topics. The main parts of the legislation addressed the 'Reception, care and treatment of Lunatics', 'Care and Treatment', 'Proceedings in Lunacy in Presidency-towns', 'Proceedings in Lunacy outside Presidency-towns', 'Establishment of Asylums', 'Expenses of Lunatics' and various other 'Rules'. When the 1912 Act came into force, it applied to over quarter of a billion people whose mental health needs were served by just over 7,000 beds (Overbeck-Wright, 1921).

One of the central fears of the day, and an issue carefully addressed in the 1912 Act, was the improper detention of sane people for nefarious reasons. Section 18(2) prohibited reception orders being 'made upon a certificate founded only upon facts communicated by others' and required the medical officer to distinguish 'facts observed by himself from facts communicated by others'.

The Act gave significant power to Magistrates to make decisions regarding people who were deemed to be of unsound mind. They could, *inter alia*, appoint substitute decision-makers, have people committed to an asylum, and detain people pending transfer to asylums. Some of these decisions required the agreement of a medical officer. Some limits were placed on the length of time a person could be detained pending a medical examination (Section 16). While it may be very far removed from modern rights-based legislation, there were some provisions for the

rights of the mentally ill. In Section 15, Magistrates were directed to investigate any person with a mental illness who 'is cruelly treated or neglected by any relative or other person having the charge of him'. Although similar protections had existed prior to the 1912 Act, they were seldom employed (Mills, 2006).

Interestingly, the 1912 Act made some distinctions between capacity for making different decisions and did not treat decision-making capacity as a global concept. Sections 46 and 65(2) drew a distinction between a person having capacity to manage 'himself' (sic) and having capacity to manage their 'affairs'. While this demonstrated a degree of nuance in the concept of capacity, it still undermined the person's right to manage their financial and family matters. This loss of financial autonomy was further compounded by Sections 49 to 56 which gave the courts 'power to dispose of lunatic's property for certain purposes' and described a wardship process. This was further compounded in Sections 67 to 80, which addressed the management of the property and affairs of people found to be of unsound mind. There was the potential for the revision of a declaration of unsoundness of mind should someone's clinical condition have changed (Section 60). Despite the focus on how care would be paid for, provisions were made for people who could not pay for their treatment and who had no assets; under Section 86, their treatment was paid for by the government.

The 1912 Act had many progressive features. It was, for example, one of the first pieces of mental health law to consider voluntary admissions (Section 4). The status of voluntary patients was not recognized in the English and Welsh law until 1930 (Somasundaram, 1987) and, even today, many countries only consider involuntary patients in their mental health legislation. The 1912 Act also addressed 'wandering or dangerous lunatics', mental illness in the armed forces, and mentally ill offenders and prisoners. All of these were important issues at the time, and many remain so today.

While the Lunacy Act, 1912 was in force, people could be found to be 'criminal lunatics' under the Code of Criminal Procedure, 1973, the Prisoners Act, 1900 or the Indian Army Act, 1911. 'Wandering lunatics' and 'criminal lunatics' presented particular challenges to services over this period and greatly increased the numbers admitted to asylums. These people often proved difficult to discharge, greatly

increasing the cost of running the institutions (Mills, 2006). While the 1912 legislation did not change this situation drastically, its detailed consideration of such cases was a welcome addition to the rather complex legislative landscape. Section 84 began the licensing of asylums at a state level and licenses could be revoked if asylums were not providing effective treatments. In addition, the Act evolved to a degree over time; e.g. in 1922, the term ‘mental hospital’ replaced ‘lunatic asylum’ (Somasundaram, 1987).

2.1.4 Constitution of India, 1949 and Representation of the People Act, 1950

The Constitution of India is the largest constitution in the world, comprising almost 400 articles (Rao and Panchmukhi, undated). As India moves to embrace rights-based mental health legislation, it is clear that many of the principles are already underpinned by the country’s highly progressive Constitution. While the Constitution predates the CRPD, and does not explicitly refer to disability or mental illness, it protects many civil rights and includes protections of social and economic rights, such as education. The Constitution guarantees many fundamental rights including rights to equality, freedom and protection from exploitation. Article 21 provides protection from gross violations of these fundamental rights, prohibiting deprivations of life or personal liberty unless prescribed by law. The Constitution also gives consideration to issues that would be seen as more peripheral in other jurisdictions; e.g. Article 47 aims to prohibit alcohol (though few states have adopted this) (Khandelwal et al., 2004).

These constitutional provisions are, however, just one part of a legal landscape that also includes other, more problematic provisions. The Representation of the People Act, 1950, for example, prohibits people of ‘unsound mind’ from holding public office. Similar provisions concerning people who have been found to be of ‘unsound mind’ exist in the Hindu Marriage Act, 1955, Indian Succession Act, 1925 and Indian Contract Act, 1872 (Narayan and Shikha, 2013). Depending on how these provisions are applied, they may provide protections for people with mental illness or they may actively foster discrimination and marginalization.

2.1.5 India's Mental Health Act, 1987

India gained independence in 1947, but continued to use the Indian Lunacy Act, 1912 until it was replaced by the Mental Health Act, 1987. The Act had been drafted in 1950, but took 37 years to receive presidential assent (Trivedi, 2002). It did not come into effect in all states and union territories until 1993 (Rastogi, 2005).

Despite these delays with implementation, India's 1987 Act introduced many positive changes to mental healthcare in India. The Act is divided into 10 chapters and has 98 Sections. It adopted a more human rights-based approach to care, replaced much of the stigmatizing terminology, created the Central and State Mental Health Authorities (SMHAs), simplified admission and discharge policies, and facilitated proxy consent for involuntary admission and the admission of minors (Rastogi, 2005; Nambi et al., 2016). It was also the first of India's mental health acts to consider outpatient treatment and thus helped shift the focus of mental healthcare from the psychiatric hospitals to the community, at least in theory. The Act also introduced separate in-patient services for people with addiction-based problems and provided children with separate mental health services.

Despite these advances, the 1987 Act was heavily criticized for a number of reasons. First, it failed to align with government policy, India's Mental Health Program or many World Health Organization guidelines. Second, the new legislation approached mental illness from a legal perspective rather than a clinical one and consequently placed arguably excessive power in the hands of judges rather than clinicians. Third, the Act did little to address stigma or the inappropriate use of mental health legislation, or to educate society as a whole about mental illness. Fourth, little consideration was given to psychiatry outside of admission. Finally, the police were often the only means of transporting involuntary patients to hospital, which added to stigma (Nambi et al., 2016). The 1987 Act also gave insufficient consideration to General Hospital Psychiatric Units, as it focused on stand-alone psychiatric hospitals and nursing homes (Math et al., 2011). Rastogi (2005) identified this as a limitation and suggested that their inclusion would improve their general standard and the treatment that people with mental health problems received in such settings. A major

injustice occurred where no relatives came forward to support a person in hospital, as such people could then, in theory, be detained indefinitely.

Overall, some of the innovations of the 1987 Act were steps in the right direction, but they still fell short of the legislative standards of the time. For example, the Act simplified the admission and discharge processes (Rastogi, 2005), but made no mention of rehabilitation or care after discharge. The 1987 Act also gave consideration to research (which was not present in the 1912 Act) and prohibited research without valid consent, but allowed relatives to provide consent on the patient's behalf. Even in 1987, a more detailed consideration of this complex issue was required.

2.2 Modern Indian Legislation Related to Mental Health

India's early ratification of the CRPD in 2007 clearly put a significant onus on India to update its mental health legislation. As the Mental Health Act (MHA), 1987 was drafted in 1950, it was felt that it would not be possible to revise it and, so, a decision was taken to replace it with the MHCA. The new legislation, which was commenced in 2018, is complemented by the Rights of Persons with Disabilities Act (RPWDA), 2016, which replaced the Persons with Disabilities Act (PWDA), 1995. The RPWDA, 2016 also has significant implications for people with mental illness owing to the CRPD's definition of 'persons with disabilities' which includes those with long-term mental illness (United Nations, 2006; Article 1). The details of the Rights of Persons with Disabilities Act, 2016 and MHCA are discussed in detail below. This section presents a *descriptive* outline of the legislation, summarising its contents and providing the basis for the *analysis* presented in subsequent chapters. How the legislation relates to the CRPD and the WHO-RB will predominantly be discussed in the chapters relating to those specific documents.

The rules that provide the practical structure for the implementation of the Act were published in June 2017 and in January 2018, the guidelines and procedures for disability certification were released. (Balakrishnan, et al., 2019).

2.2.1 India's Rights of Persons with Disabilities Act 2016

India's RPWDA, 2016 received the assent of the President of India on 27 December 2016 and was commenced on 15 June 2017. The Act followed on from the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (Suresh, 2014), which - critically - preceded the United Nations' (UN) Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2006; Rao et al., 2016; Kalmegh et al., 2018; Raveesh et al., 2019). Against this background, the purpose of India's RPWDA is 'to give effect to the United Nations Convention on the Rights of Persons with Disabilities'. The Act's Preamble notes that the UN General Assembly adopted the Convention 'on the 13th day of December, 2006'; 'India is a signatory to the said Convention'; 'India ratified the said Convention on the 1st day of October, 2007'; and 'it is considered necessary to implement the Convention'.

2.2.1.1 Introduction

There are many enhancements to the RPWDA in comparison to the PWDA. Most significantly, there is a distinct shift from a medical model towards a social and rights based model, the basis for this transition is described in the preamble.

The Preamble of the Act lays out a number of underpinning principles of which the first one is '*respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons*'. The preamble goes on to include, *inter alia*, '*non-discrimination*', '*full and effective participation and inclusion in society*', '*respect for difference and acceptance of persons with disabilities as part of human diversity and humanity*' and '*respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities*'. The Act describes 21 disabilities a significant increase from the seven described in the PWDA (Balakrishnan et al., 2019). However, this thesis will primarily focus on its implications for individuals with mental illness as this is the main objective of this study. The Act is divided into 17 Chapters and contains 102 articles. Each chapter will be discussed below.

2.2.1.2 Chapters

2.2.1.2.1 Preliminary

The preliminary section of the act includes two articles. Section 1 identifies the name of the act and describes how its commencement will be notified. Section 2 of the Act covers definitions, which addresses many key terms. A ‘person with a disability’ is defined as *‘a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others’* (Section 2 (s)). This is a vastly superior definition compared to the PWDA, which in defining disability just listed medical conditions. It highlights the shift away from the medical model. The PWDA also gave no meaningful consideration to family or care givers but the RPWDA defines a ‘care giver’ as *‘any person including parents and other family Members who with or without payment provides care, support or assistance to a person with disability’* (Section 2(d)). Discrimination is defined in very broad term (Section 2(h)). Notably this was not defined in the earlier act. Other key terms that receive definitions include *‘high support’* (Section 2(l)), *‘person with a benchmark disability’* (Section 2(r)), *‘reasonable accommodation’* (section 2(y)) and *‘rehabilitation’* (Section 2(za)). Section 2(zc) defines ‘specified disabilities’ by referral to ‘the Schedule’. This section included at the end of the act includes five domains: physical, intellectual, mental behavioural, others, and multiple disabilities. The Schedule also leaves room for revisions, which may be notified by the central government. In this section mental illness is defined as *‘a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life’*, the schedule continues to state that intellectual disability is not included under the umbrella of mental illness. This is much more specific than the definition found in the PWDA which simply defined *‘mental illness’* as *‘any mental disorder other than mental retardation’* (Section 2(q)).

2.2.1.2.2 Rights and entitlements

The earlier PWDA had contained the term rights in the long version of its title and it discussed deprivations of rights (Sections 59 and 62) and the protections and safeguarding of rights (Sections 58, 59, 61 and 62) but it failed to articulate specific rights or contextualise existing rights for individuals with disabilities. By contrast,

Chapter 2 of the RPWDA lays out thirteen rights and entitlements. Section 3, addresses Equality and non-discrimination and makes a number of statements that challenge the provision of contemporary mental healthcare. This section places an onus on the Government to *'ensure that the persons with disabilities enjoy the right to equality, life with dignity and respect for his or her integrity equally with others'* (Section 3(1)) and to *'utilise the capacity of persons with disabilities by providing appropriate environment'*. It prohibits the deprivation of *'personal liberty only on the ground of disability'*. However Section 3(3) provides a degree of flexibility as it states that *'No person with disability shall be discriminated on the ground of disability, unless it is shown that the impugned act or omission is a proportionate means of achieving a legitimate aim'*. The definition of *'a legitimate aim'* will have significant implications for individuals with disabilities in particular those with mental illness.

Specific protections are also given to women and children with disabilities (Section 4) and again the onus is placed on the appropriate Government to ensure their equal enjoyment of rights (Section 4(1)) and freedom of expression (Section 4(2)). The right to live in the community where necessary to receive support in order to do so, is protected (Sections 5). Protections from *'torture, cruel, inhuman or degrading treatment'* and protections from involuntary participation in research is provided (Section 6). These sections does not overtly align with some of the UN's Special Rapporteurs who have described non-consensual treatment as a form of torture (UN Human Rights Council, 2013). Protection from abuse, violence and exploitation are included in the act which lays out provisions to protect individuals from people or institutions who might abuse them, it addresses the reporting and investigation of a case of abuse (section 7(3)), the rescue and protection of the abused individual, the right of the individual who experienced the abuse to receive information about their legal rights (Section 7(4)). Further protections from harm are legislated for in relations to situations of risk, armed conflict, humanitarian emergencies and natural disasters (Section 8).

The RPWDA states that *'No child with disability shall be separated from his or her parents on the ground of disability'* (Section 9(1)) the only exception to this is with a court order and in circumstances where it is in the *'best interests of the child'*. This is noteworthy as it is one of the few areas in the India legislation where a best interest

principle has been retained. Where a child does have to be separated from their family the order of preference for placement is, first with a near relative, second in a community based family setting and only in exceptional circumstances in a *'shelter home run by the appropriate Government or non-governmental organisation'* (Section 9(2)). This is in sharp contrast to the PWDA where there is extensive consideration of institutions (Sections 50-56) and their role, but very limited consideration of community based living and the role of family. Reproductive rights, access to information regarding family planning and protection from forced sterilisation are provided (Section 10). Voting rights are also protected, this in particular addressed accessibility and mandates that all materials are easily understandable (Section 11).

A legal onus is put on the appropriate Government to ensure that persons *'with disabilities are able to exercise the right to access any court, tribunal, authority, commission or any other body having judicial or quasi-judicial or investigative powers without discrimination on the basis of disability'* (Section 12 (1)). This includes the provision of support measures (Section 12(2)), accessibility of legal documents and recording of testimonies, arguments and opinions (Section 12(4)). The most significant and consequential right affirmed in the CRPD and the one that has caused the most debate has been article 12, 'equal recognitions before the law', in the RPWDA this is addressed under legal capacity (Section 13). This protects a person with disabilities rights to own and inherit property, control their financial affairs and access credit (Section 13(1)). The Government shall ensure that *'persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life and have the right to equal recognition everywhere as any other person before the law'* (Section 13(2)). This closely mirrors the language of Articles 12.1 and 12.2 of the CRPD. The RPWDA also seeks to put an authority in charge of raising social awareness to support persons with disabilities in exercising their legal capacity (Sections 15(1)). This authority will set up support armaments and 'other measures' for individuals with high support needs and those living in institutions (Section 15(2)). Some additional information about these support arrangements is described: individuals that are supporting persons with disabilities shall abstain from providing support where there is a conflict of interests (Section 13(3)), shall avoid undue influence and *'shall respect the autonomy, dignity*

and privacy’ of the person with disability. A person with a disability can alter a support arrangement and this decision will apply prospectively (Section 13(4)).

Provisions for limited guardianship are provided for (Section 14) this occurs when a court or designated authority finds that, despite having been provided with adequate and appropriate support, and individual remains unable to make legally binding decisions. The limited guardian takes legally binding decisions on behalf of the individual with a disability, in consultation with them. Limited guardianship is defined as *‘a system of joint decision which operates on mutual understanding and trust between the guardian and the person with disability, which shall be limited to a specific period and for specific decision and situation and shall operate in accordance to the will of the person with disability.’* (Section 14(1)). Many of the provisions and practicalities of limited guardianship are to be notified by the state government including the right to appeal decisions (Section 14(3)).

The consideration of legal capacity, a formal definition of guardianship, or autonomy were not present in the PWDA.

2.2.1.2.3 Education

Chapter three of the RPWDA makes provisions for including individuals with disabilities in main stream education, this includes sporting and recreational activities. Accessibility, reasonable accommodation, the provision of support, specific considerations for individuals who are blind or deaf, identification of disabilities, and monitoring of the participation of individuals with disabilities are all addressed (Section 16). Practical provisions are made to realise these aims, including, surveying school children every five years, addressing teacher training and staffing levels, establishing resource centres, the provision of assistive devices, the availability of scholarships and the Act also suggests *‘suitable modifications in the curriculum and examination system’* (Section 17). The RPWDA goes on to provide protections for individuals with disabilities in adult education too (Section 18).

Education was also addressed in the PWDA (Sections 26-31) which promoted free and often integrated education, it gave greater consideration to *‘schemes and programmes for non- formal education’* (Section 27), *something which has been*

removed from the RPWDA. However many of its other provisions have continued in the RPWDA. The PWDA did not provide for adult education.

2.2.1.2.4 Skill development and employment

The RPWDA requires that *'the appropriate Government shall formulate schemes and programmes including provision of loans at concessional rates to facilitate and support employment of persons with disabilities especially for their vocational training and self-employment'* (Section 19(1)). These schemes and programmes promote the inclusion of persons with disabilities in all mainstream vocational training, ensure adequate supports, addresses exclusive skill training programmes, facilitates access to finance, and collects data on individuals with disabilities receiving skill training and in self-employment (Section 19(2)).

Government establishments are prohibited from discrimination on the grounds of disability relating to employment, although exceptions can be made based on the type of work involved (Section 20(1)). Government workplaces must *'provide reasonable accommodation and appropriate barrier free and conducive environment'* (Section 20(2)). Protections for individuals who acquire a disability while working are also provided (Section 20(4)). Every government establishment must have a formally registered equal opportunity policy (Section 21) and must maintain appropriate records concerning persons with disabilities (Section 22). A grievance procedure is outlined (Section 23). Based on the definition of establishment (Section 2 (i)), Sections 21 and 22 appear to apply to all establishments private and Government. Whereas, Sections 20 and 23 apply to Government establishments only. The RPWDA provides extensive additional consideration in comparison to the PWDA's references to vocational training and employment (Sections 26-41).

2.2.1.2.5 Social security, health, rehabilitation and recreation

Provisions are made to promote social security, health, rehabilitation and recreation for individuals with disabilities. The Government has an obligations, within the limit of

its economic capacity, to provide *‘schemes and programmes to safeguard and promote the right of persons with disabilities for adequate standard of living to enable them to live independently or in the community’* (Section 24(1)). The *‘quantum of assistance to the persons with disabilities under such schemes and programmes shall be at least 25% higher than the similar schemes applicable to others’* (Section 24(1)), with due regard for diversity (Section 24(2)).

These schemes will provide for - community centres; facilities for persons including children with disabilities who have no family or have been abandoned; support during disasters or conflict; support to women with disability for livelihood and parenting; access to safe drinking water and appropriate and accessible sanitation; aids and appliances, medicine and diagnostic services and corrective surgery free of cost; disability pension; unemployment allowance; care-giver allowance; comprehensive insurance scheme; and *‘any other matter which the appropriate Government may think fit’*, subject to various conditions (Section 24(3)).

The Act puts an onus on the appropriate Government to provide persons with disabilities with free local healthcare *‘subject to such family income as may be notified’*. All healthcare facilities, including private hospitals, must provide barrier free access and give priority to individuals with disabilities (Section 25(1)). Government and the local authorities shall also *‘take measures and make schemes or programmes to promote healthcare and prevent the occurrence of disabilities’* through research; preventive measures; screening; training staff; awareness campaigns; promoting perinatal care; public education; providing healthcare during natural disasters; providing essential medical facilities for life saving emergency treatment and procedures; and promoting *‘sexual and reproductive healthcare’* (Section 25(2)).

The Government shall also provide *‘insurance schemes for their employees with disabilities’* (Section 26) and, in collaboration with local authorities, within their economic capacity, are to provide rehabilitation services, *‘particularly in the areas of health, education and employment for all persons with disabilities’* (Section 27(1)). This can occur through *‘non-Governmental Organisations’* (Section 27(2)). There are also requirements for government to support *‘research and development’* (Section 28). The rights of all persons with disabilities to participate in cultural and recreational life

on an equal basis with others is protected (Section 29); and participation in sporting activities is also addressed (Section 30).

Social security was addressed in the PWDA (Sections 66-68) but this consideration was superficial. The provisions regarding insurance schemes mirrors similar legislation in Section 67 of the PWDA. Provisions relating to healthcare in the prior legislation, were limited to prevention of disabilities (Section 25), these are substantially expanded in the RPWDA. Culture, sport and recreation received almost no consideration and no provision for a care-giver allowance was present in the earlier legislation.

2.2.1.2.6 Special Provisions for Persons with Benchmark Disabilities

The RPWDA specifies that a '*person with benchmark disability*' means '*a person with not less than 40% of a specified disability where specified disability has not been defined in measurable terms and includes a person with disability where specified disability has been defined in measurable terms, as certified by the certifying authority*' (Section 2(r)). The government is obliged to provide every child with benchmark disability with free local education until the age of eighteen, this can be in a neighbourhood school or a special school as chosen by the individual (Section 31). In addition, all public institutions of higher education and any receiving Government funding shall reserve at least 5% of their places for persons with benchmark disabilities (Section 32(1)). The upper age limit for persons with benchmark disabilities is also relaxed by five years (Section 32(2)). The government will oversee this through an expert committee with representation of persons with benchmark disabilities (Section 33).

All government establishments (Section 2(k)), with some exceptions, must reserve at least 4% of its workforce vacancies for persons with benchmark disabilities. One percent must be reserved for individuals with blindness and low vision, who are deaf and hard of hearing, or individuals with locomotor disability including cerebral palsy, leprosy cured, dwarfism, acid attack victims and muscular dystrophy. An additional 1% is to be reserved for individuals with autism, intellectual disability, specific learning disability, mental illness or multiple disabilities (Section 34).

Employers in the private sector will receive incentives from the government, within the limit of their economic capacity, *‘to ensure that at least 5% of their work force is composed of persons with benchmark disability’* (Section 35).

There shall also be 5% reservations in *‘allotment of agricultural land and housing in all relevant schemes and development programmes, with appropriate priority to women with benchmark disabilities’*; *‘all poverty alleviation and various developmental schemes with appropriate priority to women with benchmark disabilities’*; and *‘allotment of land on concessional rate, where such land is to be used for the purpose of promoting housing, shelter, setting up of occupation, business, enterprise, recreation centres and production centres’* (Section 37).

The concept of benchmark disabilities is new to the RPWDA and so such consideration is absent from the PWDA. However, the sections relating to employment made provisions for reservation of posts (Section 33), this was at least three percent, and many of the other provisions were also included. Specific consideration was given to non-discrimination in government employment (Section 47). Some similar measures also existed for the allotment of land in the PWDA (Section 43).

2.2.1.2.7 Special Provisions for Persons with Disabilities with High Support Needs

Chapter VII of the RPWDA addresses *‘special provisions for persons with disabilities with high support needs’*, this allows individuals with benchmark disabilities who consider themselves to be in need of high support, to apply for an assessment which certifies their level of need and the nature of the support they require (Section 38). *‘High support’* means *‘an intensive support, physical, psychological and otherwise, which may be required by a person with benchmark disability for daily activities, to take independent and informed decision to access facilities and participating in all areas of life including education, employment, family and community life and treatment and therapy’* (Section 2(l)). The concepts of benchmark disabilities and high support needs were absent from the PWDA.

2.2.1.2.8 Duties and Responsibilities of Appropriate Governments

The RPWDA puts extensive responsibilities on the appropriate Government. While, many of these obligations are referenced in other sections of the Act, Chapter VIII directly addresses their duties and responsibilities. The government has a duty to '*conduct, encourage, support or promote awareness campaigns*' that protect the Rights outlined in the RPWDA. This includes campaigns to address *inter alia*, tolerance, respect the recognition of the skills and abilities, the promotion of family life, employment rights and educational rights for persons with disabilities (Section 39). These goals will be complimented through human resource development, which will train government officials, promote education regarding disabilities, and support the independence of individuals with disabilities (Sections 47).

Standards are to be developed regarding accessibility for the physical environment, transportation, information and communications (Section 40). All government and private buildings must conform to accessibility guidelines which are to be developed (Section 44). Some of these are directly addressed in the RPWDA, '*access to transport*' (Section 41), '*access to information and communication technology*' (Section 42), and '*universally designed consumer products*' (Section 43). Time frames are given for making existing infrastructure and premises accessible (Sections 45) and for adhering to the rules on accessibility (Section 46).

The PWDA contained many of these elements however they were spread throughout the legislation. Awareness campaigns were addressed in relation to 'steps for the prevention of occurrence of disabilities' (Section 25). Rudimentary elements of accessibility were addressed in laws concerning 'non-discrimination in the built environment' (Section 46). These measures lacked the breath and cohesion seen in the current legislation.

2.2.1.2.9 Registration of Institutions for Persons with Disabilities and Grants to Such Institutions

In relation to the registration of institutions, no individual can establish or run any institution for persons with disabilities unless they are in accordance with a certificate of registration. Institutions that care for individuals with mental illness, that hold appropriate registration are exempt (Section 50). Institutions established or run by the State or Central Governments are also exempt (Sections 54). The Act makes provisions

to create an authority to oversee this process (Section 49), to apply for and grant registration (Section 51) and to appeal a refusal to grant certification (Section 53). In addition, the appropriate Government may grant financial assistance to registered institutions to provide services and to implement the schemes and programmes in line with the Act (Section 55). Similar provisions existed in the PWDA (Sections 50-55).

2.2.1.2.10 Certification of Specified Disabilities

The Central Government commits to produce external guidelines for assessing the extent of an individual's specified disability (Section 56) and designate '*certifying authorities*', describing the degree of experience and qualification required to make a diagnosis (Section 57). A '*specified disability*' is a disability in one of the five domains in the Schedule to the Act (Section 2(zc)): 'physical', 'intellectual', 'mental behaviour', other specific disabilities, and 'multiple disabilities'.

In the Schedule, '*physical disability*' includes '*locomotor disability*' ('*leprosy cured person*', '*cerebral palsy*', '*dwarfism*', '*muscular dystrophy*' and '*acid attack victims*'), '*visual impairment*' (blindness and '*low vision*'), '*hearing impairment*' (deaf and '*hard of hearing*'), and '*speech and language disability*' (such as aphasia), with further details provided for each sub-category (Schedule, Section 1). Intellectual disability' is '*a condition characterised by significant limitation both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behaviour which covers a range of every day, social and practical skills*'; this includes '*specific learning disabilities*' and '*autism spectrum disorder*' (Schedule, Section 2).

'Mental illness' means '*a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, but does not include retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence*' (Schedule, Section 3). Other specific disabilities can be due to '*chronic neurological conditions*' (such as multiple sclerosis and Parkinson's disease) and '*blood disorder*' (such as haemophilia, thalassemia, and sickle cell disease) (Schedule, Section 4).

‘Any person with specified disability may apply’ for ‘a certificate of disability’ and the mechanism for doing so is described (Section 58). There is provision for appeal, should an individual’s application be declined (Section 59). No schedule describing domains of disabilities existed in the PWDA but some of these categories were mentioned in the definition of disability (Section 2(i)), however, no elaboration or description was included.

2.2.1.2.11 Central and State Advisory Boards on Disability and District Level Committee

The RPWDA creates the Central Advisory Board on Disability (Section 60(1)). The Board is comprised of *‘the Minister in charge of Department of Disability Affairs in the Central Government, Chairperson’*; *‘the Minister of State in charge dealing with Department of Disability Affairs in the Ministry in the Central Government, Vice Chairperson’*; *‘three Members of Parliament’*; various public officials; the chairpersons and directors of a range of organisations; *‘five members who are experts in the field of disability and rehabilitation’*; *‘ten members, as far as practicable, being persons with disabilities, to represent non-governmental organisations concerned with disabilities or disabled persons organisations’*; and various others (Section 60(2)). There are provisions relating to *‘terms and conditions of service of members’* (Section 61), *‘disqualifications’* (Section 62), *‘vacation of seats by members’* (Section 63) and meetings (Section 64).

The Board is the national-level consultative and advisory body on disability matters responsible for the evolution of policy for the empowerment of persons with disabilities (Section 65(1)). Its specific roles include: advising government; policy development; reviewing and coordination of activities; advocacy; making recommendations to ensure accessibility, reasonable accommodation, and non-discrimination; and monitoring the impact of legislation, policy and programmes (Section 65(2)).

In addition to the ‘Central Advisory Board on Disability’ which functions on a national level, each Indian State will have a ‘State Advisory Board on Disability’. These Boards have a very similar role to the Central Board but at the State level (Section 71).

These boards are also comprised of Government ministers, secretaries and Members of the State Legislature, experts in the field of disability and rehabilitation and persons with disabilities (Section 66(2)). The *'terms and conditions of service'* (Sections 67), *'disqualification'* (Section 68), *'vacation of seats'* (Section 69) and meetings (Section 70) are described in the legislation. Of note, an individual is disqualified from being on either of these boards if they are 'of unsound mind and stands so declared by a competent court' (Section 62(1)(b)).

These bodies, in many ways, are the continuation of the Central (Sections 3-12) and State (Sections 13-24) Coordination Committees which were described in the PWDA.

2.2.1.2.12 Chief Commissioner and State Commissioner for Persons with Disabilities

The Central Government may *'appoint a Chief Commissioner for Persons with Disabilities'* (Section 74(1)) and *'two Commissioners to assist the Chief Commissioner'* (Section 74(2)). All must have *'special knowledge or practical experience in respect of matters relating to rehabilitation'* (Section 74(3)). An advisory committee will be set up to assist the Chief Commissioner, this will comprising of not more than eleven experts from different disabilities (Section 74(8)). The roles of Chief Commissioner will include: identify provisions of law or policy, which are inconsistent with the RPWDA and recommend corrective steps; inquire into deprivation of rights relevant to Central Government and advocate for individuals in these circumstances; review and improve existing legal safeguards; review and remedy factors that inhibit the enjoyment of rights of persons with disabilities; support the implementation of treaties and other international instruments relating to disability; undertake and promote research; promote awareness, monitor implementation of the RPWDA and related policy; and monitor utilisation of funds disbursed by the Central Government for the benefit of persons with disabilities (Section 75(1)). The RPWDA lays out actions that appropriate authorities must take on receiving recommendations from the Chief Commissioner, and time frames for doing so (Section 76). Powers are given to the Chief Commissioner (Section 77) and an annual report is required (Section 78).

In addition to the Central Government appointing a Chief Commissioner, *'the State Government may, by notification, appoint a State Commissioner for Persons with Disabilities'* (Section 79(1)). The State Commissioner will also have an advisory committee of experts (Section 79(7)). The functions of the State Commissioner are the same as those of the Chief Commissioner, but at State level, apart from the requirement to *'study treaties and other international instruments on the rights of persons with disabilities and make recommendations for their effective implementation'* (Section 75(1)(e)) (Section 80). The effect of a recommendation by the State Commissioner is the same as that of the Chief Commissioner, but at State level (Section 81). The powers of the State Commissioner are outlined (Section 82) and an annual report is required (Section 83).

The PWDA created a Chief Commissioner for persons with disabilities (Section 57), who acted on a national level and State level Commissioners for persons with disabilities (Section 60). While these Commissioners had broadly similar roles (Section 58, 61 and 62), they were less well developed than those described in the subsequent legislation.

2.2.1.2.13 Special Court

The RPWDA creates a special court at a State level to provide for prompt trials relating to offenses under the Act (Section 84). It also creates a Special Public Prosecutor to conduct cases in those special courts (Section 85). No similar mechanisms were present in the PWDA.

2.2.1.2.14 National Fund for Persons with Disabilities

THE RPWDA creates the National Fund for persons with disabilities (Section 86) which will be comprised of multiple sources. The management and use of the Fund will be prescribed for outside of the RPWDA (Section 86(2)). Provisions are made for 'accounts and audit' (Section 87). No National Fund was present in the PWDA.

2.2.1.2.15 State Fund for Persons with Disabilities

At a state level, the RPWDA creates the State Fund for persons with disabilities which is under the control of the State Government (Section 88). Provisions are made for accounts, audit and related matters (Sections 88(3-6)). No provision for a State level fund was included in the PWDA.

2.2.1.2.16 Offences and Penalties

The RPWDA has greatly expanded the sections relating to offences and penalties giving them their own chapter (Sections 89-95), the PWDA addressed '*Punishment for fraudulently availing any benefit meant for persons with disabilities*' (Section 69). Offences include any contravention of the provisions of the Act (Section 89); offences by companies (Section 90); fraudulently availing any benefit meant for persons with benchmark disabilities (Sections 91); and failure to furnish information requested in pursuance of the provisions of the Act (Section 93).

Individuals with disabilities receive extensive protections, with prison sentences and fines prescribed for: insulting or intimidating with intent to humiliate a person with disability in any public place (Section 92(a)); assaulting any person with disability with intent to dishonour him or outrage the modesty of a woman with disability (Section 92(b)); denying a person with disability food or fluids (Section 92(c)); the sexual exploitation of a '*child or woman with disability*' (Section 92(d)); voluntarily injuring, damaging or interfering with the use of any limb or sense or any supporting device of a person with disability (Section 92(e)), and carrying out a termination of pregnancy without the express consent of the individuals with disability (some exceptions are provided in this provision) (Section 92(f)).

2.2.1.2.17 Miscellaneous

Finally, '*miscellaneous*' provisions in the RPWDA cover the 'application of other laws' (which is '*not barred*') (Section 96); '*protection of action taken in good faith*' for certain government officials (Section 97); '*power to remove difficulties*' encountered in implementation of the Act during the first two years from the date of commencement (Section 98); '*power to amend Schedule*' of '*specified disability*' (Section 99); and the '*power of Central Government*' (Section 100) and '*State Government*' (Section 101) to

make rules about various matters. Finally, the Persons with Disabilities (Equal Opportunity Protection of Rights and Full Participation) Act, 1995 is repealed (Section 102(1)). Many similar miscellaneous provisions were included in the PWDA.

2.2.1.3 Reception

The RPWDA has been described as an attempt to apply the CRPD while, ‘considering the socio-cultural and local needs of the society, and the available resources’ (Math et al., 2019). The RPWDA provides improved definitions of key constructs in disability care, an enhanced focus on rights, and guidelines for assessment and certification of disabilities, although there are concerns about a lack of sufficient consideration of the needs of individuals with mental illness, centralisation of disability certification, and insufficient clarity about screening instruments, resource allocation and guidelines for inclusive education (Balakrishnan et al., 2019). Math et al (2019) have described the implications of the RPWDA for individuals with mental illness, they identify Sections 12 to 15 as those having the most relevance. They highlight how the repeated references to the states and authorities acting within their ‘economic capacity and development’ gives a degree of leeway that may totally undermine the act.

Other concerns relate to the observations that the RPWDA relies excessively on non-governmental organizations and does not sufficiently address the needs of families of persons with mental illness, especially when resource limitations in mental health services in India (Isaac, 2015; Jiloha, 2015; Patel et al., 2016) mean that family members often need to be deeply involved in mental healthcare (Narayan and John, 2017; Pavitra et al., 2019). It has also been recommended that there should have been special emphasis and dedicated social welfare measures to bring people with mental illness into the mainstream, and support them to overcome the environmental and attitudinal barriers that they face (Rao et al., 2016). There are, in addition, ongoing concerns regarding scales for assessing mental disability; challenges in psychiatric disability certification; issues concerning certifying temporary versus permanent disability; quantification of disability; certifying autism, mental illness and learning disability (and combinations); challenges in providing reservation in higher educational

institutions and employment (Math et al., 2019); and specific concerns related to persons with neurodevelopmental disorders (John et al., 2018).

In terms of case law the RPWDA has already had some success in advancing the rights of persons with disabilities in the fields of education (e.g. J&K Board Of Professional ... vs Vasundhara Sharma And Others on 15 October, 2019) and employment (e.g. Bhavya Nain vs. Delhi High Court Administration). The role and powers of the Commissioner has also been established (Railway Board vs. Prashant Kumar, Civil Writ Petition 7548 / 2014, Delhi High Court).

Some of the concerns that psychiatrists raise, in relation to mental illness, are discussed in the focus group component of our research. This is included in Chapter 5 of this thesis.

2.2.2 India's Mental Healthcare Act 2017

On the 8 August 2016 the Rajya Sabha (the upper house of the Indian parliament) unanimously passed The Mental Healthcare Bill, 2016. The stated aim of the Bill was *'to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto'* (preamble) This has now been adopted as the IMHA which received the assent of the President on 7 April, 2017. This legislation had been eagerly anticipated and was necessary, from a legal point of view, following India's signing of the CRPD (Bhaumik, 2013; Rane and Nadkarni, 2013; Sachan, 2013; Thippeswamy et al., 2012). This section presents a *descriptive* outline of the MHCA, a summary of its content and a comparison of the current provisions with those of the preceding Mental Health Act, 1987. This provides the basis for the *analysis* presented in subsequent chapters.

2.2.2.1 Introduction

The MHCA itself is divided into 126 sections which are grouped into 16 chapters, these are discussed in the sections below. The act's explicitly stated aim is to 'align and harmonise the existing laws with the said Convention (CRPD)'. This is a bold step and

makes India's new Act one of the most interesting and potentially progressive in the world (Kalmegh et al., 2018; Duffy and Kelly, 2019a).

2.2.2.2 Chapters

2.2.2.2.1 Preliminary' Matters and Definitions

Section one of the MHCA states that the Act extends 'to the whole of India' (Section 1(2)). Some Indian legislation excludes certain states for example the Indian Trusts Act 1882 which excludes Jammu and Kashmir and Andaman and Nicobar Islands. Some provisions are made for specific states (Section 114). The MHCA was to come into force on 'such date as the Central Government may...appoint'; or 'nine months from the date' of presidential assent (Section 1(3)). Presidential assent was provided on 7 April 2017 and the legislation was commenced on 29 May 2018.

Section two defines key terms including 'care-giver', who is 'a person who resides with a person with mental illness and is responsible for providing care to that person and includes a relative or any other person who performs this function' (Section 2(1)(e)); 'family', which is 'a group of persons related by blood, adoption or marriage' (Section 2(1)(h)); 'relative', which is 'any person related to the person with mental illness by blood, marriage or adoption' (Section 2(1)(za)); and 'minor', which is 'a person who has not completed the age of 18 years' (Section 2(1)(t)). The definitions for family and care-giver were not present in the 1987 Act, the closest term in that legislation to care-giver is 'friend'.

'Mental illness' is 'a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence' (Section 2(1)(s)). 'Mental healthcare' includes 'analysis and diagnosis of a person's mental condition and treatment as well as care and rehabilitation of such person for his mental illness or suspected mental illness' (Section 2(1)(o)). This is a notably broad definition of 'mental healthcare', consistent with the legislation's generally broad remit and considerable ambition. While the term mental illness appeared eight times in the MHA it was not defined,

neither was mental healthcare. A very general definition of a 'mentally ill person' was included, 'a person who is in need of treatment by reason of any mental disorder other than mental retardation' (Section 2(l)).

'Mental health establishment' means 'any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness' where 'persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation', including 'any general hospital or general nursing home' but not family homes (Section 2(1)(p)). This differs importantly from the MHA which in its definition of 'psychiatric hospital' or 'psychiatric nursing home' excluded 'any general hospital or general nursing home established or maintained by the Government and which provides also for psychiatric services'. This change has led to the need for registration for many more institutions and will be discussed in subsequent chapters.

'Informed consent' is 'consent given for a specific intervention, without any force, undue influence, fraud, threat, mistake or misrepresentation, and obtained after disclosing to a person adequate information including risks and benefits of, and alternatives to, the specific intervention in a language and manner understood by the person' (Section 2(1)(i)). Of note, this definition makes no direct reference to capacity. The 1987 Act did not define consent and made limited reference to it except in relation to research (Section 81).

A 'psychiatrist' is 'a medical practitioner possessing a post-graduate degree or diploma in psychiatry'. This has to have been awarded or recognised by the University Grants Commission, the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognised by the Medical Council of India. A 'grandfather clause' is also included which allows any medical officer 'who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Act' (Section 2(1)(y)). This closely aligns with the prior definition of a psychiatrist (Section 2(r)). A 'mental health professional', is a psychiatrist or a 'professional registered with the concerned State Authority under Section 55' ('Functions of State Authority') or 'a professional having a post-graduate degree (Ayurveda) in Mano

Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam’ (Section 2(1)(r)). Non-medical mental health professionals were excluded from the MHA. ‘Medical officer in charge’ means ‘the psychiatrist or medical practitioner [in] charge of that mental health establishment’ (Section 2(1)(m)). A ‘medical practitioner’ is ‘a person who possesses a recognised medical qualification’ as defined in (i) ‘the Indian Medical Council Act, 1956’; (ii) ‘the Indian Medicine Central Council Act, 1970’; or (iii) ‘the Homoeopathy Central Council Act, 1973’, and who is registered (Section 2(1)(n)).

Many allied health professionals roles are also defined, including ‘clinical psychologist’ (Section 2(1)(g)), ‘mental health nurse’ (Section 2(1)(q)) and ‘psychiatric social worker’ (Section 2(1)(x)). These definitions focus on qualifications required and were not present in the previous legislation. They do not have the same flexibility, that is provided to the psychiatrist, for individuals with extensive experience but lacking formal training.

2.2.2.2.2 Mental Illness and Capacity to Make Mental Healthcare and Treatment Decisions

According to the MHCA, ‘mental illness shall be determined in accordance with such nationally or internationally accepted medical standards (including the latest edition of the International Classification of Disease of the World Health Organisation) as may be notified by the Central Government’ (Section 3(1)) (WHO, 1992). The MHCA includes a number of protective provisions to prevent inappropriate use of diagnosis. The determination of illness should only occur ‘for purposes directly relating to the treatment of the mental illness or in other matters as covered’ in relevant legislation’ (Section 3(2)). Mental illness cannot be determined on the basis of any reason not directly relevant to mental health status, this includes ethnicity, culture, political affiliations, values, morals, religious convictions or employment status (Section 3(3)). ‘Past treatment or hospitalisation in a mental health establishment though relevant, shall not by itself justify any present or future determination of the person’s mental illness’ (Section 3(4)). Finally, ‘The determination of a person’s mental illness shall

alone not imply or be taken to mean that the person is of unsound mind unless he has been declared as such by a competent court' (Section 3(5)).

The MHCA also provides a definition of mental capacity, which is to be judged without reference to any pre-existing diagnoses: 'Every person, including a person with mental illness shall be deemed to have capacity to make decisions regarding his mental healthcare or treatment if such person has ability to (a) understand the information that is relevant to take a decision on the treatment or admission or personal assistance; or ['or' is an error and should read 'and'] (b) appreciate any reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance; or ['or' is an error and should read 'and'] (c) communicate the decision under sub-clause (a) by means of speech, expression, gesture or any other means' (Section 4(1)) (Duffy and Kelly, 2019b). Information 'shall be given to a person using simple language, which such person understands or in sign language or visual aids or any other means to enable him to understand the information' (Section 4(2)). This is an important, helpful provision.

In addition, 'where a person makes a decision regarding his mental healthcare or treatment which is perceived by others as inappropriate or wrong, that by itself, shall not mean that the person does not have the capacity to make mental healthcare or treatment decisions' (Section 4(3)). The prior mental health law did not give the level of consideration to diagnosis or capacity, references to each are superficial and indirect.

2.2.2.2.3 Advance Directive

The MHCA's consideration of advance directives is one of the key constructs of the legislation and does much to harmonise India's law with the CRPD. No provision for advance directives existed in the 1987 Act. Every adult has a right to 'make an advance directive in writing', specifying 'the way the person wishes to be cared for and treated for a mental illness'; 'the way the person wishes not to be cared for and treated'; and 'the individual or individuals, in order of precedence' they want to appoint as their 'nominated representative' (Section 5(1)). This – importantly - can be done

‘irrespective of [the person’s] past mental illness or treatment for the same’ (Section 5(2)).

The person’s advance directive comes into force when the individual ‘ceases to have capacity to make mental healthcare or treatment decisions and remains in effect until they regain capacity’ (Section 5(3)). It can be over-ruled if the person has capacity (Section 5(4)); and is ‘ab initio void’ if it is ‘contrary to any law’ (Section 5(5)). An advance directive ‘may be revoked, amended or cancelled by the person who made it at any time’ (Section 8(1)), this provision makes no reference to capacity and taken at face value implies that it can be edited by an individual lacking mental capacity. The directive must ‘be made in the manner as may be specified’ in regulations (Section 6); shall be kept in ‘an online register’ which is ‘available to the concerned mental health professionals as and when required’ (Section 7); but does not apply to ‘emergency treatment’ (Section 9).

Regarding the effect of an advance directive, it is the duty of ‘every medical officer in charge of a mental health establishment and the psychiatrist in charge of a person’s treatment’ to treat individuals, in accordance with a ‘valid advance directive’ (Section 10). Should a mental health professional or a care-giver desire to not follow an advance directive they can make an application to the appropriate Mental Health Review Board (MHRB) and see to ‘review, alter, modify or cancel the advance directive’ (Section 11(1)). ‘After giving an opportunity of hearing to all concerned parties (including the person whose advance directive is in question)’ the Board shall ‘either uphold, modify, alter or cancel the advance directive’. The MHRB must consider any or all of the five following items, (a) whether the advance directive was made by the person out of his own free will; (b) whether the person intended the advance directive to apply to the present circumstances; (c) whether the person was sufficiently well informed to make the decision; (d) whether the person had capacity to make the advanced directive; or (e) whether the content of the advance directive is legal (Section 11(2)). The utility of having a provision that requires a MHRB to assess someone capacity at a past point in time is highly questionable.

At a practical, day-to-day level, ‘the person writing the advance directive and his nominated representative’ must ensure treating practitioners have ‘access to the advance directive’ (Section 11(3)) and the legal guardian shall have right to make an

advance directive for a minor (Section 11(4)). ‘A medical practitioner or a mental health professional shall not be held liable’ for (a) ‘any unforeseen consequences on following a valid advance directive’ (Section 13(1)) or (b) ‘not following a valid advance directive, if he has not been given a copy’ (Section 13(2)). These are reasonable pragmatic measures, likely to foster confidence among health professionals dealing with advance directives.

2.2.2.2.4 Nominated Representative

The role of the Nominated representative is new to the MHCA and is a significant shift away from the pre-CRPD legislation. The MHCA states that every adult ‘shall have a right to appoint a nominated representative’ (Section 14(1)) who must be a competent, consenting adult (Section 14(3)) who is nominated in writing (Section 14(2)). ‘Where no nominated representative is appointed’, the following persons, ‘in the order of precedence, shall be deemed to be the nominated representative’, first, the individual appointed as the nominated representative in the advance directive; second, ‘a relative’; third, ‘a care-giver’; forth, ‘a suitable person appointed as such by the MHRB; or finally (e) the MHRB ‘shall appoint the Director, Department of Social Welfare, or his designated representative, as the nominated representative’ (Section 14(4)). In the interim, ‘a person representing [a registered] organisation [...] working for persons with mental illness, may temporarily be engaged by the mental health professional’ as a nominated representative (Section 14(4)).

A person who has appointed a nominated representative ‘may revoke or alter such appointment at any time’ (Section 14(6)), again there is no stipulation here regarding capacity. A MHRB may replace the nominated representative ‘if it is of the opinion that it is in the interest of the person with mental illness to do so’ (Section 14(7)). This is a departure from the language of the CRPD, and much of the rest of the MHCA, which shifts the paradigm away from best interests towards rights, will and preference. ‘The appointment of a nominated representative, or the inability of a person with mental illness to appoint a nominated representative, shall not be construed as the lack of capacity’ to make mental healthcare decisions (Section 14(8)). ‘All persons with mental illness shall have capacity to make mental healthcare or

treatment decisions but may require varying levels of support from their nominated representative to make decisions' (Section 14(9)).

'In case of minors, the legal guardian shall be their nominated representative', unless a MHRB directs otherwise (Section 15(1)); for example, should a legal guardian fail to act in the best interests of the minor or be 'not fit' for the role, the MHRB 'may appoint any suitable individual' in their place (Section 15(2)).

Nominated representatives have a considerable range of responsibilities, including the following:

- (a) 'Consider the current and past wishes, the life history, values, cultural background and the best interests of the person with mental illness';
- (b) 'Give particular credence to the views of the person with mental illness to the extent that the person understands the nature of the decisions under consideration';
- (c) 'Provide support to the person with mental illness in making treatment decisions';
- (d) 'Have right to seek information on diagnosis and treatment to provide adequate support to the person with mental illness';
- (e) 'Have access to the family or home based rehabilitation services as provided';
- (f) 'Be involved in discharge planning';
- (g) 'Apply to the mental health establishment for admission' (under Section 87, 89 or 90);
- (h) 'Apply to the concerned Board on behalf of the person with mental illness for discharge' (under Section 87, 89 or 90);
- (i) 'Apply to the concerned Board against violation of rights of the person with mental illness in a mental health establishment';
- (j) 'Appoint a suitable attendant' (under Section 87);
- (k) 'Have the right to give or withhold consent for research' (Section 17).

2.2.2.2.5 Rights of Persons with Mental Illness

In a similar manner to the RPWDA the consideration of rights in the MHCA is extensive and greatly enhanced in comparison to the legislation it replaces. Chapter 5 of the MHCA outlines a series of 'rights of persons with mental illness' under 11 headings each explored below.

Most dramatically, perhaps, 'every person shall have a right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government' (Section 18(1)), 'services of affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and care-givers' (Section 18(2)). This is an extraordinary and hugely important part of the legislation, granting a justiciable right to mental healthcare to India's 1.3 billion people, one sixth of the planet's entire population (Duffy and Kelly, 2019a). No such right exists to healthcare in general in India and no such provision was present in the MHA.

To achieve this, the government 'fund a wide range of services (Section 18(3)), including 'acute mental healthcare services' (outpatient and inpatient); 'half-way homes, sheltered accommodation, supported accommodation'; 'services to support family of person with mental illness or home based rehabilitation'; 'hospital and community based rehabilitation establishments and services'; 'child mental health services and old age mental health services' (Section 18(4)). In addition, the government shall 'integrate mental health services into general healthcare services'; 'provide treatment in a manner, which supports persons with mental illness to live in the community and with their families'; ensure that 'long term care' is 'used only in exceptional circumstances, for as short a duration as possible, and when 'community based treatment' has failed; ensure services are available locally insofar as possible; and pay for access elsewhere if needed for children and the elderly (Section 18(5)).

Persons living below the poverty line or who are destitute or homeless 'shall be entitled to mental health treatment and services free of any charge' (Section 18(7)). The government 'shall ensure that the mental health services shall be of equal quality to other general health services' (Section 18(8)). Medicines on the Essential Drug List shall be free at facilities run or funded by the government, as shall 'essential

medicines from any similar list relating to the appropriate ayurveda, yoga, unani, siddha, homoeopathy or naturopathy systems' (Section 18(10)). This list contains 11 psychotherapeutic agents including, for example, olanzapine, fluoxetine, lithium and diazepam. The 'Government shall take measures to ensure that necessary budgetary provisions in terms of adequacy, priority, progress and equity are made for effective implementation' of these provisions (Section 18(11)).

Social inclusion is also addressed in the legislation, every person with mental illness shall have a right to live in society; and should not remain in a mental health establishment merely because family supports, accommodation or community services are lacking (Section 19(1)). Mentally ill individuals who have been abandoned by their family will be given legal aid to facilitate them 'exercising his right to family home and living in the family home' (Section 19(2)) and access to 'half-way homes, group homes and the like' (Section 19(3)). The MHA gave virtually no consideration to community based treatments.

Looking at rights more broadly, the MHCA also states that 'every person with mental illness shall have a right to live with dignity' (Section 20(1)); 'be protected from cruel, inhuman or degrading treatment in any mental health establishment' and shall have rights to (a) 'live in safe and hygienic environment'; (b) 'adequate sanitary conditions'; (c) 'reasonable facilities for leisure, recreation, education and religious practices'; (d) 'privacy'; (e) 'proper clothing'; (f) 'not be forced to undertake work in a mental health establishment and to receive appropriate remuneration for work'; (g) 'have adequate provision for preparing for living in the community'; (h) 'adequate provision for wholesome food, sanitation, space and access to articles of personal hygiene, in particular, women's personal hygiene'; (i) 'not be subject to compulsory tonsuring (shaving of head hair)'; (j) 'wear own personal clothes' and 'not be forced to wear uniforms'; and (k) 'be protected from all forms of physical, verbal, emotional and sexual abuse' (Section 20(2)). It is notable that while Section 20(2) builds on Article 15 of the CRPD, which in turn stems from Article 5 of the UDHR, the term torture is omitted. This is of particular relevance in light of the comments of the UN Rapporteurs described in Chapter 1. All of these rights based provisions greatly expand the scant protections seen in the MHA (Section 81).

‘Every person with mental illness shall be treated as equal to persons with physical illness in the provision of all healthcare’ (Section 21(1)). Any child, under the age of three, of a woman receiving inpatient care shall not be separated from her unless there is risk to the child or temporary separation ‘is in the interest and safety of the child’ (when supervised access may be appropriate) (Section 21(2)). Insurers must make provisions for mental healthcare on a par with physical healthcare (Section 21(4)). This is a highly significant provision which if implemented would drastically improve the lives of individuals with mental health conditions.

‘A person with mental illness and his nominated representative shall have the rights’ to information about relevant legislative provisions and ‘criteria for admission’; the ‘right to make an application to the concerned Board for a review of the admission’; ‘the nature of the person’s mental illness and the proposed treatment plan’ (Section 22(1)). The patient shall have the right to confidentiality in respect of health and care (Section 23(1)) except when ‘release of information to the nominated representative’ is necessary for healthcare professionals to fulfil statutory duties; it is necessary to release information to other health professionals providing care; when release ‘is necessary to protect any other person from harm or violence’; by order of a statutory authority; or ‘release of information in the interests of public safety and security’ (Section 23(2)). The right to confidentiality applies to photographs and ‘all information stored in electronic or digital format in real or virtual space’ (Section 24). ‘All persons with mental illness shall have the right to access their basic medical records’ (Section 25(1)) unless ‘disclosure would result in (a) serious mental harm to the person with mental illness; or (b) likelihood of harm to other persons’ (Section 25(2)), in which case the mental health professional shall inform the patient ‘of his right to apply to the concerned Board [MHRB] for an order to release such information’ (Section 25(3)). Access or medical records, confidentiality, or appropriate grounds for breaching it, were not well considered under the MHA.

Inpatients shall have the right to refuse or receive visitors and to refuse or receive and make phone calls (Section 26(1)), and the right to access email (Section 26(2)). Exceptions to these restrictions include, communications or visits from various statutory and legal actors, and the person’s medical practitioner (Section 26(4)). There are rights to free ‘legal aid’ (Section 27) this is a huge expansion in comparison to the

legal aid provided in the MHA (Section 91). Individuals have a right to ‘make complaints about deficiencies’ in services (Section 28), a greatly enhanced protection from the passing reference to complaints in the MHA (Section 13(2)(a)).

2.2.2.2.6 Duties of Appropriate Government

Chapter 6 of the MHCA gives the government extensive duties ‘to plan, design and implement’ programmes to promote mental health, prevention mental illness (Section 29(1)) and ‘reduce suicides and attempted suicides’ (Section 29(2)). The government must also take all measures to ensure that (a) ‘the provisions of this Act are given wide publicity’; (b) ‘programmes to reduce stigma associated with mental illness’ are implemented effectively; and (c) ‘appropriate government officials [including police officers] are given periodic sensitisation and awareness training on the issues under this Act’ (Section 30). These are broad, population-level responsibilities that will likely prove essential for effective implementation of the legislation across India’s vast population and terrain.

The government also has responsibilities under the Act in relation to human resources, education, training (Section 31) and ‘effective co-ordination between services provided by concerned Ministries and Departments such as those dealing with health, law, home affairs, human resources, social justice, employment, education, women and child development, medical education to address issues of mental healthcare’ (Section 32). The government shall also ‘make efforts to meet internationally accepted guidelines for number of mental health professionals on the basis of population, within ten years from the commencement of this Act’ (Section 31(3)). This is, arguably, one of the most important provisions of the entire Act and will prove vital for the successful realisation of the Act’s considerable potential.

Substantially more responsibilities are placed on the Government than in the MHA (Section 94) and more thought is given to the prevention of mental illness and education concerning mental illness.

2.2.2.2.7 Central Mental Health Authority

The Central Government shall establish a 'Central Mental Health Authority' (CMHA) (Section 33). Membership is set out to include various public officials and health professionals as well as 'two persons representing persons who have or have had mental illness', 'two persons representing care-givers of persons with mental illness or organisations representing care-givers' and 'two persons representing non-governmental organisations which provide services to persons with mental illness' (Section 34(1)). Members with conflicts of interest cannot participate in relevant deliberations or decisions (Sections 39 and 44(5)).

Once the new Authority is established, 'all the assets and liabilities of the Central Authority for Mental Health Services constituted under [the Mental Health Act, 1987] shall stand transferred to, and vested in, the Central Authority' (Section 42(a)). The Central Authority will meet at least twice yearly (Section 44(1)) and its functions include: registering and supervising all mental health establishments, developing quality and service provision norms, dealing with complaints, maintaining a register of clinicians, training appropriate professionals, and advising the Central Government.

These roles build on those held by the Central Authority for Mental Health Services described in the MHA (Section 3) but the more significant change is the membership of the Authority and the minority position held by psychiatrists. The MHA did not describe the composition of the Central Authority for Mental Health Services.

2.2.2.2.8 State Mental Health Authority

Every State Government shall establish a 'State Mental Health Authority' (Section 45). The composition of its members is very similar to the Central Authority but at a state level, with extensive inclusion of individuals with mental illness and advocates (Section 46(1)). The same protection exist concerning conflict of interests (Sections 51 and 56(5)) and the transfer of assets and liabilities of the State Authority for Mental Health Services to the SMHAs (Section 54(a)). The State Authority will meet at least four times yearly (Section 56(1)) and its functions will be the same as the Central

Authority but function at a state level, this is with the exception of advising Central Government (Section 55(1)).

In a similar manner to the Central authority the roles of the State Authority are expanded compared to those of the State Authority for Mental Health Services described in the MHA (Section 4) but the prescription of the composition of the Authority is the most significant shift and greatly limits the ability of psychiatry to dictate the mental health agenda on both a national and a state level.

2.2.2.2.9 Finance, Accounts and Audit

The Central Government may allocate funds to the Central Authority to be used for the purposes of the MHCA (Section 57) and the State Government may do likewise for the State Authority (Section 61). Various rules and regulations apply, along with various forms of oversight (e.g. annual reports) (Sections 57-64). This consideration to funding and finance was not present in the MHA.

2.2.2.2.10 Mental Health Establishments

All mental health establishments must be registered under the Act (Section 65(1)). For registration, each establishment must fulfil (a) 'the minimum standards of facilities and services as may be specified by regulations made by the [Central or State] Authority'; (b) 'the minimum qualifications for the personnel engaged'; (c) 'provisions for maintenance of records and reporting'; and (d) 'any other conditions as may be specified by regulations' (Section 65(4)). 'While specifying the minimum standards for mental health establishments [the Authority may] have regard to local conditions' (Section 65(5)(c)).

Section 66 outlines a detailed 'procedure for registration, inspection and inquiry of mental health establishments'. The 'Authority shall cause to be conducted an audit of all registered mental health establishments by such person or persons (including representatives of the local community) as may be prescribed, every three years, so as to ensure that such mental health establishments comply with the requirements of minimum standards' (Section 67(1)). The establishment may be charged for this audit (Section 67(2)). The Authority may, 'order an inspection or

inquiry of any mental health establishment’ (Section 68(1)) to ensure they are adherent to this Act. A mental health establishment can appeal if registration is not granted (Section 69).

The Central or State ‘Authority shall maintain a register of mental health establishments (Section 71). In addition, a mental health establishment must display their certificate of registration’ (Section 70(1)) and the contact details of the local MHRB, and facilitate access to it for review (Section 72(2)). It is important to that under Section 2(1)(p) ‘general hospital psychiatric units’ are also included as mental health establishments this was not the case in the MHA (Section 2(q)). There are also many parallels here with Sections 5 to 13 of the MHA which dealt with psychiatric hospitals and psychiatric nursing homes.

2.2.2.2.11 Mental Health Review Boards

The SMHAs will establish MHRBs (Section 73(1)) with each Board comprising (a) ‘a District Judge, or an officer of the State judicial services who is qualified to be appointed as District Judge or a retired District Judge’ (who shall chair the Board); (b) a ‘representative of the District Collector or District Magistrate or Deputy Commissioner’; (c) a psychiatrist and a medical practitioner; and (d) two persons with mental illness or care-givers or persons representing relevant organisations (Section 74(1)). Various disqualifications apply (individuals who have been declared of unsound mind are not excluded here) (Section 74(2)) and the term of office is five years (Section 75(1)). A quorum is three members (Section 76(2)) and decisions will be made by consensus, majority vote, or the president or chairperson’s ‘casting vote’ (Section 76(1)).

‘Any person with mental illness or his nominated representative or a representative of a registered non-governmental organisation, with the consent of such a person,’ can challenge a decision of the mental health establishment or a violation of rights under the MHCA (Section 77(1)). Application to the MHRB relating to independent (voluntary) patients should be heard within 90 days (Section 80(1)). Applications ‘for appointment of nominated representative’ (Section 14(4)(d)), ‘challenging admission of a minor’ (Section 87) and ‘challenging supported admission’

(Section 89(10) and (11)) shall be dealt with within seven days (Section 80(2)). Appeals relating to supported admission under Section 90 [‘beyond 30 days’] within 21 days (Section 80(3)) and all other applications within 90 days (Section 80(4)).

‘The proceeding of the Board shall be held *in camera*’ (Section 80(5)) and, and if they concern an individual with mental illness, at the mental health establishment (Section 80(8)). Parties ‘may appear in person or be represented by a counsel or a representative of their choice’ (Section 80(7)); others may attend under certain circumstances (Section 80(9)); and the patient ‘shall have the right to give oral evidence’ (Section 80(10)). The Board can require witnesses to attend (Section 80(11)) and will give its decision in writing within five days (Section 80(13)).

Section 81 of the MHCA states ‘The Central Authority shall appoint an Expert Committee to prepare a [binding] guidance document for medical practitioners and mental health professionals, containing procedures for assessing, when necessary [...] the capacity of persons to make mental healthcare or treatment decisions’. It is included in this section of the Act with no explanation and appears unrelated to the MHRB, it could be inferred that they will have a role to play, but this is not explicitly stated.

‘The powers and functions of the Board shall, include all or any of the following’:

- (a) ‘To register, review, alter, modify or cancel an advance directive’;
- (b) ‘To appoint a nominated representative’;
- (c) ‘To receive and decide application from a person with mental illness or his nominated representative or any other interested person against the decision of medical officer or mental health professional in charge of mental health establishment’ under Sections 87 (‘admission of minor’), 89 (‘supported admission’) or 90 (‘supported admission beyond 30 days’).
- (d) ‘To receive and decide applications in respect non-disclosure of information’ (Section 25(3));
- (e) ‘To adjudicate complaints regarding deficiencies in care and services’ (Section 28);

- (f) 'To visit and inspect prison or jails and seek clarifications from the medical officer in-charge of health services in such prison or jail' (Section 82(1)).

'Where it is brought to the notice of a Board or the Central Authority or State Authority, that a mental health establishment violates the rights of persons with mental illness, the Board or the Authority may conduct an inspection and inquiry and take action to protect their rights' (Section 82(2)). 'The Board, in consultation with the Authority, may take measures to protect the rights of persons with mental illness as it considers appropriate' (Section 82(3)). There are penalties for noncompliance with 'orders or directions of the Authority or the Board' including fines and cancelling 'the registration of such mental health establishment' (Section 82(4)). Appeal is 'to the High Court' (Section 83).

There were no MHRBs or similar mechanism in the 1987 Act instead appeals were to the District or High Courts (Sections 49 and 76). Voluntary patients seeking to leave could be held for review by a Board, however this was comprised only of two medical officers (Section 18(3)). Some of the inspection and review process was carried out by inspectors called *Visitors* (Sections 37 and 38) and some of the provisions for appeals are directed towards Magistrates (Section 19(3)). Very limited consideration was given to capacity assessment but where it is mentioned this assessment is done by a Magistrate (Section 24).

2.2.2.2.12 Admission, Treatment and Discharge

Chapter 12 of the MHCA outlines four different kinds of admission: 'independent admission' (Sections 85, 86 and 88), 'admission of minor' (Section 87), 'supported admission' (Section 89) and 'supported admission beyond 30 days' (Section 90). Each will be considered here in turn.

2.2.2.2.12.1 Independent Admission

An 'Independent patient or an independent admission' refers 'to the admission of [a] person with mental illness, to a mental health establishment, who has the capacity to make mental healthcare and treatment decisions or requires minimal support in

making decisions’ (Section 85(1)). This is comparable to a ‘voluntary admission’ in many other jurisdictions. All admission should be independent unless a supported admission unavoidable (Section 85(2)). An ‘Independent admission’ occurs at the request of the patient (Section 86(1)) the admitting service must be satisfied that (a) ‘the person has a mental illness of a severity requiring admission’; (b) ‘is likely to benefit from admission and treatment’; and (c) ‘has understood the nature and purpose of admission’; ‘has made the request for admission of his own free will’; and possesses mental capacity (Section 86(2)).

An ‘independent patient’ must ‘abide by order and instructions or bye-laws of the mental health establishment’ (Section 86(4)) and cannot be treated without informed consent (Section 86(5)). Discharge must occur ‘immediately on request made by such person or if the person disagrees with his admission’ (Sections 88(1) and 86(7)), unless ‘the mental health professional is of the opinion that’:

- (a) ‘Such person is unable to understand the nature and purpose of his decisions and requires substantial or very high support from his nominated representative’; or
- (b) ‘Has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself’; or
- (c) ‘Has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him’; or
- (d) ‘Has recently shown or is showing an inability to care for himself to a degree that places the individual at risk of harm to himself’ (Section 88(3)).

In these situations, an independent patient may be detained for a period of 24 hours to allow further assessment, and to consider a ‘supported admission’ (Section 88(3)). The person shall then ‘be either admitted as a supported patient’ or discharged within 24 hours (Section 88(4)).

The admission and discharge of voluntary patients was addressed in Sections 15, 17 and 18 of the MHA. No consideration was given to the capacity or support needs of the individual seeking admission or to the possibility of coercion. The grounds for conversion of a voluntary admission into an involuntary admission were also more lax

with an initial holding time of 72 hours and the criteria for being held was that the medical officer-in-charge was not satisfied that discharge was in the interest of the individual (Section 18(3)).

2.2.2.2.12.2 Admission of a Minor

For the admission of a minor (i.e. a person not yet 18 years of age) (Section 2(1)(t)), ‘the nominated representative of the minor shall apply to the medical officer in charge of a mental health establishment for admission’ (Section 87(2)). Admission may occur ‘if two psychiatrists, or one psychiatrist and one mental health professional or one psychiatrist and one medical practitioner’, have independently examine the minor in the prior seven days and both independently conclude based on the examination and collateral, that:

- (a) ‘The minor has a mental illness of a severity requiring admission’;
- (b) ‘Admission shall be in the best interests of the minor, with regard to his health, well-being or safety, taking into account the wishes of the minor if ascertainable and the reasons for reaching this decision’;
- (c) ‘The mental healthcare needs of the minor cannot be fulfilled unless he is admitted’; and
- (d) ‘All community based alternatives to admission have been shown to have failed or are demonstrably unsuitable for the needs of the minor’ (Section 87(3)).

‘A minor so admitted shall be accommodated separately from adults, in an environment that takes into account his age and developmental needs’ (Section 87(4)), during this time the nominated representative or an attendant must stay with the minor (Section 87(5)). Consent for treatment will be sought from the nominated representative (Section 87(7)), if they no longer support admission, ‘the minor shall be discharged’ (Section 87(8)). The MHRB must be notified about the admission of a minor within 72 hours (Section 87(9)) and, if the admission continues beyond 30 days, the MHRB must review the minor (Section 87(12)).

The admission and discharge of minors was addressed in Sections 16, 17 and 18 of the MHA. The admission only required the opinion of one clinician, and the need to exhaust community based treatment and safeguards during such an admission were not present in the earlier legislation. Rather than notifying the MHRB, Visitors had a duty to 'examine every minor admitted as a voluntary patient' (Section 38).

2.2.2.2.12.3 Supported Admission

This section of the MHCA covers admission and treatment without a patients consent. The legislation states that a person 'shall' be admitted as a 'supported admission' 'upon application by the nominated representative of the person' if:

- (a) The person has been examined within seven days, by one psychiatrist and a mental health professional or a medical practitioner, and both independently conclude based on the examination and collateral information, that the person has a mental illness of such severity that the person has recently threatened or attempted to harm themselves or others or has shown an inability to care for themselves;
- (b) The clinicians involved should take into account any advance directive, and be of the opinion that admission to the mental health establishment is the least restrictive care option; and
- (c) The person is ineligible to be an independent patient (Section 89(1)).

The 'supported admission' must end when the person no longer meets these criteria (Sections 89(3) and 89(13)), should this occur the person must be discharged or can remain as an 'independent patient' (Section 89(5)). Should a person be a supported patient for 30 days (Section 89(2)), their admission needs to meet the criteria for continuation under Section 90.

The patient 'shall be provided treatment after taking into account (a) an advance directive if any; or (b) informed consent of the patient with the support of his nominated representative' (Section 89(6)). If the person 'requires nearly 100% support from his nominated representative in making a decision in respect of his treatment,

the nominated representative may temporarily consent to the treatment plan of such person on his behalf' (Section 89(7)). The medical officer must 'review the capacity of the patient to give consent every seven days' (Section 89(8)).

All 'supported admissions' must be notified to the MHRB within three days (for 'a woman or a minor') or seven days (others) (Section 89(9)). 'A person admitted under this section or his nominated representative or a representative of a registered non-governmental organisation with the consent of the person, may apply to the concerned Board for review of the decision' to admit the person (Section 89(10)). The MHRB will perform a binding review within seven days (Section 89(11)).

These provisions replace the Admission of mentally ill persons under certain special circumstances (Sections 19) and admissions via reception order (Section 20-25) of the MHA. The criteria in the MHCA is much more clearly defined and narrower. Under the MHA, a magistrate could issue a reception order if they were satisfied that 'the mentally ill person is suffering from mental disorder of such a nature and degree that it is necessary to detain him in a psychiatric hospital or psychiatric nursing home for treatment'. The thirty day time frame is also a reduction compared to the ninety days under Section 19 or the loose time frame of Section 20. The consideration of nominated representatives and advance directives is a welcome addition, it attempts to enhance autonomy and replaces the substitute decision making paradigm described in Section 35 of the MHA.

2.2.2.2.12.4 Supported Admission Beyond 30 Days

In the event that a 'supported' patient 'requires continuous admission and treatment beyond 30 days' (or readmission within seven days of discharge) (Section 90(1)), the nominated representative must apply to the mental health professional in charge of a mental health establishment. They can extend the admission in the following circumstances:

- (a) Two psychiatrists have independently examined the person in the preceding seven days and independently conclude that the person has a mental illness

‘of a severity that the person (i) has consistently over time threatened or attempted to cause bodily harm to himself; or (ii) has consistently over time behaved violently towards another person or has consistently over time caused another person to fear bodily harm from him; or (iii) has consistently over time shown an inability to care for himself to a degree that places the individual at risk of harm to himself’;

- (b) ‘Both psychiatrists, after taking into account an advance directive, if any, certify that admission to a mental health establishment is the least restrictive care option possible under the circumstances’; and
- (c) ‘The person continues to remain ineligible to receive care and treatment as a independent patient’ (Section 90(2)).

These admissions must be reported to the MHRB within seven days (Section 90(3)) and ‘the Board shall, within a period of 21 days from the date of last admission or readmission [...] permit such admission or readmission or order discharge of such person’ (Section 90(4)), bearing in mind ‘(a) the need for institutional care to such person; (b) whether such care cannot be provided in less restrictive settings based in the community’ (Section 90(5)).

‘The Board may require the medical officer or psychiatrist in charge of treatment of such person with mental illness to submit a plan for community based treatment and the progress made, or likely to be made, towards realising this plan’ (Section 90(6)). In addition, the ‘non-existence of community based services’ cannot justify such an admission (Section 90(7)), which is limited to 90 days (Section 90(8)) but can be extended for 120 days and periods of 180 days thereafter, if relevant criteria are met (Section 90(9)).

The patient ‘shall be provided treatment, after taking into account (a) an advance directive; or (b) informed consent of the person with the support from his nominated representative’ (Section 90(11)). If the patient ‘requires nearly 100% support from his nominated representative, in making decision in respect of his treatment, the nominated representative may temporarily consent to the treatment plan of such person on his behalf’ (Section 90(12)). The medical officer must ‘review

on the expiry of every fortnight, the capacity of such person to give consent' (Section 90(13)).

The patient 'or his nominated representative or a representative of a registered non-governmental organisation with the consent of the person, may apply to the concerned Board for review of the decision of the medical officer or mental health professional in charge of medical health establishment to admit such person in such establishment and the decision of the Board thereon shall be binding on all parties' (Section 90(14)).

Discharge occurs 'if the Board refuses to permit admission or continuation thereof or readmission', 'on the expiry of the periods' defined, or 'earlier if such person no longer falls within the criteria' (Sections 90(10) and 90(15)). The person may then remain as an independent patient (Section 90(16)). The MHA gave no specific consideration to prolonged involuntary admissions.

2.2.2.2.12.5 Treatment

'An independent' or 'supported' patient may be granted leave subject to conditions (Section 91). Patients who are absent without leave can be returned by the police (Section 92). Patients can be moved between mental health establishments by order of the MHRB, provided justification is given to the individuals and their nominated representative' (Section 93(1)). The leave provisions are more straightforward than those described in Sections 45 and 46 of the MHA and the readmission of a supported patient, who refuses to return, no longer requires the involvement of a Magistrate (MHA, Section 45(4)).

'Emergency treatment' 'may be provided by any registered medical practitioner to a person with mental illness either at a health establishment or in the community, subject to the informed consent of the nominated representative, where the nominated representative is available, and where it is immediately necessary to prevent (a) death or irreversible harm to the health of the person; or (b) the person inflicting serious harm to himself or to others; or (c) the person causing serious damage to property belonging to himself or to others where such behaviour is believed to flow directly from the person's mental illness' (Section 94(1)). This

provision 'includes transportation of the person with mental illness to a nearest mental health establishment for assessment' (Section 94(1)) but excludes electroconvulsive therapy (Section 94(3)). This emergency treatment limited to 72 hours, increasing to seven days during a disaster (Section 94(4)).

The following treatments cannot be provided: '(a) electroconvulsive therapy without the use of muscle relaxants and anaesthesia; (b) electroconvulsive therapy for minors; (c) sterilization of men or women, when such sterilization is intended as a treatment for mental illness;' (d) the chaining of individuals in any manner (Section 95(1)). However, 'if, in the opinion of psychiatrist in charge of a minor's treatment, electroconvulsive therapy is required, then, such treatment shall be done with the informed consent of the guardian and prior permission of the concerned Board' (Section 95(2)).

Psychosurgery shall require informed consent from the patient and approval from the MHRB (Section 96(1)). A patient 'shall not be subjected to seclusion or solitary confinement, and, where necessary, physical restraint may only be used when (a) it is the only means available to prevent imminent and immediate harm to person concerned or to others; (b) it is authorised by the psychiatrist' (Section 97(1)). 'Physical restraint shall not be used for a period longer than it is absolutely necessary to prevent the immediate risk of significant harm' (Section 97(2)); must be recorded and justified (Section 97(3)); 'shall not be used as a form of punishment or deterrent' or 'on the ground of shortage of staff' (Section 97(4)); and must be notified to the relevant Board (Sections 97(7) and 97(9)). The patient's nominated representative must be informed within 24 hours (Section 97(5)). Emergency care, electroconvulsive therapy, psychosurgery, seclusion or restraint were not directly mentioned in the MHA.

During transitions of care (e.g. discharge, transfer, or change of psychiatrist), the psychiatrist 'shall consult with' the patient, 'the nominated representative, the family member or care-giver with whom the person with mental illness shall reside on discharge from the hospital, the psychiatrist expected to be responsible for the person's care and treatment in the future, and such other persons as may be appropriate, as to what treatment or services would be appropriate for the person' (Section 98(1)).

Researchers 'shall obtain free and informed consent from all persons with mental illness for participation in any research involving interviewing the person or psychological, physical, chemical or medicinal interventions' (Section 99(1)). If the person 'is unable to give free and informed consent but does not resist participation', permission 'shall be obtained from concerned State Authority' (Section 99(2)). The State Authority may allow the research 'based on informed consent being obtained from the nominated representative' if:

- (a) 'The proposed research cannot be performed on persons who are capable of giving free and informed consent';
- (b) 'The proposed research is necessary to promote the mental health of the population represented by the person';
- (c) 'The purpose of the proposed research is to obtain knowledge relevant to the particular mental health needs of persons with mental illness';
- (d) 'A full disclosure of the interests of persons and organisations conducting the proposed research is made and there is no conflict of interest involved'; and
- (e) 'The proposed research follows all the national and international guidelines and regulations concerning the conduct of such research and ethical approval has been obtained' (Section 99(3)).

Consent may be withdrawn at any time (Section 99(5)) and the Act does 'not restrict research based study of the case notes of a person who is unable to give informed consent, so long as the anonymity of the persons is secured' (Section 99(4)). Some of these protections, concerning research, were included in the MHA but they received less comprehensive consideration (Section 81).

2.2.2.2.13 Responsibilities of Other Agencies

Chapter 13 of the MHCA outlines '*responsibilities of other agencies*' including police officers, magistrates and custodial institutions. Regarding police officers, the officer in-charge of a police station has an obligations to '*take under protection*' any person (a) found wandering if they believe the individual is mentally ill and unable to care for

themselves; or (b) any person they believe to be *'a risk to himself or others by reason of mental illness'* (Section 100(1)). The officer must inform the person of *'the grounds for taking him into such protection'* or else inform his nominated representative *'if in the opinion of the officer such person has difficulty in understanding'* (Section 100(2)).

The person *'shall be taken to the nearest public health establishment as soon as possible but not later than 24 hours from the time of being taken into protection, for assessment of the person's healthcare needs'* (Section 100(3)); they must not *'be detained in the police lock up or prison in any circumstances'* (Section 100(4)). If, following assessment (Section 100(5)), the *'medical officer or mental health professional in-charge [...] finds that such person does not have a mental illness of a nature or degree requiring admission to the mental health establishment, he shall inform his assessment to the police officer [who] shall take the person to the person's residence or in case of homeless persons, to a Government establishment for homeless persons'* (Section 100(6)). The police must try to trace and inform the family of *'a person with mental illness who is homeless or found wandering in the community'* (Section 100(7)), this is one of the provisions of the Act where family get special consideration. The police must also inform the Magistrate if a *'person with mental illness and is being ill-treated or neglected'* (Section 101(1)). Any person who believes *'that a person has mental illness and is being ill-treated or neglected'* must report this to the police (Section 101(2)). Following such a report, *'the Magistrate may cause the person with mental illness to be produced before him'* (Section 101(3)) and *'may, order in writing (a) that the person is conveyed to a public mental health establishment for assessment and treatment'*, or (b) authorise admission for up to 10 days to enable assessment and *'plan for necessary treatment, if any'* (Section 102(1)). After this period, *'the medical officer or mental health professional in charge of the mental health establishment shall submit a report to the Magistrate and the person shall be dealt with in accordance with the provisions of this Act'* (Section 102(2)). These provisions enhance the prior measures (MHA, Section 23-25). The protections for people being ill-treated or neglected is possibly weaker but this appears to have occurred as the prior legislation gave extensive consideration to guardianship and substitute making whereas, the new Act intentionally avoids these concepts.

Section 103 outlines specific provisions for the transfer of *'prisoners with mental illness'* to mental health establishments and a requirement that *'the medical officer of a prison or jail shall send a quarterly report to the concerned Board certifying therein that there are no prisoners with mental illness in the prison or jail'* (Section 103(3)). The Board may visit the prison to enquire about prisoners with mental illness (Section 103(4)). In addition, *'the appropriate Government shall [set up a] mental health establishment in the medical wing of at least one prison in each State and Union territory'* (Section 103(6)).

'If it appears to the person in-charge of a State run custodial institution (including beggars homes, orphanages, women's protection homes and children homes) that any resident of the institution has, or is likely to have, a mental illness, then, he shall take such resident of the institution to the nearest mental health establishment run or funded by the appropriate Government for assessment and treatment' (Sections 104(1) and 104(2)). Finally, the MHRB can advise the courts *'if during any judicial process before any competent court, proof of mental illness is produced and is challenged'* (Section 105). Sections 37 to 39 of the MHA addressed needs of prisoners. The provisions of the MHCA are a dramatic shift away from those of the MHA with a strong move to not have individuals with mental illness in a custodial setting.

2.2.2.2.14 Restriction to Discharge Functions by Professionals Not Covered by Profession

The MHCA states that *'no mental health professional or medical practitioner shall discharge any duty or perform any function not authorised by this Act or specify or recommend any medicine or treatment not authorised by the field of his profession'* (Section 106). This provision attempts to address the fears that many psychiatrists had concerning the inclusion of homeopaths under the umbrella term of medical practitioner (Mehta, 2019) (Section 2(1)(n)) and the inclusion of multiple practitioners of alternative medical systems, including Unani and Ayurveda under the term *'mental health professional'* (Section 2(1)(r)(iii)). Due to the exclusion of all practitioners from outside of a western medical paradigm in the MHA, no such provision was needed.

As discussed above Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy are given recognition under the MHCA. This occurs with regard to mental health establishments (Section 2(1)(p)), mental health professionals (Section 2(1)(r)), essential medicines (Section 18(10)) and membership of the CMHA (Section 34(1)(c)). The consideration of these practices together under an umbrella term like ‘traditional medicine’ is unhelpful and reductionistic, sadly the MHCA makes minimal discrimination between these approaches. However, their inclusion acknowledges their high rate of utilisation (Byrnes, 2014; Thirthalli et al., 2016), the WHO’s global strategy (WHO, 2013b) and their potential role in enhancing mental health services (Patel et al., 2016; Thirthalli et al., 2016).

Ayurveda, Unani and Siddha systems have significant overlap and draw on the humoral theory of illness, the most scientific research has been conducted in relation to Ayurvedic medicine. Ayurvedic practice has a preliminary evidence base in the treatment of schizophrenia (Agarwal et al., 2007), anxiety (Pratte et al., 2014), depression and insomnia (Speers et al., 2021). Neurobehavioral effects of ayurvedic treatments have been demonstrated in animal models (Drug et al., 2015). However, significant future research is required. Unani and Siddha medicine have a very limited evidence base within the scientific literature (Miraj and Kiani, 2016; Subbarayappa, 1997).

Yoga, naturopathy and homoeopathy have received significant attention in ‘Western’ countries. Yoga and naturopathy is a drugless system of medicine practiced in India and is commonly employed to treat chronic diseases, these include mental health conditions though it is more commonly utilised for obesity, diabetes, hypertension, and arthritis (Panneerselvam et al., 2020). A recent pilot study demonstrated benefit from yoga and naturopathy on depression and anxiety in Covid-19 patients (Jenefer Jerrin et al., 2021). Yoga alone has a growing evidence base for a range of mental health conditions (Cramer et al, 2013; Cramer et al., 2017; Cramer et al., 2018). By contrast, homeopathy does not appear to provide any benefit over placebo in mental health conditions (Rotella et al., 2020).

2.2.2.2.15 Offences and Penalties

Specific penalties are outlined in the MHCA for operating ‘a mental health establishment without registration’ (Section 107(1)); serving as a mental health professional in an unregistered establishment (Section 107(2)); and contravening ‘any of the provisions of this Act’ or ‘any rule or regulation made thereunder’ (Section 108). Companies, too, are responsible if they knew of the offence or neglected their roles (Section 109(2)). These sections closely mirrors the ‘penalties and procedures’ sections of the MHA (Sections 82-87).

2.2.2.2.16 Miscellaneous

The Central Government may require the Authority or MHRB to provide any information concerning their activities (Section 110(1)). The State Government is granted similar powers in relation to the State Authority and MHRB (Section 110(2)). The Authority is bound by the written directions it received from the Central Government, while the Central Authority may ‘express its views’ (Section 111(1)), the decision of the Central Government is final (Section 111(2)). If necessary, the Central Government can supersede the Central Authority for up to six months, under certain conditions (Section 112(1)); perform the Authority’s roles itself (Section 112(2)); and appoint a fresh Authority (Section 112(3)). The State Government is granted similar powers in relation to the State Authority (Section 113). There are ‘special provisions for states in north-east and hill states’ owing to ‘communication, travel and transportation difficulties’, relating to the functioning of MHRBs and time-lines within the Act (Section 114).

With regard to India’s criminalisation of suicide in the Penal Code, Section 115 of the MHCA, specifies that ‘notwithstanding anything contained in Section 309 of the Indian Penal Code any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the said Code’ (Section 115(1)). ‘The appropriate Government shall have a duty to provide care, treatment and rehabilitation to a person, having severe stress and who attempted to commit suicide, to reduce the risk of recurrence of attempt to commit suicide’ (Section 115(2)). This is a de facto decriminalisation of suicide and an explicit commitment to provide care to those affected. Abetting suicide remains a

crime under India's Penal Code. The MHA made no reference to suicide or the Penal Code.

Further provisions govern a 'bar of jurisdiction' for 'any suit or proceeding in respect of any matter which the Authority or the Board is empowered by or under this Act to determine' (Section 116); 'transitory provisions' (Section 117); legal protection for Government and members of the Authority or Board (Section 119); the 'overriding effect' of the Act on 'other law' and related measures (Section 120); the 'power of Central Government and State Governments to make rules' (Section 121); the 'power of Central Authority to make regulations' (Section 122); the 'power of State Authority to make regulations' (Section 123); the laying of Central Government rules and Central Authority regulations 'before each House of Parliament' (Section 124(1)); and the laying of State Government rules and State Authority regulations 'before each House of the State Legislature' (Section 124(2)).

If difficulty arises implementing the Act, in its first two years, the Central Government may, make such provisions, consistent with the act that remove the difficulty (Section 125(1)). Finally, the Mental Health Act, 1987 is repealed, subject to transitional arrangements (Section 126).

2.2.2.3 Reception

Overall, India's MHCA presents a very broad range of provisions which, if implemented, will affect virtually every element of mental health services in India. Many of the changes are clearly informed by the Act's explicit aim to meet the requirements of the CRPD. The new Indian legislation has stimulated considerable discussion in the psychiatry literature. In April 2019, on the second anniversary of the MHCA receiving Presidential assent (7 April 2017), the *Indian Journal of Psychiatry*, official publication of the Indian Psychiatric Society (IPS), published a dedicated supplement with no fewer than 33 articles relating to the legislation in various ways (Dalal, 2019; Vaishnav, 2019). While one line of discourse was that the new legislation was not needed in the first place, and that amendments to the Mental Health Act, 1987 would have sufficed, there was nonetheless an acceptance of the facts that the

new Act would have practical and legal implications in practice and needed to be understood (Kumar, 2019).

The themes of the papers in the supplement reflected many of the themes that had emerged over the previous two years and, indeed, during the development of the legislation itself (Suresh, 2014; Isaac, 2015; Jiloha, 2015): the role of the CRPD and human rights standards in shaping the legislation (Ameen et al., 2019; Raveesh et al., 2019a); the need for specific amendments to facilitate implementation (Math et al., 2019a; Singh, 2019); issues relating to consent and research (Ali et al., 2019a); assessments of capacity for mental healthcare decisions (Namboodiri, 2019); advance directives and nominated representatives (Philip et al., 2019); alternatives to restraint (Raveesh et al., 2019b; Raveesh and Lepping, 2019); suicide and attempted suicide (Vadlamani and Gowda, 2019); child and adolescent psychiatry (Sharma and Kommu, 2019); old age psychiatry (Sivakumar et al., 2019); the homeless mentally ill (Swaminath et al., 2019); community treatment orders (Gowda et al., 2019a); civil commitment (Mannekote et al., 2019); the development of rules and regulations (Narayan and Shekhar, 2015; Hongally et al., 2019a); the perspectives of care-givers (Pavitra et al., 2019); and liabilities and penalties (Hongally et al., 2019b). Many of these themes feature throughout the remaining chapters in this thesis, especially in relation to their implications in terms of human rights.

The April 2019 supplement to the *Indian Journal of Psychiatry* also included very welcome papers looking at the practical challenges of implementation (Singh, 2019); the needs for appropriate training (Harbishettar and Murthy, 2019), peer-group support (Harbishettar et al., 2019a) and a 'code of practice' (Nallur, 2019); documentation under the new legislation (Gajera et al., 2019; Hongally et al., 2019b); its impact on addiction and addiction services (Mohan and Math, 2019); issuing of certificates (Ali et al., 2019b); discharge planning (Gowda et al., 2019b); dealing with statutory bodies (Prashanth et al., 2019); the potential role of technology (Kumar et al., 2019); the Rights of Persons with Disabilities Act, 2016 (Math et al., 2019b); the implications of the MHCA in relation to founding and managing a mental health establishment (Gowda et al., 2019c); and health insurance for mental illness (Bijal et al., 2019).

Other papers covered issues relating to ethics (Indla and Radhika, 2019); the doctor-patient relationship (Harbishettar et al., 2019b); violence against doctors (Reddy et al., 2019); and ethical and legal issues relating to the sale of medicines by registered medical practitioners at their clinics (Math et al., 2019c). One of the most interesting papers concerned the cost of implementing the new legislation, which the authors estimated at 940,730 million rupees (€12 billion or £11 billion) annually (Math et al., 2019d). The authors also pointed out, however, that the annual cost to the government of *non-investment* in mental health services was 6.5 times more than that.

The background to many of these issues, and the implications of the MHCA itself in terms of human rights, are explored in detail the remaining chapters of this thesis. More specifically, Chapter 3 provides a point by point comparison of the MHCA with the WHO Checklist on Mental Health Legislation (WHO, 2005) and Chapters 4 examines the legislation in the context of the CRPD. Finally Chapter 5 analyses the perspectives of psychiatrists working in India.

In terms of case law the MHCA has been involved in some notable Supreme Court Judgements. For example, it has had success in protecting the rights of prisoners with mental illness, including the right to privacy and dignity (Accused 'X' Vs. State of Maharashtra, 2019). It was also interestingly and cleverly used to provide protection from discrimination on the basis of sexual orientation (Navtej Singh Johar and Ors. Vs. Union of India Thr. Secretary Ministry of Law and Justice, 2018). It's provisions in relation to the decriminalisation of suicide have been discussed in a judgement concerning euthanasia (Common Cause (A Regd. Society) Vs. Union of India and Another, 2018).

2.2.3 Analysis of the interaction between the Indian Mental Healthcare Act 2017 and The Rights of Persons with disabilities Act 2016

The RPWDA and the MHCA, despite having a common aim, were not developed together as one entity. Consequently, there are elements of each act that are partially discordant. It is clear that the MHCA only seeks to have jurisdiction over mental healthcare, consequently at times it only affirms rights in the context of mental

healthcare and leaves the boarder protections for the RPWDA. A good example of this is in relation to discrimination in which the MHCA provisions appear very circumscribed (Section 21), however it is defined in broader terms in the RPWDA (Section 2(h)).

2.2.3.1 Decision making supports

There could be additional clarity concerning the interaction between the support and guardianship arrangement (RPWDA, Sections 13 and 14) and how they relate to the role of the nominated representative (MHCA, Sections 14-17). The limited nature of the guardianship may still allow for a nominated representative, however, a guardian is only provided when a person is unable to make legally binding decisions. This is an area where the lack of clarity about the need for capacity, to revoke or alter a nominated representative is even more problematic. It does not appear that a guardian can simply be revoked by an individual who continues to be unable to make legally binding decision, therefore it appears to be the more robust construct, the range of decisions a limited guardian can take also appears to be broader. However, the role of the nominated representative is more clearly described in the legislation and more checks and balances exist.

2.2.3.2 Involuntary treatments

Section 3(4) of the RPWDA prohibits the deprivation of liberty on the basis of a disability, this strongly aligns with the provisions of the CRPD. The MHCA's very existence could be seen as potentially inhibiting liberty as a result of disability. The MHCA also contains provisions for emergency treatments, restraint, and involuntary (supported) admissions. While, these have many protections and safeguards in place concerning their use, they nonetheless represent a deprivation of liberty. Does this deprivation occur due to the disability, (i.e. the mental illness) or does it occur due to the acute presentation and level of risk? However, individuals with mental illness have their acute mental state and level of risk assessed more frequently due to the

presence of a mental illness, leading to a reduction of liberty. This complex relationship will be discussed in more comprehensively in later chapters.

2.2.3.3 Definitions of mental illness

The MHCA defines mental illness as:

‘a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence’ (Section 2(s)).

The RPWDA describes a person with disability as:

‘a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others’ (Section 2(s)).

The schedule in the RPWDA, includes a mirrored definition of mental illness but omits the phrase ‘mental conditions associated with the abuse of alcohol and drugs’, (this appears to be an incomplete phrase in the MHCA possibly missing the words ‘this includes’). This section is too significant for there to be a grammatical error with the potential for legal ambiguity. The inclusion of individuals with substance misuse under mental health legislation, but excluding them from disability legislation, could put them in a vulnerable situation. They could be subject to the coercive measures of the MHCA but excluded from the rights and protections provided in the RPWDA.

2.3 Summary

India’s mental health legislation has undergone extensive reform over the past five years, with the Rights of Persons with Disabilities Act 2016 and the Mental Healthcare

Act 2017. Many changes have helped to protect rights, but others are more complex, and the two pieces of legislation do not always rest easily with each other. The attempt to align with the CRPD will hopefully reduce involuntary treatments and enhance community based and rehabilitative services, it also does much to broaden the definition of mental healthcare, addressing more of the social needs and context. However, this ambitious desire, to provide national legislation that incorporates the CRPD, appears to have led to a degree of opacity in the finer details concerning coercive measures. Irrespective of this limitation, it is a bold piece of legislation that has the potential to greatly raise the quality of life for those with mental illness in India.

B. Research

3. Black letter analysis of India's adherence with the WHO-RB Checklist

3.1 Introduction

The background and context of the WHO-RB (WHO, 2005), its checklist, and India's legislation, are discussed in Chapter One and Chapter Two of this thesis. This chapter uses the lens of this checklist to explore India's new legislation. Writing legislation concordant with the standards of the WHO-RB presents many challenges and often requires a highly nuanced understanding of the relevant ethical issues (Kelly, 2011).

Other authors have used the WHO-RB, and its checklist, to evaluate the mental health legislation of different jurisdictions. Ofori-Atta et al. have previously used it to inform their evaluation of mental health legislation in Ghana (2010). A more quantitative, formal approach was adopted by Kelly (2011) who compared 166 of the checklist items with English, Welsh and Irish mental health legislation (Kelly, 2015). The Mental Health Act 2007 in England and Wales met 54.2% of the WHO standards, while the Irish Mental Health Act 2001 met 48.2%. Both Mental Health Acts were found to inadequately address fundamental principles; particularly in the areas of, the rights of voluntary patients, vulnerable patient groups, emergency treatments and economic and social rights.

Shao et al. (2010) used elements from the WHO-RB to evaluate the legislation in five cities in China. While it used a less comprehensive approach than that employed by Kelly (2011), it highlighted many potential areas where mental health legislation could be enhanced. Specifically, it identified that the oversight, review and appeal processes in the studied cities could be improved. They used their study findings to add weight to the case for national mental health law in China, which subsequently occurred in 2013 (Shao et al., 2015).

3.2 Aims

The research in this chapter aims to conduct a 'black letter' analysis of the concordance between India's legislation and the WHO-RB checklist. The secondary aim

of this chapter are to identify legislative areas where there are high and low levels of concordance between the WHO-RB and India's legislation. It examines key omissions in areas of, otherwise, good concordance, identifies areas of intentional non-concordance and discusses the ethical concepts pertinent to these items. Finally, recommendations are made for potential future amendments to the legislation and areas that need to be comprehensively addressed in policy, are highlighted.

3.3 Methods

This study utilises a 'black letter' approach, similar to that used by Kelly (2011; 2015). In such an analysis, the focus is on the *content* of the legislation rather than its *effect*. Therefore, this chapter primarily compares the written content of the MHCA to all 175 items of the WHO-RB's checklist. Where an item is not addressed in the MHCA, the RPWDA was the second piece of legislation that was reviewed. If relevant legislation was not found there either, other pieces of Indian legislation were also analysed; e.g. the Indian Penal Code 1860, the Code of Criminal Procedure 1973, and the Medical Termination of Pregnancy Act 1971. These other pieces of legislation were identified by a review of the literature on the topic, discussions with experts during focus groups (described in Chapter 5) and searching, India Code, an on line registry of Indian legislation (Government of India, 2020).

In order to draw clear and useful information from the results, the concordance of India's legislation with the WHO standards were classified in a binary manner. This method has been employed in prior analyses of the WHO-RB (Duffy and Kelly, 2017a; Kelly, 2011; Kelly, 2015). Where there was an element of uncertainty, this dichotomous classification system was continued, but the particular item was discussed in more detail in the text, along with potential justifications for, and implications of, the deviation, where appropriate.

Alphanumeric designations for each human rights standard are provided to assist with clarity and cross-referencing with the WHO-RB (to which the capital letters in this chapter's text and tables refer). The WHO-RB's checklist is divided into 27 sections, each identified by a capital letter (A to ZA). Specific standards contained in each section are further identified by numbers, lower case letters and Roman numerals. For

clarity and to assist with navigation, these have been included in parentheses in the text. For brevity the descriptions of the items contained in the tables in this chapter are occasionally edited; for the precise definitions, the WHO-RB should be consulted. All references to sections of Indian legislation in this chapter relate to the MHCA unless stated otherwise. We did not look at state laws or at Indian mental health policy, though we have discussed policy which is mentioned in the relevant legislation.

Two specific methodological points merit mention here. First, emergency treatments laid out in the IMHA are not considered as ‘involuntary treatments’ in our analysis; they are instead compared to the WHO-RB guidelines on ‘emergency treatments’ (M). Second, the WHO-RB considers ‘involuntary treatment (when separate from involuntary admission)’ (J); under the IMHA supported (involuntary) treatment is not directly considered outside of a supported (involuntary) admission. However, there is a possibility that in the context of an advance directive a person could receive involuntary treatment outside the context of a supported admission and so we have retained this section and discussed this further in the paper.

Due to the substantial size of the WHO-RB the results and discussion are presented together for each of the 27 sections. This approach was adopted to allow the discussion to naturally build on the results rather than necessitate a reader to skip back and forth through this chapter. Following this we have a broader discussion on the legislation as a whole.

3.4 Results

3.4.1 Overall results

On an individual item level the Indian legislation was concordant with 112/175 (64%) of the WHO-RB checklist items. 89/175 (50.9%) of these items were addressed in the MHCA, 16/175 (9.1%) in the RPWDA and 7/175 (4%) in other legislation. Of the non-concordant items, 11/175 (6.3%) were identified as areas of well justified non-concordance. Of the 175 items, 123 (70.3%) were either concordant or their deviation from the WHO-RB was well justified. This leaves 52/175 (29.7%) items that were not

addressed in the legislation and could either be addressed in policy or may require a revision of the legislation.

3.4.2 Individual section results

3.4.2.1 Preamble and objectives (A)

3.4.2.1.1 Results

The level of concordance between India's legislation and the 'Preamble and objectives' section of the WHO-RB are described in Table 3.1. All six items in this section are addressed in the Indian legislation. The preamble to the MHCA frames the Act in the context of human rights (A1a), it states its explicit aim is 'to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare'. It also states that legislation is to 'align and harmonise the existing laws' with the CRPD. While this emphasises the human rights of persons with mental disorders in general terms, the preamble in the RPWDA lays out eight specific principles, including dignity, individual autonomy, non-discrimination and accessibility.

The importance of accessible mental health services for all (A1b) is alluded to in the preamble in the declaration of its aim quoted above; this right is then made much more explicit in Section 18(1), which states that 'Every person shall have a right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government and services and for matters connected therewith or incidental thereto'.

The MHCA remains highly circumscribed in its affirmation of non-discrimination (Item A2a). While Section 21 concerns the right to equality and non-discrimination, its focus is on the provision of mental healthcare in an equal level with persons receiving healthcare for physical illness. Section 18(8) makes the same provision and Section 18(1) grants a universal right to access mental healthcare. The RPWDA goes a step further and sets non-discrimination as one of its core principles in its preamble; it describes a broad, holistic concept of non-discrimination. This includes 'the right to equality, life with dignity and respect for his or her integrity equally with

others', personal liberty and it places an onus on the government 'to ensure reasonable accommodation for persons with disabilities'.

The desire to improve access to mental health services (A2c) is not only affirmed but exceeded in the MHCA, which has opted not just to improve access to mental healthcare but to grant a justiciable right to its entire population (Section 18(1)). No such right exists in India to general healthcare. Section 18 goes on to describe the range of services that shall be provided, their need to be provided locally, and it places the responsibility for delivering this on the government.

The emphasis on a community-based approach (A2d) is addressed throughout the MHCA. Treatment is to be provided 'in a manner, which supports persons with mental illness to live in the community and with their families' (Section 18(5)(b)) and 'long term care in a mental health establishment' should only occur in exceptional circumstances. Section 19 affirms community living and it addresses individuals who have been abandoned by their families and makes provision for community based care facilities outside of mental health establishments. In relation to the admission of minors (Section 87(3)(d)) and supported admission beyond 30 days (Sections 90(5)(b), 90(6) and 90(7)), the preference for community based treatment is categorically stated. Such unambiguous statements are not present in relation to independent admissions (Section 86) or supported admissions for the first 30 days (Section 89), although Section 89 does state that the admitting psychiatrists should 'certify' that 'admission to the mental health establishment is the least restrictive care option possible in the circumstances.

3.4.2.1.2 Discussion

Right from its inception, the MHCA was designed to have a strong emphasis on human rights (Murthy, 2010) and sought to improve access to mental healthcare (Firdosi and Ahmad, 2016). The proposed level of access to mental healthcare is unmatched internationally and has the potential to create a dramatic shift in how mental health is addressed globally. The WHO (2018) have highlighted the potential for legislation to become a serious driving force in healthcare and, if India can deliver on this justiciable right to mental healthcare, it will set a fascinating precedent (Duffy and Kelly, 2019a).

The provisions addressing protections from discrimination are of particular importance in light of the role stigma plays in preventing individuals accessing treatment (Shidhaye and Kermode, 2013) and the prevalence of stigma in mental health (Gerlinger et al., 2013). In addition, it is known that stigma in India can have far-reaching consequences, beyond access to healthcare (Grover et al., 2016). For this reason, more specific anti-discrimination legislation is needed in Indian mental health legislation, or more specific provision could be laid out in Section 3(3) of the RPWDA.

Table 3.1: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to the preamble and objectives (A)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA)	Relevant section of the MHCA
A1a	Does the legislation have a preamble which emphasises the human rights of people with mental disorders?	Yes	-	Preamble
A1b	Does the legislation have a preamble which emphasises the importance of accessible mental health services for all?	Yes	-	Preamble, Section 18
A2a	Does the legislation specify that the purpose and objectives to be achieved include non-discrimination against people with mental disorders?	No	Yes	Sections 18(1), 18(8), 21(1)(a), RPWDA Preamble (b), Section 3
A2b	Does the legislation specify that the purpose and objectives to be achieved	Yes	-	Preamble, Sections 18-28

	include promotion and protection of the rights of people with mental disorders?			RPWDA Sections 3-15
A2c	Does the legislation specify that the purpose and objectives to be achieved include improved access to mental health services?	Yes	-	Section 18
A2d	Does the legislation specify that the purpose and objectives to be achieved include a community-based approach?	Yes	-	Sections 18(5)(b), 18(5)(c), 19, 87(3)(d), 90(5)(b), 90(6), 90(7)

MHCA – Mental Healthcare Act, 2017

3.4.2.2 Definitions (B)

3.4.2.2.1 Results

The manner of concordance between India's legislation and the 'Definitions' section of the WHO-RB are described in Table 3.2. The MHCA presents a clear definition of mental disorder (Section 2(1)(s)) and the grounds for lacking mental capacity are described in Section 4. However, the RPWDA presents a slightly different definition of mental disorder, which excludes substance misuse (RPWDA, the schedule, Section 3). The fact that there is a major typographical error in the definition of capacity, the additional guidance on assessing capacity which will be provided by the Central Authority (Section 81) and the ambiguity in relation to substance misuse, resulted in this study classifying the MHCA as non-concordant in relation to clear definitions (B1). It is not clear why particular terms have been chosen (as required by the WHO) (B2), especially as the MHCA aligns itself with the ICD (WHO, 1992), but does not use its terminology, opting for 'mental illness' instead of the ICDs, 'mental disorder'. Section 3(1) allows for other national or international standards to be used, but the Act only references the ICD.

The MHCA (Section 2(1)(s) and RPWDA (Schedule, Section 3) are clear that mental illness does ‘not include mental retardation’ (B3). The picture regarding substance misuse is less clear, as the MHCA appears to include ‘mental conditions associated with the abuse of alcohol and drugs’, but the line referencing substance use is omitted from the RPWDA (B3). The punctuation in the MHCA also introduces a degree of ambiguity: it is unclear if substance misuse disorders are sufficient in and of themselves to fall under the definition of mental illness. Personality disorder is totally omitted from the two pieces of legislation; this may be of particular relevance in light of the provisions of Section 115, which places a duty on the government to provide care to anyone attempts suicide (B3).

While all key terms (B4) and ‘interpretable terms’ (B6) are clearly defined and, in general, used consistently in the MHCA (B5), addressing the issues highlighted above would bring greater clarity. In addition, there are other minor typographical errors in the Act, for example in section 2(1)(r)(i) where ‘clause (x)’ should read ‘clause (y)’.

3.4.2.2.2 Discussion

Clear definitions are an essential component of any legislation. This is especially true in circumstances where definitions may influence the limitation of rights. The CRPD (United Nations, 2006), for example, requires that ‘any deprivation of liberty is in conformity with the law’ (Article 14). In this context, the MHCA has provisions for ‘supported’ admission, questioning the capacity of an individual, and challenging advance directives, hence robust definitions are essential in all of these areas. The MHCA, however, meets just two of the six suggested standards.

Adequate diagnosis of mental illness is essential for high quality mental healthcare, but the MHCA is regrettably silent on the categories of professional qualifications or clinical skills required to diagnose mental illness. While this may be a product of the work-force limitations (Patel et al., 2016; van Ginneken et al., 2017), it is still essential that some safeguards are in place, as there is a need for high level clinical training and judgement for accurate diagnosis (American Psychiatric Association, 2013).

Another significant omission in this section is the failure to make any mention of personality disorder. Under the MHCA, a mental health service has a ‘duty to provide care, treatment and rehabilitation to a person, having severe stress and who attempted to commit suicide’. Certain personality disorders are associated with higher rates of suicidality (Chesney et al., 2014) and individuals with these diagnoses can make up a significant proportion of the work-load of psychiatric services. In an American population, approximately 15% of adults have at least one personality disorder (American Psychiatric Association, 2013). Newton-Howes et al. (2008) highlight that this may increase to 50% in individuals attending secondary care. While rates of personality disorder in India are unclear, it is inevitable that many individuals with such difficulties will come into contact with the mental healthcare services. Failure to make direct reference to personality disorder may lead to individuals with very severe levels of disability not receiving support that they need (Rao et al., 2016) or it may lead to inappropriate supported admissions and treatment. Greater clarity is needed.

Also, in relation to suicidality, the National Mental Health Survey of India, 2015-16 (Gururaj et al., 2016), identified a wide range in the prevalence of high suicide risk across different states, this may require certain states to adopt a more focused approach to addressing to suicide prevention and providing treatment for individuals with such thoughts.

Table 3.2: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation’s standards relating to Definitions (B)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA)	Relevant section of the MHCA
B1	Is there a clear definition of mental disorder/mental illness/mental disability/mental incapacity?	No	No	Section 2(1)(s), 4

B2	Is it evident from the legislation why the particular term (above) has been chosen?	No	No	Section 3(1)
B3	Is the legislation clear on whether or not mental retardation/intellectual disability, personality disorders and substance abuse are being covered in the legislation?	No	No	MHCA Section 2(1)(s), RPWDA Seclude Section 3
B4	Are all key terms in the legislation clearly defined?	No	No	Section 2, Section 4(1)
B5	Are all the key terms used consistently throughout the legislation (i.e. not interchanged with other terms with similar meanings)?	Yes		Throughout
B6	Are all “interpretable” terms (i.e. terms that may have several possible interpretations or meanings or may be ambiguous in terms of their meaning) in the legislation defined?	Yes		Throughout

MHCA – Mental Healthcare Act, 2017

3.4.2.3 Access to mental healthcare (C)

3.4.2.3.1 Results

The manner of concordance between India’s legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.3. Access to mental healthcare is generally well addressed. The MHCA provides services on an equal basis with physical healthcare (C2), is beginning to integrate these services into primary healthcare (C4), promotes deinstitutionalization (C8) and a rehabilitative approach (C6), and provides access to psychotropic drugs (C5) and insurance (C7).

The largest omission in this area relates to funding (C1), which is only addressed in vague terms. No percentage of national income is protected, and no specific proportion of the health budget is to be dedicated to mental healthcare. With regard to the requirement to allocate culturally appropriate resources to underserved populations (C3), the MHCA grants equality in mental healthcare (Section 21(1)), prohibits discrimination (including discrimination due to culture) (Sections 18(2) and 21(1)(a)) and ensures individuals receive information in a language or form they can understand (Section 22(1)(d)). However, these steps appear insufficient to address the needs of underserved populations.

3.4.2.3.2 Discussion

Overall, the MHCA represents a sea change for Indian legislation and will hopefully prove transformative in reducing stigma and closing the treatment gap. Access to mental healthcare is the single greatest bioethical issue in healthcare today. Globally, a strong majority of people affected by mental illness - 75% in many low-income countries - do not have access to the treatment they need (WHO, 2019).

The National Mental Health Survey of India, 2015-16 (Gururaj et al., 2016) represents the most comprehensive assessment of the mental health needs of India and has major implications for access to services. This survey collected data across 12 states, using nearly 500 mental health professionals, on 39,532 individuals. This study used multi-stage, stratified, random cluster sampling of households, and employed qualitative and quantitative methods. It was more comprehensive than prior studies, targeting topics that had been neglected, for example, substance misuse and suicidality. It highlighted factors that must be considered when evaluating the MHCA, while they are broad topics, they most fundamentally impact access to healthcare.

First, the document clearly describes the significant treatment gap for individuals with mental illness, and advocates for enhanced mental health infrastructure. The current prevalence for any mental health problems was 10.6%, with 0.4% of the population meeting criteria for a current psychotic illness, 0.9% were deemed to have a high suicide risk in the past month. Urban metropolitan populations had higher rates of all illness, this is of significant relevance with India's shift towards

urbanisation. Over 50% of individuals with mental health problems found their work, social life and family life to be impaired by their illness. The survey estimated that 150 million individuals were in need of mental health care. However, the treatment Gap for mental health disorders ranged from 70-92%. For major mental disorders it was 73.6%. This demonstrated the magnitude of the need for mental healthcare in India. The authors perceived the MHCA as supportive in addressing some of these issues and looked to the National Mental Health Programme to develop plans and provide funding. They identified the need for 'financial provisions, strengthening of the required facilities, human resources and drug logistics', as demonstrated in this thesis these receive inadequate consideration in the MHCA. To address this treatment gap the survey authors also suggest a national mental health literacy strategy, this is supported by both the MHCA and the RPWDA.

Second, Gururaj et al. (2016) draw attention to the significant regional variations. For example, 24.3% of individuals with mental illness reported that they were illiterate, but this varied significantly between states. This will necessitate states with lower levels of literacy to promote mental health education and treatment in ways that are more accessible. The survey also highlighter the wide range in household income throughout India, this demonstrates the need for affordable services and that particular states with low levels of income may require specific provisions to facilitate access to mental health services. The survey also identified that some states had twice the burden of mental health morbidity; these data and information regarding levels of current staffing could be used to prioritise funding and recruitment.

The recent pressures that have been placed on all health systems by Covid 19 have further exacerbated these challenges in mental healthcare delivery across India (Sharma et al., 2020).

Standing at over 1.25 billion, the population of India is the second largest in the world, behind only China. The United Nations (UN) predicts that by 2022 India's population will surpass that of China and by 2030 its population will reach 1.5 billion (UN Department of Economic and Social Affairs, Population Division, 2015). Mental health is a major concern in India; major depressive disorder is the leading cause of years lived with disability, while anxiety is the ninth leading cause (Global Burden of

Disease Study 2013 Collaborators, 2015). The number of individuals affected by mental illness is enormous; it is estimated that 2.5 million people have schizophrenia, 8.8 million have bipolar affective disorder (BPAD), 48.4 million have depression, 36.8 million have anxiety disorders and 13.4 million have alcohol dependence. (Baxter et al., 2016). In 2013, just under 31 million disability-adjusted–life-years (DALY) were due to mental, neurological and substance misuse disorders. Schizophrenia accounted for 1.7 million of those, BPAD for 1.8 million, depression for 11.5 million, alcohol and substance misuse for 3 million, and dementia for 1.8 million (Charlson et al., 2016).

Despite the large burden of mental illness only 10% of Indians with mental health problems receive evidence-based treatments (Murthy, 2011). Large treatment gaps exist due to insufficient funding of mental, neurological, and substance use disorders (Charlson et al., 2016). In 2011, India spent 4.16% of its gross domestic product on health; 0.06% of this was allocated at a national level for outpatient psychiatric care (WHO, 2011). The failure to clearly lay out a funding pathway for the MHCA may well prove to be the most concerning omission given its ambitious provision of a right to mental healthcare. Currently, Indian mental health services are significantly under resourced, with less than 1% of India's health budget going to mental health (Patel et al., 2016). As mentioned above, the right to mental healthcare in the MHCA gives legal footing to demands for additional resources and places an onus on the government to provide appropriate services (Section 18(10)). Underfunding may inhibit the feasibility of the MHCA and potentially lead to sections of the legislation being ignored or dismissed as impractical, which would be regrettable. The MHCA's failure to follow through on its articulation of a right to mental healthcare with robust legislative provisions for funding might well prove its undoing.

There is also a lack of emphasis on primary healthcare in the MHCA. This is regrettable as the need for primary healthcare has long been recognised in India (Bhore Committee, 1946), but services are still insufficient in many areas and fall far short of the national minimum standards (Powell-Jackson et al., 2013). Some of this may be explained by the fact that individuals living in developing countries are often reluctant to engage with primary healthcare and view it as being of low quality (Singh et al., 2018).

As the burden of mental illness is increasingly recognized, funding is being increased with the hope of ensuring more people receive high quality healthcare. India is implementing a variety of initiatives to address this large need, close the treatment gap, and reduce the disability adjusted life years (DALYs) lost to mental, neurological and substance misuse disorders (Evans-Lacko et al., 2016). These initiatives need to be supported by clear, pragmatic and robust mental health law in line with international human rights legislation. It remains to be seen how pragmatic the MHCA will be. The WHO-RB suggests that 'legislation state that mental health services should be provided on an equal basis with physical health care' (C2); this is far surpassed by the MHCA which provides a legally binding right to mental healthcare (Section 18(1)). This represents substantial progress in a country which, like most countries, has no legally enforceable right to general healthcare (Duffy and Kelly, 2019a).

Table 3.3: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to access to mental healthcare (C)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA)	Relevant section of the MHCA
C1	Does the legislation make provision for the financing of mental health services?	No	No	Sections 18(3), 18(11), 57, 61
C2	Does the legislation state that mental health services should be provided on an equal basis with physical health care?	Yes	-	Section 21(1)
C3	Does the legislation ensure allocation of resources to underserved populations and	No	No	Sections 18(2), 21(1), 22(1)(d)

	specify that these services should be culturally appropriate?			
C4	Does the legislation promote mental health within primary healthcare?	Yes	-	Section 18(5)(a))
C5	Does the legislation promote access to psychotropic drugs?	Yes	-	Section 18(10)
C6	Does the legislation promote a psychosocial, rehabilitative approach?	Yes	-	Sections 2(1)(o), 18(4)
C7	Does the legislation promote access to health insurance in the private and public health sector for people with mental disorders?	Yes	-	Section 21(4), RPWDA Sections 2(x), 24(3)(j)
C8	Does the legislation promote community care and deinstitutionalisation?	Yes	-	Sections 18(5)(c), 20(2)(g), 87(3)(d), 90(5)(b), 90(6), 90(7)

MHCA – Mental Healthcare Act, 2017

3.4.2.4 The rights of users of mental health services (D)

3.4.2.4.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.4. Generally, both the MHCA and RPDWA adequately affirm the rights of users of mental health services. India's legislation addressed 14 of the 16 standards in the WHO-RB. Ten of these standards are directly addressed in the MHCA and four others benefit from additional provisions in the RPWDA. Some of the items that are concordant could be enhanced with further protections. The two areas where deficiencies were identified relate to,

first, the minimum condition of a mental health facility (D5) and, second, privacy (D6), including, the minimum levels of privacy that need to be respected (D6a).

Protection from cruel, inhuman and degrading treatment within mental health establishments is provided in section 20(2) of the MHCA and a broader protection in other contexts is present in the RPWDA (Section 6(1)). Privacy is discussed under this topic, of cruel, inhuman and degrading treatment, in the MHCA (Section 20(2)(d)). Despite this, no explicit description of a right to privacy exists and no consideration of privacy outside of mental health establishments is present. The only reference to privacy in the RPWDA is in section 13(5), which places an onus on individuals supporting capacity to respect the privacy of the individual they are supporting. The meaning of privacy is also not explored in any kind of meaningful detail. Regarding the minimal conditions to be maintained in mental health facilities for a safe, therapeutic and hygienic environment, the MHCA refers to minimum standards but allows them to be decided outside of the legislation (Sections 18(9), 65(3), 65(4)(a), 66(9), 67(1), 68(1), 122(2)(e) and 123(2)(a)).

The provisions that address forced labor (D7), educational and vocational training (D8) and respect and dignity (D1) were all greatly enhanced by the protections in the RPWDA. Often, the MHCA only protects such rights in the setting of inpatient care. For example, the MHCA forbids inadequately remunerated or forced labor (Section 20(2)(f)), but only in mental health establishments. In contrast, the RPWDA prohibits all exploitation of individuals with disabilities (Section 7).

The right to confidentiality (D2) is well protected and the circumstances in which it can be breached are well described (D2b). However, the right to appeal a breach of confidentiality (D2c) is cumbersome and protracted. Initially, an appeal is made to the MHRB (Section 77) and subsequently to the State High Court (Section 83). The initial appeal, can however, take up to 90 days (Section 80(4)). No direct sanctions are laid out for breaches of confidentiality (D2a), but sanctions for any breach of the MHCA by individuals (Section 108) or companies (Section 109) are described. While this is concordant with the WHO-RB, there are areas where the protections could be enhanced.

3.4.2.4.2 Discussion

The protection of human rights for those with psychosocial disabilities has often been poor (Drew et al., 2011), Kleinman (2009) described it as a ‘failure in humanity’.

Despite this, mental health legislation is increasingly defined and shaped by human rights. Many countries are beginning to align their legislation and policy with international instruments (World Health Organisation, 2018), and the impact of this is starting to be seen in India (Raveesh et al., 2019). This is a welcome, necessary progression away from legislation that is primarily centered on involuntary treatment and forensic issues.

Many of the standards relating to the rights of individuals using mental health services are addressed in both the MHCA and the RPWDA. While protections from cruel and inhumane treatment are provided in the MHCA, its provisions for treatment without consent (Section 89), electroconvulsive therapy and restraint (Sections 95 and 97) would be seen by some as internally inconsistent (United Nations Human Rights Council, 2013; 2016). This is discussed in more detail in Chapter 4.

Privacy is a fundamental human right (United Nations, 1948; 2006), but in-depth discussion of the subtleties of privacy is often absent from the medical literature and from legislation (Duffy and Kelly, 2017c). As privacy is considered in the MHCA under the section relating to cruel, inhuman and degrading treatment (Section 20(2)(d)), it must be seen as a non-derogable right in this context (United Nations Economic and Social Council, 1985). Such rights cannot be limited in any circumstances and, as such, the MHCA’s failure to consider different domains of privacy (D6) or stipulate minimum levels of privacy (D6a) is of particular concern. The WHO-RB provides a rare and highly useful examination of the varying elements of privacy in a variety of contexts (WHO, 2005). Protections outside of mental health establishments are, however, completely absent in the Indian legislation.

The deviation from the WHO-RB guidelines in relation to minimum standards allows the relevant authority to have regard to local service infrastructure (Section 65(5)(c)). While, this is a pragmatic provision, it will be important that clear and effective policy is promptly implemented at local level. This must remain under careful review to mitigate the risk of non-observance of rights. In light of the numerous

limitations in services identified by Gururaj et al. (2016), there is a major need for robust minimum standards to be developed. These deficiencies are nationwide and include, *inter alia*, health information systems, staffing shortages, problems in sourcing medication and a lack of rehabilitation services.

It is very reasonable that the two areas of non-concordance with the WHO-RB may be dealt with in policy rather than law. In the case of the minimum standards for mental health establishments, this is even suggested in the MHCA. However, in other healthcare settings national standards are often ignored and consequently they may benefit from protection in law (Powell-Jackson et al., 2013).

Table 3.4: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to the rights of users of mental health services (D)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA)	Relevant section of the MHCA
D1	Does the legislation include the rights to respect, dignity and to be treated in a humane way?	No	Yes	Section 20 RPWDA Sections 3(1), 13(5)
D2	Is the right to patients' confidentiality regarding information about themselves, their illness and treatment included?	Yes	-	Section 23. 24
D2a	Are there sanctions and penalties for people who contravene patients' confidentiality?	Yes	-	Section 108 and 109
D2b	Does the legislation lay down	Yes	-	Section 23 (2)

	exceptional circumstances when confidentiality may be legally breached?			
D2c	Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to release information?	Yes	-	Section 77, 80(4), (83)
D3	Does the legislation provide patients free and full access to information about themselves (including access to their clinical records)?	Yes	-	Section 25(1)
D3a	Are circumstances in which such access can be denied outlined?	Yes	-	Section 25(2)
D3b	Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to withhold information?	Yes	-	Sections 25(3), 28, 69
D4	Does the law specify the right to be protected from cruel, inhuman and degrading treatment?	Yes	-	Section 20(2), RPWDA Section 6(1)
D5	Does the legislation set out the minimal conditions to be maintained in mental health facilities for a safe, therapeutic and hygienic environment?	No	No	Sections 18(9), 65(3), 65(4)(a), 66(9), 67(1), 122(2)(e) and 123(2)(a)

D6	Does the law insist on the privacy of people with mental disorders?	No	No	Section 20(2)(d), RPWDA 13(5)
D6a	Is the law clear on minimal levels of privacy to be respected?	No	No	Section 20(2)(d), RPWDA 13(5)
D7	Does the legislation outlaw forced or inadequately remunerated labour within mental health institutions?	No	Yes	Section 20(2)(f)), RPWDA Section 7
D8	Does the law make provision for educational activities; vocational training; leisure and recreational activities; and religious or cultural needs of people with mental disorders?	No	Yes	Section 20(1)(c), RPWDA Sections 2(w), 2(x), 16-19, 29, 30
D9	Are the health authorities compelled by the law to inform patients of their rights?	Yes		Section 22(1)
D10	Does legislation ensure that users of mental health services are involved in mental health policy, legislation development and service planning?	Yes		Sections 34(1), 46(1), 74(1)

MHCA – Mental Healthcare Act, 2017

3.4.2.5 The rights of families and other carers (E)

3.4.2.5.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.5. The WHO-RB checklist has five standards relating to the rights of family and carers (E), only one of which the

Indian law concords with. The rights of family and carers are neither explicit nor automatic in the new Indian legislation: their rights to information (E1), to be involved in treatment planning (E2) and to appeal involuntary admission (E3) are predominantly mediated through the role of the nominated representative. While the MHCA arguably allows for families to be side-lined from an individual's treatment, many provisions give them preferential rights; these are discussed below. The construct of the nominated representative helps realise additional rights for the individual receiving treatment, including, discretionary privacy, confidentiality and the ability to make decisions free family interference, should they desire this.

Discharge-planning appears to be the only time when the family members have some entitlement to information and are automatically encouraged to become involved in treatment planning. The family have an right to appeal the appointment of the nominated representative through Section 16; should this be successful, and if the MHRB decides to install a family member as the new nominated representative, they then have the ability to appeal a supported admission or treatment decision, too.

No special provisions are made for appealing for the discharge of mentally ill offenders (E5), although judges have the right to divert such people away from the criminal justice system; should they subsequently be detained under Section 89 or 90 of the MHCA, the relevant rights, described above, would apply.

3.4.2.5.2 Discussion

The role of families and carers (E) can present significant challenges even to experienced mental health professionals. The path between confidentiality and collaboration can become a tightrope with both families and patients sometimes feeling aggrieved. Chan and O'Brien (2011) describe this balance, and highlight how resource limitations further complicate the issue. This analysis adopted a literal approach and consequently classified the MHCA as non-concordant with four out of five of the WHO-RB items. These rights are partly indirectly protected in the MHCA, through the role of the nominated representative. Outside of this framework, the entitlements of family and carers are limited (Duffy and Kelly, 2017c).

In certain circumstances, the MHCA gives special consideration to families and caregivers outside of the role of the nominated representative. If an individual is being discharged to live with a family member or care-giver, the treating psychiatrist may consult with them prior to discharge (Section 98(1)). When an individual with mental illness is homeless or found wandering in the community, the police have a duty to trace and inform their family (Section 100(7)). Relatives and carers are also given special consideration when the individual with mental illness has not nominated a representative; in these cases, they can opt to become the nominated representative (Section 14(4)). In situations where a family does not agree with a person's choice of nominated representative, they can appeal to a MHRB (Section 16). Relatives and caregivers can apply to alter or cancel advance directives (Section 11(1)). Mental healthcare should be delivered in a manner that is acceptable to an individual's family and care givers (Section 18(2)). However, the MHCA gives the individual receiving treatment a mechanism to prevent their family's unwanted inclusion in their care. The legislation relating to family members in these matters appear to be an intentional and pragmatic deviation from the WHO-RB.

India has a strong sense of family values, often family members are highly involved in providing care to those with mental illness (Avasthi, 2010; Chavan et al., 2018). The MHCA's limitations on family rights could prove substantial (Ramachandra et al., 2017; Duffy and Kelly, 2017c). Asoken (2014) has already raised concerns that a nominated representative may do more harm than good, and questioned their relevance in Indian culture. Pavitra et al. (2019) have looked at the MHCA from an Indian context and describe the current provisions as 'an alien Western law enforced on Indian cohesive family dynamics'; they suggest that the potential to exclude the family needs to be revised. While, Indian families can play a very strong role in the lives of those with mental illness, this can also be to their detriment (Mahomed et al., 2019). Advance directives can provide protection from unwanted intrusion by family members and from familial coercion. In practice, where advance directives have been made, over 80% of individuals appoint a direct family member as their nominated representative (Pathare, 2015). Consequently, the concerns that this legislation will lead to the widespread exclusion of family may be unfounded.

Many Indian mental health professionals appear to desire legislation which provides more automatic inclusion of relatives, in line with the WHO-RB standards. It remains to be seen how widely the role of the nominated representative will be utilised and how often it will exclude the family in practice.

Table 3.5 Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to the rights of families and other carers (E)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
E1	Does the law entitle families or other primary carers to information about the person with a mental disorder (unless the patient refuses the divulging of such information)?	No	No*	Sections 14(4), 17(d) and 22(1)
E2	Are family members or other primary carers encouraged to become involved in the formulation and implementation of the patient's individualised treatment plan?	No	No*	Sections 14(4), 17, 22(1)(c), 98(1)
E3	Do families or other primary carers have the right to appeal involuntary admission and treatment decisions?	No	No*	Sections 14(4), 16, 17(h), 77(1), 82(1)(c), 87(8)

E4	Do families or other primary carers have the right to apply for the discharge of mentally ill offenders?	No	No	-
E5	Does legislation ensure that family members or other carers are involved in the development of mental health policy, legislation and service planning?	Yes	-	Sections 34(1) and 46(1)

*denotes a well justified area of non-concordance

MHCA – Mental Healthcare Act, 2017

3.4.2.6 Competence, capacity and guardianship (F)

3.4.2.6.1 Results

The manner of concordance between India’s legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.6. The MHCA primarily addresses healthcare decisions; consequently, it provides well-described mechanisms for managing the mental healthcare needs of individuals who are unable to do so themselves. In doing this, it is well aligned with the WHO-RB. However, the RPWDA addresses other ‘legally binding decisions’ in its provisions relating to guardianship (Section 14), but these often fall short of the standards of the WHO-RB. These deficiencies may be dealt with in further guidelines that will be provided outside of the Act (Section 101(2)(c)).

Limited guardianship appears to run in parallel with the nominated representative, though this is not directly stated in the legislation. Through these two constructs, India’s legislation provides a mechanism for managing the affairs of people with mental disorders (F1). While competency is not defined in the MHCA, it is not used in relation to an individual’s capacity (F2) and, as a result, this item was classified as concordant. The MHCA lays down criteria for determining mental capacity (F3) (Section 4) (although a significant typographical error is noted above) and proposes the development of a guidance document (Section 81(1)). Regarding the capacity to appoint a nominated representative, this is not considered at the time of making the

advanced directive, but rather it is considered by a MHRB if an individual subsequently seeks to alter an advance directive that is in effect (Section 11(2)(d)).

In the legislation, however, advance directives, nominated representatives and the definition of 'capacity' pertain only to decisions concerning healthcare. The criteria for requiring a guardian, by contrast, are less well defined. The RPWDA states that 'where a district court or any designated authority, as notified by the State Government, finds that a person with disability, who had been provided adequate and appropriate support but is unable to take legally binding decisions, may be provided further support of a limited guardian' (Section 14(1)).

The procedure for the appointment of limited guardians is clearly described, but the duties, duration (F5) and areas of responsibility (F6) are to be determined by the state governments. In the RPWDA, there is no provision for systematic reviews of limited guardianship (F7), although state governments may prescribe this; there is, however, a right to appeal the decision to appoint one (F8) (Section 14(3)).

With regard to 'nominated representatives', there is no such direct right to appeal a decision of incapacity (F4) in the MHCA, although any grievance about mental healthcare can be brought to a MHRB (Section 77(1)). The periodic review of individuals lacking capacity to make mental healthcare decisions is addressed in the legislation (Section 89(8) and 90(13)). The MHCA is very clear regarding appointment (Section 14), duties and responsibilities (Section 17) of the nominated representative. However, no guidelines on duration are present, the nominated representative appears to remain in place for as long as an individual lacks capacity. It should be noted that the nominated representatives do not act on behalf of the person lacking capacity in the manner described in the WHO-RB (F5), but rather they support decision-making.

3.4.2.6.2 Discussion

Historically, professionals' judgements about mental competency and capacity have done much to limit and violate the rights of individuals with mental illness (Shorter, 1997). Too often, formal and informal guardianship arrangements have been used excessively. Capacity is increasingly seen as dynamic and decision specific, whereas in

the past is was seen as global and all too often the loss of capacity was irreversible. India's new legislation reflects this more recent comprehensive perspective.

There is growing research about the mental capacity of people receiving treatment for physical and mental health conditions (Lepping et al., 2015; Murphy et al., 2018; Curley et al., 2019a; 2019b); this highlights how nuanced and prevalent these issues are. Many individuals on medical wards have impaired capacity and individuals who are involuntarily detained due to mental illness often retain capacity to make many treatment decisions. Some jurisdictions, including Northern Ireland, have now shifted their legislation away from mental illness (however defined) and centered it on mental capacity (Kelly, 2016). This attempts to remove the discrimination created by having mental health law that can question an individual's capacity (Szmukler and Kelly, 2016). India, like many other jurisdictions (Dawson and Szmukler, 2006), did not opt for this approach.

More broadly, the CRPD strongly affirms the legal capacity of individuals with disability (Article 12) and the WHO, through the QualityRights initiative, has called into question the validity of capacity assessment altogether (World Health Organization, 2019b).

Of note, the grounds for activating a nominated representative and a limited guardian are different in the Indian legislation and the protections concerning each are not aligned. Another particularly grey area relates to an outpatient who is deemed to lack capacity. Acting on their advanced directive could create a *de-facto* community treatment order, which would create problems as discussed below. At times, it appears that India's legislation, by attempting to adhere to the CRPD, minimises references to capacity and coercion. This means that there is a lack of clear review process and that essential items are excluded from the legislation; limited guardianship is a prime example of this.

The MHCA and the RPWDA meet only three of the eight standards suggested by the WHO-RB in relation to competence, capacity and guardianship, however, there is scope for many of these deficiencies to be addressed in policy. It will be important that such policy is pragmatic, comprehensive and timely.

Table 3.6 Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to competence, capacity and guardianship (F)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
F1	Does legislation make provision for the management of the affairs of people with mental disorders if they are unable to do so?	No	Yes	Section 5-10, 14-17, 89(7), 90(12). RPWDA Section 14, 101(2)(b)
F2	Does the law define "competence" and "capacity"?	Yes	-	Section 4
F3	Does the law lay down a procedure and criteria for determining a person's incapacity/incompetence with respect to issues such as treatment decisions, selection of a substitute decision-maker, making financial decisions?	No	No	Section 4, 11(2)(d), 81. RPWDA 14, 101(2)(b)
F4	Are procedures laid down for appeals against decisions of incapacity/ incompetence, and	No	No	Section 4, 5(3 and 4), 81, 89(8),

	for periodic reviews of decisions?			90(13). RPWDA 14, 101(2)(b)
F5	Does the law lay down procedures for the appointment, duration, duties and responsibilities of a guardian to act on behalf of a patient?	No	No	Sections 5(3), 14,15,17 RPWDA 14, 101(2)(b)
F6	Does the law determine a process for establishing in which areas a guardian may take decisions on behalf of a patient?	No	No	Section 17, RPWDA 14, 101(2)(b)
F7	Does the law make provision for a systematic review of the need for a guardian?	No	No	Section 89(8), 90(13). RPWDA Section 14
F8	Does the law make provision for a patient to appeal against the appointment of a guardian?	No	Yes	Section 16, RPWDA Section 14(3)

MHCA – Mental Healthcare Act, 2017

3.4.2.7 Voluntary admission and treatment (G)

3.4.2.7.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.7. These provisions are generally well dealt with under India's law. The only omission is that the MHCA does

not state that voluntary patients should be informed at the time of admission about the circumstances under which their independent admission could become a supported admission (G5), but they are entitled to have a copy of the MHCA and to receive information about their admission and treatment plan (Section 22(1)(a)).

3.4.2.7.2 Discussion

The one area where Indian legislation is not compliant with this section of the WHO-RB may actually be an intentional deviation in order to reduce levels of coercion. Many individuals in other jurisdictions have described their experience of coercion during voluntary admissions (O'Donoghue et al; 2014) and have expressed their desire to 'keep voluntary care voluntary' (Gerle et al., 2019). Informing independent patients that they can be made supported patients, if they meet certain criteria, could be considered a form of coercion. These individuals would not be subject to the protections that being a supported patient would afford them but may still have a limitation of autonomy. The provision to inform and involve independent patients in their care seen in the MHCA appears sufficient and the failure to legislate for the WHO-RB item appears well justified and less coercive.

The provision that the MHCA makes for 'less restrictive community based establishments including halfway homes, group homes' (section 19(3)) will hopefully further promote the increasing role of voluntary admissions in Indian psychiatry (Murthy et al., 2017).

Table 3.7 Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to Voluntary admission and treatment (G)

Legislative issue	MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA

G1	Does the law promote voluntary admission and treatment as a preferred alternative to involuntary admission and treatment?	Yes	-	Section 85(2)
G2	Does the law state that all voluntary patients can only be treated after obtaining informed consent?	Yes	-	Section 86(5)
G3	Does the law state that people admitted as voluntary mental health users should be cared for in a way that is equitable with patients with physical health problems?	Yes	-	Section 21(1)
G4	Does the law state that voluntary admission and treatment also implies the right to voluntary discharge/refusal of treatment?	Yes	-	Section 86(5), 86(7)
G5	Does the law state that voluntary patients should be informed at the time of admission that they may only be denied the right to leave if they meet the conditions for involuntary care?	No	No*	Section 22(1)(a)

*denotes a well justified area of non-concordance

MHCA – Mental Healthcare Act, 2017

3.4.2.8 Non-protesting patients (H)

3.4.2.8.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.8. The WHO-RB makes recommendations concerning non-protesting patients (H), but these are not

considered in the MHCA. If a patient lacks the capacity to be an independent patient, they must be admitted as a supported admission.

3.4.2.8.2 Discussion

The MHCA's lack of consideration of non-protesting patients is a particular concern. In 2011, 38% of India's mental health patients had been in hospital for over a year and 14% for over five years (WHO, 2013a). The rising prevalence of dementia in India (Charlson, et al., 2017) highlights the particular urgency of the need for legislation in this group, as individuals with dementia often require significant support to exercise their capacity.

The non-protesting patient's status prevents an individual who is not refusing admission from being an involuntary patient, mitigating stigma and legal ramifications (WHO, 2005, p45-46). The European Court of Human Rights has previously ruled on cases relating to such patients (e.g. *HL v. United Kingdom*), but their primary concern has been affording them the protection rather than preventing the stigma or legal implications of an involuntary admission. Other countries who have recently revised legislation have not referenced non-protesting patients; these countries include England, Wales, Ireland and China (Shao et al., 2010; Kelly 2011),

A robust process for reviewing admissions is vital. The concerns raised above about non-protesting patients may be addressed by the transition away from 'involuntary admissions' to 'supported admission' which includes this patient cohort. In many jurisdictions, non-protesting patients are admitted without the legal protection afforded by involuntary status (i.e. automatic review of their admissions and treatment) (Kelly, 2011). Under the MHCA, if an individual's capacity is impaired to the extent that they need a high level of support in decision-making, they should then be admitted in a supported manner. This will afford them the necessary protections. We are yet to see how this will be implemented; it is possible that this will be underutilized and many individuals may remain in hospital without their informed consent.

Table 3.8 **Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to non-protesting patients (H)**

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
H1	Does the law make provision for patients who are incapable of making informed decisions about admission or treatment, but who do not refuse admission or treatment?	No	No	4(1), 5(3), 86(1)(c)
H2	Are the conditions under which a non-protesting patient may be admitted and treated specified?	No	No	89(1)(c), 90(2)(c)
H3	Does the law state that if users admitted or treated under this provision object to their admission or treatment they must be discharged or treatment stopped unless the criteria for involuntary admission are met?	No	No	

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3.4.2.9 Involuntary admission (when separate from treatment) and involuntary treatment (where admission and treatment are combined)

(I)

3.4.2.9.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.9. The MHCA appears to associate the need for supported admission (Section 89(1)(c) and 90(2)(c)) with the

provision of treatment without informed consent (Section 89(7) and 90(12)). The criteria for evaluating if the two are required are closely aligned; both are based on the level of support needed to make these decisions. It is possible under the legislation that a person would be ineligible to be an independent patient but not require 'nearly hundred per cent. support from his nominated representative', hence I consider both Sections I and J of the WHO-RB. Section I of the WHO-RB deals with involuntary admission and treatment, and comparison with the MHCA is in some ways limited as the MHCA does not legislate for involuntary admission directly. A person may, however, be admitted against their will using a 'supported admission' (Sections 89 and 90); consequently, this procedure is compared to the WHO guidelines. Most of the provisions described for involuntary admission are addressed clearly in India's legislation, with a few exceptions.

No automatic review process (I5) occurs during the initial admission order. If a Section 89 admission continues for its maximum thirty days and ongoing supported admission is required under Section 90, the MHRB is informed at this stage and they must review the admission (Section 90(5)). Also, minors who are admitted for more than 30 days must be reviewed within seven days (Section 87(12)).

India's 2017 Act does not mention that the admission must be required for therapeutic purposes (I1c); this is, however, a requirement for independent admissions (Section 86(2)(b)) and is alluded to in the MHCA as a supported admission has to be considered to be the least restrictive care option (Section 89(1)(b)). While long-term supported patients have reviews at a maximum frequency of once every 180 days, no periodic reviews occur for long-term independent adults (I9). Mandatory reviews occur in the case of minors who are admitted (after thirty days) (Section 87(12)).

The WHO-RB suggests that patients, family and legal representatives be informed of the reasons for admission and of their rights of appeal (I7). In India, this information is to be imparted through the nominated representative, who, if not already selected by an advance directive, defaults to a relative or care-giver. If an individual receiving treatment has stated a different preference for their nominated representative, the family may not be entitled to any information or to appeal an admission. The Indian Act does, however, direct the medical officer to provide the

individual and their nominated representative with information concerning the admission, the MHCA and their right to appeal.

While the WHO-RB recommends that two accredited mental health professionals agree that the individual meets the given criteria for admission (I2), the MHCA requires one psychiatrist and one other mental health professional or medical practitioner (Section 89(1)(a)). This item is classified as concordant with the WHO-RB, but this is a debatable point.

3.4.2.9.2 Discussion

Indian law addresses eight of the 12 items in relation to involuntary admission and treatment. As discussed above, the item concerning passing information to families (I7), appears to be a well-justified area on non-concordance.

The WHO (2018) reported that in 2017 there were 15,890 involuntary admissions in India. A therapeutic purpose is not a prerequisite for a 'supported admission' in India's legislation and this opens up the possibility of prolonged admissions without consent and without significant benefit to the individual in hospital. Other countries require a therapeutic purpose for admission; for example, Ireland's Mental Health Act, 2001, in its definition of mental disorder, can require that 'the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent' (Section 3(1)(ii)). Such a provision is also included in Norwegian and Danish mental health legislation (Saya et al., 2019).

Van der Post et al. (2014) identified that patients repeatedly admitted in an involuntary manner have lower levels of satisfaction about the care they are receiving, so it is important to admit individuals who stand to benefit from an admission, unless there is an issue related to risk. The MHCA's strong alignment with supported admission, and the ability to provide treatment without consent, do much to protect from non-therapeutic admissions. In some countries, such as Germany, admission and treatment are separate, and this can lead to situations where an individual is admitted against their will and then refuse treatment (Saya et al., 2019).

There is a need for the MHCA to address its review process. Internationally, many involuntary admissions are less than a month (Kelly et al., 2018; Hwang et al., 2020). As the MHCA allows for 51 days of supported admission prior to an automatic review, a significant proportion of people admitted in a supported manner will experience coercion without receiving such a review. Involuntary admissions disproportionately occur to individuals with other vulnerabilities, including social isolation, unemployment and migrant populations (Ma et al., 2019; Rodrigues et al., 2019, Walker et al., 2020). These vulnerabilities heighten the need for prompt review. Even with clear criteria for involuntary admission, paternalistic impulses often influence psychiatrist's decision-making (Feiring and Ugstad, 2014) and the subjective elements of legislation that are moulded into common practice often attempt to reduce the risk of harmful outcomes (Fistein et al., 2016). Both of these factors increase coercion and underscore the need for prompt objective external review.

The failure to legislate for the automatic review of long term independent patients is worrying especially in the absence of consideration of non-protesting patients (as discussed above). If the MHCA is applied rigidly, all long term voluntary patients will have capacity and will have been made aware of their rights. However, in practice, many voluntary patients experience coercion too (O'Donoghue et al., 2014).

The allowance of non-mental health trained doctors to be one of the certifying agents for supported admissions appears to be an appropriate deviation from the WHO-RB, in light of the paucity of psychiatrists and other mental health professionals seen in many parts of India (World Health Organization, 2018).

Table 3.9 Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to involuntary admission^{[1][2][3]} (when separate from treatment) and involuntary treatment (where admission and treatment are combined) (I)

Legislative issue	MHCA concordance	Indian legislation concordance	Relevant section of the MHCA

			(other than the MHCA0	
I1a	Does the law state that involuntary admission may only be allowed if there is evidence of mental disorder of specified severity?	Yes	-	Section 89(1)(a)
I1b	Does the law state that involuntary admission may only be allowed if there is serious likelihood of harm to self or others and/or substantial likelihood of serious deterioration in the patient's condition if treatment is not given?	Yes	-	Section 89(1)(a)
I1c	Does the law state that involuntary admission may only be allowed if admission is for a therapeutic purpose?	No	No	
I2	Does the law state that two accredited mental healthcare practitioners must certify that the criteria for involuntary admission have been met?	Yes	-	Section 89(1)(a)
I3	Does the law insist on accreditation of a facility before it can admit involuntary patients?	Yes	-	Sections 65, 66
I4	Is the principle of the least restrictive environment applied to involuntary admissions?	Yes	-	Sections 89(1)(b), 90(2)(b)
I5	Does the law make provision for an independent authority (e.g. review	No	No	Sections 87(12), 90(5), 90(6)

	body or tribunal) to authorise all involuntary admissions?			
I6	Are speedy time frames laid down within which the independent authority must make a decision?	Yes	-	Section 80(2)
I7	Does the law insist that patients, families and legal representatives be informed of the reasons for admission and of their rights of appeal?	No	No*	Section 17(d), 22, 98(1), 100(7)
I8	Does the law provide for a right to appeal an involuntary admission?	Yes	-	Sections 89(10), 90(14)
I9	Does the law include a provision for time-bound periodic reviews of involuntary (and long-term “voluntary”) admission by an independent authority?	No	No	Section 87(12), 90(4), 90(5), 90(6)
I10	Does the law specify that patients must be discharged from involuntary admission as soon as they no longer fulfil the criteria for involuntary admission?	Yes	-	Section 89(13), 90(15)

*denotes a well justified area of non-concordance

MHCA – Mental Healthcare Act, 2017

3.4.2.10 Involuntary treatment (when separate from involuntary admission) (J)

3.4.2.10.1 Results

The manner of concordance between India’s legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.10. Comparison between

the MHCA and the WHO-RB is complex as involuntary treatment is not directly considered in India's law.

The MHCA states that all persons have the capacity to make treatment decisions but may require varying levels of support from their nominated representative (Section 14(9)); consequently, treatments are not 'involuntary'. This reference to capacity appears to relate to *legal* capacity, but the MHCA also describes grounds for assessing capacity; these references appear to relate to *mental or decision making* capacity. The MHCA proposes creating a guidance document to aid medical practitioners in assessing an individual's capacity to make treatment decisions (Section 81), with independent patients defined as having the capacity to make such decisions (Section 85) and supported patients requiring high levels of support (Sections 89 and 90).

Under the MHCA, treatment without informed consent can only be given in the context of a supported admission; for this, the patient must be suffering from a mental disorder (J1a) and be 'unable to make mental healthcare and treatment decisions independently (J1b) and needs very high support from his nominated representative in making decisions' (Section 89). While this has been classified as concordant, it stops just short of the WHO-RB description that they would 'lack capacity'. This minor deviation, facilitates a supported decision-making framework and affirms the fact that many supported patients will retain the capacity to make certain treatment decisions. The MHCA also describes risk criteria for admission and illness criteria but does not stipulate that treatment should improve capacity or will likely bring about an improvement (J1c).

While the legislation requires the development of a treatment plan (Section 22(1)(c)), it does not require a second practitioner to agree on it (J3). A second practitioner is required to evaluate if supported admission is necessary (Section 89(1)(a) and Section 90(2)(a)). The duration (J5), review (J7) and appeal processes (J6) for supported treatments are as for a supported admission; consequently, they do not evaluate the treatment to the degree envisaged by the WHO-RB.

The MHRBs are primarily interested in reviewing the appropriateness of admission rather than the treatment received (J4). They have a role in authorizing more potentially serious treatments like psychosurgery, prolonged admission in

minors and ECT in minors, but no role in other treatments. In prolonged admission, the MHRB 'may require the medical officer or psychiatrist in charge of treatment of such person with mental illness to submit a plan for community-based treatment and the progress made, or likely to be made, towards realising this plan.' (Section 90(6)). Individuals receiving treatment can appeal their admission and seek to change their advance directive or nominated representative, but their ability to appeal treatment decisions (J6) is less clear; while it is likely possible, it is highly convoluted and thus subject to delay.

3.4.2.10.2 Discussion

As discussed in Section I, the MHCA separates supported treatment and supported admission. While, the criteria for both are closely aligned, they are not combined; this is appropriate and reflects the high level of decision-making capacity often seen in involuntary patients (Owen et al., 2008; Mandarelli et al., 2018, Curley et al., 2019b) and facilitates the supported decision-making framework sought by the MHCA. However, by reframing what can be coercive practice as supported decision making, many of the review and appeal processes are removed. This raises the question: might this legislation actually result in more coercion (Duffy and Kelly, 2017b)?

Even in a supported decision-making framework, some coercion will still be present under the Indian legislation, but it will involve an individual's nominated representative and thus possibly be more subtle. The inclusion of carers or relatives usually enhances the decision-making process (Giacco et al., 2018), but these individuals may also have a limited understanding of mental illness and/or have competing interests; hence, the need for a robust review process. The inclusion of the individual receiving treatment through supported decision-making is to be welcomed and the WHO strongly supports this (WHO, 2019). However, this should not lead to the removal of protections.

India has separated involuntary treatment from involuntary admission but has not provided the same review process for treatment. Individuals need to be given more opportunity to challenge the treatment they are receiving, even if their status as a supported patient is well justified.

Table 3.10 Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to Involuntary treatment (when separate from involuntary admission) (J)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
J1a	Does the law set out the criteria that must be met for involuntary treatment, including: Patient suffers from a mental disorder?	Yes	-	Sections 89(1)(a), 90(2)(a)
J1b	Does the law set out the criteria that must be met for involuntary treatment, including: Patient lacks the capacity to make informed treatment decisions?	Yes	-	Sections 14(9), 86(3), 89(1)(c), 90(2)(c)
J1c	Does the law set out the criteria that must be met for involuntary treatment, including: Treatment is necessary to bring about an improvement in the patient's condition, and/or restore the capacity to make treatment decisions, and/or prevent serious deterioration, and/or prevent injury or harm to self or others?	No	No	Sections 89(1)(a), 90(2)(a)
J2	Does the law ensure that a treatment plan is proposed by an	Yes	-	Section

	accredited practitioner with expertise and knowledge to provide the treatment?			2(1)(g), 2(1)(n), 2(1)(q), 2(1)(r), 2(1)(y), 2(1)(x), 22(1)(c)
J3	Does the law make provision for a second practitioner to agree on the treatment plan?	No	No	Sections 89(1)(a), 90(2)(a)
J4	Has an independent body been set up to authorise involuntary treatment?	No	No	Section 87(12), 87(13), 90(6), 95(2), 96(1)(b)
J5	Does the law ensure that treatment is for a limited time period only?	Yes	-	Section 87(11), 87(12), 89(2), 89(4), 89(17), 90(9)
J6	Does the law provide for a right to appeal involuntary treatment?	No	No	Sections 8(1), 16, 22(1)(b), 89(10), 90(14)
J7	Are there speedy, time-bound, periodic reviews of involuntary treatment in the legislation?	No	No	Section 87(11), 87(12)

3.4.2.11 Proxy consent for treatment (K)

3.4.2.11.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.11. The term proxy consent is not present in the MHCA, but sections 89(7) and 90(12) describe the possibility for effective proxy consent during supported admissions. However, this proxy decision is made by the nominated representative who is obliged to 'consider the current and past wishes, the life history, values, cultural background and the best interests of the person with mental illness' (Section 17(a)) and to 'give particular credence to the views of the person with mental illness to the extent that the person understands the nature of the decisions under consideration' (Section 17(b)).

As touched on above, there is no clear mechanism to appeal against a treatment decision to which proxy consent has been given (K2). However, the individual can appeal their admission; their capacity is reviewed every seven to fourteen days; and they have the right to alter their advance directive or nominated representative at any time. For pragmatic reasons there is no provision to appeal emergency treatments (Section 94), though it should be noted that these can last up to three days and up to seven during a disaster or emergency (Section 94(4)).

3.4.2.11.2 Discussion

The Committee on the Rights of Persons with Disabilities (2014) have commented that 'the human rights-based model of disability implies a shift from the substitute decision-making paradigm to one that is based on supported decision-making'. It perceives substitute decision-making regimes and guardianship as a denial of an individual's right to legal capacity, and highlights that individuals with psychosocial disabilities are disproportionately affected.

While the MHCA has moved away from substitute decision-making, it acknowledges that some individuals will require 'a very high level of support approaching hundred per cent' (Sections 86(3), 89(7) and 90(12)). When read in the

context of the described role of the nominated representative, this fits with in the description of a supported decision making model based on ‘the best interpretation of their will and preferences’ rather than best interests (WHO,2019c). The review procedure for treatment as separate from admission is concerningly convoluted and may led to coercion (as discussed above).

Supported decision-making is a relatively new concept and there is limited empirical research on the topic, but it appears that it is acceptable to both patients and carers (Jeste et al., 2018). In an Indian sample of individuals receiving treatment for their mental health, only 8% were unhappy with their family making decisions for them regarding admission under the framework of the MHCA (Pathare et al., 2015). As with Ireland’s Assisted Decision-Making (Capacity) Act 2015, there is much to be worked out with regard to the subtle decisions defining grey areas and the often flexible boundaries of various concepts (Kelly, 2017). Consequently, the implementation of India’s legislation may prove very instructive on an international level.

Table 3.11 Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation’s standards relating to proxy consent for treatment (K)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
K1	Does the law provide for a person to consent to treatment on a patient’s behalf if that patient has been found incapable of consenting?	Yes	-	Sections 89(7), 90(12), 94(1)
K2	Is the patient given the right to appeal a treatment decision to which a proxy consent has been given?	No	No	Sections 8(1), 16, 22(1)(b),

				89(10), 90(14)
K3	Does the law provide for use of “advance directives” and, if so, is the term clearly defined?	Yes	-	Sections 5-13

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3.4.2.12 Involuntary treatment in community settings (L)

3.4.2.12.1 Results

The manner of concordance between India’s legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.12. Involuntary treatment in the community setting (L) is only referred to in the context of emergencies (Section 94). Outside of emergency treatment, the legislation concerning advance directives and capacity creates the possibility for involuntary community treatment. It is not explicitly stated that advance directives only apply to admitted individuals, although this appears to be the intention of the MHCA. However, it is possible that, when an individual ceases to have capacity (Section 5(3)), their advance directive may state a preference for supported (involuntary) treatment in the community. This opens up the possibility of supported treatment separate from admission, and a version of community treatment orders with relatively poorly delineated parameters and absent review mechanisms.

3.4.2.12.2 Discussion

The potential effects of advance directives are vast, despite a paucity of evidence for their effectiveness (Rugkåsa, 2016; Kisely et al., 2017) and findings that they produce significant feelings of coercion and control in individuals subject to them (Corring et al., 2017). Clinicians often overestimate their effectiveness and underestimate the impact they have on the individual receiving treatment (Riley et al., 2016). While treatment in the community can initially appear to be a less restrictive option than inpatient care, the availability of these ‘less restrictive’ means of coercion could

possibly result in a lower threshold for their use. Unintended or poorly regulated community treatment orders would be highly problematic and very concerning, so it would be advisable to explicitly exclude them from legislation or, at the very least, add appropriate protections. Asokan (2014) might well prove prescient in describing the proposed advance directive legislation as a ‘Pandora’s box’.

Table 3.12: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation’s standards relating to involuntary treatment in community settings (L)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
L1	Does the law provide for involuntary treatment in the community as a “less restrictive” alternative to an inpatient mental health facility?	No	No	Section 5, 10
L2	Are all the criteria and safeguards required for involuntary inpatient treatment also included for involuntary community-based treatment?	No	No	

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3.4.2.13 Emergency situations (M)

3.4.2.13.1 Results

The manner of concordance between India’s legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.13. In emergency situations, interventions often occur without the supervision of a qualified psychiatrist and, as a result, it is important that sufficient protections are provided to minimize any

limitations of rights. Generally, the WHO-RB's suggestions for emergency situations (M) are well addressed in the MHCA, with four of the seven WHO-RB standards met directly in the legislation. The three areas that are non-concordant are arguably well justified.

The criteria and procedures for emergency treatment are clearly laid out in the MHCA (Section 94). In addition to posing a risk to yourself or others (M1), the MHCA adds a third criterion to justify emergency treatment - serious damage to property (Section 94(1)). Emergency treatment in the MHCA can only be administered by medical professionals and not other mental health professionals (M3), as suggested in the WHO-RB, but, despite this deviation, this item has been classified as concordant.

Emergency treatments are limited to three days (M4) (Section 94(4)). There are two exceptions to this time limit: in emergency situations it can be extended to seven days (Section 94(4)) and in North-East and Hill States it is extended to five days due to local infrastructure (Section 114(1)). The emergency treatment is terminated after 72 hours or when an individual is assessed at a mental health establishment; consequently, there are no emergency admissions stemming from emergency treatments; instead they fall under the remit of the admission-related legislation (Sections 85-8 and 89-90).

The first and most important omission in relation to emergencies is that there are no guidelines for timely appeal against such treatment (M7). The nominated representative's consent is required if they are present (Section 94(1)), but, outside of this, the individual or the family can only appeal to the MHRB, which can take up to 90 days (Section 80(4)). This makes the appeal process too slow to be effective.

The second omitted factor is that the Indian legislation does not specify the need to initiate procedures for involuntary admission and treatment (M5), if needed, as soon as possible after the emergency situation has ended, although there is provision for transportation to a mental health establishment as part of emergency treatment (Section 94(1)). Emergency treatment is terminated by either the passing of 72 hours or assessment at a mental health establishment (Section 94(4)).]

The concern here is that it is possible under the MHCA for treatment to be given in the community, while delaying assessment at a mental health establishment. This could even potentially be abused as an *ad hoc* community treatment order, where

people could repeatedly receive emergency treatments without being brought to a mental health establishment or assessed by a psychiatrist. If used appropriately, on the other hand, this may be highly appropriate, as an individual with delirium or acute intoxication may need to be brought to a general hospital rather than a mental health establishment, or an individual with an extreme adjustment reaction may rapidly improve - and this legislation spares them being unnecessarily brought to a mental health establishment.

The final and well-justified non-concordant item relates to research in the emergency situation (M6). While electroconvulsive therapy (ECT) (Section 94(3)), psychosurgery (Section 96 (1)) and sterilization (Section 95(1)(c)) are forbidden in this context (M6), research can be permitted in emergencies once it has ethical approval and complies with all national and international guidelines (Section 99). This is an important and highly necessary deviation from the WHO-RB: if safe, effective treatment is to be delivered in emergency situations, it is vital there is an evidence base to support it. Ideally this would be gathered in non-emergency situations but research questions may arise for which this is not possible, and the MHCA allows for research in such circumstances.

3.4.2.13.2 Discussion

There is an abundance of ethical issues that arise during the treatment of psychiatric emergencies, including but not limited to capacity, confidentiality and safety (Allen et al., 2015). Once the MHCA is implemented, it will be important to ensure that emergency treatment is not used inappropriately. National or state level policy will likely play an important role in regulating its use.

Wheat et al. (2016) highlight that, in dealing with psychiatric emergencies, patient safety is the primary issue, followed by the need to manage the presenting symptoms, the third key issue they identify is the need to consider the underlying cause. The list of organic causes of mental health presentations, and in particular acute behavioral disturbance is vast (Freudenreich et al., 2011). One study from the USA analysed 400 emergency department presentations with psychiatric symptoms and found that only 45% were subsequently admitted to a mental health facility; by

contrast, some 71% required some form of laboratory testing (Bourdreaux et al., 2009).

A psychiatric hospital might not serve the needs of all individuals with acute presentations with symptoms of mental illness and might in fact, prove highly counterproductive for some. Even where the primary issue is a psychiatric one, Brookers et al. (2007) have demonstrated that the majority of individuals can be supported without resorting to admission. The lack of a requirement to initiate a mental health admission is a pragmatic and beneficial deviation from the WHO-RB, but the use of the provision needs to be closely monitored, especially in the absence of an appeal or review process.

There has long been a paucity of research addressing psychiatric emergencies (Lukens et al., 2006) and strictly following the WHO-RB recommendations may perpetuate that. The debate about the ethical issues that arise concerning consent to research in emergency situations is not limited to the field of mental health (CRASH Trial Management Group, 2004). The MHCA has quite robust provisions in general: if the individual cannot give consent to research, the nominated representative can consent, provided that the State Authority is satisfied the research meets certain criteria (Section 99(3)). This aligns favorably with England and the European Union's regulations on research on patients who cannot consent (Coats and Shakur, 2005).

The appeals process is very delayed in many jurisdictions even for involuntary admissions: under the Irish Mental Health Act 2001, it can take up to three weeks, while in India the automatic review period is significantly longer. This makes the review of emergency treatments impractical under these provisions, and this failure to provide any oversight mechanism for emergency treatments is worrying and could lead to a significant limitation of rights.

Table 3.13: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to emergency situations (M)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
M1	Are the criteria for emergency admission/treatment limited to situations where there is a high probability of immediate and imminent danger or harm to self and/or others?	Yes	-	Section 94(1)
M2	Is there a clear procedure in the law for admission and treatment in emergency situations?	Yes	-	Section 94
M3	Does the law allow any qualified and accredited medical or mental health practitioner to admit and treat emergency cases?	Yes	-	Section 94(1)
M4	Does the law specify a time limit for emergency admission (usually no longer than 72 hours)?	Yes	-	94(4), 114(1)
M5	Does the law specify the need to initiate procedures for involuntary admission and treatment, if needed, as soon as possible after the emergency situation has ended?	No	No*	Sections 94(1), 94(4)
M6	Are treatments such as ECT, psychosurgery and sterilization, as well as participation in clinical or experimental trials outlawed for people held as emergency cases?	No	No*	Sections 17(k), 94(3), 96(1), 95(1)(c), 99

M7	Do patients, family members and personal representatives have the right to appeal against emergency admission/treatment?	No	No	Sections 80(4), 94(1)

*denotes a well justified area of non-concordance

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3.4.2.14 Determinations of mental disorder (N)

3.4.2.14.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.14. The legislation does not, however, define the level of skill required to determine mental disorder (N1a) or specify the categories of professions who assess for mental disorders (N1b). The accreditation of these practitioners is, however, codified in law and operated by independent bodies, the CMHA and the SMHA, as required by the WHO-RB (N2). The RPWDA addresses the certification of specified disabilities and states that guidelines will be produced for 'assessing the extent of specified disability in a person' (Section 56) and that individuals will be designated 'having requisite qualifications and experience, as certifying authorities, who shall be competent to issue the certificate of disability' (Section 57). Despite these sections of the RPWDA, the two applicable items in the WHO-RB have been classified as non-concordant, as the described guidelines are not included in the legislation and this only relates to the certification of specified disabilities. Many individuals will receive treatment for mental illnesses without receiving certification of disability and this assessment will be separate from the diagnosis and treatment they receive in the mental health services.

3.4.2.14.2 Discussion

India's legislation is poorly concordant with WHO-RB requirements in terms of diagnosis, despite an entire section of the MHCA being dedicated to the determination of mental illness (Section 3). The validity of psychiatric diagnoses has long been contested. In a Canadian study of 875 referrals, non-psychiatric physicians were

inaccurate in their diagnosis 44.8% of the time; this was more pronounced in affective disorders, personality disorders and psychosis (Al Salem et al., 2020). Even lower levels of diagnostic accuracy were seen in a Taiwanese sample of non-psychiatrically trained physicians and increased clinical experience did not significantly alter accuracy (Su et al., 2011).

With high levels of stigma associated with psychiatric diagnoses, both internationally (Rössler, 2016) and in India (Gaiha et al., 2020), it is important that diagnoses are not made inappropriately or without comprehensive assessment. The failure of the MHCA to legislate for these standards might, however, relate to human resource limitations: India has just 0.30 psychiatrists per 100,000 population (Patel et al., 2016). With such small numbers of psychiatrists, overly restrictive guidelines concerning diagnosis could – paradoxically - restrict access to treatment. It is essential that India's treatment gap for mental disorders is reduced; good diagnosis is required to achieve this and there is a fine balance to be struck between accuracy and availability of diagnosis. Enhanced provisions in either legislation or policy could assist this process.

Table 3.14 Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to determinations of mental disorder. (N)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
N1a	Does the legislation define the level of skills required to determine mental disorder?	No	No	Section 3
N1b	Does the legislation specify the categories of professionals who	No	No	Section 3

	may assess a person to determine the existence of a mental disorder?			
N2	Is the accreditation of practitioners codified in law and does this ensure that accreditation is operated by an independent body?	Yes	-	Section 2(1)(g), 2(1)(n), 2(1)(q), 2(1)(r), 2(1)(y), 2(1)(x), 43(1)(d), 55(1)(d), 65(4)(b), 122(2)(f)

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3.4.2.15 Special treatments (O)

3.4.2.15.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.15. While the MHCA is only concordant with five out of the ten standards relating to special treatments, some of the areas of non-concordance are well justified.

For example, psychosurgery is not forbidden in involuntary patients (O3) as suggested by the WHO-RB, but is permitted with the consent of the individual and MHRB approval (Section 96(1)). This is a well-justified area of non-concordance as it acknowledges the potential capacity to make treatment decisions in supported patients. Informed consent is not required for ECT in certain circumstances (O4); this deviation from the WHO-RB prevents individuals unable to give informed consent from being deprived a highly effective treatment. Also, the use of ECT in minors (O6), while very highly regulated, is not outright prohibited. This is highly contentious but at least allows the possibility of considering its use in extreme circumstances.

Greater clarity could be provided in relation to consent to medical and surgical treatments (O2). The MHCA makes only one reference to medical treatments and none to surgical treatment (except psychosurgery) (Section 96(a)). In an emergency (O2a), 'any medical treatment' can be given if it directly relates to the emergency (Section 94(1)). While this may cover an episode of delirium, this provision does not appear to apply inside a mental health establishment (once the person has been assessed) or to a supported patient. It also appears to be focused on psychiatric treatment; it is unclear if this could be used for medical or surgical treatment in a general hospital.

No direct reference is made in the MHCA or RPWDA to the need for informed consent prior to medical and surgical procedures. This is addressed in the Indian Penal Code, 1860. Section 89 of the Indian Penal Code is problematic, in light of the RPWDA, as it makes reference to 'the guardian or other person having lawful charge' of a person 'of unsound mind'. However, the government must ensure that persons with disabilities enjoy legal capacity on an equal basis with others (RPWDA, Section 13(2)) and, on this basis, consent would be required from all individuals capable of giving it.

Where the capacity to give informed consent is absent in the long term (O2b), a limited guardian may make legally binding decisions on behalf of the individual who lacks mental capacity (RPWDA, Section 14); this might align with the provisions of the Penal Code. In light of these provisions, this item has been classified as concordant here. The limited guardian mechanism could also apply in an emergency situation, but, for pragmatic reasons, the limited guardian would need to be in place before the emergency arose – and, hence, this is classified as non-concordant here.

The protections relating to sterilisation (O1) are clear in the legislation, but the law concerning abortion is more ambiguous. No mention is made of abortion in the MHCA. Terminations of pregnancy are permitted in certain contexts in India (Medical Termination of Pregnancy Act, 1971, Section 3(2)), with the woman's consent (Section 3(4)(b)); provisions are also made for women lacking mental capacity (Section 3(4)(a)) and this is further clarified in the RPWDA, 2016, which states that termination of pregnancy may be allowed in cases of severe disability where the opinion of the medical practitioner and the guardian of the woman with disability are considered (Section 92(f)). The MHCA, RPWDA and Medical Termination of Pregnancy Act, 1971

all fail, however, to explicitly state that ‘the mere fact of having a mental disorder should not be a reason for sterilisation or abortion without informed consent’ (O1a). They also do not give explicit protection from abortion in the absence of consent.

3.4.2.15.2 Discussion

Emergency medical or surgical treatment in the absence of consent is poorly described in India’s legislation. There is a significant amount of case law on this topic (Kumar et al., 2015), but ‘the common law application of consent is not fully developed in India’ (Nandimath, 2009). The association between mental and physical illness is well established and significant (Scott et al., 2016). Analysing a Nordic cohort, Wahlbeck et al. (2011) demonstrated that the life expectancy of individuals with mental disorders was 15 to 20 years less than those without mental disorders. In light of these two facts, it essential that no additional barriers are put in the way of individuals with mental illness accessing medical and surgical treatments. Unambiguous legislation for emergency medical treatment would be of great assistance, rather than relying on case-law.

In relation to the termination of pregnancy, meaningful research on this topic is severely challenging and often subject to significant levels of bias (Reardon, 2018). Despite this, with over 15 million abortions per annum occurring in India (Singhn et al., 2018), it is important that there are clear guidelines for individuals seeking a termination who may have impaired capacity, or their guardians. Both the RPWDA and the Medical Termination of Pregnancy Act, 1971 appear to work from a substitute decision-making paradigm here, rather than a supported decision-making one.

The RPWDA is so keen to avoid capacity assessment that it uses a highly subjective description of disability. Terminations are allowed without consent in ‘severe cases of disability and with the opinion of a registered medical practitioner and also with the consent of the guardian of the woman with disability’ (RPWDA, Section 92(f)). This is another example of the Indian legislation shying away from clear capacity assessment in order to align with the CRPD and the WHO (2019). This results in a questionable level of increased autonomy and greatly reduced protections for individuals with mental illness. A reluctance to provide clear legislation for termination of pregnancy in individuals with impaired capacity is not

uncommon. Ireland's recent Health (Regulations of Termination of Pregnancy) Act 2018, omitted any discussion of the topic despite a risk to mental health being grounds for a termination.

As discussed above in Section I, involuntary or supported patients retain a high level of decision-making capacity (Mandarelli et al., 2018) and this should be respected in legislation. The deviation from the WHO-RB in the area of psychosurgery is a small but important step in this direction. Rigid adherence to the WHO-RB would prevent supported patients from receiving a potentially beneficial treatment. The MHCA correctly identifies decision-making capacity rather than status of admission as the key issue here.

A similar stance has been taken in relation to ECT;. Requiring informed consent for ECT in all circumstances would also prohibit certain individuals from receiving a highly beneficial treatment; allowing individuals make a supported decision in relation to this with their nominated representative is a well justified area of non-concordance. Many Indian psychiatrists also see the provision of ECT to minors in extreme cases as a well-justified departure from the WHO-RB (Balhara and Mathur, 2012; Grover et al., 2017). Careful monitoring will be needed to ensure that these treatments are appropriately used and that the legislation achieves a balance between facilitating the delivery of effective treatment and inhibiting the provision of more serious treatment in an unregulated manner. It is worth noting here that the prohibition of unmodified ECT introduced by the MHCA has proven highly controversial among Indian psychiatrists (Andrade et al., 2012; Ray 2016; Andrade et al., 2017; Duffy et al., 2019b).

Table 3.15: The concordance of Indian legislation with the World Health Organisation Checklist on Mental Health Legislation's standards relating to special treatments. (O)

Legislative issue	MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA

O1	Does the law prohibit sterilization as a treatment for mental disorder?	Yes	-	95(1)(c), RPWDA 10(2)
O1a	Does the law specify that the mere fact of having a mental disorder should not be a reason for sterilization or abortion without informed consent?	No	No	92(f), 95(1)(c). Medical Termination of Pregnancy Act, Section 3
O2	Does the law require informed consent for major medical and surgical procedures on persons with a mental disorder?	No	Yes	Section 94(1). RPWDA 13(2). Indian Penal Code Section 87, 89 Indian Constitution Article 21d
O2a	Does the law allow medical and surgical procedures without informed consent, if waiting for informed consent would put the patient's life at risk?	No	No	Section 94(1). RPWDA 13(2), 14
O2b	In cases where inability to consent is likely to be long term, does the law allow authorization for medical and surgical procedures from an independent review body or by proxy consent of a guardian?	No	Yes	RPWDA Section 14, Indian Penal Code Section 89

O3	Are psychosurgery and other irreversible treatments outlawed on involuntary patients?	No	No*	96(1)
O3a	Is there an independent body that makes sure there is indeed informed consent for psychosurgery or other irreversible treatments on involuntary patients?	Yes	-	96(1)
O4	Does the law specify the need for informed consent when using ECT?	No	No*	Sections 89(7), 90(12), 95(2)
O5	Does the law prohibit the use of unmodified ECT?	Yes	-	95(1)(a)
O6	Does the law prohibit the use of ECT in minors?	No	No*	Sections 95(1)(b), 95(2)

*denotes a well justified area of non-concordance

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3.4.2.16 Seclusion and restraint (P)

3.4.2.16.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.16. Overall, the MHCA does much to address the WHO-RB standards for seclusion and restraint. It comprehensively addresses three of the six items. It should be noted that the Indian legislation prohibits seclusion and is therefore adherent in terms of seclusion. The WHO-RB considers seclusion and restraint together. The three areas of omission are all addressed in part in the Indian legislation, but not to a degree sufficient to meet the WHO-RB's standards.

The procedures for use of restraint are well described in Section 97 of the MHCA. Although it only allows it to be used for the shortest period that is absolutely necessary, there is no maximum time period it can last (P3) and no prohibition on one period of restraint following another (P4). While the MHCA states that staff shortages cannot be grounds for the use of restraint and suggests the development of measures to address human resource requirements, it stops short of developing appropriate structural and human resource requirements to minimize its use (P5).

3.4.2.16.2 Discussion

Seclusion and restraint are areas of increasing concern in psychiatry, with strong opposition mounting against their use (WHO, 2019d). Even if it is accepted that they are necessary in certain contexts, geographical and temporal variations in use clearly require explanation and regulation (Steinert et al., 2010; Ulla et al., 2012). There is virtually no evidence for the effectiveness (Sailas and Fenton, 2000) or safety (Nelstrop et al., 2006) of their use, and they have been associated with severe adverse outcomes (Sailas and Fenton, 2000). Rates of restraint and coercive practices are more prevalent in India compared to European countries (Gowda et al., 2018). In a Finish study, Ulla et al. (2012) demonstrated that legislative change could have a meaningful impact on the use of seclusion and restraint, although the authors also commented that this was insufficient in and of itself.

In this analysis, consideration was given to classifying the items on repeated episodes of restraint (P4) and the time limit on restraint (P3), as well justified deviations from the WHO-RB, as the MHCA's position may be safer for patients. An inflexible rule on duration of physical restraint may result in excessive reliance on chemical restraint or potential risks to the individual or others. After review, however, it was classified as non-concordant, as no mention was given to any time-frames and there was no consideration of repeated episodes. The inclusion of the statement 'for a period longer than it is absolutely necessary to prevent the immediate risk of significant harm' (Section 97(2)), is helpful and offers some protections, but would still permit repeated or prolonged episodes of restraint.

The failing in regard to the appropriate structural and human resource requirements could be justifiably addressed in policy rather than legislation. Human resource limitations present major challenges for Indian mental health services (Patel et al., 2016) and it is reasonable to suggest that they may influence the high rates of coercive practices (Gowda et al., 2018).

In light of the growing perception within the UN of restraint as a cruel and inhuman treatment (United Nations Human Rights Council, 2013; WHO, 2019d) and the fact that psychiatry in India uses high levels of coercive measures (Gowda et al., 2018), it is essential that coercive practices occur within very clearly described legal parameters and that extensive processes are in place to limit use. Careful consideration must to be given to all factors that may contribute to such practices. Hence, it is important that definitive and robust guidelines are provided and enforced as part of implementation of the MHCA.

Table 3.16: The concordance of Indian legislation with the World Health Organisation Checklist on Mental Health Legislation's standards relating to Seclusion and restraint. (P)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
P1	Does the law state that seclusion and restraint should only be utilized in exceptional cases to prevent immediate or imminent harm to self or others?	Yes	-	Sections 97(1), 97(2)
P2	Does the law state that seclusion and restraint should never be used as a means of punishment or for the convenience of staff?	Yes	-	Section 97(4)

P3	Does the law specify a restricted maximum time period for which seclusion and restraints can be used?	No	No	Section 97(2)
P4	Does the law ensure that one period of seclusion and restraint is not followed immediately by another?	No	No	Section 97(2)
P5	Does the law encourage the development of appropriate structural and human resource requirements that minimize the need to use seclusion and restraints in mental health facilities?	No	No	Section 31, 97(4)
P6	Does the law lay down adequate procedures for the use of seclusion and restraints, including: who should authorise it; that the facility should be accredited; that the reasons and duration of each incident be recorded in a database and made available to a review board; and that family members/carers and personal representatives be immediately informed when the patient is subject to seclusion and/or restraint?	Yes	-	Section 97 Section 97(1)(b)

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3.4.2.17 Clinical and experimental research (Q)

3.4.2.17.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.17. The MHCA addresses all of the items in relation to clinical and experimental research in Section 99. This is supported by the RPWDA which affirms the need for free and informed consent under its 'protection from cruelty and inhuman treatment' provisions (RPWDA, Section 6(2)).

3.4.2.17.2 Discussion

India's MHCA comprehensively covers the standards relating to clinical and experimental research. In addition to addressing these important standards, both the MHCA and RPWDA do much to pro-actively promote research in individuals impacted by mental illness (e.g. RPWDA Sections 17(j), 25(2)(a), 28, 47(2), 75(1)(f) and 80(e)). The legislation importantly does not inhibit research in individuals unable to consent, as this results in individuals receiving treatments without an evidence base.

Carrying out research in people with mental illness has many challenges which are of particular significance when participants have reduced levels of decision-making capacity (Ali et al., 2019). Palmer et al. (2013) suggest conceptualising consent to research in individuals with mental illness as an 'ongoing dialogue'. Such measures are often hard to accurately capture in law. Decisions about consenting to participate in research fit well within a supported decision-making frame-work, however (Dunn and Jeste, 2001; Palmer et al., 2007).

Ali et al. (2019) examined the MHCA in detail and its interaction with the Indian Council of Medical Research guidelines. They describe the many areas where decision-making capacity can be impaired and identify steps that can be taken to address this. The main lacuna they identified was in the law relating to consenting mentally ill prisoners who lack capacity. Overall, however, the legislation's lack of prohibition on research on individuals with impaired capacity is greatly to be welcomed, as it facilitates the creation of an evidence base for the treatment of people with impaired capacity and for treatment in emergency situations.

Table 3.17: The concordance of Indian legislation with the World Health Organisation Checklist on Mental Health Legislation's standards relating to clinical and experimental research. (Q)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
Q1	Does the law state that informed consent must be obtained for participation in clinical or experimental research from both voluntary and involuntary patients who have the ability to consent?	Yes	-	Section 99(1), RPWDA Section 6(2)
Q2a	Where a person is unable to give informed consent (and where a decision has been made that research can be conducted): Does the law ensure that proxy consent is obtained from either the legally appointed guardian or family member, or from an independent authority constituted for this purpose?	Yes	-	Sections 17(k), 99(2 and 3), RPWDA Section 6(2)
Q2b	Where a person is unable to give informed consent (and where a decision has been made that research can be conducted): Does the law state that the research cannot be conducted if the same research could	Yes	-	Section 99(3), RPWDA Section 6(2)f

	be conducted on people capable of consenting, and that the research is necessary to promote the health of the individual and that of the population represented?			

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3.4.2.18 Oversight and review mechanisms (R)

3.4.2.18.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.18. The WHO-RB describes 24 standards in relation to oversight and review mechanisms; the MHCA is concordant with 16 of these and there is one well justified area of non-concordance. In order to examine the Indian oversight and review mechanisms, it is important to understand the role of three bodies created or re-defined by the MHCA: MHRBs, SMHAs and the CMHA. These are described in detail in Chapter 2.

The MHRBs are set up as quasi-judicial bodies to review processes related to involuntary treatments, with a strong focus on supported admissions (R1). Despite this, all supported admissions are not automatically reviewed (R1ai), as a review is not mandatory during the first 30 days of a supported admission. However, MHRBs must be informed within seven days of such an admission occurring (Section 89(9)(b)) (three days in the case of a minor or female) (Section 89(9)(a)). During these initial 30 days, the admitted individual, their nominated representative or a representative of a registered non-governmental organisation with the consent of the person, may appeal to the MHRB to review the decision concerning the supported admission (R1aii) (Section 89(10)); these appeals can take seven days to hear (Section 89(11)). Long term independent patients have no automatic review process (R1aiii). While, MHRBs do not necessarily review people receiving treatment against their will (R1aiv), they do review supported patients under the MHCA and treatment without informed consent can only occur in this context. MHRBs also regulate psychosurgery (Section 96(b)) and

ECT in minors (Section 95(2)), although modified ECT can be delivered to supported patients without the review of a MHRB (Sections 95(2) and 96(b)) (R1av).

To protect the rights of people with mental disorders (R2), the regulation and oversight of the MHRBs is complemented and enhanced by the SMHAs and the CMHA. These are primarily focused on care received in mental health establishments, but some of the responsibilities of the Central and State Authorities could relate to community-based care. These bodies can specify quality and service provision norms (Sections 43(1)(b) and 55(1)(b)) and provide guidance on capacity assessment (Section 81(2)). The MHRBs in collaboration with the SMHAs may take appropriate steps to protect the rights of persons with mental illness (Section 82(3)). The Central Authority may regulate the use of restraint (Section 97(8)), ECT in minors (Section 95(2)) and psychosurgery (Section 96(2)).

In addition, the RPWDA establishes two bodies, which may also reduce intrusive treatments: the State and Central Advisory Boards on Disability (Chapter XI). Their roles include advising government, developing policy, monitoring the impact of laws, and taking up the cause of persons with disability. All these steps may well result in the reduction of intrusive treatments, but this is not an explicit aim of these bodies (MHCA Sections 43 and 55, RPWDA, Sections 65 and 71). Nonetheless, this item was classified as concordant in light of all these mechanisms to reduce intrusive treatments, although it is clear that more practical measures could also be taken, especially in relation to ECT in supported patients.

The roles of SMHAs and the CMHA include registering all mental health establishments (R2aiv) and maintaining a list of registered clinical psychologists, mental health nurses and psychiatric social workers (R2aiv) (Sections 43(1)(d) and 55(1)(d)). Guidelines relating to psychiatrists are addressed in the Indian Medical Council Act, 1956 (Section 2(1)(y)). No register is defined in the MHCA for occupational therapists, counsellors, psychotherapists or other specialties, but this item was nevertheless classified as concordant overall.

The Indian legislation makes no reference to the maintenance of statistics on supported admissions, restraint, ECT or psychosurgery, as suggested by the WHO-RB (R2aiii). Without such a register, there can be no publication of regular statistics (R2avi). The only information published on a regular basis is a register of all mental health establishments (Sections 43(1)(a) and 55(1)(a)), and a list of registered mental health professionals (Sections 43(1)(d) and 55(1)(d)). The authority of the SMHAs

(Section 55) and CMHA (Section 43) are not clearly laid out in the legislation (R2c), but their roles are described in the MHCA.

In general, procedures for submissions, investigations and resolutions of complaints are well outlined in the MHCA (R3a). This is particularly robust in relation to inpatients, but the right to complain regarding outpatient care is less clearly described. The WHO-RB suggests a time-limit after the occurrence of an incident within which a complaint can be made (R3bi); this is not present in the Indian legislation. This may result in appeals occurring long after an event and will place an additional burden on the MHRBs, but it enhances the patient's rights and is another example of a well-justified deviation from the WHO-RB. The only non-justified deviation in relation to appeals or complaints is that the MHCA does not grant individuals a right to an interpreter during any proceedings (R3biv), although they and their nominated representative have a right to receive the information in a language and form that can be understood (Section 22(1)(d)).

3.4.2.18.2 Discussion

Oversight and review (R) are essential components of mental health law. They are of particular importance for a piece of mental health legislation that will apply to 1.3 billion people spread across 27 state jurisdictions, governing the delivery of mental healthcare through a combination of state facilities, centrally run hospitals, charity organizations and private enterprises (Duffy and Kelly, 2019b).

The lack of a more timely automatic review process, is concerning. The right to automatic periodic review has long been discussed and was included in the WHO's ten basic principles for mental health law (1996). The MHRBs are informed within seven days (Section 89(9)) of a supported admission but, in the first thirty days of admission, reviews only occur if the admitted individual or someone representing them requests a review (Section 89(10)). Should the supported admission continue beyond 30 days under Section 90, then the MHRB has 21 days in which to determine if the admission should be permitted (Section 90(4)). Consequently, an individual could be admitted for up to 51 days without an automatic review.

By comparison, in Ireland, automatic reviews occur within 21 days of admission, Ireland has sought to reduce this further to concord with Article 5(4) of the European Convention on Human Rights. Cronin et al. (2017) analysed the mental health legislation in five high income jurisdictions, including Ireland, and found that a right to automatic review was only present in three of the five. Where it was present it ranged from seven to 28 days, although in England, Wales and Scotland, individuals known to the mental health service could be detained for up to six months without an automatic review.

There is significant merit in reviewing long-term 'independent' patients too, as many have impaired decision-making capacity (Okai et al., 2007), calling into question the validity of their independent status. This is especially important in light of the fact that India has high levels of prolonged admissions, with 14% of patients being admitted for over 5 years (WHO, 2013a). McNerney et al. (2018) highlight that, even after long-term admission, quality of life can be greatly enhanced by transfer to the community, so it is important to continually assess an individual's suitability for discharge.

Regarding the maintenance of statistics on supported admissions, restraint, ECT or psychosurgery, most of this information will, in theory, be available through MHRBs (Sections 89(9), 90(3), 95(2), 96(1)(b) and 97(7)). Consequently, a national register could be established with relative ease. Upadhaya et al. (2016), however, highlight the many challenges that low- and middle-income countries face in creating mental health information systems. One of the countries they look at is India. They highlight issues with collecting and compiling data, as well as limitations in human resources.

In a subsequent study from the same research group, many steps are identified that needed to be taken to create these information services, including improving governance and securing finance (Semrau et al., 2019). Ahuja et al. (2018) highlight the role of such information in advocating for individuals using services. Information from Finnish registers has been used to attempt to reduce the use of coercive measures and practices there have begun to change (Välimäki et al., 2019). If such a register is developed, experience from Finland would indicate that clear protocols will be required if the data collected are to be meaningful (Laukkanen et al., 2020). India

will have particular challenges implementing this at national, state and district levels due to the scale of the project and the existing infrastructure (Ahuja, 2018).

The review, regulation, oversight and complaints processes primarily address the needs of inpatients in the Indian legislation, as Sections 43(1)(c), 55(1)(c), 68(1) and 82(1)(e) all only relate to mental health establishments. Procedures for outpatients could be made more robust and additional clarity added in delineating the roles of the Central and State authorities and the Central and State advisory Board on Disabilities. All these oversight and review mechanisms will, of course, be of little use if they are not integrated into regular, day-to-day practice. Close monitoring will be needed in the early stages of implementation of the MHCA to ensure this occurs.

Table 3.18: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to oversight and review mechanisms. (R)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
R1	Does the law set up a judicial or quasi-judicial body to review processes related to involuntary admission or treatment and other restrictions of rights?	Yes	-	Section 74, 78, 80
R1a(i)	Does the above body: Assess each involuntary admission/ treatment?	No	No	Section 87 (9-13), 89(9-11), 90(3-6,14)

R1a(ii)	Does the above body entertain appeals against involuntary admission and/or involuntary treatment?	Yes	-	Section 77, 82(1), 89(10), 90(14)
R1a(iii)	Does the above body review the cases of patients admitted on an involuntary basis (and long-term voluntary patients)?	No	No	Section 87 (9-13), 89(9-11), 90(3-6,14)
R1a(iv)	Does the above body regularly monitor patients receiving treatment against their will?	Yes	-	Section 87 (9-13), 89(9-11), 90(3-6,14)
R1a(v)	Does the above body authorise or prohibit intrusive and irreversible treatments (such as psychosurgery and ECT)?	No	No	Sections 95(2) and 96(b)
R1b	Does the composition of this body include an experienced legal practitioner and an experienced healthcare practitioner, and a “wise person” reflecting the “community” perspective?	Yes	-	Section 74
R1c	Does the law allow for appeal of this body’s decisions to a higher court?	Yes	-	Section 83
R2	Does the law set up a regulatory and oversight body to protect the rights of people with mental disorders within	Yes	-	Sections 43, 55, 82(2) RPWDA 65, 71

	and outside mental health facilities?			
R2a(i)	Does the above body conduct regular inspections of mental health facilities?	Yes	-	Section 67(1), 68(1)
R2a(ii)	Does the above body provide guidance on minimising intrusive treatments?	Yes	-	Section 43 (1)(b), 43(1)(e) 55(1)(b), 55(1)(e), 95(2), 96(2) RPWDA 65, 71
R2a(iii)	Does the above body maintain statistics; on, for example, the use of intrusive and irreversible treatments, seclusion and restraints?	No	No	89(9), 90(3), 95(2), 96(1)(b), 97(7)
R2a(iv)	Does the above body maintain registers of accredited facilities and professionals?	Yes		Sections 43(1)(a), 43(1)(d) , 55(1)(a), 55(1)(d), Medical Council Act 2(1)(y)
R2a(v)	Does the above body report and make recommendations directly to the appropriate government minister?	Yes		Section 34(1), 43(1)(f), 46(1)

R2a(vi)	Does the above body publish findings on a regular a basis?	No	No	43(1)(a and d), 55(1)(a and d)
R2b	Does the composition of the body include professionals (in mental health, legal, social work), representatives of users of mental health facilities, members representing families of people with mental disorders, advocates and lay persons?	Yes		Sections 34(1) and 46(1)
R2c	Is this body's authority clearly stated in the legislation?	No	No	Section 43, 55
R3a	Does the legislation outline procedures for submissions, investigations and resolutions of complaints?	Yes		Sections 28, 43(1)(c), 55(1)(c), 77(1), 82(1)(e)) RPWDA (Sections 4(c), 23(2))
R3b(i)	Does the law stipulate the time period from the occurrence of the incident within which the complaint should be made?	No	No *	Section 28
R3b(ii)	Does the law stipulate a maximum time period within	Yes		Section 80

	which the complaint should be responded to, by whom and how?			
R3b(iii)	Does the law stipulate the right of patients to choose and appoint a personal representative and/or legal counsel to represent them in any appeals or complaints procedures?	Yes		Section 14, 27
R3b(iv)	Does the law stipulate the right of patients to an interpreter during the proceedings, if necessary?	No	No	Section 22(1)(d),
R3b(v)	Does the law stipulate the right of patients and their counsel to access copies of their medical records and any other relevant reports and documents during the complaints or appeals procedures?	Yes	-	Section 25(1)
R3b(vi)	Does the law stipulate the right of patients and their counsel to attend and participate in complaints and appeals procedures?	Yes	-	Section 80(10)

*denotes a well justified area of non-concordance

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3.4.2.19 Police responsibilities (S)

3.4.2.19.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.19. The area of police responsibility (S) is well covered. The legislation ensures that persons with mental disorders are protected against unlawful arrest and detention, and are directed towards appropriate healthcare services (S1) (Section 100). This provision could be strengthened to include people who have severe mental illness but are not wandering or at risk of harming themselves or others. As the legislation currently stands, Section 100 could not be applied to a severely ill individual who was not wandering or posing a risk to himself or others.

While the Indian legislation does not explicitly state that family members, carers or health professionals can obtain police assistance in situations where a patient is highly aggressive (S2), this is information that the police can consider as a reason to believe that a person has a mental illness (Section 100(1)). While the IMHA is clear on the role and responsibilities of police regarding individuals in the community and prisoners serving a custodial sentence, it is less clear concerning persons arrested for criminal acts (S3). It does give provision for a magistrate to convey such a person to a mental health establishment if required (Section 102). While all of these items were classified as concordant, they could each be enhanced with extra provisions. The only omission is that no special provision is made to allow police to assist in taking a person to a mental health establishment who requires a supported admission (S4); inclusion of the role of police in Section 94 would help resolve this situation.

3.4.2.19.2 Discussion

If police are to play a role in mental healthcare it is vital that they are appropriately trained and covered by the necessary legal provisions to adequately meet the needs of individuals. If a dogmatic application of the CRPD is widely adopted, there will be an increased police involvement in the treatment of individuals with mental illness and as a result, increased criminalization (Freeman et al., 2015). The WHO appears to be disturbingly comfortable with this (Duffy and Kelly, 2020d; Hoare and Duffy, 2021).

The involvement of police in a pathway to care is often an indicator of increased levels of coercion (Holman et al., 2018). Police training on identifying mental illness is often quite limited and this can lead to increased levels of coercion. In a

cohort of 4,211 individuals in the USA, people with mental illness and especially, co-morbid mental illness and substance misuse disorders, were more likely to experience the use of force during interactions with the police (Morabito et al., 2017).

Despite these concerns, police involvement is often highly positive and some excellent, proactive steps have been taken to meet the needs of individuals with psychological distress. In North East India, for example, the police set up a tele-counselling service to address the needs of people in their area (Hazarika et al., 2021). The police's input in Indian psychiatry is of great importance. One study concerning individuals found wandering highlighted that 28% were brought to mental health establishments by the police, who were also involved in tracing families in over a third of cases (Singh et al., 2016). Historically, police have also had a very significant involvement in alcohol related issues (Adityanjee, et al., 1989).

Singh et al. (2016) highlighted that there are often issues concerning cooperation between the mental health services and the police. The new legislation will hopefully do something to address this, although this will need to be monitored. The involvement of police in bringing a person who needs admission to hospital would have been classified as a well justified omission in this analysis, if an alternative pathway had been suggested, including provision for managing violence, but with no such pathway suggested, this is likely to fall to the police. Without better legislative protections, their role will lack clarity.

Table 3.19: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to Police responsibilities. (S)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
S1	Does the law place restrictions on the activities of the police to ensure	Yes	-	Section 100

	that persons with mental disorders are protected against unlawful arrest and detention, and are directed towards the appropriate healthcare services?			
S2	Does the legislation allow family members, carers or health professionals to obtain police assistance in situations where a patient is highly aggressive or is showing out-of-control behaviour?	Yes	-	Section 100(1)
S3	Does the law allow for persons arrested for criminal acts, and in police custody, to be promptly assessed for mental disorder if there is suspicion of mental disorder?	Yes	-	Section 102
S4	Does the law make provision for the police to assist in taking a person to a mental health facility who has been involuntarily admitted to the facility?	No	No	Section 102
S5	Does the legislation make provision for the police to find an involuntarily committed person who has absconded and return him/her to the mental health facility?	Yes	-	Section 92

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3.4.2.20 Mentally ill offenders (T)

3.4.2.20.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.20. The provisions

concerning mentally ill offenders are limited in the MHCA, but relevant matters are covered in the Code of Criminal Procedure, the Prisoners Act and the Indian Penal Code.

The appropriate diversion of offenders with mental health disorders in lieu of prosecution (T1) is briefly alluded to in the MHCA, but it does not give special consideration to the gravity of the offence, the person's psychiatric history, mental health state at the time of the offence, the likelihood of detriment to the person's health, or the community's interest in prosecution, as required by the WHO-RB. This occurs in the Criminal Code of procedure (Section 330(3)). The MHCA also makes some provisions for people who are not fit to stand trial (T2) although this, again, is covered in more depth in the Code of Criminal Procedure. The provisions for individuals 'acquitted on such ground of unsoundness of mind' are also described in the Code of Criminal Procedure (Sections 333-335). Should they need to be 'detained in safe custody', the procedure around their release is described in Section 338. The MHCA does not directly refer to diversion to mental health services at the sentencing stage (T4), but permits magistrates to convey people before them to mental health establishments and permits transfer of prisoners to inpatient services too.

The IMHA allows for the transfer of a convicted prisoner to a mental health facility if required (T5) (Section 103(1)), but the MHCA does not prohibit keeping a prisoner in the mental health facility for longer than the sentence (T5a). The Prisoners Act, 1900, however, states that a prisoner may be admitted to a mental health establishment for 'the remainder of the term for which he has been ordered or sentenced to be detained or imprisoned, or, if on the expiration of that term it is certified by a medical officer that it is necessary for the safety of the prisoner or others that he should be further detained under medical care' (Section 30(1)).

Specific provisions are also made in relation to offenders in the armed services, in the Air Force Act, 1950 (Sections 144-148), Army Act, 1950 (Sections 145-149) and Navy Act, 1957 (Sections 143-144, 180), but the particulars of the interaction between these and the MHCA and the RPWDA are yet to be established.

3.4.2.20.2 Discussion

The challenges that mentally ill offenders face are substantial (Grounds, 2019), it is paramount that sufficient measures are in place to ensure that they receive the treatment they need. A large discrepancy between the MHCA and the WHO-RB concerns mentally ill offenders, but many of these important items are addressed elsewhere in Indian legislation. Forensic psychiatry in India is in continual development (Asokan, 2014) and Kallivayalil et al. (2009) astutely recount how the current, unsatisfactory situation evolved from a long history of governmental apathy. In addition to substantive reform, it is also important that terminology is consistent across all Indian legislation, in order to improve overall coherence. Many older acts need updating to remove terms like ‘lunatic’ and affirm a consistent legal stance on capacity which is compatible with the UN-CRPD.

Table 3.20: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation’s standards relating to Mentally ill offenders. (T)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
T1	Does the legislation allow for diverting an alleged offender with a mental disorder to the mental health system in lieu of prosecuting him/her, taking into account the gravity of the offence, the person’s psychiatric history, mental health state at the time of the offence, the likelihood of detriment to the person’s health and the community’s interest in prosecution?	No	Yes	Sections 102, 105 Criminal Code of procedure 330(3)

T2	Does the law make adequate provision for people who are not fit to stand trial to be assessed, and for charges to be dropped or stayed while they undergo treatment?	No	Yes	Sections 102, 105, Code of Criminal Procedure, sections 328-338
T2a	Are people undergoing such treatment given the same rights in the law as other involuntarily admitted persons, including the right to judicial review by an independent body?	No	Yes	Code of Criminal Procedure, section 330(2)
T3	Does the law allow for people who are found by the courts to be “not responsible due to mental disability” to be treated in a mental health facility and to be discharged once their mental disorder sufficiently improves?	No	Yes	Code of Criminal Procedure, section 333-335, 338. Penal Code Section 84
T4	Does the law allow, at the sentencing stage, for persons with mental disorders to be given probation or hospital orders, rather than being sentenced to prison?	Yes	-	Section 102(1)(a), Section 103(1),
T5	Does the law allow for the transfer of a convicted prisoner to a mental health facility if he/she becomes mentally ill while serving a sentence?	Yes	-	Section 103(1), Prisoners Act Section 30(1),

T5a	Does the law prohibit keeping a prisoner in the mental health facility for longer than the sentence, unless involuntary admission procedures are followed?	No	Yes	Section 103, Prisoners Act Section 30(1),
T6	Does the legislation provide for secure mental health facilities for mentally ill offenders?	Yes	-	Section 103(6)

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3.4.2.21 Discrimination (U)

3.4.2.21.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.21. Section 18(2) of the MHCA prohibits discrimination in accessing mental healthcare 'on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis'. However, the MHCA only addresses discrimination in the provision of mental healthcare. The RPWDA provides much broader protections; it prohibits discrimination 'on the basis of disability' (Section 2(h)), which includes mental illness. This provides individuals with psychosocial disabilities broad protections in a wide range of areas highlighted in the Table below.

3.4.2.21.2 Discussion

Individuals with mental illness experience barriers in many areas of life and these have impacts in personal, social, occupational, educational and health domains (Ngui et al., 2010). Often the effects of discrimination can be worse than the condition itself (Thornicroft et al., 2016). There is a paucity of research on discrimination in low- and middle-income countries (Thornicroft et al., 2016).

India was one of 17 countries included in a study looking at discrimination in individuals with depression which found that 79% of individuals had experienced discrimination in at least one of the assessed domains (Lasalvia et al., 2013). A similar

study of individuals with schizophrenia found that India scored relatively low, compared to other countries, in terms of negative experienced discrimination and anticipated discrimination (Thornicroft et al., 2009). Despite this, individuals still experienced negative discrimination in many domains; positive discrimination was rare and, often, anticipated discrimination further disempowered people with schizophrenia. Böge et al. (2018) studied 924 people in five Indian cities and identified high levels of perceived stigma in participants, but noted significantly more pronounced levels in women. In Southern India, Venkatesh et al. (2015) found that almost 75%, of 445 people in a community-based sample displayed stigma towards individuals with mental illness.

The provisions of the RPWDA have the potential to drastically transform the lives of individuals with mental illness in India and are a testament to the influence of the CRPD. This will undoubtedly have an impact on people with disabilities, including those with psychosocial disabilities. Many of the provision of the RPWDA, the measures to facilitate inclusive education in Section 17, and the Act itself, amount to a population-level intervention to address discrimination. Such interventions have been demonstrated to have a short-term impact (Thornicroft et al., 2016). However, as discussed in Chapter 1 of this thesis, there are needs specific to individuals with mental illness which are not considered in the RPWDA, as demonstrated by the presence of a specific Mental Healthcare Act. The MHCA could do more to address discrimination against individuals with mental illness in areas outside of healthcare and, additionally, specific consideration could be given to this population in the RPWDA.

Table 3.21: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to discrimination. (U)

Legislative issue	MHCA concordance	Indian legislation concordance	Relevant section of the MHCA

			(other than the MHCA0	
U1	Does the law include provisions aimed at stopping discrimination against people with mental disorders?	No	Yes	Section 18(2), 21(1). RPWDA Preamble, Sections, 2(h), 3, 8(1), 12(1), 12(3), 13(1), 13(2), 16(l), 18, 29 65(2)(e, 20, 71(2)(e),

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3.4.2.22 Housing (V)

3.4.2.22.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.22. In summary, Indian legislation is concordant with the WHO-RB in terms of housing (V), but relies heavily on the RPWDA rather than the MHCA for this.

3.4.2.22.2 Discussion

India has a huge homeless population of nearly 450,000 families (Kaur and Pathak, 2016). Addressing homelessness has a central place in India's socio-political agenda (Ministry for Housing and Urban Affairs, 2013; NITI Aayog, 2018). Services are now being provided in cities across India, often targeting groups with other vulnerabilities,

like women and children, but services in general remain highly limited (Ul Hassan et al., 2019). Data on homelessness in developing countries often lacks reliability.

The bidirectional association between homelessness and mental illness is well established and this association has also been observed in Indian populations (Tripathi et al., 2013; Gowda et al., 2017). India's infrastructure for providing halfway homes, long stay and support houses is highly limited. As a result of the MHCA and the RPWDA, the Supreme Court of India has directed the government to draft policy on establishing residential facilities for the homeless mentally ill (Ul Hassan et al., 2019).

This section of India's legislation is excellent, as robust general provisions are present in the RPWDA, but, in addition to this, the specific needs of individuals with mental illnesses are considered in the MHCA. If this approach was adopted of other topics, like civil issues or employment, it would greatly enhance the protections for individuals with mental illness in the legislation.

Table 3.22: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to housing. (V)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
V1	Does the law ensure non-discrimination of people with mental disorders in the allocation of housing?	No	Yes	RPWDA Sections 12(3), 65(2)(e), 71(2)(e)
V2	Does the law make provision for housing of people with mental disorders in state housing schemes or through subsidized housing?	No	Yes	RPWDA Section 12(3)

V3	Does the legislation make provision for housing in halfway homes and long-stay, supported homes for people with mental disorders?	Yes	-	MHCA Sections 18(4)(b), 19(3), 121(4)(b)

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3.4.2.23 Employment (W)

3.4.2.23.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.23. Employment is only mentioned in the MHCA to prohibit forced labour in mental health establishments (Section 20(2)(f)). The RPWDA, however, is, again, more comprehensive on this theme, prohibiting discrimination in government establishments and providing vocational training and reasonable accommodation in public sector employment. No mention is made of the private sector in relation to this. The RPWDA protects one per cent of government jobs for individuals with autism, intellectual disability, specific learning disability, mental illness and multiple disabilities. In light of the prevalence of mental illness, this does not provide for equal employment opportunities, as suggested in the WHO-RB (W3).

3.4.2.23.2 Discussion

Gaining and retaining employment is a key factor in social integration for people with mental illness and the vital role of employment in recovery is well established (Modini et al., 2016). In an American cohort of 77,326 individuals, severity of mental illness was inversely correlated with rates of employment (Luciano and Meara, 2014). Nearly two thirds of countries prohibit discrimination during recruitment on the grounds of mental illness and one third of countries have legal protections against discontinuing employment on the basis of mental illness (Nardodkar et al., 2016).

Rates of employment among individuals with severe mental illness are higher in India compared to other countries (Khare et al., 2020). This appears to be especially

true in rural areas and it also seems that the majority of people without employment are keen to access it. These findings relating to the urban-rural divide are, however, disputed by research based on census data, which finds greater difficulty gaining employment in rural areas for individuals with mental illness (Narahasisetti and Castro, 2016).

Research in India has examined barriers that individuals with mental illness face in relation to employment and have identified steps that can aid their removal. A qualitative study of individuals with severe mental illness and professional degrees described many of the factors that promote successful participation in the workforce. These include reducing work stress, accommodation around shift work, flexible timings, supportive superiors, favourable leave policies and an ability to disclose information about their illness (Thomas et al., 2019). Some of these could be addressed in legislation if it focused on the particular challenges of mental illness.

Rangarajan et al., (2020) used in depth qualitative interviews to identify what reasonable accommodation is needed with regard to employment for individuals with severe mental illness. Many of the identified areas are of particular importance to individuals with psychosocial disabilities (e.g. modification of the work schedule and sensitivity of mental health needs during work related appraisals). Both of these papers highlight the need for additional specific measures that are tailored to the needs of people with mental illness, rather than disabilities in general. This is an area where the RPWDA or the MHCA could enhance its protections; alternatively, this could be addressed in policy.

Table 3.23: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to employment. (W)

Legislative issue	MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA

W1	Does the law make provision for the protection of persons with mental disorders from discrimination and exploitation in the work place?	No	Yes	RPWDA Section 20
W2	Does the law provide for “reasonable accommodation” for employees with mental disorders, for example by providing for a degree of flexibility in working hours to enable those employees to seek mental health treatment?	No	Yes	RPWDA Sections 2(h), 2(y), 20(2), 65(2)(e), 71(2)(e)
W3	Does the law provide for equal employment opportunities for people with mental disorders?	No	No	RPWDA Section 34(1)
W4	Does the law make provision for the establishment of vocational rehabilitation programmes and other programmes that provide jobs and employment in the community for people with mental disorders?	No	Yes	RPWDA Section 19

MHCA – Mental Healthcare Act, 2017

3.4.2.24 Social security (X)

3.4.2.24.1 Results

The manner of concordance between India’s legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.24. Grants and pensions are adequately addressed in the RPWDA.

3.4.2.24.2 Discussion

Providing disability income support to people with mental illness is not always prioritised by policy-makers who can tend to focus on disabilities that are visible, more

objectively diagnosed, permanent and perceived as externally caused (McAllister, 2020). As mental illness struggles to meet some of these criteria, the protections of the RPWDA are of particular importance. The issuing of disability certification in India requires additional research. While Nagarajan et al. (2020) found no variation on the basis of gender, earlier studies indicated that women in India were less likely to receive disability certification, despite having a similar burden of illness (Balhara et al., 2013). Prior to the RPWDA many people with mental health conditions found it difficult to access financial supports (Kashyap et al., 2012). It remains to be seen if the new legislation will reform the income supports for individuals with mental illness.

Table 3.24: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to social security. (X)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
X1	Does legislation provide for disability grants and pensions for people with mental disabilities?	No	Yes	RPWDA Section 24
X2	Does the law provide for disability grants and pensions for people with mental disorders at similar rates as those for people with physical disabilities?	No	Yes	RPWDA Section 24

MHCA – Mental Healthcare Act, 2017

3.4.2.25 Civil issues (Y)

3.4.2.25.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.25. These issues are the mostly within remit of the RPWDA and are addressed comprehensively, including provisions for protections in political (Section 11), economic (Section 13(1)), social (Section 5), cultural (Section 29 and 30), civic (Section 11), and judicial (Section 12(1)) realms. From its outset, the RPWDA identifies its aim as addressing needs across the whole range of life. The definitions of both 'barriers' (Section 2(c)) and 'discrimination' (Section 2(h)) seek to protect 'fundamental freedoms in the political, economic, social, cultural, civil or any other field'. The protections of individuals with disabilities concord with the WHO-RB.

3.4.2.25.2 Discussion

The new Indian legislation, especially the RPWDA, does much to address and protect civil and political rights, although the fact that these are addressed in the RPWDA has both positive and negative consequences. By addressing these issues in general disability legislation they have greater legal momentum and apply to a larger number of people. As a result, there will be more cases to define case-law, more people will be familiar with the legislation, and organising advocacy groups will be easier.

The drawback is that the specific needs of individuals with mental illness can be different and these can get lost in general legislation. For example, the ability of individuals with psychosocial disabilities to vote or hold political office may be called into question, or additional barriers may be present in attempting to access credit. As discussed in previous chapters, disability advocates sometimes ignore or fail to consider mental illness (Shakespeare and Watson, 1997; Mulvany, 2000).

India's affirmation of voting rights is strongly welcome, because, despite being protected by international human rights treaties, only 11% of countries allow people with mental illness universal and equal suffrage (Bhugra et al., 2016). India's support of civic engagement, through individuals with mental illness and their carers being represented on MHRBs and Central and State Authorities, is also very welcome; similar projects in other jurisdictions have been well received (Irmansyah et al., 2020).

Access to credit and mortgages is also of vital importance in breaking out of the negative trap that poverty and serious mental illness create (Burns, 2015; Kuruvilla and Jacob, 2007; Trani et al., 2015). Marginalisation, too, consistently appears as a major cause and consequence of severe mental illness (Thapa and Kumar, 2015; Hall et al., 2019), so removing barriers to cultural and sporting events has the potential to produce significant benefits.

There is one serious failing in terms of civil participation in the RPWDA, as membership of the Central and State Advisory Boards on Disability is prohibited for individuals who are 'of unsound mind and stands so declared by a competent court' (Sections 62(1)(b) and 68(1)(b)).

Table 3.25: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to civil issues. (Y)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
Y1	Does the law uphold the rights of people with mental disorders to the full range of civil, political, economic, social and cultural rights to which all people are entitled?	No	Yes	Section 2(c), 2(h), 511, 13, 29, 30

MHCA – Mental Healthcare Act, 2017

3.4.2.26 The protection of vulnerable groups (Z)

3.4.2.26.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.26. The legislation in

India in relation to the protection of vulnerable groups, addresses many of the needs of minors but only provides basic and general protections of women and minorities. Of the 13 items in the WHO-RB, India's legislation is concordant with seven of them.

There are two standards on which the MHCA fails to fully align with the WHO-RB's protection of minors. First, the MHCA does not give sufficient weight to the opinion of the minor (Z4 minors); their view is to be *considered* in relation to admission (section 87(3)(b)) and the nominated representative should give *consideration* to their wishes (Section 17). However, no clear consideration has to be given to their wishes for outpatient treatment, and the complexity of a parent separating their preference for treatment from the child's wishes is not explored. In light of the vulnerable situation such minors are in, a more explicit affirmation of the need to take their opinion into consideration, is warranted.

Second, psychosurgery is not explicitly prohibited in minors (Z5 minors), although it has to be approved by a MHRB and the individual's informed consent would be required. While a minor would not be able to provide this informed consent themselves, this is the term used in Section 87(7) to describe consent to treatment by a nominated representative. Consequently, an explicit prohibition would be a welcome protection.

With regard to the protection of women, the MHCA again only addresses gender-based discrimination (Z1 women) in relation to healthcare, and not more broadly. The RPWDA, by contrast, affirms the equality of men and women in its preamble and legislates that the government must take measures to ensure that women attain equal rights with others in all areas of life. The Indian legislation does not, however, provide women with adequate privacy in mental health establishments (Z2a women) or ensure that they have separate sleeping facilities from men (Z2b women).

Regarding minorities, the MHCA affirms non-discrimination concerning healthcare (Sections 18(2) and 21(1)(a)). While, the RPWDA affirms non-discrimination in general (Section 3), the MHCA gives this more detailed consideration (Z1 minorities). It prohibits discrimination on the grounds of 'gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis', although these provisions only apply to the receipt of mental healthcare.

The broader protections against discrimination in the RPWDA relate to individuals with disabilities, but do not consider specific minority populations. No additional review body monitors the involuntary admission of minorities or ensures non-discrimination (Z2 minorities). The MHCA and the RPWDA make no direct reference to refugees or asylum-seekers (Z3 minorities); the prohibition of discrimination on 'any other basis' (MHCA, Section 18(2)) would apply to them, but, in light of their vulnerability, specific protections would be beneficial.

3.4.2.26.2 Discussion

The MHCA itself is an acknowledgement that certain groups need to be singled out for protection or affirmative action; its provision of a right to mental healthcare in a country that does not have a right to general healthcare is a striking demonstration of this fact (Duffy and Kelly, 2019). And while the Act offers limited protections that are specific to women and minorities, it makes good provisions for the protection of minors.

There has been a shift in the ethics around decision-making in minors, with increasing weight given to 'children's experience and understanding' rather than age being used as a sole determinant (Alderson, 2007). The nuance of this is often hard to capture in legislation and rigid legal definitions have hindered further development in this area (Hein et al., 2015a). Interestingly, many countries allow children to be criminally responsible for their actions, earlier than they allow them to make mental health treatment decisions (Noroozi et al., 2018). Despite these challenges, it is increasingly clear that children can have high levels of decision-making capacity and their perspective should be taken into account (Hein et al. 2015b); both the MHCA and RPWDA could do more to facilitate this. This may also require changes in other legislation relating to consent to medical treatments.

Psychosurgery occasionally takes place in minors (Smeets et al., 2018), although this is generally deep brain stimulation (DBS) in cases of refractory Tourette's syndrome, so it could be debated whether or not this is an irreversible treatment. Indian authors on the topic have highlighted that minors are generally excluded from psychosurgery for obsessive compulsive disorder (OCD) or major depressive disorder (MDD), although they do not indicate total prohibition (Doshi et al., 2019). If provisions were in the MHCA to allow DBS but prohibit

psychosurgery for OCD and MDD, then it could be argued that this was a reasonable deviation from the WHO-RB.

In relation to the protection of women, the MHCA does give some additional protections; if a female minor is admitted and their nominated representative is male, they must appoint a female attendant (Section 87(6)). Also, in a supported admission under Section 89, the MHRB must be informed within 3 days in the case of a woman, compared to seven in the case of an adult male (section 89(9)). The consideration of privacy in the MHCA is superficial at best (Duffy and Kelly, 2017c). Privacy and confidentiality are often poorly considered in mental health law and poorly examined in medical research. While, the MHCA affirms the general right to privacy, it falls well short of the requirements of the WHO-RB in this area. The failure to give women's privacy special consideration has added importance because women are not guaranteed separate sleeping facilities from men.

The MHCA does not make specific mention of refugees or asylum-seekers and this is consistent with most of India's laws. India is generally deficient in terms of refugee legislation, is not a signatory to the 1951 Refugee Convention and has no domestic refugee law. However, at the end of 2015, India had over 200,000 'persons of concern' to the UN High Commissioner for Refugees (UN High Commissioner for Refugees, 2017). These individuals have a high prevalence of mental illness and face many barriers to accessing services (von Werthern et al., 2018); as such, they warrant particular legislative protection.

The failings in relation to the protection of women and minorities seen in the Indian legislation mirror those seen in England, Wales and Ireland (Kelly, 2011).

Table 3.26 Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to protection of vulnerable groups (Minors) (Women) (Minorities) (Z)

Legislative issue	MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA

Z1 (minors)	Does the law limit the involuntary placement of minors in mental health facilities to instances where all feasible community alternatives have been tried?	Yes	-	(Section 87(3)(d))
Z2a (minors)	If admitted, does the legislation stipulate that minors should have a separate living area from adults?	Yes	-	Section 87(4)
Z2b (minors)	If admitted, does the legislation stipulate that the environment is age appropriate and considers the developmental needs of minors?	Yes	-	Section 87(4)
Z3 (minors)	Does the law ensure that all minors have an adult to represent them in all matters affecting them, including consenting to treatment?	Yes	-	Sections 15, 17, 87(5), 87(7), 87(8)
Z4 (minors)	Does the law stipulate the need to take the opinions of minors into consideration on all issues affecting them (including	No	No	Sections 17(a), 17(b), 87(3)(b)

	consent to treatment), depending on their age and maturity?			
Z5 (minors)	Does legislation ban all irreversible treatments for children?	No	No	Sections 87(7) 96(1)(b)
Z1 (women)	Does legislation allow women with mental disorders equal rights with men in all matters relating to civil, political, economic, social and cultural rights?	No	Yes	Sections 18(2), 21 RPWDA, preamble, Sections 3, 4
Z2a (women)	Does the law ensure that women in mental health facilities: have adequate privacy?	No	No	Section 20(2)(d), 20(2)(e), 87(6)
Z2b (women)	Does the law ensure that women in mental health facilities: are provided with separate sleeping facilities from men?	No	No	
Z3 (women)	Does legislation state that women with mental disorders should receive equal mental health treatment and care as men, including access to mental health services and care in the community, and in relation to	Yes	-	Sections 18(2), 21

	voluntary and involuntary admission and treatment?			
Z1 (minorities)	Does legislation specifically state that persons with mental disorders should not be discriminated against on the grounds of race, colour, language, religion, political or other opinions, national, ethnic or social origin, legal or social status?	Yes	-	Sections 18(2), 21(1)(a) RPWDA Preamble, Sections 2(h)
Z2 (minorities)	Does the legislation provide for a review body to monitor involuntary admission and treatment of minorities and ensure non-discrimination on all matters?	No	No	Section 82
Z3 (minorities)	Does the law stipulate that refugees and asylum-seekers are entitled to the same mental health treatment as other citizens of the host country?	No	No	Section 18(1)(2)

MHCA – Mental Healthcare Act, 2017

3.4.2.27 Offences and penalties (AZ)

3.4.2.27.1 Results

The manner of concordance between India's legislation and the WHO-RB in this section, and the relevant legislation, are described in Table 3.27. Both the MHCA and the RPWDA deal with offences and penalties. General penalties against individuals who violate the MHCA are laid out in Section 108. Penalties are described for some specific individuals, those who run mental health establishments without registration (Section 107(1)) and unregistered mental health professionals (Section 107(2)). Mental health establishments who do not comply with the State Authority or the MHRB are addressed in Section 82(4) and companies who commit an offence under the MHCA are considered in Section 109.

In the RPWDA, general provisions against offences are made for individuals (Section 89) and companies (section 90). The RPWDA also gives extensive consideration to fraudulently availing any benefit meant for persons with benchmark disabilities (Section 91), failure to furnish information or documentation related to the RPWDA (Section 93) and atrocities (Section 92). These atrocities include humiliation, assault, starvation, and sexual exploitation of persons with disabilities. The Indian legislation comprehensively addresses these two WHO-RB items.

3.4.2.27.2 Discussion

Penalties directed at mental health establishments could have a particular impact on General Hospital Psychiatric Units (GHPUs), which were not considered mental health establishments in the 1987 Mental Health Act. This provision could have the positive effect of incentivising GHPUs to bring their level of mental healthcare up to the required standard, but – equally – hospitals that primarily deal with physical health conditions may decide that it is easier to close their psychiatric services rather than comply with the standards. Psychiatrists are concerned that this could shift mental healthcare back to stand alone psychiatric hospitals and consequently increase stigma (Duffy et al., 2018; Duffy et al., 2019a). This is explored more in Chapter Five of this thesis.

Hongally et al. (2019) have highlight how the new legislation places a number of obligations on psychiatrists and, in particular, how it necessitates adequate medical records and professional registration. In particular, the need for enhanced record-

keeping may reduce the case-load that psychiatrists can see. The 1987 Act gave specific consideration to presenting accounts and involuntary admissions. Supported admissions and accounts continue to be an area which might benefit from specific consideration.

Table 3.27: Concordance of Indian legislation with the WHO Checklist on Mental Health Legislation's standards relating to offences and penalties. (AZ)

Legislative issue		MHCA concordance	Indian legislation concordance (other than the MHCA0	Relevant section of the MHCA
AZ1	Does the law have a section dealing with offences and appropriate penalties?	Yes		MHCA Sections 82(4), 107-109. RPWDA Sections 89-95
AZ2	Does the law provide appropriate sanctions against individuals who violate any of the rights of patients as established in the law?	Yes		MHCA Section 107-108, RPWDA Section 89-95

MHCA – Mental Healthcare Act, 2017

3.5 Overall discussion

India's MHCA and RPWDA have done much to bring India's law in line with the WHO-RB.

Owing in large part to these two ambitious pieces of legislation, India addresses, or justifiably deviates from, 70.3% of the checklist items. This far surpasses other countries whose

legislation has been compared to the WHO-RB; e.g. legislation in England and Wales meets 54.2% of the standards, while Irish legislation meets just 48.2% (Kelly, 2011). It also provides significantly more of the protections than some of the regional Chinese legislation previously did (Shao et al., 2010).

Many of the items of the WHO-RB checklist relate to coercive practices. In the majority of these cases, the Indian legislation is concordant, but on occasions it has significant omissions. The usefulness of the WHO-RB in identifying these issues highlights the merits of the WHO-RB checklist, especially because the most recent WHO publications on this topic, the QualityRights material (WHO, 2012; WHO 2019e), are opposed to coercive measures and consequently do not explore any legal protections in relation to them.

India's legislators set out to comply with the CRPD not the WHO-RB. The MHCA's attempt to be fully compliant with the CRPD has led, at times, to vague language and opaque terminology on key topics in relation to coercive practices. For example, there is ambiguity concerning the inter-relatedness of capacity, consent and the nominated representative. In a similar manner, there are insufficient protections concerning limited guardianship in the RPWDA. In an attempt to minimise restriction of rights, the MHCA and the RPWDA may actually result in a greater level of coercion, owing especially to this opacity and lack of adequate review processes. Careful and comprehensive review will be needed to ensure this does not occur.

Another way of attempting to adhere to the stricter interpretation of the CRPD outlined by the UN Committee on the Rights of Persons with Disabilities (2014), which has led to many of the areas of non-concordance, is with a fusion mental health law. This is where the issues dealt with in the MHCA and RPWDA would be dealt with in general legislation. One of the key benefits of this option is that any consequent limitations of rights do not occur on the basis of a disability or having a mental health problem (Dawson and Szmukler, 2006). This is – broadly – the system being implemented in Northern Ireland, in its new mental capacity legislation which focuses on decision-making capacity, largely regardless of diagnosis (Kelly, 2016).

The need for dedicated legislation is, however, highlighted by the existence of the CRPD, which is explicit in stating that it does not create any new rights but rather identifies a need for specific disability legislation. Dealing with social rights in mental health legislation allows for specific consideration of factors that relate to mental illness, such as fluctuating levels of insight, periods of diminished decision-making

capacity, occupational and educational barriers, and the stigma and discrimination directed at people with mental illness. The RPWDA is a very helpful middle ground. While it does not consider barriers from a perspective of mental health, it does not leave protections to general legislation either, but rather considers matters from the perspective of an individual with a disability.

Indian legislation has made many progressive deviations from the WHO-RB. The majority of these facilitate enhanced decision-making in supported patients or offer individuals a mechanism to keep their treatment private from their family. These both facilitate greater autonomy and resonate with the content of the CRPD. Some of the areas where India's legislation was classified as non-concordant could be reclassified as well justified areas of non-concordance with minor alterations (e.g. items related to non-protesting patients or community treatment orders). Minor clarifications or even robust policy could make India concordant in these areas.

Three groups remain at particular potential risk: patients being treated in the community under advanced directives, non-protesting patients and long-term independent (voluntary) patients. The role of supported treatment in a community setting needs to be directly addressed. Community treatment orders may represent a less restrictive form of treatment in certain cases, but ambiguity in the area of advance directives may circumvent the proposed safeguards and potentially limit the rights of individuals concerned. It does not appear that the legislation was designed to permit this and it is not how it is currently being used, but it is not specifically prohibited. Similarly, additional consideration should be given to non-protesting patients, although a supported admission framework may indeed prove the most appropriate means of facilitating admission in many such cases. It is important to assess if this is used appropriately for non-protesting patients. The review of long term voluntary patients is also an area of concern as they do not have access to a regular review process.

Two important administrative issues arise which, if addressed, could further improve the new legislation. First, other Indian legislation needs to be revised and updated to bring it in line with the new MHCA (e.g. the Medical Termination of Pregnancy Act, 1971). Second, clear governance of funds and provision for funding the MHCA and the RPWDA are needed; this should be in the form of a minimum

percentage of a clear objective measure, such as overall health spending or gross domestic product.

Some of the areas of non-concordance with the WHO-RB relate to the fact that the emphasis of the MHCA is on admission. Broadening this emphasis to include treatment more directly would have two benefits: first, it would allow supported inpatients to have more influence over their treatments and give them a right to appeal treatment, aside from their legal status (J6); and, second, it would open up many of the protections of the MHCA to outpatients.

3.5.1 Strengths

This chapter's analysis of Indian legislation in the context of the WHO-RB has two chief strengths. First, the author and his supervisor are experienced in the systematic analysis of mental health legislation using the WHO-RB and its Checklist for Mental Health Legislation (Kelly, 2011; Duffy and Kelly, 2017a). Second, the author and his supervisor have an external vantage point on the Indian legislation. Both work primarily outside of India and were not involved in the development or drafting of the Indian legislation. Within India, the new legislation is a controversial and much discussed topic, so an external perspective is of significant merit.

3.5.2 Limitations

In addition to offering certain advantages, the author's external vantage point on the Indian legislation is also a limitation of this work, because not working inside the Indian system limits the ability to fully understand the context of the legislation on the ground. To mitigate this, Indian psychiatrists were consulted regularly throughout the programme of work reflected in this thesis and three trips to India were carried out during this period.

It is also important to note the limitations inherent in any 'black letter' analysis of legislation (as presented in this chapter). The focus of a 'black letter' analysis is to look at the theory of the law rather than its realization. Ultimately, however, the realization of legislation is more important than its theoretical value (Sen, 2009). This may prove particularly relevant in the context of the MHCA owing to the great ambition inherent in the legislation.

The WHO-RB acknowledges that not all items need to be included in legislation and, even within the MHCA, there are sections that state that specific issues will be addressed in policy. This may be an entirely reasonable course of action that allows the realisation of a given item in a manner that is cognisant of the context of a given state, region or institution. However, in this analysis, these items have been classified as non-concordant.

Well-written law that is excessively idealistic and poorly implemented may well do more harm than poorly written legislation that is pragmatic and well implemented. The new Indian legislation is still in the early days of implementation and it will take a number of years to see how it is fully realized.

3.6 Conclusion

The MHCA is a significant step towards greater recognition and protection of the rights of the mentally ill in India. Legislators have closely aligned the law with the WHO-RB and, through the RPWDA, address many social rights that are often neglected in mental health law. They have attempted to align with the CRPD and, where they have included measures that are coercive, they have generally included the recommended protections from the WHO-RB. They have also, however, on occasion, blurred certain provisions to try and maintain a balance between being concordant with the CRPD but yet deliver pragmatic mental health law that can meet the needs of individuals with severe mental illness. The MHCA and the RPWDA may actually give more protections in certain areas, as outlined above. Finally, despite having been withdrawn by the WHO, the WHO-RB demonstrates its merit in this analysis and has clearly shaped both the MHCA and RPWDA to a significant extent.

It is worth noting that this 'black letter' analysis has only evaluated the *content* of the legislation, so careful review is required of the implementation and realisation of the new law. As mentioned, overly ambitious legislation can end up being ignored due to funding limitations or societal values, whereas poorly written law, well administered, can help significantly to meet the needs of people with mental illness.

4. The incorporation of the United Nations' Convention on the Rights of Persons with Disabilities into Indian Law

4.1 Introduction

The background and context of the CRPD (UN, 2006) and India's legislation, are discussed above in chapters one and two. This Chapter examines how the MHCA and the RPWDA fulfil their explicit aims of aligning and harmonising with the CRPD. The incorporation of International law into domestic law can be a very complex procedure, however, and different countries have used a variety of methods to realise this. These can be broadly categorised as direct and indirect methods (Mullan, 2012).

Using a direct method, international legislation is given the force of law at a domestic level, whereas indirect incorporation uses the international legislation as an interpretive lens for domestic legislation. One of the complications with direct incorporation centres on clarifying what, precisely, is being incorporated into domestic law. In the case of the CRPD, the role of the UN Committee on the Rights of Persons with Disabilities is one such consideration. This Committee plays a key role in interpreting the CRPD, so a direct incorporation of the entire CRPD could potentially lead to an external agency substantially shaping, domestic legislation.

The Preambles of both the RPWDA and MHCA suggest indirect incorporation the CRPD into both pieces of legislation. This stops short of giving the CRPD full legal effect in India but still accords considerable weight to the convention. Much of the content of these two Acts is therefore written to give direct effect to many of the individual components of the CRPD. Section 96 of the RPWDA makes it clear that the CRPD-informed RPWDA sits on a par with other Indian legislation, whereas the MHCA is more robust and accords itself over-riding priority in respect of other Indian laws (Section 120).

4.2 Aim

This chapter seeks to conduct a black letter analysis of the concordance between India's legislation and the UN's CRPD. As a secondary outcome we examine the Concordance with the Committee on the Rights of Persons with Disabilities

interpretation of the CRPD and we explore the areas where India's legations may fall short. Finally, recommendations are made for potential future amendments to the legislation and areas that need to be comprehensively addressed in policy, are highlighted.

4.3 Methods

As in Chapter 3, this analysis adopts a black letter approach (i.e. it is concerned with the legislation as it is written), matters concerning the realisation of the legislation are not the focus of our study. This chapter examines how the RPWDA and the MHCA give effect to the specific components of the CRPD. Policy and other legislation are also mentioned where relevant, but their examination has not been exhaustive. For each article and sub-article of the CRPD, we identify and examine relevant sections of the RPWDA and MHCA.

In contrast to the previous chapter, a binary judgement on whether or not each CRPD article is adequately addressed has not been made, instead, the key issues relating to each statement are highlighted and discussed. This has been done for two reasons. First, other black letter analyses of other jurisdictions concordance with the CRPD could not be identified. This prevented the type of comparison that was possible Chapter 3. Second, some of the articles of the CRPD can appear mutually inconsistent, especially where a balancing or weighting of rights is required (Duffy and Kelly, 2017b).

This chapter focuses on Articles 5 to 30 of the CRPD which provide rights to people with disabilities. Articles 1 to 4 are more general in nature and Articles 31 to 50 relate primarily administrative and procedural issues, so these are not examined in the same fashion here.

As the results are not classified in a binary manner, each article's results and discussion is combined, and a broader discussion occurs after the results section

4.4 Results

4.4.1 Article 5: Equality and Non-Discrimination

Sections of the RPWDA and the MHCA that relate to Article 5 of the CRPD are summarised in Table 4.1. Both the MHCA and the RPWDA do much to promote

equality. The Preamble of the RPWDA, in line with the CRPD, makes non-discrimination one of the core principles for the empowerment of persons with disabilities. Discrimination is given a very broad definition in the RPWDA (Section 2(h)). 'Barrier' is also defined in very broad terms (Section 2(c)). The RPWDA then prohibits discrimination based on disability, albeit with a caveat:

'unless it is shown that the impugned act or omission is a proportionate means of achieving a legitimate aim' (Section 3(3)).

The term 'legitimate aim' is not defined and this leaves a large margin for potentially legal discrimination, although the legislation goes on to articulate specific prohibitions on discrimination in access to justice (Section 12(1)); property ownership, finance and control of financial affairs (Section 13(1)); educational institutions (Section 16(i)); and employment in government institutions (Section 20(1)). The government also has a broad duty to ensure 'reasonable accommodation for persons with disabilities' (Section 3(5)):

Again, the caveat ('without imposing a disproportionate or undue burden') is not defined and thus creates a potentially significant loophole. Even so, both the Central and State Advisory Boards on Disability have clear roles in ensuring accessibility and reasonable accommodation (Sections 65(1) and 71(2)(e)), and hopefully this will facilitate realisation of Article 5.3 of the CRPD ('reasonable accommodation'), further supported by the RPWDA's inclusion of 'denial of reasonable accommodation' in its definition of 'discrimination' (Section 2(h)). Additional legal protections are provided by the establishment of a 'Special Court' and 'Special Public Prosecutor' (Chapter XIII) (although their scope and admissibility criteria will need careful evaluation) and the Act's specification of offences and penalties (Chapter XVI).

The MHCA directly addresses equality for people with mental illness in comparison to people with physical illness, prohibiting discrimination in mental healthcare on the basis of 'gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class or disability' (Section 21(a)). Section 18(2) affirms the 'right to access mental healthcare and treatment' without discrimination in a fashion similar to Section 21, but with the additional prohibition of discrimination on 'any

other basis'. The MHCA, however, addresses equality *only* in terms of healthcare provision. Addressing discrimination and equality more broadly is left to the RPWDA.

Sections 4 and 14(9) of the MHCA discuss capacity, which has strong implications for equality before the law, but the MHCA considers *only* capacity to make 'mental healthcare decisions'. Additional legal protection against discrimination in relation to mental healthcare is provided in Section 27, which entitles a person with mental illness to free legal services to exercise their rights under the Act. Further protection from discrimination could be realised through Sections 107 to 109 which deal with offences and penalties. The MHCA does not, however, mention 'reasonable accommodation', although Sections 4(2) and 22(1)(d) promote the use of appropriate language and aids to enhance understanding, while Section 18(2) states that 'mental healthcare and treatment' shall be 'accessible'.

Despite these significant measures to increase equality, it is arguable that the very existence of law that applies to certain people (e.g. those with mental health problems or disabilities) but not to others is intrinsically discriminatory (Szmukler and Bach, 2015). The same rationale could, however, be used to call the entire CRPD into question as it sets existing human rights standards in the very specific context of people with disabilities (Duffy and Kelly; 2017b). This issue is, however, addressed in Article 5.4 of the CRPD which states that 'specific measures which are necessary to accelerate or achieve *de facto* equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention'. The very existence of the RPWDA and the MHCA indicate that Indian legislators agree that steps to accelerate equality do not amount to discrimination.

Table 4.1 Incorporation of Article 5 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and Mental Healthcare Act, 2017

Article of the	Abridged description of CRPD article and sub-articles	Key sections in the	Key sections in the	Notes

CRPD		RPWDA	MHCA	
5	Equality and non-discrimination	2(h), 3, 13	18(2, 8), 21	-
5.1	Equality before and under the law and non-discriminatory entitlement to the equal protection and benefit of the law.	13(2)	4, 14(9)	Potential for loss of capacity under the MHCA
5.2	Prohibition of all discrimination on the basis of disability and guarantee of legal protection against discrimination.	Preamble, 3, 84, 85, 89-95	18(2, 8), 21, 27, 107-109	
5.3	The state's role to ensure reasonable accommodation is provided to eliminate discrimination	2(h, y), 3(5), 65(2)(e), 71(2)(e)	4(2), 18(2), 22(1)(d)	Large exemptions relating to accommodations
5.4	Measures to accelerate equality shall not be considered discrimination.	Not addressed	Not addressed	The existence of the MHCA and the RPWDA are an acknowledgment of this

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.2 Article 6: Women with Disabilities

Sections of the RPWDA and the MHCA that relate to Article 6 of the CRPD are summarised in Table 4.2. The RPWDA specifies 'equality between men and women' as a principle in its Preamble (g). Section 4(1) states that 'Government and the local authorities shall take measures to ensure that the women and children with disabilities enjoy their rights equally with others'; this aligns closely with Article 6.1 of the CRPD.

This is very positive, although the implications of Section 4(1) are so broad that more specific additional legislation or comprehensive policy would also be of great assistance. Such measures are mostly absent from the RPWDA itself, although Section 24(2) gives consideration to gender in the creation of schemes to promote an adequate standard of living for people with disabilities; Section 24(3)(d) gives women with disabilities support to raise children; Section 25(2)(f) gives women with disabilities a right to perinatal care; Section 25(2)(k) provides for sexual and reproductive healthcare ‘especially for women with disability’; Sections 37(a) and 37(b) give women priority in land, housing and property schemes for people with disabilities; and Section 92(d) makes the sexual exploitation of a woman with disability an offence.

The MHCA explicitly protects women from discrimination in accessing (Section 18(2)) and receiving (Section 21(1)(a)) mental healthcare. However, it remains to be seen if advance directives and nominated representatives will do more to empower women or if issues relating to literacy and education will result in increased coercion. This potential limitation of rights through the adoption of rights-based legislation may be compounded if the legislation is applied in a system that can be patriarchal (Batra and Reio, 2016).

Some provisions in the MHCA aim specifically to protect women and girls. For example, female minors with male nominated representatives require a female attendant (Section 87(6)); the supported admission of a female has to be reported to the local MHRB in three days rather than the seven for adult males (Section 89(9)(a)); and women with children under the age of three years have a right to not be separated from their child during admission, as far as is possible and safe (Section 21(2-3)). However, the MHCA fails to comply with many important practical steps suggested by the *WHO Resource Book on Mental Health, Human Rights and Legislation* (WHO-RB) (WHO, 2005; Duffy and Kelly 2017a) including, for example, rights concerning privacy and guaranteeing single sex sleeping facilities.

Overall, positive steps are taken in both the RPWDA and MHCA to protect women and girls, but more needs to be done to enhance the general development, advancement and empowerment of women with disabilities, as is called for in Article 6.2 of the CRPD. In 2018, India ranked 108 out of 149 countries in terms of gender equality and also had a high level of ‘missing women’ owing, in part, to gendered lack of access to healthcare (World Economic Forum, 2018). In addition, failure to protect women with disabilities from discrimination in India leads to under reporting of sexual violence (Dawn, 2014), exploitation and poverty

(Poreddi et al., 2015), and impaired sexual and reproductive health (Dean et al., 2017). Specific legislation protecting women in institutions and protecting women with disabilities from domestic violence could do much more to further the rights of women with disabilities (National CRPD Coalition-India, 2019).

In light of these considerations a robust governmental response is merited. Improved data collection would also greatly enhance our understanding of the current situation; all state and national routine data relating to women could usefully be stratified based on whether they have a disability or not; and - likewise - all data relating to disability could be linked to data on gender. This is not always the case at present (National Disability Network & National Committee on the Rights of Persons with Disabilities, 2017).

Table 4.2 Incorporation of Article 6 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
6	Women with disabilities	Preamble, 4	18(2), 20(2)(h), 21(1)(a), 21(2-3),	General lack of specific provisions
6.1	States Parties will take measures to ensure women and girls with disabilities have full and equal enjoyment of all human rights and fundamental freedoms	4(1), 24(2), 24(3)(d), 25(2)(f, k), 37(a-b), 92(d)	87(6), 89(9)(a)	-
6.2	States Parties shall take measures to ensure development, advancement	Not addressed	Not addressed	More focused on equality

	and empowerment of women, to guarantee them human rights and fundamental freedoms			with minimal consideration of empowerment

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.3 Article 7: Children with Disabilities

Sections of the RPWDA and the MHCA that relate to Article 7 of the CRPD are summarised in Table 4.3. The RPWDA takes many steps to support the rights of children with disabilities. The Act's Preamble states one of the key principles of the RPWDA is 'respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities' (h). This statement, in combination with the provisions of Section 4 ('Women and children with disabilities'), addresses, at least in part, Article 7.3 of the CRPD, which states that:

States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.

Article 7.1 of the CRPD requires states to 'take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children'. This is reflected in the RPWDA which states that 'the appropriate Government and the local authorities shall take measures to ensure that the women and children with disabilities enjoy their rights equally with others' (Section 4(1)). In addition, the RPWDA provides specific protections for living with family in a home environment (Section 9), inclusive education (Sections 16 to 17,

and 31(1)) and abandoned or orphaned children (Section 24(3)(b)), and also provides protection from sexual exploitation (Section 92(2)). These measures complement the extensive protections that exist elsewhere, for example, in both the Constitution of India and various policy documents (National CRPD Coalition-India, 2019).

The RPWDA does not, however, adequately address Article 7.2 of the CRPD, which requires that ‘in all actions concerning children with disabilities, the best interests of the child shall be a primary consideration’. The RPWDA mentions the ‘best interest of the child’ only once, and in a very specific context:

No child with disability shall be separated from his or her parents on the ground of disability except on an order of competent court, if required, in the best interest of the child (Section 9(1)).

By contrast, in the MHCA ‘the best interests of the child’ is the underpinning principal for how a nominated representative to a minor should act (Section 15(2)(a)) and ‘best interest’ is a necessary motivation for the admission of a minor (Section 87(3)(b)).

The MHCA also takes many other steps to incorporate CRPD-based rights in relation to children (Sharma and Kommu, 2019). It is, for example, necessary to exhaust community-based treatment options prior to the admission of a child (Section 87(3)(c-d)); this measure partly protects children’s ‘human rights and fundamental freedoms’ in line with Article 7.1 of the CRPD. Section 87(8) of the RPWDA allows admissions of children to continue only with the permission of the nominated representative and Section 87(4) ensures that children are accommodated separately from adults. Section 87(5) directs that the nominated representative or an attendant appointed by them must stay with the minor at all times during the admission.

Section 95(1) of the MHCA states that ‘electroconvulsive therapy for minors’ shall not be used, but Section 95(2) adds that ‘if, in the opinion of psychiatrist in charge of a minor’s treatment, electroconvulsive therapy is required’ it can be done with the permission of the MHRB.

Overall, while many of these measures clearly seek to protect the rights of minors with mental health needs, it is possible that they might also act as additional barriers to accessing healthcare under certain circumstances (Sharma and Kommu,

2019). This has been raised by Indian psychiatrists in particular in relation to electroconvulsive therapy (Duffy et al., 2018; Duffy et al., 2019b). Access to all forms of mental healthcare is especially important issue for children and adolescents as they experience a significant treatment gap in India (Sharan and Kumar, 2016; Siddeswara et al., 2018).

Section 87(3)(b) of the MHCA gives some weight to the views of the minor but stops short of the rights described in Article 7.3 of the CRPD, which recommends comprehensive evaluation of the views of the minor with consideration being given to their age and maturity and the provision of age-appropriate material to aid them. This relative lack of acknowledgement of the evolving capacity of the child is also seen in India's Juvenile Justice (Care and Protection of Children) Act, 2015 (National Disability Network and National Committee on the Rights of Persons with Disabilities, 2017). Sharma and Kommu (2019) highlight how this is out of step with both international norms and modern understandings of adolescent development. They also highlighted the difficult transition from the nominated representative holding all the power to individuals being able to make autonomous decisions upon turning 18.

As there are over eight million children with disabilities in India (Office of the Registrar General and Census Commissioner, India, 2019), it is vital that they are given specific consideration in legislation. The definition of mental illness in Section 2(s) of the MHCA specifically excludes 'mental retardation' and, while these individuals' needs are somewhat addressed in the RPWDA, their exclusion from the MHCA may leave people with 'mental retardation', autism spectrum disorders and specific learning disabilities in a legal lacuna during times of acute need. This is particularly problematic in light of the uncertain relationship between limited guardianship in the RPWDA and the nominated representative in the MHCA (Sharma and Kommu, 2019; Duffy and Kelly, 2017c).

Other problems include the MHCA's failure to prescribe minimum standards for facilities to which children can be admitted (Sharma and Kommu, 2019), which may allow violations of Article 7.1 of the CRPD (i.e. the requirement to 'ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis'). Sharma and Kommu (2019) also highlight the missed opportunity to advocate for and protect orphans with mental illnesses, children of people with

mental illnesses, and children in custodial institutions; these issues could be addressed outside of the MHCA, but – wherever they are addressed – they are vitally important in according with Article 7 of the CRPD.

Overall, both the RPWDA and the MHCA make many specific provisions for the protection of the rights of children with disabilities, but more could be done to enshrine ‘best interests’ as the guiding principle; greater consideration could be given to a transitional phase between ages 16 and 18, when additional rights and responsibilities are transferred from the guardian to the child; and more could be done to give the minor a voice in the decision-making process. With such high levels of deprivation among children in India (National Disability Network and National Committee on the Rights of Persons with Disabilities, 2017), it is vitally important that children with disabilities are protected, and that relevant policies and programmes are inclusive in accommodating children with disabilities. Finally, it should be noted that age is not explicitly included as one of the grounds under which discrimination is prohibited in Section 21(1)(a) of the MHCA.

Table 8.4 Incorporation of Article 7 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016, and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
7	Children with disabilities	4	-	-
7.1	States Parties shall take all measures to ensure children with disabilities enjoy human rights and fundamental freedoms on an equal basis with other children	4(1), 5(2)(b), 9, 16, 17, 24(3)(b), 31(1), 92(d)	-	Discrimination on the basis of age not explicitly prohibited

7.2	Concerning children with disabilities, the best interests of the child shall be a primary consideration	9(1)	15(2)(a), 87(3)(b)	Could be addressed in broader terms in the RPWDA
7.3	Children with disabilities have the right to express their views, their views being given due weight on an equal basis with other children, and to be provided assistance to realize that right	Preamble, 4(2)	87(3)(b)	Not fully addressed in either the RPWDA or MHCA

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.4 Article 8: Awareness-Raising

Sections of the RPWDA and the MHCA that relate to Article 8 of the CRPD are summarised in Table 4.4. Section 39 of the RPWDA addresses many of the elements of Article 8. Section 39(2) comprehensively addresses awareness relating to rights, dignity and the capabilities of persons with disabilities. These are very well covered and careful consideration is given to practical steps that will aid realisation of these provisions. Section 39(2)(d), for example, mandates the provision of ‘orientation and sensitisation at the school, college, university and professional training level on the human condition of disability and the rights of persons with disabilities’.

All sections of Article 8.2 of the CRPD (which presents specific measures for awareness-raising) are well addressed in Section 39(2) of the RPWDA with the exception of the CRPD requirement for media to ‘portray persons with disabilities in a manner consistent with the purpose of the present Convention’. The National CRPD Coalition-India (2019) highlights how the lack of legislation in this area effectively leaves private media companies unregulated in their stereotypical depiction of people with disabilities. A similar omission occurs in relation to the CRPD requirement to combat ‘stereotypes, prejudices and harmful practices’. While the RPWDA promotes non-discrimination and inclusion in a general sense, it does not present explicit steps

to tackle stigma, prejudice or stereotypes.

The MHCA by contrast directly addresses stigma in relation to mental illness (Section 30(b)). The MHCA also gives more general consideration to raising awareness of mental health issues and reducing stigma, although this is not considered in great detail in the legislation (Section 30).

The RPWDA gives special consideration to awareness campaigns for persons with disabilities above and beyond those considered in the CRPD. It proposes campaigns to ‘protect persons with disabilities from all forms of abuse, violence and exploitation’ (Section 7(1)) and promotes awareness about legal capacity (Section 15(1)). However, a broad interpretation of what constitutes harmful practice (addressed in Article 8.1 of the CRPD) may result in many of the provisions of the MHCA being perceived as in violation of the CRPD. These may include electroconvulsive therapy, supported admissions and treatments in emergency settings, all of which can occur under the MHCA. These are discussed in detail in the general discussion below.

Notwithstanding many of these generally positive measures, concerns have been raised about decreasing funding for awareness programs in India (National CRPD Coalition-India, 2019), translation of human rights information into state languages, and provision of training in all 21 state languages (Disability Rights India Foundation, National Centre for Promotion of Employment for Disabled People & National Committee on the Rights of Persons with Disabilities, 2018). The relevant programs that are being rolled out, as directed by the legislation, are reported as being limited, often inadequate and highly heterogeneous (National Disability Network and National Committee on the Rights of Persons with Disabilities, 2017).

Table 4.4 Incorporation of Article 8 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the	Abridged description of CRPD article and sub articles	Key sections	Key sections	Notes

CRPD		in the RPWDA	in the MHCA	
8	Awareness-raising	39	30	-
8.1.a	States parties take measures to raise awareness throughout society, regarding persons with disabilities, to foster respect for rights and dignity	39(2)(a)	30(a)	-
8.1.b	States parties take measures to combat stereotypes, prejudices and harmful practices relating to persons with disabilities	39(2)(a)	30(b)	Limited consideration in the RPWDA
8.1.c	States parties take measures to promote awareness of the capabilities and contributions of persons with disabilities	39(2)(b)	-	-
8.2.a.i	Public awareness campaigns to nurture receptiveness to the rights of persons with disabilities	7(1)(d), 15(1), 39	-	-
8.2.a.ii	Public awareness campaigns to promote positive perceptions and greater social awareness	39	-	-
8.2.a.iii	Public awareness campaigns to promote recognition of skills, merits and abilities including in the workplace	39(2)(b, e)	-	-
8.2.b	Fostering an attitude of respect for the rights of persons with disabilities in the education system	39(2)(c,f)	-	-
8.2.c	Encouraging the media to portray persons with disabilities in a manner consistent with the Convention	92(a)	30(a)	Very limited
8.2.d	Promoting awareness-training programmes regarding persons with	7(1)(d), 15(1),	30	-

	disabilities and their rights	39		

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.5 Article 9: Accessibility

Sections of the RPWDA and the MHCA that relate to Article 9 of the CRPD are summarised in Table 4.5. In Article 9, accessibility refers ‘to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public’. The RPWDA duly incorporates accessibility as a core principle in its Preamble (f). Many of the specifics of Article 9 are not included in the RPWDA, although Section 40 addresses this topic in a more general way:

The Central Government shall, in consultation with the Chief Commissioner, formulate rules for persons with disabilities laying down the standards of accessibility for the physical environment, transportation, information and communications, including appropriate technologies and systems, and other facilities and services provided to the public in urban and rural areas.

Infrastructural and physical entities are addressed in Sections 41, 44, and 46 of the RPWDA and, although many of these provisions are rather general, they do not include exemptions based on economic feasibility as many of the other parts of the RPWDA do. Sections 65(2)(e) and 71(2)(e) give the Central and State Advisory Boards on Disability a role in recommending steps to maximise accessibility. They also have a general role in monitoring the impacts of laws, policies and programs (Sections 65(2)(f) and 71(2)(f)). This, however, does not relate directly to monitoring accessibility; additional provisions will be needed to ensure that this monitoring of accessibility aligns with necessary standards and guidelines.

The MHCA ensures access to mental healthcare and treatment (Chapter V) including making information easily understandable to people with disabilities (Section

4(2)). Notwithstanding these commitments, however, little has been achieved in these areas in recent years and existing legislation is commonly ignored (National CRPD Coalition-India, 2019). Even simple day-to-day tasks such as using public transport are greatly impacted by the failure to realize the provisions of the RPWDA (Alagappan et al., 2018). Significant budgetary provisions are required if existing legislative and policy commitments are to come to fruition (National Disability Network and National Committee on the Rights of Persons with Disabilities, 2017). If both policy and legislation remain under-powered, other methods for implementing large scale societal change will have to be explored.

Table 4.5 Incorporation of Article 9 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
9	Accessibility	Preamble, 40, 41, 42	18(2)	-
9.1.a	The identification and elimination of barriers to accessibility regarding buildings, transportation and other facilities, including schools, housing, medical facilities and workplaces	2(c, s), 20(2), 25(1)(b), 40, 41	-	-
9.1.b	The identification and elimination of barriers to accessibility regarding Information and communications	2(c, s), 20(2) 42	-	-
9.2.a	States parties take measures to develop and monitor standards and guidelines for the accessibility of public services	65(2)(f), 71(2)(f)	-	General provision
9.2.b	States parties take measures to ensure	2(i), 40,	-	-

	private entities that offer public services take into account accessibility for persons with disabilities	41(2), 44, 46		
9.2.c	States parties take measures to provide training for stakeholders on accessibility issues	47(1)(a, b)	-	General provision
9.2.d	States parties take measures to provide signage in Braille and in easy-to-read forms in public buildings and facilities	40, 41(1), 42, 44, 45, 46	-	Hinges on what is developed by Section 40
9.2.e	States parties take measures to provide live assistance and intermediaries, to facilitate accessibility to public buildings and facilities	40, 41(1)(a), 44, 45, 46	-	-
9.2.f	States parties take measures to promote assistance and support to persons with disabilities to access information	2(f, n), 4(c), 40, 42, 65(2)(e),	2(1)(i), 4(2), 22(1)(d)	-
9.2.g	States parties take measures to promote access for persons with disabilities to new information and communications technologies	2(f, n), 17(f), 29(g)	-	Multiple incentives to research but not specific to accessibility.
9.2.h	States parties take measures to promote the design, development, production and distribution of accessible information and communication technologies	29(g), 43		

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.6 Article 10: Right to Life

Article 10 requires States Parties to ‘reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others’. The right to life is explicitly affirmed in Section 3(1) of the RPWDA, but is not directly mentioned in the MHCA. The MHCA does permit legal provisions to protect life in emergency circumstances; this gives the right to life priority in emergency circumstances (Section 94(1)(a)). This balancing of rights in the MHCA will be discussed in the general discussion below.

The right to life is also affirmed in the Constitution of India which states that ‘no person shall be deprived of his life or personal liberty except according to procedure established by law’ (Article 21). Case-law has demonstrated that the definition of ‘life’ in the Constitution is in line with what is intended in the CRPD; it does not just relate to life as the opposite to death, but encompasses a right to a healthy life (Sunil Batra v. Delhi Administration, 1978 AIR 1675) and to enjoy human dignity (Maneka Gandhi v. Union of India, 1978 AIR 597, 1978 SCR (2) 621). As described in Francis Coralie v. Union Territory of Delhi (1981 AIR 746, 1981 SCR (2) 516):

‘The right to live includes the right to live with human dignity and all that goes along with it’

Despite the contents of Article 3(1) of the RPWDA, some commentators do not feel that the right to life is protected in the MHCA or the RPWDA (National Disability Network and National Committee on the Rights of Persons with Disabilities, 2017; National CRPD Coalition-India, 2019).

Affirming the right to life in the context of disability is important as there are many factors that reduce life expectancy in people with disabilities (Thomas and Barnes, 2010). Affirming the right to life in the context of mental illness is also vital as the treatment gap for people with mental illness in India can be as high as 95% (Patel

et al., 2016; Sagar et al., 2017). Even in countries with smaller treatment gaps, the life expectancy of people with mental illness is reduced by over ten years (Walker et al., 2015; Chang et al., 2011). While India's delay in large-scale deinstitutionalisation may be negatively impacting the right to life (National CRPD Coalition-India, 2019), Indian psychiatrists have expressed concerns that the provisions of the MHCA could create barriers in accessing mental healthcare and this, too, could limit the right to life (Duffy et al., 2018).

4.4.7 Article 11: Situations of Risk and Humanitarian Emergencies

Article 11 obliges states to take 'all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters'.

This right is comprehensively addressed in Section 8 of the RPWDA. Section 8(1) affirms the general principles of Article 11, while Sections 8(2-4) consider practical implementation and the relationship of these measures to the Disaster Management Act, 2005. Section 8(4) even considers accessibility requirements during reconstruction following an armed conflict or natural disaster.

The MHCA, on the other hand, contains very limited consideration of disasters or humanitarian emergencies, just pointing out, for example, that these situations can lengthen the period of emergency treatment (Section 94(4)). This limited consideration is regrettable: psychosocial disabilities need particular consideration in the context of disasters and emergency situations because these conditions can limit access to treatment and precipitate new-onset illness (Amaddeo and Tansella, 2012).

Finally, the consideration of disasters and humanitarian emergencies in the RPWDA is both complicated and compromised by the definition of disaster in the Disaster Management Act, 2005 which, some argue, refers to only natural disasters and excludes human conflicts (National CRPD Coalition-India, 2019). Regrettably, routine data collected by India's National Disaster Management Authority is not stratified by disability status, so the magnitude of this issue is not clear (National Disability Network and National Committee on the Rights of Persons with Disabilities, 2017). It is clear, however, that extensive additional training and planning will be

needed to incorporate the needs of people with disabilities into disaster management plans in the future (Kett and van Ommeren, 2009). Failure to support people with disabilities in emergency and disaster situations especially compromises their right to life because they experience higher rates of mortality in these circumstances compared to people without disabilities (Mace and Doyle, 2017).

4.4.8 Article 12: Equal Recognition Before the Law

Sections of the RPWDA and the MHCA that relate to Article 12 of the CRPD are summarised in Table 4.6. Equal recognition before the law is a key component of the CRPD and it is a major driving force for the reform of disability and mental health legislation. An exhaustive evaluation of the adherence of Indian legislation to Article 12 is a mammoth task and would require substantial input from multiple different specialities (Byrne et al., 2018). Here, we describe key pertinent issues that arise in relation to this right in the MHCA and the RPWDA.

The RPWDA affirms equal legal capacity for people with disabilities (Section 12(2)) and includes sub-sections on property, financial affairs and the nature of informal support arrangements (Section 13). Formalised support arrangements, in the form of limited guardianship, are addressed in Section 14. Some parties argue that limited guardianship is a violation of the CRPD (National CRPD Coalition-India, 2019), but it could be in line with Article 12.4 of the CRPD if limits, protections and review mechanisms are described. This is the chief area of possible non-concordance with Article 12, although State Governments may provide further rules on this matter to remedy this (Section 101(2)(b)).

Another area in which the RPWDA deviates from the CRPD concerns membership of the State and Central Advisory Boards on Disability, as the RPWDA states that people declared by a court to be ‘of unsound mind’ are prohibited from being members of these boards (Sections 62(1)(b) and 68(1)(b)). These provisions actively call into question the capacity of people with psychosocial disability and appear inconsistent with the CRPD.

Turning to the MHCA, greater consideration is given to capacity in this piece of legislation compared to the RPWDA, possibly based on the idea that mental capacity

can fluctuate substantially in people with psychosocial disabilities. This topic is often poorly addressed in mental health legislation. In its 'General Comment' on Article 12, the UN Committee on the Rights of Persons with Disabilities (2014) affirms that legal and mental capacity are distinct concepts. The MHCA, however, makes no overt distinction between these two forms of capacity. The MHCA protects an individual's 'capacity' once they can '(a) understand the information that is relevant to take a decision on the treatment'; '(b) appreciate any reasonably foreseeable consequence of a decision or lack of decision'; *and* (in its current draft the Act states 'or' but this is clearly a typographical error) (c) 'communicate the decision' (Section 4(1)).

The MHCA affirms individuals' right to make healthcare choices 'perceived by others as inappropriate or wrong' (Section 4(3)) providing they have capacity. When people cease to have capacity, advance directives can come into force (Section 5(3)). A decision that a person lacks capacity needs to be reviewed every one to two weeks (Sections 89(8) and 90(13)), although this is not as rigorous as described by the CRPD (Article 12.4).

For the most part, these provisions seem to refer to *mental* capacity because they assume 'capacity' is dynamic and can be lost. *Legal* capacity appears to be addressed in Section 14(9), which states that 'all persons with mental illness shall have capacity to make mental healthcare or treatment decisions but may require varying levels of support'.

The MHCA does not provide any further detail on assessment of capacity but makes provision for an Expert Committee to prepare guidance (Section 81). The Draft Mental Healthcare Rules 2017 (Ministry of Health and Family Welfare, 2017) also make reference to this Expert Group but add no additional information.

In the MHCA, two constructs support decision-making for people who require support in making decisions that relate to mental healthcare: the nominated representative (Chapter IV) and advance directive (Chapter III). The parallel construct of the nominated representative in the RPWDA is the limited guardian (Section 14). There is no mirror legislation providing for advance directives in the RPWDA, and it is unclear how the limited guardian and the nominated representative relate to each other.

Several other provisions of the MHCA uphold Article 12.4 of the CRPD which

requires states parties to 'ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law'. A nominated representative must consider the 'current and past wishes, the life history, values, cultural background and the best interests of the person with mental illness' when fulfilling their duties (Section 17(a)) and a MHRB can alter or cancel an advance directive if they feel coercion was used (Section 11(2)(a)). The MHCA principle of the least restrictive care option (Section 89(1)(b)) aligns with the CRPD's concept of proportionality. Overall, the provisions relating to nominated representatives in the MHCA are much more robust than those concerning limited guardianship in the RPWDA.

There is however, a broader issue about the tension between legal capacity and *any* form of treatment without consent in the first place. The UN Committee on the Rights of Persons with Disabilities (2014) has been clear on this point:

Forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (Article 17); freedom from torture (Article 15); and freedom from violence, exploitation and abuse (Article 16). This practice denies the legal capacity of a person to choose medical treatment and is therefore a violation of Article 12 of the Convention (Paragraph 42).

In response to this position, some countries, such as the UK, are explicitly *not* attempting to adhere to the interpretation of the Committee (Independent Review of the Mental Health Act 1983, 2018). India appears to be aligned with the UK rather than the Committee on this point.

Finally, taking an even broader view of the position of the mentally ill and disabled in India, it is worth noting that there are many discriminatory laws that do not provide equal recognition before the law (Cherian et al., 2013). Most of these laws are *not* in the process of being reformed and neither the MHCA nor the RPWDA will counteract them. Even so, while broader, multi-level reform of such other laws is awaited, many improvements could be expedited by robust, pragmatic applications of the MHCA and RPWDA.

Table 4.6 Incorporation of Article 12 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
12	Equal recognition before the law	13(2)	4, 5, 14(9), 81	-
12.1	Persons with disabilities have the right to recognition as persons before the law.	13(2)	4(1)	Limitation in the MHCA
12.2	Persons with disabilities enjoy legal capacity on an equal basis with others	13(2), 62(1)(b), 68(1)(b)	4, 5(4)	Limiting the input of people found to be of 'unsound mind'
12.3	Access to support in exercising legal capacity	14(1), 101(2)(b)	4(2), 5-17	Limited guardianship is poorly defined
12.4	Governmental provisions of safeguards to prevent abuse that relates to the exercise of legal capacity	13(3), 13(5), 14(1)	11(2)(a), 17(a), 22(1)(b), 89(1)(b), 89(8), 89(10), 90(13)	RPWDA has less provision for protections and review
12.5	The equal right of persons with disabilities to own or inherit property, to control their own financial affairs	13(1, 3)	-	-

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.9 Article 13: Access to Justice

Sections of the RPWDA and the MHCA that relate to Article 13 of the CRPD are summarised in Table 4.7. These rights are primarily and comprehensively addressed in the RPWDA. The relevant protections are strengthened by the inclusion of ‘access to justice’ in the definition of ‘public facilities and services’ (Section 2(x)). The provisions described in Section 12 of the RPWDA (‘Access to justice’) appear to use key requirements of Article 13 of the CRPD, translate them into an Indian context, and provide additional protections and supports for access. Section 27 of the MHCA provides people with mental illness with free legal services to exercise their rights under the MHCA.

Section 47(1)(a) of the RPWDA addresses training for those working in key fields, although prison staff are a notable omission. This is an important group in light of limited resources in prisons and high rates of incarceration among people with disabilities (Kallivayalil et al., 2009; Goyal et al., 2011). The MHCA also makes brief mention of ‘periodic sensitisation and awareness training on the issues under this Act’ for ‘appropriate Government officials including police officers and other officers of the appropriate Government’ (Section 30(c)). Considering the significant role that such officers play in the MHCA (Sections 100 and 101), specific mental health training may be needed to promote meaningful access to justice for people with mental illnesses, especially as the accessibility of Indian courts for this group has been repeatedly called into question (National CRPD Coalition-India, 2019; National Disability Network and National Committee on the Rights of Persons with Disabilities, 2017).

Table 4.7 Incorporation of Article 13 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the	Abridged description of CRPD article and sub-articles	Key sections	Key sections	Notes

CRPD		in the RPWDA	in the MHCA	
13	Access to Justice	2(x), 12	27	-
13.1	Effective access to justice for persons with disabilities on an equal basis with others	12	19(2), 27	-
13.2	Appropriate training for those working in the field of administration of justice, including police and prison staff	47(1)(a)	30(c)	Prison staff omitted and police training could be expanded

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.10 Article 14: Liberty and Security of Person

Sections of the RPWDA and the MHCA that relate to Article 14 of the CRPD are summarised in Table 4.8. The Preamble (a) of the RPWDA states that the ‘respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons’ is a core principle of the Act. Section 3(4) states that ‘no person shall be deprived of his or her personal liberty only on the ground of disability.’ Section 5 affirms the right to live in the community, which also supports liberty. The RPWDA, however, gives no particular consideration to people who are deprived of their liberty, despite this occurring in practice.

In the MHCA, Sections 89, 90 and 94 provide a legal framework for the treatment of people who lack capacity. Even so, Article 14 of the CRPD remains problematic for law-makers writing mental health legislation because it addresses the right to liberty and security – a right that is curtailed or suspended during treatment without consent under mental health legislation. Article 14.1 of the CRPD states that ‘the existence of a disability shall in no case justify a deprivation of liberty’.

Consequently, the involuntary admission or treatment of a person on the grounds of

mental illness can be seen as incompatible with the CRPD (Kelly, 2014a). In India, Sections 3(4) and 3(5) of the MHCA prohibit deprivation of liberty *solely* on the grounds of a diagnosis or prior treatments; other requirements must be met. This, however, is *still* declared discriminatory by the Office of the UN High Commissioner for Human Rights (2009). The tensions inherent in this situation will be discussed below.

Table 4.8 Incorporation of Article 14 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
14	Liberty and security of person	Preamble, 3(4)	19(1)	-
14.1.a	States Parties shall ensure persons with disabilities enjoy the right to liberty and security of person	Preamble, 3(4), 5	19, 89, 90, 94	Possible violation in MHCA
14.1.b	States Parties shall ensure persons with disabilities are not deprived of their liberty unlawfully; the existence of a disability shall not justify a deprivation of liberty.	3(4)	3(4&5), 4, 19, 89, 90, 94	Potential inconsistency as mental illness is part of the reason for treatment without consent
14.2	State parties shall ensure that if a person with disabilities is deprived of their liberty it is on an equal basis with others and that they receive reasonable accommodation	-	4, 19, 89, 90, 94	RPWDA gives no consideration to people deprived of

				their liberty; MHCA appears inconsistent with this

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.11 Article 15: Freedom from Torture or Cruel, Inhuman or Degrading Treatment or Punishment

Sections of the RPWDA and the MHCA that relate to Article 15 of the CRPD are summarised in Table 4.9. Section 6 of the RPWDA provides protection from cruelty and inhuman treatment, including protection from research without ‘free and informed consent’. General penalties and offenses to deter people from maltreating people with disabilities are included in Chapters XVI of the RPWDA and XV of the MHCA.

Precisely what constitutes cruel and inhuman treatment is given greater consideration in the MHCA (Section 20). This provides explicit protections from cruel, inhuman and degrading treatment in mental health establishments. It provides rights to, *inter alia*, a safe and hygienic environment, adequate sanitary conditions, privacy, proper clothing and protection from physical, verbal, emotional and sexual abuse. Steps are taken to address some of the major human rights infringements often considered to be torture, including prohibition of unmodified electroconvulsive therapy (i.e. without anaesthetic) (Section 95(1)(a)), prohibition of seclusion or solitary confinement (Section 97(1)), and regulation and substantial limitation of physical restraint (Section 97), including banning restraint as a form of punishment or deterrent in any circumstance (Section 97(4)). The Act, however, permits modified electroconvulsive therapy (i.e. with anaesthetic), restraint in certain contexts and the admission and treatment of persons without capacity - and these could be seen cruel or inhuman treatments owing to lack of consent in certain cases.

The MHCA addresses medical research in Section 99(1), which requires ‘free and informed consent from all persons with mental illness for participating in any research involving interviewing the person or psychological, physical, chemical or medicinal interventions’. Section 99 legislates for research in non-protesting patients who lack capacity and provides for protection for people involved in such research. This may be seen as a deviation from a very literal reading of Article 15.1 of the CRPD which states that ‘no one shall be subjected without his or her free consent to medical or scientific experimentation’.

If, however, people with impaired mental capacity are to receive treatment, it is vital that such treatments are based on evidence. Some of the necessary research cannot be performed on people with capacity (e.g. research into the conditions that cause the lack of mental capacity in the first place). Even so, the MHCA’s facilitation of research might also be at odds with the RPWDA which states that ‘no person with disability shall be a subject of any research’ without ‘his or her free and informed consent’ (Section 6(2)). In addition, where a person lacks mental capacity in the context of a mental illness, and they have a nominated representative, that nominated representative can ‘give or withhold consent for research’ under the MHCA (Section 17(k)). Overall, however, and despite the inconsistencies between the MHCA, RPWDA and CRPD, it is important that there is provision to include people who cannot consent in medical research, although it is also vital that adequate protections are in place for this.

Finally, in relation to Article 15 of the CRPD, the monitoring of institutions is of particular relevance given the low standards seen in many reports, poor levels of record-keeping, and increased numbers of deaths in institutions (National CRPD Coalition-India, 2019). More comprehensive guidelines need to be developed and implemented in mental health establishments, some of which have been found to have inhuman and degrading conditions (Human Rights Watch, 2014). In addition, while India is a signatory to the UN Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment (‘Convention against Torture’), it has yet to ratify it; ratification would, hopefully, add urgency to addressing many of these matters in practice.

Table 4.9 Incorporation of Article 15 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
15	Freedom from torture or cruel, inhuman or degrading treatment or punishment	6	20	-
15.1	No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment, or non-consensual experimentation	6	2(i), 17(k), 20, 89(7), 90(12), 95(2), 96, 97,	Treatment can be given without consent; modified electroconvulsive therapy is allowed
15.2	States Parties shall take all effective measures to prevent persons with disabilities from being subjected to torture or cruel, inhuman or degrading treatment or punishment	89, 92,	107-109	Nothing directly penalises torture or cruel, inhuman treatment

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.12 Article 16: Freedom from Exploitation, Violence and Abuse

Sections of the RPWDA and the MHCA that relate to Article 16 of the CRPD are summarised in Table 4.10. The right to freedom from exploitation, violence and abuse

is addressed in Section 7 of the RPWDA which outlines legal remedies, prevention, rehabilitation and the role of police. No mention is made of gender-based violence, as suggested in Article 16.1 of the CRPD. This is a significant omission in light of the high rates of intimate partner violence seen among people with disabilities (Brownridge, 2006; Hughes et al., 2012).

Article 16.3 of the CRPD requires that all programmes that serve people with disabilities are monitored by independent authorities. Multiple bodies monitor services for people with disabilities under the RPWDA, including the Central Advisory Board on Disability (Section 65(2)(f)), State Advisory Board on Disability (Section 71(2)(f)), the Chief Commissioner (Section 75(1)(h)) and the State Commissioner (Section 80(g)). This monitoring is not, however, independent and does not explicitly refer to protection from exploitation, violence and abuse.

Section 7(3) of the RPWDA outlines provisions for promoting the recovery of a person who has been the victim of such abuse, as required by Article 16.4 of the CRPD; these provisions include the rescue of the victim, rehabilitation, protection, financial support and free legal aid. In line with Article 16.5 of the CRPD, Sections 7(2) to 7(5) of the RPWDA address the identification, investigation, prosecution of abuse. The MHCA presents protections from ‘all forms of physical, verbal, emotional and sexual abuse’ while the person is in a mental health establishment (Section 20(2)(k)).

Overall, the RPWDA and the MHCA cover many of the key requirements of Article 16 of the CRPD, but could be improved by specific consideration of vulnerable groups such as children, women and the elderly, in greater accordance with the convention.

Table 4.10 Incorporation of Article 16 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes

16	Freedom from exploitation, violence and abuse	7	20(2)(k)	-
16.1	States Parties shall take all appropriate measures to protect persons with disabilities from exploitation, violence and abuse, including gender-based aspects	7	20(2)(f, k)	No mention is made of gender-based violence
16.2	States Parties shall take all appropriate measures to prevent all forms of exploitation, violence and abuse	7	20(2)(f, k)	-
16.3	To prevent exploitation, violence and abuse, States Parties shall ensure that facilities and programmes designed to serve persons with disabilities are independently monitored	65(2)(f), 71(2)(f), 80(g)	68	Not regularly monitored and not independent
16.4	The provision of physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse	7(1)(c)	-	Not as comprehensive as suggested
16.5	Legislation and policies to ensure that exploitation, violence and abuse against persons with disabilities are identified, investigated and prosecuted	7(2-5), 89, 92	-	Extensively developed

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.13 Article 17: Protecting the Integrity of the Person

The right to integrity of the person is directly affirmed in Section 3(1) of the RPWDA which states that 'the appropriate Government shall ensure that the persons with

disabilities enjoy the right to equality, life with dignity and respect for his or her integrity equally with others'. The Preamble (a) also states that a core principle of the Act is 'respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons'.

The MHCA makes no direct mention of physical or mental integrity, however it provides a right to live with dignity (Section 20(1)). In addition, It is hoped that the Act's paradigm shift from substitute decision-making to supported decision-making, through nominated representatives and advance directives, will help preserve integrity. The attempted shift from involuntary to 'supported' treatments may also help. Despite this change in terminology, however, treatment can still occur without consent. This may be seen to violate personal integrity, especially if integrity is conceptualized as something that is primarily realized or violated in the short term rather than the medium or long term.

This issue highlights the importance of defining 'integrity' clearly. Moving from India to Europe for the purpose of this discussion, Article 3 of the European Union's (EU) *Charter of Fundamental Rights* (2000), defines integrity in more detail, outlining, *inter alia*, three key principles (aside from issues relating to cloning, which do not arise here). First, free and informed consent of the person concerned is required, according to procedures laid down in law; in India, this is addressed in relation to research in Section 6(2)(i) of the RPWDA. While there are circumstances in which treatments can be administered without the person's consent under the MHCA, these are laid down in law and are thus concordant with the EU's definition of integrity. Second, the EU highlights prohibition of eugenic practices as another key principle of integrity; sterilization is prohibited in both the MHCA (Section 95(1)(c)) and RPWDA (Section 10(2)). Third, the EU lists prohibition on making the human body a source of financial gain as another principle of integrity; commercial surrogacy is banned in India's Surrogacy (Regulation) Bill, 2018 (Parry and Ghoshal, 2018).

Finally, however, treatment without consent and coercive treatment practices permitted under the MHCA may call into question the concordance of the MHCA with this article of the CRPD. These issues will be discussed further in Chapter 9.

4.4.14 Article 18: Liberty of Movement and Nationality

Sections of the RPWDA and the MHCA that relate to Article 18 of the CRPD are summarised in Table 4.11. The right to liberty of movement and nationality has been strikingly omitted from both the RPWDA and MHCA. The Preamble (a) of the RPWDA acknowledges ‘inherent dignity, individual autonomy including the freedom to make one’s own choices’ and Section 2(h) defines discrimination in very broad terms. General rights relating to legal capacity (Section 13) and equality and non-discrimination (Section 3) might also go some way towards supporting liberty of movement and nationality. Outside of these very general provisions, however, there are no specific protections of the right to movement or nationality in either the RPWDA or MHCA.

Looking at other pieces of legislation, India’s Registration of Births and Deaths Act, 1969 makes the registration of births and deaths compulsory across the country (Section 8), but makes no specific reference to disability. The national rate of birth registration is only 58% and is even lower among people with disabilities; 80% to 90% of children with disabilities do not have birth certificates, according to some reports (National Disability Network and National Committee on the Rights of Persons with Disabilities, 2017).

The Passports Act of 1967 also makes no reference to disability or illness. Article 21 of the Constitution of India (‘Protection of life and personal liberty’) has been established to include the right to a passport (*Satwant Singh Sawney v. D. Ramarathnam*, Assistant Passport Officer, 1967 AIR 1836, 1967 SCR (2) 52), but there is still remarkably little discussion of rights to travel, emigration or passports in the critical or academic literature relating to the RPWDA and MHCA. This is consistent with the broader fact that travel for disabled people is a very poorly researched field in general (Bauer, 2018). Crossing international borders, accessing passports and migration are much more complex than standard travel, and this makes the requirements for research and greater supports for rights in this area more urgent.

Table 4.11 Incorporation of Article 18 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016

and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
18	Liberty of movement and nationality	Preamble , 2(h), 3, 13	-	Only the most general references that could be interpreted to apply to this area
18.1.a	The right to acquire and change a nationality and not be deprived of nationality arbitrarily or on the basis of disability	-	-	
18.1.b	The right to obtain, possess and utilize documentation of their nationality	-	-	
18.1.c	The freedom to leave any country	-	-	
18.1.d	The right to enter one's own country	-	-	
18.2	Children with disabilities shall be registered immediately after birth and have the right to a name, a nationality and to know and be cared for by their parents	-	-	

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.15 Article 19: Living Independently and Being Included in the Community

Sections of the RPWDA and the MHCA that relate to Article 19 of the CRPD are summarised in Table 4.12. The right to live independently and be included in the community is explicitly affirmed in the RPWDA (Section 5). In addition, 'the

appropriate Government shall endeavour that the persons with disabilities are (a) not obliged to live in any particular living arrangement; and (b) given access to a range of in-house, residential and other community support services, including personal assistance necessary to support living with due regard to age and gender' (Section 5(2)).

The CRPD requirement for community services and facilities to be available on an equal basis to persons with disabilities is partly addressed. Some clarity is provided by the RPWDA's definitions of 'information and communication technology' (Section 2(n)) and 'public facilities and services' (Section 2(x)), but, despite these helpful definitions, the term 'public facilities and services' is not used elsewhere in the Act. Nonetheless, the RPWDA promotes equality, non-discrimination (Section 3) and accessibility, including access to 'facilities and services provided to the public in urban and rural areas' (Section 40) and public service buildings (Sections 45 and 46).

Community based independent living is explicitly affirmed for people with mental illness in the MHCA (Section 19). Some of these provisions provide less flexibility than suggested in Article 19 of the CRPD, as the normative emphasis of the MHCA is on living with the family (Section 19(2)). This section of the MHCA implies that the family home is the primary or default option for accommodation outside of hospital and this could be perceived as a forced living arrangement.

Community treatment of mental illness has a limited history in India as large-scale psychiatric hospitals have traditionally received most funding and the majority of patients. Community-based interventions remain underfunded and poorly developed in many areas (Gururaj et al., 2016; Murthy et al., 2017). Community-based rehabilitation for disabilities has been in place since the late 1970s, but services are often sparse and face significant challenges (Kumar et al., 2012). They are hampered by a lack of statistical information and a paucity of resources, and their impact is further limited by isolation from other related governmental departments (e.g. education, employment). The National Disability Network and National Committee on the Rights of Persons with Disabilities, (2017) acknowledge that services to support independent living are almost non-existent. For these reasons, additional protections promoting community-based living would be welcome; neither the RPWDA nor MHCA is sufficient in this regard.

Table 4.12 Incorporation of Article 19 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
19	Living independently and being included in the community	2(n, x), 5	19	-
19.a	The opportunity to choose the place of residence and where and with whom one lives	5(2)(a)	19	MHCA is very general and implies people live with families
19.b	Persons with disabilities have access to a range of in-home, residential and other community support services	5(2)(b)	19(2, 3)	-
19.c	Community services and facilities for the general population are available on an equal basis to persons with disabilities	3, 40, 45(2), 46	-	General provisions only

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.16 Article 20: Personal Mobility

Sections of the RPWDA and the MHCA that relate to Article 20 of the CRPD are summarised in Table 4.13. Personal mobility gives people with disabilities substantial independence. This right is partly addressed in the RPWDA which provides for access to transport for persons with disabilities (Sections 40 and 41). This includes providing facilities and enhancing accessibility at transport hubs and on public transport, retro-

fitting existing transport, and improving the accessibility of roads. Section 41(2) directs the government to develop schemes to promote mobility at an affordable cost, consistent with Article 20.d of the CRPD.

These provisions in the RPWDA do not provide the degree of freedom envisaged in Article 20, but appear pragmatic and realistic. Some of the provisions come, however, with the caveat that they are to be implemented ‘wherever technically feasible and safe for persons with disabilities, economically viable and without entailing major structural changes in design’ (Section 41(1)(b)); this clause may limit impact. In addition, little consideration is given to personal mobility outside of *public* transport and the very general overall protections relating to accessibility discussed above. Nor does Section 41 overtly address ‘assistive technologies and forms of live assistance and Intermediaries’ or ‘training in mobility skills’, both of which are required by Article 20.b of the CRPD.

Article 20 is a critically important article of the CRPD. The provision of mobility technology is often very limited in low- and middle-income countries, but when it is delivered it greatly enhances community participation (Jefferds et al., 2010). Additional research and services are especially needed to address hearing, communication and cognition-based difficulties, many of which impact substantially on mobility (Matter et al., 2017). Tangcharoensathien and colleagues (2018) describe many pervasive barriers to accessing assistive technologies in low- and middle-income countries, which need to be addressed. Increasing uptake of mobility assistance will require greater availability of relevant programmes, raising awareness, consultation with device-users, and substantially increased funding and research. Additional consideration of this area in both policy and legislation could greatly promote the personal mobility of people with disabilities and – in many cases – transform their lives.

Table 4.13 Incorporation of Article 20 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
20	Personal mobility	40, 41	-	-
20.a	Facilitating the personal mobility of persons with disabilities	41	-	Only relates to public transport
20.b	Facilitating access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries	41(2)	-	No mention of live assistance; limited consideration of other forms of assistance
20.c	Providing training in mobility skills to persons with disabilities and to specialist staff	-	-	Only general comments
20.d	Encouraging entities that produce mobility aids, devices and assistive technologies	29(g), 30(3)(c), 41(2)	-	-

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.17 Article 21: Freedom of Expression and Opinion, and Access to Information

Sections of the RPWDA and the MHCA that relate to Article 21 of the CRPD are summarised in Table 4.14. The right to ‘freedom of expression and opinion, including the freedom to seek, receive and impart information and ideas on an equal basis with

others and through all forms of communication’ is not comprehensively addressed in the RPWDA. There is limited mention of freedom of expression and opinion. Section 4(2) provides children with disabilities protection to express their views on all matters affecting them. For adults, no such specific protection is provided in the RPWDA, although provisions to ensure equality and non-discrimination might grant protection in this area (Section 3(1)). In addition, definitions of ‘barrier’ (Section 2(c)), ‘communication’ (Section 2(f)), ‘information and communication technology’ (Section 2(n)) and ‘public facilities and services’ (Section 2(x)) implicitly and explicitly place effective communication at the centre of the RPWDA.

The right to *access* information is primarily addressed in Section 42 which directs that ‘all contents available in audio, print and electronic media are in accessible format’ and that all ‘persons with disabilities have access to electronic media by providing audio description, sign language interpretation and close captioning’. The Internet is not directly mentioned in the RPWDA, but India’s National Informatics Centre (2018) has released guidelines for Indian government websites that aim to make websites citizen-centred and improve accessibility for people with disabilities. Section 12(4)(a) of the RPWDA also places responsibility on government to ensure that all their public documents are in accessible formats, but there is no explicit time-frame provided for this and nor is it clear if this will be cost-free for citizens (as required by Article 21 of the CRPD). Section 12(4)(c) addresses augmentative and alternative communication.

It remains to be seen if these provisions will be successful in encouraging private entities to provide information and services in an accessible manner. For example, Section 25(1) requires ‘the appropriate Government and the local authorities’ to ‘take necessary measures for the persons with disabilities to provide...barrier-free access in all parts of Government and private hospitals and other healthcare institutions and centres’. Sections 44, 45 and 46 address this in relation to building work, consistent with Section 40 (‘Accessibility’), but the effects of these measures also remain to be seen.

The broad definition of communication in Section 2(f) gives alternative modes of communication an important place in the legislation and Section 2(c) highlights communicational factors as potential barriers for people with disabilities. Sections

16(v) and 17 facilitate the use of sign languages, Braille, and augmentative and alternative communication in educational settings. Similar protection is present outside of educational settings through Section 40 which includes ‘communications’ as part of ‘accessibility’. The realisation of this section is dependent on the Chief Commissioner’s rules concerning accessibility for persons with disabilities.

In the MHCA, people with mental illness have a right to receive information in ‘simple language, which such person understands or in sign language or visual aids or any other means to enable him to understand the information’ (Section 4(2)). This right to information ‘in a language and form that such person receiving the information can understand’ is further emphasised in Section 22(d).

Sign language is well recognised in the RPWDA and the MHCA. The Indian Sign Language Research and Training Centre is represented on the Central Advisory Board (Section 60(2)(q)(ix) of the RPWDA). Consideration is given to the training of teachers who are qualified in sign language (Section 17(c)), which is also promoted in television programs (Section 29(h)) and government information (Section 42(ii)). The role of sign language is also acknowledged in the MHCA (Section 4(2)).

Table 4.14 Incorporation of Article 21 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
21	Freedom of expression and opinion, and access to information	2(c, f, n, x), 3(1), 4(2), 12(4)(a), 40, 42	4(2), 22(d)	Freedom of expression only discussed in relation to children
21.a	Provision of information intended for the	12(4)(a)	-	-

	general public to persons with disabilities in accessible formats and technologies	, 42		
21.b	Accepting and facilitating the use of sign languages, Braille, augmentative and alternative communication	2(c, f), 16(v), 17(c, f), 40	-	-
21.c	Urging private entities to provide information and services in accessible and usable formats for persons with disabilities	25(1)(b) , 44, 46	-	Limited provisions outside of buildings and healthcare
21.d	Encouraging the mass media to make their services accessible to persons with disabilities	29(h), 42	-	Limited provisions
21.e	Recognizing and promoting the use of sign languages	29(h), 42(ii), 60(2)(q) (ix),	4(2)	-

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.18 Article 22: Respect for Privacy

Sections of the RPWDA and the MHCA that relate to Article 22 of the CRPD are summarised in Table 4.15. Limited consideration is given to the right to privacy in the RPWDA and MHCA. The RPWDA states that ‘any person providing support to the person with disability shall not exercise undue influence and shall respect his or her autonomy, dignity and privacy’ (Section 13(5)). There is no other mention of privacy in the RPWDA. The MHCA mentions privacy just once, where it grants people a right to privacy while in mental health establishments (Section 20(2)(d)).

The MHCA also considers confidentiality, although this is absent from the

RPWDA and CRPD. The distinction between confidentiality and privacy is helpful and important in considering the rights of people with disabilities (Duffy and Kelly, 2017c). The nominated representative system allows for confidentiality to be maintained concerning family if a person so desires. This protection is important in cultures with strong and powerful family structures, although it has proven unpopular with some who are concerned that families might be excluded from care decisions (Duffy et al., 2018).

The slow pace of deinstitutionalisation is a concern for the realisation of the right to privacy (Murthy et al., 2017). The development of community-based living and the supports suggested in the RPWDA and the MHCA would greatly benefit privacy. The RPWDA includes provisions regarding information-gathering, but clear data protection policies are also required. The RPWDA could be more explicit in its support of privacy and give specific consideration to confidentiality.

Table 4.15 Incorporation of Article 22 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
22	Respect for privacy	13(1, 5)	20(2)(d), 23(1)	Only considered very generally in the RPWDA and only relates to while an inpatient in the MHCA
22.1	The right to freedom from interference with privacy, family, home or correspondence or other types of communication for people with disabilities	13(1, 5)	23(1), 24(2)	
22.2	State protection of the privacy of personal, health and rehabilitation information of persons with disabilities		23(1), 24(2)	No mention of medical records in the RPWDA

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.19 Article 23: Respect for Home and the Family

Sections of the RPWDA and the MHCA that relate to Article 23 of the CRPD are summarised in Table 4.16. Many of the rights relating to respect for the home and family are addressed in the RPWDA and some receive specific consideration in the context of mental illness. There is general consideration of family life in both the RPWDA (Section 9 and 10) and MHCA (Section 19). Both Acts directly address the protection of fertility (Section 10(2) of the RPWDA and Section 95(1)(c) of the MHCA) and community-based family life (Section 9 of the RPWDA and Section 19 of the MHCA), and both give consideration to the separation of children from parents (Section 9(1) of the RPWDA and Section 21(2) of the MHCA). The MHCA's consideration of separation relates only to periods of admission to mental health establishments and only to children under the age of three years.

The RPWDA presents no specific right to marry or found a family and, although this issue could be addressed under the broad heading of 'discrimination' (Section 2(h)), specific provisions might also need to be provided. Some consideration is given to the topic in Section 39(2)(c) which mandates awareness campaigns that 'foster respect for the decisions made by persons with disabilities on all matters related to family life, relationships, bearing and raising children'. Section 10(1) also gives rights to 'information regarding reproductive and family planning'. But neither of these measures meet the requirements of the CRPD in this regard.

Neither the RPWDA nor the MHCA gives parents with disabilities adequate entitlement to supports in parenting as suggested in Article 23.2 of the CRPD. The RPWDA hints at something that may, in time, provide some help in this area when it suggests that the government should develop schemes to provide care-givers with an allowance for assisting persons with disabilities with high support needs (Section 24(3)(i)). While this does not directly address parenting, it is a step in that direction, provided funding is adequate and definitions are clear. The RPWDA outlines children's

rights to 'home and family' (Section 9) and 'community life' (Section 5), and 'to freely express their views on all matters affecting them' (Section 4(2)).

Many concerns have been raised about the role and rights of the broader family under the MHCA (Duffy et al., 2018) because, outside the role of the 'nominated representative', family now have more limited rights (Duffy and Kelly, 2017c). The lack of clear definitions in the area of limited guardianship (discussed above) could further diminish these rights and will need to be comprehensively addressed. While this is a concern of Indian psychiatrists it is not the focus of the CRPD.

Table 4.16 Incorporation of Article 23 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
23	Respect for home and the family	9, 10	19	-
23.1.a	The right of all persons with disabilities to marry and to found a family	2(h), 39(2)(c)	-	The right to marry not explicitly included
23.1.b	The rights of persons with disabilities to decide the number and spacing of their children	10(1)	-	-
23.1.c	The right to retain fertility	10(2)	95(1)(c)	-
23.2	Appropriate assistance to persons with disabilities in the performance of their child-rearing responsibilities	24(3)(i)	-	No meaningful provisions
23.3	Children with disabilities have equal rights with respect to family life.	4(1), 5, 9	-	-

23.4	A child shall not be separated from his or her parents against their will, except in accordance with applicable law, and not on the basis of a disability	9(1)	21(2)	The MHCA considers separation during admission
23.5	Where necessary, provision of alternative care within the wider family or within the community in a family setting	9(2)	19	-

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.20 Article 24: Education

Sections of the RPWDA and the MHCA that relate to Article 24 of the CRPD are summarised in Table 4.17. As in the case with most social rights, the right to education is primarily addressed in the RPWDA rather than the MHCA. The RPWDA supports an inclusive education system (Sections 2(m) and 16). The underpinning aims of education suggested in Article 24 of the CRPD (to develop human potential, dignity and self-worth) are not directly affirmed in the context of education in the RPWDA, but are addressed in general terms in its Preamble and Section 3 ('Equality and non-discrimination'). The aim of fostering personality, talents, creativity, and mental and physical abilities through the education system is generally not considered, although limited consideration is given to this in the context of culture and recreation (Section 29(a)) and sporting activities (Sections 30(2) and 30(3)). While effective participation in a free society does not directly underpin the provision on education, it is central to the RPWDA in an overall sense (Preamble and Sections 2(c) and 17(f)).

Free education is provided to all children from age six to 14 years under the Constitution of India (Article 21A) and the Rights of Children to Free and Compulsory Education Act, 2009. The RPDWA extends this to the age of 18 for people with benchmark disabilities (Sections 2(r) and 31) and gives schools a duty to provide reasonable accommodation (Sections 2(y), 3(5) and 16(iii)). General and individualised

supports for effective education are elaborated in detail (Sections 16 and 17) and include teaching augmentative and alternative modes of communication (Section 17(f)), although insufficient consideration is given to orientation or mobility skills; Section 41(2) gives limited consideration to personal mobility, but falls short of the requirements of Article 24 of the CRPD. Adult education is considered in Sections 18 and 19.

The RPWDA gives significant consideration to sign language; it facilitates the learning of sign language through training of teachers (Section 17(c)) and promotion of its use (Section 17(f)). The RPWDA also supports the linguistic identity of the deaf community through the promotion of sign language interpretation or sub-titles on television (Section 29(h)) and in media (Section 42(ii)), and by the inclusion of a member of the Indian Sign Language Research and Training Centre on the Central Advisory Board on Disability (Section 60(2)(q)(ix)).

Overall, while many of the CRPD requirements relating to education are addressed in the RPWDA, it is notable that people with disabilities in India, as is often the case elsewhere, have generally low levels of education (Mathias et al., 2018) and very limited employment options (Awasthi et al., 2017). The RPWDA represents a very progressive step in this area but its implementation will require close monitoring as the scale of the issue it seeks to address is enormous.

Table 4.17 Incorporation of Article 24 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
24	Education	2 (l, m, x), 16-23	20(2)(c)	-
24.1.	An inclusive education system directed to	Pre	-	-

a	development of human potential and a sense of dignity and self-worth, and the strengthening of respect for human rights	amble, 2(m), 3, 16, 17(d)		
24.1. b	An inclusive education system directed to the development by persons with disabilities of their personality, talents, creativity, and mental and physical abilities	29(a), 30(2), 30(3)(c)	-	Very limited and not in the context of education
24.1.c	An inclusive education system directed to enabling persons with disabilities to participate effectively in a free society	Preamble, 2(c), 17(f)	-	A goal of the RPWDA in general (not just education)
24.2. a	Persons with disabilities are not excluded from the general education system on the basis of disability	2(m), 16, 17(d)	-	-
24.2. b	Access to an inclusive, quality and free primary education and secondary education on an equal basis with others	2(r), 31	-	From age 15 to 18, only persons with benchmark disabilities are entitled to free education
24.2.c	Reasonable accommodation of the individual's requirements	2(y), 3(5), 16(iii)	-	-
24.2. d	Support required, within the general education system, to facilitate their effective education	16, 17	-	Considerable detail present
24.2.	Individualized support measures provided	16(iv)	-	-

e	in environments that maximize academic and social development			
24.3.a	The state to facilitate the learning of augmentative and alternative modes of communication and orientation and mobility skills	17(f), 41(2)	-	Only considers communication, not orientation or mobility
24.3.b	The state to facilitate learning of sign language and the linguistic identity of the deaf community	2(f), 17(c, f), 29(h), 42(ii), 60(2)(q) (ix)	-	-
24.3.c	The state to ensure that the education of persons who are blind, deaf or deaf-blind, is delivered in the most appropriate modes for the individual	16(v)	-	-
24.4	Employment of teachers who are qualified in sign language and/or Braille, and to train professionals and staff who work at all levels of education	17(c)	-	-
24.5	The state to ensure that persons with disabilities are able to access tertiary education, vocational training, and adult education, with reasonable accommodation	18, 19	-	-

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.21 Article 25: Health

Sections of the RPWDA and the MHCA that relate to Article 25 of the CRPD are summarised in Table 4.18. The RPWDA partly considers both the right to healthcare (Section 25) and the right to health rehabilitation (Section 27). The consideration of gender required by the CRPD is addressed in Section 24(2). In general terms, healthcare is included in ‘public facilities and services’ in the RPWDA (Section 2(x)), although this phrase is not directly mentioned in the rest of the Act.

The RPWDA defines buildings used for health services as public buildings (Section 2(w)) and defines ‘discrimination’ to include discrimination ‘in the political, economic, social, cultural, civil or any other field’ (Section 2(h)); although this does not explicitly mention health, health is, presumably, included. Sexual and reproductive health are addressed in Section 25(2)(k). Taken together, these measures appear to prohibit discrimination in the area of healthcare on the grounds of disability. It would, however, be useful if this was stated more clearly in the legislation, owing not least to the already substantial barriers faced by people with disabilities accessing many public services, including healthcare.

The provision of the same quality of healthcare to persons with disabilities as to others is partly addressed in the RPWDA, and people with disabilities are given priority in attendance and treatment (Section 25). Consent in relation to research (Section 6(2)(i)), sterilisation (Section 10(2)) and termination of pregnancy (Section 92(f)) receive particular attention. Consent to medical procedures in general is not discussed in the RPWDA and this is of particular importance owing to the role of limited guardianship under the legislation (Section 14) (see above).

The issue of consent among people with mental illness is dealt with in some detail in the MHCA. ‘Informed consent’ is defined in Section 2(i) and is required for appointing a nominated representative (Section 14(3)), release of information to the media (Section 24(1)), making application to MHRBs (Section 77(1)), treatment of an independent patient (Section 86(5)), psychosurgery (Section 96(1)(a)) and research (Section 99(1)).

The right to receive healthcare as close as possible to one’s own community

(required in the CRPD) is addressed in both the RPWDA (Section 25(1)(a)) and MHCA (Section 18(5)(d)). The RPWDA does not, however, articulate an unambiguous right to health services needed by persons with disabilities specifically because of their disabilities. It could be argued that this is implicit in the text, but the level of healthcare currently received by people with disabilities in India would imply the need for explicit and emphatic legislative provisions (Gudlavalleti et al., 2014).

By way of contrast, the MHCA articulates an explicit right to mental healthcare: ‘Every person shall have a right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government’ (Section 18(1)). Government must ‘ensure that as a minimum, mental health services run or funded by Government shall be available in each district’ (Section 18(5)). These are highly detailed and ambitious provisions, providing a justiciable right to mental healthcare in a country of over 1.3 billion people for whom there is no equivalent right to general healthcare (Duffy and Kelly, 2019a). While this commitment would undoubtedly present a gargantuan resource and logistical challenge in any country, the issues it seeks to address exact enormous personal and economic costs (Gururaj et al., 2016), so any steps that might succeed in addressing these are well worth pursuing (Gupta and Basu, 2016).

Finally, while there are hints about a possible right to healthcare in the RPWDA (Sections 2(h), 2(x) and 25), there is less clarity about a prohibition against deprivation of healthcare, as required by the CRPD. Section 92 of the RPWDA makes ‘voluntarily or knowingly’ denying food or fluids to a person with disability an offence, but this does not fully meet the CRPD requirement to ‘prevent discriminatory denial of healthcare or health services or food and fluids on the basis of disability’.

Table 4.18 Incorporation of Article 25 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the	Abridged description of CRPD article and sub-articles	Key section in the	Key sections in the	Notes

CRPD		RPWDA	MHCA	
25	Health	2(h, w, x), 24(2-3), 25(1), 26, 27	18, 21(1)	-
25.a	Provision of the same range, quality and standard of free or affordable healthcare to people with disabilities	2(h, w, x), 25(1),	18, 21(1)	MHCA relates only to access to <i>mental</i> healthcare
25.b	Provision of health services needed by persons with disabilities specifically because of their disabilities	-	18(1)	Not explicitly considered in the RPWDA
25.c	Provision of health services as close as possible to people's own communities	25(1)(a)	18(4)(d)	-
25.d	Require health professionals to provide care of the same quality to persons with disabilities as to others, including consent	6(2)(i), 10(2), 25(1), 92(f)	2(i), 14(3), 21, 24(1), 77(1), 86(5), 96(1)(a), 99(1)	Consent for medical procedures not addressed in RPWDA. The role of the limited guardian needs to be clarified here also
25.e	Prohibit discrimination against persons with disabilities in the provision of health insurance and life insurance	2(x), 24(3)(j), 26	21(4)	-
25.f	Prevent discriminatory denial of healthcare	2(h, x),	21(1)	The right to

	or health services or food and fluids on the basis of disability	25, 92		healthcare is affirmed but the prohibition of deprivation is less robust

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.22 Article 26: Habilitation and Rehabilitation

Sections of the RPWDA and the MHCA that relate to Article 26 of the CRPD are summarised in Table 4.19. Rehabilitation is defined in Section 2(za) of the RPWDA and the right is discussed in Section 27. In the MHCA, Section 2(o) defines mental healthcare as including rehabilitation and there is further detail in Section 18(4). Rehabilitation is to be provided locally but there is no explicit requirement for early commencement or multidisciplinary assessment, as suggested by the CRPD.

The RPWDA emphasises rehabilitation through the appointments it makes: the Central Government will nominate five experts in the field of disability and rehabilitation to the Central Advisory Board on Disability (Section 60(2)(r)(i)), and the Chief (Section 74(3)) and State Commissioners (Section 79(2)) for Persons with Disabilities must have ‘special knowledge or practical experience in respect of matters relating to rehabilitation’.

While the word habilitation does not appear in the MHCA and appears only once in the RPWDA (in relation to ‘research and development’; Section 28), many of the components of habilitation, however, are present in both Acts. The Preamble of the RPWDA affirms ‘individual autonomy including the freedom to make one’s own choices, and independence of persons’ (a), and ‘full and effective participation and inclusion in society’ (c). Across both Acts, education, vocational training, family life, capacity and expression are considered (see above) and, occupation, political and social life are also addressed (see below).

Section 27 of the RPWDA, which requires governments to develop rehabilitation policies and services, comes with the caveat that they must do so only ‘within their economic capacity and development’. This greatly reduces the onus on governments, as ‘economic capacity’ is a decidedly vague concept; a proportion of budget to be spent on rehabilitation would be a much stronger provision. In India, only 5% to 10% of people have access to basic rehabilitation services (Mishra, 2003). Much of the funding for this relies on non-governmental organizations and the distribution of programs is heterogeneous (National Disability Network and National Committee on the Rights of Persons with Disabilities, 2017). Early intervention, in particular, is often absent (Kothari and Raturi, 2014).

Table 4.19 Incorporation of Article 26 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
26	Habilitation and rehabilitation	Preamble, 2(z), 7(1)(c), 27, 60(2)(r)(i), 74(3), 79(2)	2(o), 18(4)(c), d)	-
26.1.a	Habilitation and rehabilitation services to begin at the earliest possible stage, and to be based on multidisciplinary assessment	38	-	Very vague
26.1.b	Habilitation and rehabilitation services	25(1)(a)	17(e),	Provided for

	should be local, community-based and voluntary		18(5)(c), 18(5)(d)	under the assumption that rehabilitation is part of healthcare
26.2	Promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation	27, 28, 47(1), 47(3)	2(o), 31	-
26.3	Promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation	28, 29(g), 30(3)(c), 40	-	-

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.23 Article 27: Work and Employment

Sections of the RPWDA and the MHCA that relate to Article 27 of the CRPD are summarized in Table 4.20. The right to work and employment for people with disabilities is addressed predominantly in Chapter IV of the RPWDA ('Self-development and employment'). These Sections (19 to 23) make extensive use of the term 'establishment' (Section 2(i)) which includes both government (Section 2(k)) and private establishments (Section 2(v)).

The right to work is affirmed in general terms in government establishments, but while it is prohibited to discriminate against any person with disability in any matter relating to employment, an establishment may be exempt from this requirement depending on the type of work it carries out (Section 20(1)). In addition, while Article 27 of the CRPD requires specific prohibitions on discrimination relating to 'conditions

of recruitment, hiring and employment, continuance of employment, career advancement and safe and healthy working conditions', most of these are not comprehensively addressed in the Indian legislation, with the exception of career advancement (Section 20(3) of the RPWDA).

The provisions for the private sector are more limited, although it is required to have an equal opportunity policy (Section 21). Incentives for the private sector are suggested in order to help ensure that at least 5% of their work-force is made up of persons with benchmark disabilities (Section 35).

The duty of the state to protect the rights of persons with disabilities to 'just and favourable conditions of work', required by the CRPD, receives no specific mention in the RPWDA. There are general protections relating to 'discrimination' (Section 2(h)), 'equality and non-discrimination' (Section 3), and weak provisions in Sections 20 and 35 (above), but these general protections are significantly undermined by Section 3(3) which permits discrimination on the grounds of disability if 'it is shown that the impugned act or omission is a proportionate means of achieving a legitimate aim'. In addition, there is no explicit mention of 'equal opportunities and equal remuneration for work of equal value, safe and healthy working conditions, including protection from harassment', as suggested in the CRPD. The RPWDA does make provisions for redressing grievances in government establishments (Section 23), but there is no specific mention of 'labour and trade union rights' (also required by the CRPD).

The RPWDA makes provision for technical and vocational guidance programmes, placement services, training and education for people with disabilities (Sections 18 and 19). Section 19, in particular, outlines practical steps to empower people with disabilities to become self-employed and gain work experience. These provisions, combined with the RPWDA's equal opportunity measures (Section 21), enhance employment opportunities and career advancement for persons with disabilities. There are also provisions to promote the employment of people with benchmark disabilities in both the public (Sections 33 and 34(1)) and private (Section 35) sectors. Provisions are made for reasonable accommodation in government establishments (Section 20(2)) and protection of people who acquire a disability while working in government establishments (Section 20(4)).

The CRPD requirement for explicit protection from forced labour or slavery is

very limited in the RPWDA. It could be argued that this is addressed through general protection from discrimination (Preamble (b)), the RPWDA's expansive definition of 'discrimination' (Section 2(h)), and the Act's general 'protection from abuse, violence and exploitation' (Section 7), combined with the prohibition of 'forced labour' in the Constitution of India (Article 23(1)). However, in light of the fact that India ranked 53rd out of 167 countries for the estimated prevalence of modern slavery (Walk Free Foundation, 2018), and the vulnerable nature of some people with disabilities, specific legislation is required. The MHCA has a provision that deals with forced labour while an in-patient in a mental health establishment (Section 20(2)(f)), but does not expand on this in other contexts.

As is the case in other countries, low rates of employment are seen among people with disabilities in India, especially people with psychosocial disabilities whose rate of employment can be as low as 15% (National Disability Network and National Committee on the Rights of Persons with Disabilities, 2017). Clearly, there is urgent need for robust legal provision in this area. Moreover, it is likely that, in the future, increasing levels of informal employment in India would necessitate additional protections over time.

Table 4.20 Incorporation of Article 27 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
27	Work and employment	19, 20	-	-
27.1.a	States Parties shall prohibit discrimination on the basis of disability with regard to all matters concerning employment	20, 35	-	Public sector primarily
27.1.b	States Parties shall protect the rights of persons with disabilities to just and	2(h), 3, 20, 35	-	Weakly protected,

	favourable conditions of work			and Section 3(3) undermines it, although there are some protections for people with benchmark disabilities
27.1.c	States Parties shall ensure that persons with disabilities are able to exercise their labour and trade union rights		-	Absent from the legislation
27.1.d	States Parties shall enable persons with disabilities to have access to technical and vocational guidance programmes, placement services and training	18, 19, 39(d)	-	-
27.1.e	States Parties shall promote employment opportunities and career advancement for persons with disabilities	18, 19, 21	-	-
27.1.f	States Parties shall promote opportunities for self-employment, entrepreneurship, the development of cooperatives and starting one's own business	19	-	-
27.1.g	States Parties shall employ persons with disabilities in the public sector	20, 33, 34(1)	-	-
27.1.h	States Parties shall promote the employment of persons with disabilities in the private sector through appropriate policies and measures	35	-	Persons with benchmark disabilities only

27.1.i	States Parties shall ensure that reasonable accommodation is provided in the workplace	2(h), 2(y), 3(5), 20(2), 65(2)(e), 71(2)(e)	-	-
27.1.j	States Parties shall promote access to work experience	19	-	-
27.1.k	States Parties shall promote vocational and professional rehabilitation, job retention and return-to-work programmes	20(4)	-	-
27.2	States Parties shall ensure that persons with disabilities are not held in slavery or in servitude, and are protected, on an equal basis with others, from forced or compulsory labour	7	20(2)(f)	More explicit legislation needed

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.24 Article 28: Adequate Standard of Living and Social Protection

Sections of the RPWDA and the MHCA that relate to Article 28 of the CRPD are summarised in Table 4.21. The right to an adequate standard of living and social protection is addressed in Section 24 of the RPWDA. Specific consideration is given to ‘diversity of disability, gender, age, and socio-economic status’ (Section 24(2)), and women (Section 24(3)(d)), as suggested in the CRPD. Section 24 also provides for community centres and facilities (Section 24(3)(a)), but not accommodation or homes, although people with benchmark disabilities have a 5% reservation in housing schemes and land allotment (Section 37). People with disabilities also get free local

healthcare (as discussed above). The RPWDA provisions for social security are however, accompanied by the caveat that each government must provide the specified supports ‘within the limit of its economic capacity and development’ (Section 24(1)). In addition, the RPWDA does not meet the CRPD specifications in terms of respite care, food and clothing.

Section 20 of the MHCA delivers some more clearly defined rights. When providing a right to protection from cruel, inhuman and degrading treatment, it also states that people ‘have a right to live with dignity’ (Section 20(1)). While in a mental health establishment, all people with mental illness have rights to, *inter alia*, a safe and hygienic environment, proper clothing, adequate provision for wholesome food, facilities for leisure, recreation, education and religious practices, and provision for preparing for living in the community (Section 20(2)). People with mental illness are also to be provided with half-way homes, sheltered accommodation and supported accommodation (Section 18(4)(b)).

Housing issues for people with disabilities are poorly addressed in India in general (National CRPD Coalition-India, 2019). The Indira Gandhi Disability Pension is insufficient to cover food for a month and over 95% of people with disabilities are ineligible or do not receive it (National Disability Network and National Committee on the Rights of Persons with Disabilities, 2017). The age limit for social protection schemes needs to be removed; financial provisions should cover the cost of living as well as disability related costs; and sanitation and water systems need to be given particular consideration for people with disabilities.

Table 4.21 Incorporation of Article 28 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes

28	Adequate standard of living and social protection	24	18-20	-
28.1	The right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing	24, 37	18(11), 19(2), 20	Food and clothing not mentioned in the RPWDA
28.2.a	States Parties to ensure equal access by persons with disabilities to clean water services and other assistance for disability-related needs	5(2)(b), 24(3)(e), 40, 46, 65(2)(e), 71(2)(e)	18, 19, 20, 21	-
28.2.b	States Parties to ensure access to social protection programmes and poverty reduction programmes, in particular for women and girls with disabilities and older persons with disabilities	17(g), 24(1), 24(3)(d, f, g), 37(b)	18	-
28.2.c	States Parties to ensure access by persons with disabilities and their families living in poverty to assistance with disability-related expenses, including adequate training, counselling, financial assistance and respite care	24(1), 24(3)(d, f, g), 25(1)(a), 31, 37(b)	18	No mention of respite
28.2.d	States Parties to ensure access by persons with disabilities to public housing programmes	37	-	For benchmark disabilities
28.2.e	States Parties ensure equal access by persons with disabilities to retirement benefits and programmes	24(3)(g)	-	-

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

4.4.25 Article 29: Participation in Political and Public Life

Sections of the RPWDA and the MHCA that relate to Article 29 of the CRPD are summarised in Table 4.22. The two Acts contain limited consideration of the right to participate in political and public life, although some general protections could be inferred from the RPWDA's broad definitions of 'barrier' (Section 2(c)) and 'discrimination' (Section 2(h)). The RPWDA also mandates that polling stations are accessible to individuals with disabilities (Section 11). Provision is made for privacy and assistance by the Election Commission of India (2018), but neither the RPWDA nor MHCA articulate a right to vote for people with disabilities or mental illness.

This paucity of protection of political rights is of particular concern as people with disabilities have significantly reduced political participation which has proven resistant to legislative remedies in, for example, the US (Matsubayashi and Ueda, 2014). The level of support available to people with disabilities, their residence type and their level of need all impact on voter participation (Friedman and Rizzolo, 2017). Consequently, it is important that these factors would be considered in the RPWDA and MHCA.

Reduced participation of people with disability and mental illness in political life is an issue in many countries (Kelly, 2014b; Bhugra et al., 2016; Kelly and Nash, 2019), and, while neither the RPWDA nor the MHCA met the CRPD requirement to promote participation in public life, both include people with disabilities and mental illness on various decision-making boards, which is a good start. However, the exclusion of people of 'unsound mind' from the Central Advisory Board on Disability (Section 62(1)(b) of the RPWDA) and State Advisory Boards (Section 68(1)(b)) contrasts starkly with the CRPD. It is, however, encouraging that the protections offered by the Election Commission of India (2018) specifically apply to people with 'mental illness (psycho-social disabilities)'.

Other Indian legislation presents cause for concern too. The Representation of the People Act, 1950 disqualifies people who have been judged to be of 'unsound mind' from voting (Sections 16(1)(b) and 16(2)); some state laws bar persons of

‘unsound mind’ or who are ‘deaf-mute’ from running in elections (National CRPD Coalition-India, 2019); and the Constitution of India cites ‘unsoundness of mind’ as possible grounds for disenfranchisement (Article 326). All need reform.

Table 4.22 Incorporation of Article 29 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
29	Participation in political and public life	2(c, h), 3(3), 11	-	Representation of the People Act, 1950, Sections 16(1)(b) and 16(2)
29.a.i	Ensuring that voting procedures, facilities and materials are appropriate, accessible and easy to understand and use	11	-	-
29.a.ii	Protecting the right of persons with disabilities to vote by secret ballot, to stand for elections, to effectively hold office and perform all public functions	2(c, h), 13(5), 20, 62(1)(b), 68(1)(b)	3(3)	Limited cover of these rights; discrimination against people of ‘unsound mind’
29.a.iii	Guaranteeing free expression of the will of persons with disabilities as electors	11, 14		Not clearly protected

29.b.i	Encourage persons with disabilities to participate in non-governmental organizations and associations concerned with public and political life	29(d)	3(3)	Limited
29.b.ii	Support the forming and joining of organizations of persons with disabilities to represent persons with disabilities at international, national, regional and local levels	29(d)	3(3)	Limited; contradicted by Sections 62(1)(b) and 68(1)(b) of the RPWDA

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.4.26 Article 30: Participation in Cultural Life, Recreation, Leisure and Sport

Sections of the RPWDA and the MHCA that relate to Article 30 of the CRPD are summarised in Table 4.23. Rights to participate in cultural life, recreation, leisure and sport are moderately well protected in the RPWDA. Access to cultural materials, media and locations is, arguably, dealt with in the Act's general non-discrimination provisions (Sections 2(h) and 3(3)). The legislation also defines a 'public building', which much be accessible (Section 45(1)), quite broadly, as 'a Government or private building, used or accessed by the public at large, including a building used for...public utilities, religious, cultural, leisure or recreational activities' (Section 2(w)); this essentially covers the activities described in this article of the CRPD. Leisure, recreational and cultural services are also considered as 'public facilities and services' in the RPWDA (Section 2(x)).

In addition to these general provisions, the RPWDA also addresses directly the rights of people with disabilities to participate in culture, recreation (Section 29) and sport (Section 30), and these provisions will hopefully be underpinned by Section 40, which promotes 'accessibility' more generally.

The RPWDA gives no consideration to the potential role of ‘laws protecting intellectual property rights’ as barriers to accessing cultural materials (as required by the CRPD), but this is addressed in the Copyright Act, 1957 (Section 31(B)), as amended by the Copyright (Amendment) Act, 2012 (Section 18) (‘Compulsory licence for benefit of disabled’). Access to tourism is not explicitly considered in the RPWDA but is likely included under ‘Culture and recreation’ (Section 29).

Table 4.23 Incorporation of Article 30 of the Convention on the Rights of Persons with Disabilities into Indian law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017

Article of the CRPD	Abridged description of CRPD article and sub-articles	Key sections in the RPWDA	Key sections in the MHCA	Notes
30	Participation in cultural life, recreation, leisure and sport	2(c, h, w, x), 3(3), 45, 29, 30	-	General provisions
30.1.a	The state to ensure that persons with disabilities enjoy access to cultural materials in accessible formats	2(c, h), 29(c, f), 42, 44, 45	-	General provisions, mostly concerning accessibility
30.1.b	The state to ensure that persons with disabilities have appropriate access to television programmes, films, theatre and other cultural activities	29(a, c, f, g, h), 42(i,ii)	-	Only television explicitly mentioned
30.1.c	The state to ensure that persons with disabilities have access to places for cultural performances or services,	29, 30	-	-

	monuments and sites of national importance			
30.2	Persons with disabilities should have the opportunity to develop and utilize their creative, artistic and intellectual potential	16-18, 29(a, c, d, e, f, g)	-	-
30.3	Laws protecting intellectual property rights must not constitute an unreasonable or discriminatory barrier to access by persons with disabilities to cultural materials	-	-	Copyright Act, 1957 (Section 31(B))
30.4	Recognition and support of specific cultural and linguistic identity, including sign languages and deaf culture	2(f), 17(c), 29(b, f),	-	-
30.5. a	Encourage and promote the participation of persons with disabilities in mainstream sporting activities	16(i), 30, 47(1)(e)	-	-
30.5. b	Organize, develop and participate in disability-specific sporting and recreational activities	30(3)(f)	-	-
30.5.c	Access to sporting, recreational and tourism venues	29(c, d, e, f, g), 41	-	No mention of tourism
30.5. d	Children with disabilities have access to participation in play, recreation and leisure and sporting activities including those activities in the school system	16(i, ii), 30, 47(1)(e)	-	-
30.5. e	Access to services from those involved in the organization of recreational, tourism, leisure and sporting activities	29(c, d, e, f, g), 30, 44, 45(1)	-	-

CRPD: Convention on the Rights of Persons with Disabilities

RPWDA: Rights of Persons with Disabilities Act, 2016

MHCA: Mental Healthcare Act, 2017

4.5 Discussion

Assessment of compliance with the CRPD is complex. Some of the articles of the CRPD appear inconsistent with each other, and there are internal conflicts within the Convention that seem to require a balancing or weighing up of different rights (Duffy and Kelly, 2017b). Prior to the MHCA, Szmukler and Bach (2015) argued that no mental health legislation was fully compliant with the CRPD, suggesting that the two key issues limiting compliance related to capacity and involuntary treatment. While, there are many areas of potential non concordance, the discussion above in section 4.4 looked at the individual sections of the CRPD and analyzed how they were realized in the Indian legislation. In this section, below, the major themes of the MHCA are examined to see if they are concordant with the CRPD. This is not an exhaustive list, but an attempt has been made to cover the main themes.

4.5.1 Capacity

Legal and mental capacity have been two of the most intensely debated topics in relation to the CRPD (Appelbaum, 2019; Freeman et al., 2015; Szmukler, 2019). The CRPD leads mental health legislation away from a substitute decision-making paradigm towards a supported decision-making one, especially through the provisions of Article 12. Article 12.2 requires that ‘States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.’ Article 12 also replaces the underpinning principle of ‘best interests’ with an onus to ‘respect the rights, will and preferences of the person’ (Article 12(4)).

During the drafting of the CRPD, there was a move to create exceptions to this provision in extreme cases, to allow for involuntary treatment, but no agreement could be reached and the CRPD was finalised in its current form (MacQuarrie and Laurin-Bowie, 2014). The omission of these exceptions has been cemented by the UN Committee on the Rights of Persons with Disabilities (2014), which stated that ‘states parties must abolish policies and legislative provisions that allow or perpetrate forced

treatment, as it is an ongoing violation found in mental health laws across the globe’ (Paragraph 42). The Committee also stated that people should have ‘the right to be free from involuntary detention in a mental health facility and not to be forced to undergo mental health treatment’ (Paragraph 31).

The Committee’s views have led some countries, including England and Wales, to formally and openly ignore their guidance (Independent Review of the Mental Health Act 1983, 2018) and have placed them at significant odds with other UN organizations (Szmukler, 2019). Dawson (2015) argues that such a dogmatic interpretation of the CRPD is unrealistic and suggests less radical reforms.

The Committee’s ‘General Comment’ also differentiates between mental and legal capacity. They see mental capacity as a highly subjective medical construct with limited validity, and legal capacity as an integral, non-derogable right that is unaffected by a person’s level of cognition or mental state (Paragraph 14). No explicit distinction is made between mental and legal capacity in India’s MHCA, even though both the MHCA and the Rights of Persons with Disabilities Act, 2016 (RPWDA, 2016) discuss capacity, as laid out in Table 4.24.

Table 4.24: References to capacity in the Mental Healthcare Act, 2017 and the Rights of Persons with Disabilities Act, 2016

Section of Indian legislation referring to capacity	Meaning of legislation	Type of capacity discussed	Notes
Mental Healthcare Act, 2017, Section 4(1)	Affirmation of universal capacity provided the person can understand, appreciate and communicate information	Mental capacity	There is a typographical error in the current legislation where it states that a person must understand <i>or</i> appreciate <i>or</i> communicate. This

			should read understand <i>and</i> appreciate <i>and</i> communicate
Mental Healthcare Act, 2017, Section 4(3)	Decisions regarding mental healthcare perceived by others as inappropriate or wrong shall not mean the decision-maker lacks capacity	Mental capacity	Strong affirmation of will and preference over best interests
Mental Healthcare Act, 2017, Section 5(3)	Advance directives come into force when a person ceases to have capacity	Mental capacity	In contravention of the interpretation of the UN Committee on the Rights of Persons with Disabilities
Mental Healthcare Act, 2017, Section 5(4)	Decisions made by a person with capacity to make mental healthcare decisions shall over-ride any advance directive	Mental capacity	Implies that people without decision-making capacity cannot over-ride advance directives, but this is not explicitly stated
Mental Healthcare Act, 2017, Section 11(2)(d)	Capacity required to make advance directive but only evaluated when the advance directive comes into force	Mental capacity	It is very difficult to establish retrospective capacity in a person currently suffering from a major mental illness
Mental Healthcare Act, 2017, Section 14 (8)	The appointment of a nominated representative does not mean a person lacks capacity	Legal capacity	-
Mental Healthcare	Affirmation of universal capacity with an	Legal capacity	-

Act, 2017, Section 14(9)	acknowledgement of the need for varying levels of support		
Mental Healthcare Act, 2017, Section 81	Central Authority to prepare a guidance document for professionals, containing procedures for assessing capacity	Mental capacity	-
Mental Healthcare Act, 2017, Sections 85(1) and 86(2)(c)	Capacity with minimal support needed to be an independent patient	Mental capacity	This requires people who require moderate or high supports in making decisions to be supported patients even when they are assenting to admission
Mental Healthcare Act, 2017, Sections 89(7&8) and 90(12&13)	Regular review of capacity for people with such high support needs that their nominated representative is giving proxy consent	Mental capacity	Additional guidance will be needed to clarify level of support needed and level of capacity present
Rights of Persons with Disabilities Act, 2016, Section 13(2)	Persons with disabilities enjoy legal capacity on an equal basis with others and have the right to equal recognition before the law	Legal capacity	-
Rights of Persons	The government to support persons with disabilities in	Legal capacity	-

with Disabilities Act, 2016, Section 15	exercising their legal capacity		

The MHCA and RPWDA present a number of mechanisms that aim to promote compliance with the CRPD. These key constructs are discussed in the sections below. In many ways, these provisions all hinge on the concept of capacity. This is one of the most controversial areas of the CRPD and it is generally poorly described in the MHCA. While the legislation proposes the provision of additional guidance outside the Act, and the *Mental Healthcare (State Mental Health Authority) Rules, 2018* (Ministry of Health and Family Welfare, 2018) also make reference to an expert group, there is, at present, no additional guidance in relation to capacity, which is regrettable.

A true realization of Articles 12 to 17 of the CRPD may require a complete shift away from mental health law, which can be discriminatory. With mental health law, questions of mental capacity and the evaluation of decision-making ability are applied to people with mental illness, while people without mental illness are free to make autonomous decisions without their capacity being called into question. In contrast, a generic or ‘fusion’ law for decision-making in health and social care that evaluated mental or physical health in all people making such decisions, could, in theory, be applied equally across the population (Dawson and Szmukler, 2006). Such a law is being attempted in Northern Ireland (Szmukler and Bach, 2015). This may be one of the most significant areas where the MHCA deviates from comprehensive realization of the CRPD, as the MHCA does not adhere to a ‘fusion’ model.

Not all parties agree, however, that removal of mental illness as a justification for the restriction of liberty would be a good thing (Freeman et al., 2015; Applebaum 2019). Such a step might well result in the criminalization of people who break the law as a consequence of mental illness. It might also persevere autonomy at the expensive of dignity, or protect liberty at the expensive of health. There are many finely balanced tensions that are currently held within psychiatric systems, and specific mental health legislation might still be needed to clarify and navigate these nuanced circumstances (Duffy and Kelly, 2017b).

The RPWDA and MHCA could be seen as sidestepping controversial issues linked with capacity and limited guardianship. In relation to both of these topics, the legislation points to external guidelines (MHCA, Section 81(1); RPWDA, Section 14(1)). This could represent an attempt to move the potentially non-concordant elements outside of the Indian legislation and into policy. Alternatively, this might represent incremental application of the new legislation, with provisions in policy being easier to revise than those in legislation. This approach might also allow states with varying resource levels to realize the legislation in a graded, contextualized and possibly more successful manner.

This flexibility might well prove especially important as the debate about capacity and its place in mental health law continues (Szmukler, 2019; Flynn, 2019). It appears that the initial assessments of capacity will be based on assessments of decision-making ability (MHCA, Section 4(1)), but this might evolve in time, to place increasing weight on individual will and preference through the roles of advance directives and nominated representatives. Should advance directives become commonly employed in Indian psychiatry, a modification of the legislation might well allow them to come into force without an assessment of capacity, as suggested by Flynn (2019).

In any case, data will need to be collected on the utilization of advance directives, limited guardianship and assessments of capacity in order to ensure that the new provisions minimize coercion and promote meaningful change.

4.5.2 Advance Directives

Advance directives have emerged from the field of end-of-life care, an area in which they are now well established (Philip et al., 2019). Owing to this evolutionary path, they sometimes appear poorly designed to meet fluctuating, unpredictable mental health needs. The CRPD, however, appears to require developments in this area and many countries are rising to the challenge (Davidson et al., 2016; Morrissey, 2012).

The UN Committee on the Rights of Persons with Disabilities (2014) has shown support for advance directives, stating that ‘all persons with disabilities have the right to engage in advance planning and should be given the opportunity to do so on an

equal basis with others’ (Paragraph 17). However, they explicitly state that ‘the point at which an advance directive enters into force (and ceases to have effect) should be decided by the person and included in the text of the directive; it should not be based on an assessment that the person lacks mental capacity’. In this respect, the MHCA fails to comply with the Committee’s interpretation of the CRPD.

4.5.3 Nominated Representative

A key construct in the MHCA that is intended to maximize the capacity of people with mental illness is the nominated representative. Overall, however, the role of a nominated representative is poorly defined in the medical literature; their involvement can be highly variable across different jurisdictions; and they may have a wide variety of roles in different contexts (Davidson et al., 2016).

The mechanism by which a nominated representative may come to take up their role under the MHCA is inconsistent with the UN Committee on the Rights of Persons with Disabilities’ (2014), as it realises on an assessment of capacity. However, the nominated representative conforms to the Committee’s suggestion that countries ‘review the laws allowing for guardianship and trusteeship, and take action to develop laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person’s autonomy, will and preferences’ (Paragraph 26). The MHCA does a superior job in this regard compared to the role of limited guardianship described in the RPWDA.

Much debate has taken place as to how socially acceptable advance directives and nominated representatives are in an Indian context; how prepared people are to use them (Tekkalaki et al., 2018); the extent to which their utilisation will impact treatment (Pathare et al., 2015); and the effect they will have on families (Duffy et al., 2018). This is an ongoing issue that is likely to be clarified only during implementation of the new legislation.

4.5.4 Supported Decision-Making and Individual Will and Preference

The CRPD is very clear, even outside of the interpretations of the UN Committee on the Rights of Persons with Disabilities (2014), that there should be a shift from

substitute decision-making to supported decision-making. Again, this protection is primarily contained in Article 12. A natural outcome of this is a shift from substitute decisions being made in a person's 'best interests' to supported decisions being made in line with a person's rights, will and preferences (Craigie et al., 2019). Table 9.2 demonstrates how this shift is reflected in the MHCA by examining the relevant ethical principles concerning decision-making.

In the case of minors, 'best interests' remains the guiding principle but, in the case of adults, their will and preference are to be the key factor, although Section 17 of the MHCA ('Duties of nominated representative') also includes 'best interests' as a consideration. In any place where there is substitute decision-making, this is framed in the context of Section 17 which instructs a nominated representative to consider 'the current and past wishes, the life history, values, cultural background and the best interests of the person with mental illness'. An interesting view is taken on research with patients who are unable to give informed consent in Section 99(3)(b), where research can proceed with relevant checks and balances if it is 'is necessary to promote the mental health of the population represented by the person'.

Table 4.25: Key references to the ethical principles underpinning decision-making in the Mental Healthcare Act, 2017 and the Rights of Persons with Disabilities Act, 2016

Sections of the Act relevant to decision-making	Meaning of the legislation	Ethical principles underpinning the decision-making process
Mental Healthcare Act, 2017, Section 4	Affirmation of universal capacity, provided people can understand, appreciate and communicate information	Individual will and preference
Mental Healthcare Act, 2017, Section 14(9)	Affirmation of universal capacity with an acknowledgement of the need for varying levels of support	Individual will and preference, with support from nominated representatives

Mental Healthcare Act, 2017, Section 15(2)	Best interests the underpinning principle for nominated representatives of minors	Best interests
Mental Healthcare Act, 2017, Section 17	Current and past wishes, life history, values, cultural background and best interests to inform the decisions of nominated representatives	Individual will, preference, and best interests, with support from nominated representatives
Mental Healthcare Act, 2017, Section 87(3)(b)	Admissions of minors have to be in their best interests	Best interests
Mental Healthcare Act, 2017, Sections 89(7) and 90(12)	Substitute decision-making where a very high level of support is needed during a supported admission	Substitute decision-making framed by Section 17, justified by the risk of harm to self or others, intentionally or unintentionally
Mental Healthcare Act, 2017, Section 94	Proxy consent by nominated representative permitted in emergency contexts for medical and psychiatric treatment, with a 72-hour limit. Possible treatment without consent if nominated representative unavailable	Substitute decision-making framed by Section 17, justified by the risk of harm to self or others or harm to property
Mental Healthcare Act, 2017, Section 99(3)	Research in people without capacity to consent	Individual assent; the benefit of the mental health of the population represented by the person; substitute decision-making framed by Section 17

Rights of Persons with Disabilities Act, 2016, Section 9(1)	Best interests of a minor can be grounds for the separation of a child from its parents	Best interests
Rights of Persons with Disabilities Act, 2016, Section 12(2)	Suitable support measures for persons with disabilities in exercising legal rights	Legal rights

4.5.5 Involuntary Treatment

Provisions for involuntary treatment are greatly limited in the MHCA compared to both earlier Indian legislation and current legislation in many other jurisdictions. The word ‘involuntary’ does not appear in the MHCA. Even so, there are still contexts in which a person can be treated without consent (see below) and these provisions might well shift the paradigm back again to one driven by best interests rather than rights, will and preference (Feiring and Ugstad, 2014). The MHCA permits coercive treatments which many see as a violation of the CRPD. However, this aligns with the legislation of other jurisdictions such as Queensland, Australia (Del Villar, 2015) and England and Wales (Independent Review of the Mental Health Act, 1983, 2018). It intentionally disregards the UN Committee on the Rights of Persons with Disabilities’ (2014) interpretation of the CRPD and, in particular, its interpretation of Article 12 (‘Equal recognition before the law’).

Under the MHCA, coercive treatments can occur on the basis of risk, which can be intentional or unintentional, and can be directed at the person themselves, others or (in some instances) property. ‘Illness criteria’ would better align with the skills psychiatrists have. The impact of *potential* coercion on people in mental health services and, more broadly, all people with disabilities is difficult to quantify and should not be underestimated (Molodynski et al., 2010; Burns et al., 2011).

Taking all of this into account, it could be argued that the strong family ties and paternalistic practice of medicine in India (Rao et al., 2016) might mean that apparently coercive measures could help *realize* rights, including autonomy, through provision of care. Similarly, the removal of all formal coercion could lead to a significant increase in informal coercion, without appropriate oversight or review.

4.5.5.1 Supported Admissions

Supported admissions are described in Sections 89 and 90 of the MHCA, and relate to ‘persons with mental illness, with high support needs’. A person who has a ‘supported admission’ must have a mental illness and present a risk (Sections 89(1) and 90(2)). There is no provision for ‘supported admission’ based on illness alone or the need for treatment, as there is in some countries (Zhang et al., 2015). This is problematic from a clinical perspective because psychiatrists are much better equipped to predict the course of illness than they are to predict risk (Mulder et al., 2016). The concept of risk under the MHCA is also very broad: it includes a risk of harm to the person themselves or to other people, and a risk of harm through self-neglect. The inclusion of self-neglect as a justification for admission could be an indirect route to involuntary admission on the grounds of illness alone. There is, however, no need for evidence that treatment will benefit the person.

The wording of the MHCA may be problematic for people with moderate support needs who do not present an active risk. Such people will not qualify for ‘supported admission’ and so their right to health and healthcare may be limited. They cannot be an ‘independent patient’ owing to their lack of capacity and their need for support, but they can only be a ‘supported patient’ if there is sufficient risk identified.

4.5.5.2 Treatment During a ‘Supported Admission’

During a ‘supported admission’, treatment will generally take place under Sections 89(6) and 90(11) of the MHCA. However, sections 89(7) and 90(12) acknowledge that some people who require ‘supported admissions’ will require ‘nearly hundred per cent support’ in making treatment decisions. In these instances ‘the nominated

representative may temporarily consent to the treatment plan of such person on his behalf’.

While these arrangements constitute a form of substitute decision-making, they are framed by the Section 17 of the MHCA which puts an onus on the nominated representative to consider the wishes of the individual. Therefore, adults cannot receive treatment without some consideration being given to their preferences and significant steps being taken to maximise their decision-making capacity. At the same time, the MHCA does not deprive people with impaired ability to give informed consent from receiving effective treatments. In this respect, the MHCA attempts to balance the CRPD’s rights to ‘life’ (Article 10) and ‘health’ (Article 25) with its rights to ‘equal recognition before the law’ (Article 12), ‘liberty and security of person’ (Article 14), ‘integrity of the person’ (Article 17), and ‘freedom from torture or cruel, inhuman or degrading treatment or punishment’ (Article 15).

4.5.5.3 Emergency Treatment

Emergency treatment is described in Section 94 of the MHCA. In an emergency situation some of the rights outlined in Articles 12 to 17 of the CRPD are limited in order to protect *property*. This appears disproportionate. Admittedly, the MHCA provides the protection that emergency treatment is limited to 'seventy-two hours or till the person with mental illness has been assessed at a mental health establishment' (Section 94(4)), and it prohibits both ‘medical treatment which is not directly related to the emergency’ (Section 94(2)). In addition, it is arguable that the provisions of Section 94(1)(c) might actually *protect* rights, because an inability to intervene when a person is damaging property due to mental illness could increase the stigmatisation and criminalisation of people with mental illness (Freeman et al., 2015). This provision of the MHCA to provide emergency care without consent on the basis of damage to *property* appears especially inconsistent with the CRPD.

4.5.5.4 Restraint and Seclusion

Seclusion is prohibited under the MHCA (Section 97(1)). While seclusion is a highly contentious practice, it is still widely used internationally (Al-Maraira and Hayajneh,

2019; Steinert et al., 2010) and its prohibition in the MHCA is a highly progressive step. Seclusion potentially breaches Articles 14 ('Liberty and security of person'), 15 ('Freedom from torture or cruel, inhuman or degrading treatment or punishment'), 16 ('Freedom from exploitation, violence and abuse') and 17 ('Protecting the integrity of the person') of the CRPD.

Physical restraint is permitted under the MHCA. It is, however, only allowed in specific circumstances described in section 97. This is an example of the MHCA striking a balance between CRPD rights to health (Article 25) and life (Article 10) on the one hand, and Articles 14 through 17 on the other. Interestingly this balance also considers the right to health and life of other people in addition to the person requiring treatment.

While multiple CRPD rights are plainly limited by the use of restraint, these limitations are described in law. This is in partial compliance with Article 14(1)(b) of the CRPD which requires that 'any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty'. The description in law is clearly in line with the first part of this requirement, but the inclusion of restraint in the first place is clearly a breach of the second.

4.5.6 Research

The MHCA permits research involving people who are unable to give free and informed consent but do not resist participation (Section 99(2)). In this case, consent can be obtained from the nominated representative and the SMHA must be satisfied that the five conditions described in Section 99(3) are met.

The second condition, that the research promotes the mental health of the population represented by the person, is very interesting because it describes a utilitarian ethical principle whereby the research is occurring for the good of society at large. This is a significant departure from the individualistic principles of the CRPD and is more in keeping with the more family-centric principles of Indian society (Ademosu, 2018). The final condition, that the research follows all relevant national and international guidelines and regulations, may prove problematic, however, as it could be argued that the CRPD is an 'international guideline' that states that 'no one shall be

subjected without his or her free consent to medical or scientific experimentation’ (Article 15(1)).

4.5.7 Privacy and Confidentiality

The CRPD does not, for the most part, devote substantial attention to confidentiality in explicit terms (Article 31(1)(a)), but it’s description of ‘privacy’ also covers confidentiality, stating that ‘States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others’ (Article 22(2)).

Under the MHCA, people admitted to mental healthcare establishments have a right to privacy (Section 20(2)(d)). This is the only mention of privacy in the MHCA. Sections 23 and 24 address confidentiality. Section 23(1) articulates a right to confidentiality in respect of mental health, mental healthcare, treatment and physical healthcare. Section 24 extends this protection to photographs of people undergoing treatment at mental health establishments and to digital and electronic data. Section 23(2) outlines five conditions under which confidentiality may be breached; these are summarized in Table 9.3. Where information has to be released to protect the safety of others, the MHCA is clear that only information that is necessary to prevent harm should be released.

By including provisions for breaching confidentiality in mental health legislation rather than general health legislation, it would appear that personal health and rehabilitation information is not protected on an equal basis in people with mental illness compared to those without. Four of the five justifications for breaching confidentiality could have been included in general health legislation and if this had been the case the MHCA would have been concordant with the CRPD in relation to privacy; as matters stand, it is not.

Table 4.26 Justifications for breaching confidentiality in India’s Mental Healthcare Act, 2017

Reason for breach of right to privacy or confidentiality	Section of the Mental Healthcare Act, 2017 permitting the breach	Principles justifying the area of non-concordance with the United Nations' Convention on the Rights of Persons with Disabilities
To the nominated representative to enable him to fulfil his duties under the Act	22(2) and 23(2)(a)	To facilitate supported decision-making
To other health professionals to enable them to provide care and treatment	23(2)(b)	To protect the right to health
If it is necessary to protect any other person from harm or violence	23(2)(c)	To protect the right to life, health and freedom from violence for other people
Upon an order by the concerned Mental Health Review Board or the Central Authority or High Court or Supreme Court or any other competent statutory authority	23(2)(f)	Judicial authority
In the interests of public safety and security.	23(2)(g)	To protect the right to life, health and freedom from violence for other people

4.5.8 Electroconvulsive Therapy

ECT has proved to be one of the most controversial areas of the MHCA (Duffy et al., 2018; Duffy et al., 2019b). Psychiatrists are strongly divided regarding the limitations placed on its use by the MHCA, which totally prohibits the use of unmodified ECT (i.e. ECT without anaesthetic) (Section 95(1)(a)), bans its use in the emergency setting (Section 94(3)) and creates substantial barriers to its use in minors (Sections 95(1)(b)

and 95(2)). These provisions are in line with the *WHO Resource Book on Mental Health, Human Rights and Legislation* (WHO, 2005). The key issue in relation to the CRPD is whether ECT amounts to cruel and inhumane treatment, as this would be a violation of Article 15.

Portrayals of ECT in the media are often highly negative and may lead people to believe that such treatment is inhumane (Sienaert, 2016). In practice, a substantial evidence base supports the treatment (van Diermen et al., 2018; Mutz et al., 2019) and many Indian psychiatrists are strong advocates of it (Antony, 2015; Thippeswamy et al., 2012). However, many people who have received ECT are much less convinced of its safety (Read et al., 2019) and many more are afraid of it (Morrison, 2009). Weitz (2013) argues that ECT is a form of assault, especially when administered without informed consent.

A strong case could be made that unmodified ECT is torture and that India's prohibition of this is in line with international standards (WHO, 2005). In light of the available evidence, voluntary, modified ECT (i.e. with anaesthetic) appears to be an important treatment, although critics argue that side effects have been minimized, possibly making informed consent invalid (Seniuk, 2018). Consequently, psychiatrists need to conduct high quality research on side effects and carefully communicate their findings to people who may receive ECT if they are to be concordant with the CRPD.

The most contentious area relates to supported patients, who need a moderate or high level of support to make treatment decisions and consequently could receive ECT without having given their own free and informed consent. Banning ECT in this cohort would deprive them of an effective treatment that is available to people who are able to give informed consent. In this instance, the protection of the person's rights relies heavily on the NR, and on a difficult balancing of CRPD rights to 'life' (Article 10) and 'health' (Article 25) with the right to freedom from treatments to which the person has not consented.

4.6 Conclusion

The RPWDA and the MHCA have taken substantial steps to incorporate many elements of the CRPD. They have avoided the complexity of directly incorporating the

entire CRPD as a whole, but have still addressed the great majority of its requirements. Certain areas could be improved, especially in the areas of political rights, liberty of movement and nationality. More consideration could be given to the practical implementation of many legal provisions, although this might better occur at policy level rather than in legislation. Careful monitoring of the realisation of the RPWDA and MHCA will also be important, both for India and for other countries seeking to bring their legislation in line with the CRPD. Globally, India has taken the strongest steps to date towards legislating for social rights in this way, including, in particular, rights to free healthcare and rehabilitation.

In some areas, questionable concordance with the CRPD in the Indian legislation reflects a progressive desire to provide high quality mental healthcare (e.g. in relation to research and the role of families). In addition, some of the omissions from the legislation have moved certain controversial topics outside the RPWDA and the MHCA (e.g. limited guardianship and the finer details of assessing mental capacity). While some of these changes might appear primarily semantic, they form part of a much larger and necessarily incremental process of change to the network of laws and regulations governing these areas. For example, ‘supported’ admissions are not so far removed from more traditional ‘involuntary’ admissions in many ways, but the tone taken in the MHCA is an important and progressive change.

India has also left a few areas intentionally obscure, in relation to capacity, the role of family, and emergency treatments. But even these provisions include many checks and balances, which will hopefully facilitate a degree of flexibility in implementation so as to better meet the complex needs of people with mental health problems.

As other countries seek to develop CRPD-concordant legislation, the RPWDA and MHCA provide a carefully considered example of what is possible. India has demonstrated that passing such legislation is feasible for a middle-income country. The use of legislation to promote social rights in this way is increasingly acknowledged as an important and often over-looked step (WHO, 2017). However, legislation alone is rarely sufficient to realize social rights, especially in a context of limited resources, as is the case in India (National CRPD Coalition-India, 2019; National Disability Network and National Committee on the Rights of Persons with Disabilities, 2017). There are

numerous examples of legislation not being followed in relation to people with disabilities (Delhi Commission for Protection of Child Rights, 2010), and these matters, too, necessitate examination in their own right, but they are outside the scope of this chapter. While it remains to be seen how the RPWDA and MHCA will be realized in practice, their very existence undoubtedly promotes the rights of people with disabilities and mental illnesses, and will play an important role in societal development over the years ahead.

Mental health legislation, such as the MHCA, always presents particular challenges in practice, especially in relation to mental capacity and involuntary treatment. Psychiatrists are well-placed to promote the adoption and realization of such new legislation given their familiarity with utilizing legislation and navigating complex ethical issues (Duffy and Kelly, 2017d). Probably the most contentious Article in the CRPD in terms of mental health legislation is Article 12 which relates to 'Equal recognition before the law' (Freeman et al., 2015; Appelbaum, 2019; Byrne et al., 2018). Where practices might appear to contravene the CRPD, multiple protections have been put in place, chiefly mediated by MHRBs. Areas of non-concordance are generally the product of efforts to balance competing CRPD rights with each other, and this balancing act is often directly reflected in the text of the MHCA. The two most significant areas of potential non-concordance with the CRPD relate to the role of capacity in the MHCA and the lack of sufficient protection during emergency treatment. These limitations may reflect pragmatic compromises in a setting of limited resources, especially as some of the other provisions described in the MHCA might already prove too ambitious to be implemented in the first place. Overall, while India's MHCA might not be entirely in line with the interpretations of the UN Committee on the Rights of Persons with Disabilities (2014), the vast majority of its provisions are compatible with the CRPD itself.

5. The perspective of psychiatrists working in India on the Mental Healthcare Act 2017: a focus group analysis

5.1 Introduction

India's new mental health and disability legislation represents a radical change. The importance of the MHCA stretches far beyond India as this act has the potential to become a template for low- and middle-income countries to realise the CRPD. Many psychiatrists have excitedly anticipated this legislation (Bhaumik, 2013; Rane and Nadkarni, 2013; Sachan, 2013), however, serious concerns have also been raised that it will not be implementable or will not serve the needs of patients, carers, or mental health professionals (Rao et al., 2019; Singh, 2019; Sivakumar et al., 2019).

It is vital to ensure that the content of legislation is concordant with international guidelines; this has been the focus of the research in the preceding chapters. However, the realization of that legislation is more important (Sen, 2009). Legislation often has unintended consequences (Corrigan et al., 2004); well drafted and comprehensive legislation that does not receive funding may well have harmful consequences (Firdosi and Ahmad, 2016; Vine and Judd, 2019; Mahomed, 2020). Failure to appreciate political, economic, social and cultural contexts may result in certain groups being adversely impacted or marginalized by legislation (Math et al., 2011). These issues arose regarding the implementation of the 1987 MHA in India, its application and resourcing was not homogeneous and varied from state to state (Firdosi and Ahmad, 2016; India State-Level Disease Burden Initiative Mental Disorders Collaborators, 2020).

As a result of this need to evaluate the realization of the legislation, the perspective of psychiatrists working in different Indian states was sought. A focus group methodology was selected as the topic of the MHCA is a highly emotive one among Indian psychiatrists and one where there is a high level of disagreement (Stalmeijer et al., 2014; Krueger and Casey, 2015). It was hoped that the interactions in the focus groups would capture this discourse and the feelings it evoked. Focus groups also allowed for a larger number of mental health professionals to be included in the study.

The results of the focus groups helped to inform the black letter analysis conducted in the prior chapters. They identified important constructs in relation to existing practices, for example, the need for GHPUs to become registered. The focus groups also helped identify how key topics, like capacity and the role of nominated representatives, were interpreted by Indian psychiatrists. The content of the focus groups also set the MHCA in its broader context by highlighting such things as the role of the family, stigma, and resource limitations in Indian society. This allowed the black letter analysis to focus in these areas in more detail.

5.2 Aims

The focus group component of this research sought to address the following aims:

- Identify relevant information to inform the black letter analysis in chapter three and four. These findings were utilised to focus the analysis of these chapters, this ensured that key elements of the legislation were not overlooked or misinterpreted.
- Identify key areas of mental healthcare that are impacted by the legislation and describe the main concerns, perceptions and hopes that psychiatrists working in India held concerning the MHCA. This aim is addressed in this chapter.

5.3 Methods

5.3.1 Group composition

A combination of opportunistic and purposeful sampling (Palinkas et al., 2015) was employed to recruit focus group participants. Key academics were identified and contacted; however the majority of the individuals who agreed to organise focus groups were through contacts that existed prior to the initiation of the research project. In this respect recruitment was opportunistic. However, with this limitation acknowledged, purposeful sampling was also done, to recruit mental health professionals from a wide variety of backgrounds (Barbour, 2007; Elo et al., 2014). The focus groups included mental health professionals from public and private settings, departments linked to stand alone psychiatric hospitals and GHPUs, and academic and

clinical psychiatrists. Trips were intentionally planned to Indian states with heterogenous levels of income.

Focus groups were organised through existing local continuing professional development groups, academic groups, individual psychiatry departments in hospitals, training schemes, and special interest groups. The key psychiatrists planning groups for us organized one to four groups each. They were requested to attempt to ensure that the groups were individually relatively homogenous but that each group represented a different area of practice within psychiatry. At locations where two focus groups were conducted senior staff were interviewed separately from junior staff in an attempt to minimize group heterogeneity and issues of power relations (Stalmeijer et al., 2014). Groups with expertise relating to legislation were intentionally included (Elo et al., 2014).

The focus groups sought to evaluate the perspectives of psychiatrists working in India, however at certain sights other senior professionals from nursing, anesthetics, management, psychology and occupational therapy wished to partake in the discussions, these were included in the study. In the text we continue to refer to psychiatrists as there was limited contributions from these professionals and their comments were in line with their psychiatric colleagues.

5.3.2 Demographic and professional variables

In addition to the, the focus group recordings, demographic details were sought from the participating mental health professionals. These included: their gender, years working in psychiatry, whether they worked in private or public setting, whether they worked in an inpatient or outpatient setting, the specialties they worked in, and whether they worked in an urban or rural setting. Psychiatrists were instructed to select all variables that applied to them.

5.3.3 Development of focus group questions

The questioning route (Krueger and Casey, 2015) evolved out of extensive document analysis (Duffy and Kelly, 2017a; Duffy and Kelly, 2017c), the relevant published literature and interviews with key stake holders prior to commencement of any focus

groups. The full list of questions is included in appendix 1. Four questions were analyzed:

1. What is positive about the new legislation?
2. What are your concerns about the new legislation?
3. What needs to be done in the transitional phase?
4. What would you have done differently if you were writing the act?

The moderator and observer also debriefed after each group; this facilitated an iterative development of the questioning route, and identified key topics that would be intentionally raised if they did not emerge *de novo*. These topics were enquired about towards the end of focus groups or opportunistically if a related topic had arisen during the main discussion.

This more informal approach was opted for, instead of a more structured discussion, as the researchers wanted to allow Indian psychiatrists to focus on the topics that they thought most relevant to the legislation. Also, as limited research had been conducted in this area, a high degree of flexibility was required to allow the pertinent topics to be identified and explored, rather than the discussion be limited to topics decided in advance by the researchers.

5.3.4 Conducting groups

The meetings occurred in meeting rooms in hospitals during the work day or during time allocated for teaching sessions. Focus groups lasted between 45 and 90 minutes, and were composed of between four and twelve participants. Written informed consent was obtained from all participants prior to starting recording. All focus groups had one moderator who led the discussion and one or two observers who recorded who was speaking and documented nonverbal information. The demographic details described above were also collected at the beginning of each group.

The above questions acted as anchor points for the discussion but the moderator encouraged the group to examine the topics that it found more relevant;

on occasions where key topics were not raised, direct questions were asked relating to that topic.

5.3.5 Debriefing following groups

Following each focus group, the researchers debriefed (McMahon and Winch, 2018). This space was used to reflect on non-verbal communication, highlight the use of jargon, identify issues that arose with group management, refine existing questions, and identify topics that should be enquired about in subsequent groups.

5.3.6. Transcription

All audio data was transcribed, including as much detail as possible and Professor Kelly reviewed this transcription against the tapes for accuracy. As far as possible the notes taken during the interview describing the emotional content of the meeting and identifying the speakers was integrated with the transcribed audio recording. In transcribing, all spoken words and pauses were noted. Only when quoted below were pauses, hesitations and false starts removed unless they were of particular relevance.

5.3.7 Analysis and coding

A preliminary coding occurred to identify the range of topics covered in the focus groups. From this, two topics were selected on which to focus the analysis: ECT and assisted decision making. These were chosen for three reasons. First, they frequently arose in the focus groups and evoked strong responses from the participating professionals. Second, they represent areas of significant legislative change in India's mental health law. Finally, they are of international interest and relevant to the evolution of mental health practice.

All data were analysed in detail using thematic analysis. This form of analysis was adopted as it is highly flexible (Braun and Clarke, 2012) and allowed a broad or narrow research focus to emerge as the data was collected. This facilitated a focus on the two identified topics. The methodology was also adopted as its findings are more accessible to readers, policy makers and psychiatrists compared to other forms of qualitative analysis (Braun and Clarke, 2012; King, 2004).

Within this thematic analysis an inductive approach (Thomas, 2006) was adopted to analyse codes and identify themes from the data itself, this was chosen in an attempt to minimise the impact of the cultural diversity between the researchers and participants. Researchers also used the debriefing sessions to identify their bias and ideological starting points in order to foster this inductive approach (Fereday and Muir-Cochrane, 2006).

Due to the nature of the study topic, we adopted a constructionist epistemology. This was anticipated to be the required approach and we confirmed this following our early meetings with Indian psychiatrists. Indian psychiatry is currently in a state of flux with the new legislation and there was a wide range of views and many psychiatrists held views that were still quite dynamic, many of their perspectives also had significant emotional content. Hence, the pursuit of an objective reality through a realist epistemology was likely to be less informative (Silverman, 2014). A realist approach may have described our findings more objectively and may have been less influenced by our Eurocentric lens (Carter and Little, 2007). However, it was felt that a constructionist approach may provide more meaningful outcomes and potentially results that would be of greater use (Carter and Little, 2007). It is also possible that the views of the researchers enriched the findings (Creswell and Miller, 2000). The study opted to examine the ways in which data collected operated in society rather than just reporting the experiences, meanings, and the reality of participants (Braun and Clarke, 2006). This allowed us to consider the data we analysed in light of the MHCA which was our initial goal. Rather than simply observe the perspectives of the participants, we hoped to be able to discuss the broader socio-cultural context. However, we also set out to describe the semantic themes as these often articulated clear and important points.

Consistent with this constructivist approach, and evident from the analysis below, our thematic analysis adopted a latent rather than a semantic approach. This constructivist approach also fit better with the data we were getting, as the informants often desired to portray Indian psychiatry in a positive light and the MHCA in a negative one (Silverman, 2014). The constructionist framework allowed the analysis to be more critical of data in this regard. Also, to facilitate the focus groups, the interviewers actively participated in elements of the discussions to jointly create

an understanding of the topics, again this aligned with a constructivist approach (Carter and Little, 2007).

The six-step process described by Braun and Clarke (2006) guided the methods and results section of this chapter. Time was taken to familiarise the researchers with the data, by repeatedly listening to the recordings and reading the transcripts. This occurred prior to the identification of the two topics the analysis focuses on and was essential in that process. In addition to this, the familiarisation process also facilitated an understanding of the topics that were proximal and influential to ECT and assisted decision making.

Initial codes were then generated on all data relating to the two identified topics and also on topics that were related to them. Codes attempted to be descriptive, rather than interpretive or latent, to maintain the inductive approach (Braun and Clarke, 2012; Fereday and Muir-Cochrane, 2006). Where possible codes drew on the language of the focus group participants. Each data item was given equal attention. This included both an intentional detailed review of sections of the transcript that appeared to have limited relevant information, but also, sections with compelling examples or emotive stories were intentionally interpreted in the context of the rest of the data. The approach adopted was inclusive and comprehensive. All elements relevant to each topic were included (Thomas, 2006). Data were coded by Dr Duffy with Professor Kelly both independently and collaboratively in an iterative process (Hsieh and Shannon, 2005). For example, during the development of the major themes for advanced directives and nominated representatives there was debate about whether or not the theme of 'logistical considerations that need to be addressed prior to adopting advance directives and nominated representatives' was actually a sub theme of the theme 'reasons for opposing advance directives and nominated representatives'. To resolve this issue Dr Duffy and Professor Kelly reviewed the transcribed data relating to each potential theme. For some of the key comments, the other comments by the same professionals were also reviewed. This was done to establish if the professionals concerned were using logistical consideration as a general reason to oppose the legislation or if they appeared to be seeking a solution to these concerns. After careful review and multiple discussions, the researchers concluded that the large majority of the data supported two separate

themes. Data were coded using Nvivo. It should be noted that the researchers took an active part in the research process in this methodology.

After the coding process key themes were identified through an iterative discussion between researchers. Potential themes were discussed to identify areas of overlap, to demarcate the boundaries of each theme and to ensure that all key codes were captured. From this process the themes and sub-themes described below were arrived at. The analysis of demographic and professional characteristics only included gender and years in psychiatry in the final analysis. The reason behind the exclusion of other variables was to prevent non representative answers based on a small sample. This is discussed in more detail in the results section.

After each of these steps this document and other publications were created (Duffy et al., 2018; Duffy et al., 2019a; Duffy et al., 2019b), in these both analytical narrative and direct quotation were used to describe the themes in a well organized manner. The analytical claims were compared by the researchers to the raw data to evaluate their accuracy (Thomas, 2006).

5.4 Results and discussion

5.4.1 General findings and group description

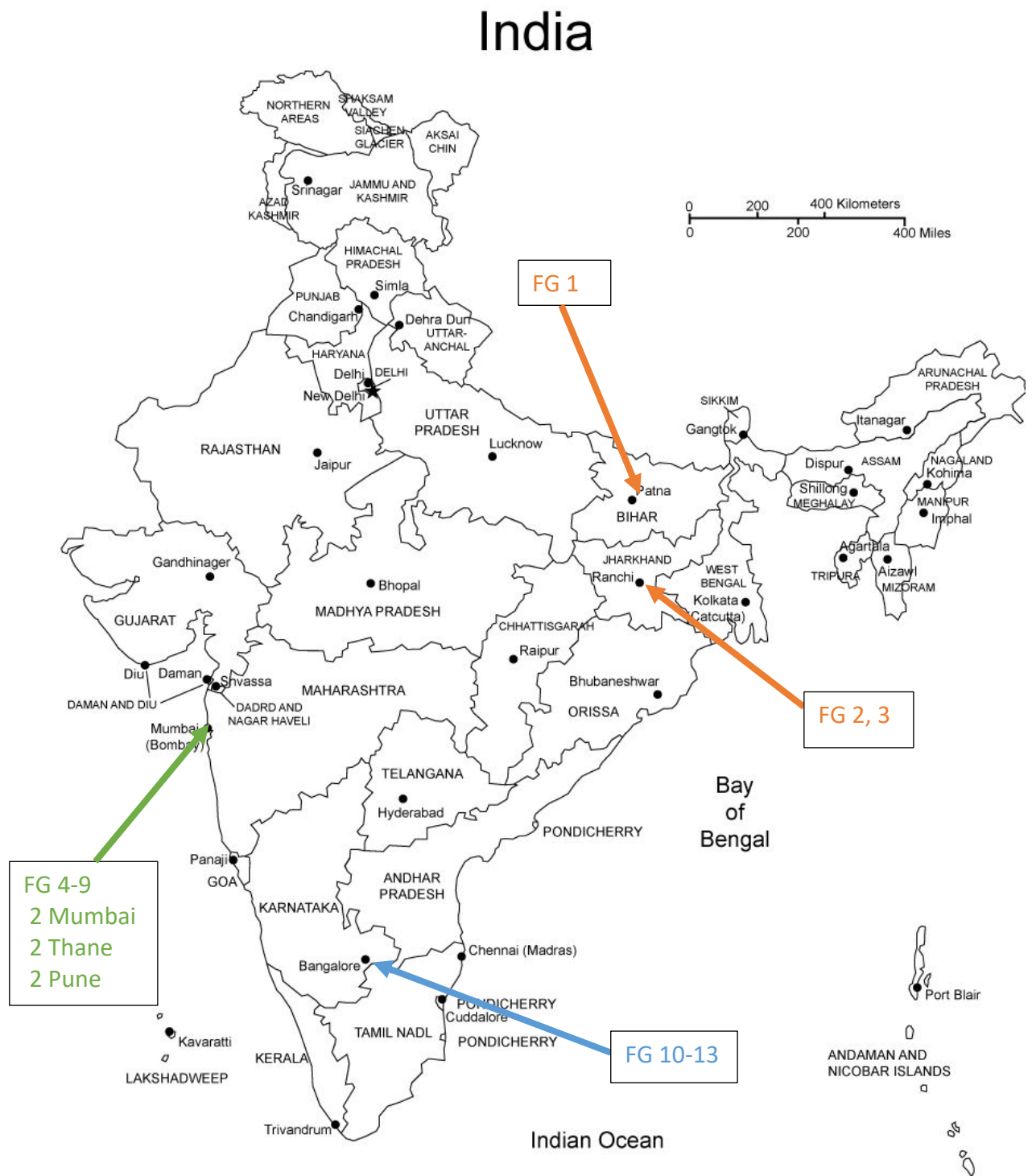
5.4.1.1 General results

Thirteen focus groups were conducted, in six cities across four Indian states. Figure 5.1 shows the location of the focus groups. Table 5.1 describes the characteristics of the 93 focus group participants, all but five were consultant psychiatrists. Overall, 9 hours and 47 minutes of recording were transcribed. The main topics that were identified are described in box 5.1. The main issues identified in the debriefing sessions following each focus group are highlighted in table 5.2. For the two topics we explored in detail we have included a relevant discussion following each respective results section.

Partial opposition to the MHCA was seen in all groups with the strongest opposition in Bihar and Jharkhand, these are states with lower levels of funding and more limited infrastructure. In general, doctors who had been practicing for a shorter period of time

were less opposed to the MHCA. Opposition to the MHCA also lessened over the time course of our study, focus groups in 2019 were the most positive concerning the act.

Figure 5.1: Location of focus groups



FG = Focus group

Trip one (December 2017) →

Trip two (November 2018) →

Trip three (December 2019) →

5.4.1.2 General discussion

The huge diversity of India cannot be underestimated, and mental health is not exempt from this heterogeneity (Singh, 2021), variations occur '*in terms of development, attitude toward women, health infrastructure, child mortality, and other sociodemographic development indexes*'. Focus groups were held in four of the 28 Indian states, no research was conducted in any of the Union territories. While it was attempted to survey a varied selection of states it is not possible to draw nationwide conclusions from four states. Regarding Gross State Domestic Product per capita ranking nationally the four included states ranked seventh, twelfth, thirtieth, and thirty-third (Indiastat, 2021). India State-Level Disease Burden Initiative Mental Disorders Collaborators (2020) identified that the four states included in this study display a wide range of prevalence's of different mental disorders. Karnataka and Maharashtra have high levels of anxiety and depression, Karnataka has some of the lowest levels of conduct disorder in the country, while Bihar and Jharkhand have some of the highest, these two neighbouring states also have high levels of idiopathic developmental intellectual disability, which is in contrast to Karnataka and Maharashtra.

There are significant issues with accessing mental healthcare in rural India (Gupta and Sagar, 2018), however there are many effective projects attempting to address the needs of individuals living in these areas (Hoeft et al., 2018; van Ginneken et al., 2017). While services may be limited in rural areas, the impact of urban living on mental health has also been highlighted (Gururaj et al., 2016). The most recent national mental health survey identified challenges in both urban and rural environments and although it noted that these issues were different it felt that they were of a similar magnitude. Eight of our focus groups included psychiatrists who did some of their work in a rural setting, however, only 22.6% of the psychiatrists involved in the focus groups worked rurally. On further analysis rural psychiatrists often had a very limited contribution to the discussion in all but 2 focus groups. Many of the outspoken psychiatrists reported that they did some rural work but mainly worked in an urban environment. Consequently, the views that were obtained relating to rural

psychiatrists are hard to interpret but where relevant their location of occupation has been noted.

It is estimated that India has about 9000 psychiatrists (Grag et al., 2019), consequently the focus groups that were conducted included approximately all 1% of Indian psychiatrists. Over 90% did both private and public work, this did not allow analysis of the differences between these two cohorts. Classification by specialty was not possible as participating psychiatrists indorsed on average 3.8 specialties. Subspecialisation is still a work in progress in India (Manjunatha et al., 2013) but as this increasingly develops the perspectives of faculties and specialists will become more important and focused on their area. Where appropriate, when a mental health professional commented on a particular specialty information has been provided about the specialty they work in.

There was a substantial body of psychiatrists doing private work, public work and doing a mixture of both, despite this their years of experience was highly associated with private work. This occurred to such a degree that it was not possible to draw conclusions about public and private work on its own however information has been provided about public and private work where relevant. The gender breakdown achieved in this study appears to reflect the levels within psychiatry in India, 14.6% of the 2829 members of the IPS were women in 2010, 20% of ordinary members were women (Sood and Chadda, 2010), rates were rising at that time. Consequently 32.3% would appear to be in line with expected figures.

One motivating factor that was ubiquitous in the comments relating to all the themes and sub themes, was that the motivation of the psychiatrists universally was to provide the highest level of care to their patients and their families. This motivation was present even when proposing quite restrictive practices, such as unmodified ECT or strongly supporting substitute decision making. This was seen in many of the themes and sub themes but was also communicated through their tone in the meetings.

Table 5.1: Demographic and professional characteristics of mental health professionals who participated in focus groups (part 1 of 2)

	FG1	FG 2	FG3#	FG4	FG5	FG6*	FG7
% Male	87.5% (7/8)	83.3% (5/6)	85.7% (6/7)	33.3% (2/6)	100% (6/6)	66.7% (4/6)	100% (10/10)
Mean years of experience (range)	18.6 (5-39)	16.3(8-33)	12.4 (8-25)	5.0 (0-16)	1.3 (.5-2)	17.8 (5-35)	17.7 (12-35)
% working in Urban setting	100% (8/8)	50% (3/6)	85.7% (6/7)	100% (6/6)	100% (6/6)	100% (6/6)	100% (10/10)
% working in rural setting	12.5% (1/8)	50% (3/6)	57.1% (4/7)	0% (0/6)	0% (0/6)	16.7% (1/6)	30% (3/10)
% Public practice	87.5%(7/8)	100% (6/6)	100% (7/7)	100% (6/6)	100% (6/6)	100% (6/6)	50% (5/10)
% Private practice	25% (2/8)	0% (0/6)	0% (0/7)	16.7% (1/6)	0% (0/6)	33.3% (2/6)	90% (9/10)
% General adult	100% (8/8)	100% (6/6)	85.7% (6/7)	83.3% (5/6)	83.3% (5/6)	83.3% (5/6)	100% (10/10)
% Liaison	37.5% (3/8)	33.3% (2/6)	42.9% (3/7)	16.7% (1/6)	66.7% (4/6)	50.0% (3/6)	40% (4/10)
% Academic	25% (2/8)	100% (6/6)	71.4% (5/7)	50.0% (3/6)	83.3% (5/6)	0% (0/6)	30% (3/10)
% Old age	50% (4/8)	16.7% (1/6)	14.3% (1/7)	16.7% (1/6)	50.0% (3/6)	66.7% (4/6)	40% (4/10)
% Forensic	25%	16.7%	0%	16.7%	16.7%	33.3%	10%

	(2/8)	(1/6)	(0/7)	(1/6)	(1/6)	(2/6)	(1/10)
% Child and adolescent	50% (4/8)	50% (3/6)	28.6% (2/7)	33.3% (2/6)	83.3% (5/6)	33.3% (2/6)	30% (3/10)
% Intellectual disability	12.5% (1/8)	33.3% (2/6)	28.6% (2/7)	16.7% (1/6)	50.0% (3/6)	33.3% (2/6)	0% (0/10)
% Addiction	87.5% (7/8)	50% (3/6)	57.1% (4/7)	33.3% (2/6)	66.7% (4/6)	83.3% (5/6)	70% (7/10)
% Inpatient work	75% (6/8)	100% (6/6)	100% (7/7)	100% (6/6)	100% (6/6)	83.3% (5/6)	100% (10/10)
% Outpatient work	100% (8/8)	100% (6/6)	85.7% (6/7)	100% (6/6)	100% (6/6)	83.3% (5/6)	100% (10/10)
Participants	8	6	7#	6	6	6*	10

Table 5.1 (continued): Demographic and professional characteristics of mental health professionals who participated in focus groups (part 2 of 2)

	FG8	FG9	FG10	FG11	FG12	FG13	TOTAL
% Male	66.7% (4/6)	50.0% (3/6)	41.7% (5/12)	42.9% (3/7)	66.7% (6/9)	50% (2/4)	67.7% (63/93)
Mean years of experience (range)	16.2 (4-35)	19.0 (5-40)	6.8 (1-39)	10.9 (2-25)	6.7 (2-20)	16.0 (2-29)	12.4 (0.5-40)
% working in Urban setting	100% (6/6)	100% (6/6)	41.7% (5/12)	85.7% (6/7)	100% (9/9)	100% (4/4)	87.1% (81/93)
% working in rural setting	0% (0/6)	0% (0/6)	58.3% (7/12)	14.3% (1/7)	1.1% (1/9)	0% (0/4)	22.6% (21/93)
% Public practice	16.7% (1/6)	16.7% (1/6)	50% (6/12)	28.6% (2/7)	88.9% (8/9)	100% (4/4)	69.9% (65/93)
% Private practice	100% (6/6)	83.3% (5/6)	58.3% (7/12)	85.7% (6/7)	33.3% (3/9)	0% (0/4)	44.1% (41/93)
% General adult	83.3% (5/6)	100% (6/6)	83.3% (10/12)	100% (7/7)	88.9% (8/9)	100% (4/4)	91.4% (85/93)
% Liaison	66.7% (4/6)	50.0% (3/6)	41.7% (5/12)	28.6% (2/7)	66.6% (6/9)	100% (4/4)	47.3% (44/93)
% Academic	16.7% (1/6)	16.7% (1/6)	83.3% (10/12)	42.9% (3/7)	66.6% (6/9)	100% (4/4)	52.7% (49/93)
% Old age	16.7% (1/6)	33.3% (2/6)	41.7% (5/12)	57.1% (4/7)	44.4% (4/9)	50% (2/2)	38.7% (36/93)

% Forensic	0% (0/6)	0% (0/6)	33.3% (4/12)	14.3% (1/7)	33.3% (3/9)	0% (0/4)	17.2% (16/93)
% Child and adolescent	33.3% (2/6)	16.7% (1/6)	50% (6/12)	42.9% (3/7)	55.6% (5/9)	50% (2/2)	43.0% (40/93)
% Intellectual disability	33.3% (2/6)	0% (0/6)	41.7% (5/12)	28.6% (2/7)	44.4% (4/9)	50% (2/2)	28.0% (26/93)
% Addiction	16.7% (1/6)	50.0% (3/6)	66.7% (8/12)	85.7% (6/7)	55.6% (5/9)	100% (4/4)	63.4% (59/93)
% Inpatient work	33.3% (2/6)	83.3% (5/6)	100% (12/12)	100% (7/7)	100% (9/9)	100% (4/4)	91.4% (85/93)
% Outpatient work	100% (6/6)	100% (6/6)	100% (12/12)	100% (7/7)	100% (9/9)	100% (4/4)	97.8% (91/93)
Participants	6	6	12	7	9	4	93

Note, clinicians were encouraged to tick all descriptions that applied to them.

FG: Focus group

*Included one consultant anesthetist responsible for ECT in the hospital and the hospitals most senior mental health administrator

Included the hospitals head of nursing, social work and occupational therapy

Box 5.1: Topics developed from the focus group study of psychiatrist in India

Topics
• ECT: in minors, unmodified • Assisted decision making: Capacity, advance directives and nominated representatives • Tradition medicine practitioners • Coercion and autonomy: Involuntary care and community treatment orders • General Hospital psychiatric units and private psychiatry • Stigma • Patient rights • Indian culture • Family: decision making, support • Drafting of the legislation: authors, consultation process, driving forces • Doctor's position in society/paternalism • Governance of the Mental Healthcare Act 2017 • Resource limitations: financial, human resource, infrastructural, lack of time. • Suicide

Table 5.2: Summary of the debriefing sessions following the focus groups

Focus group	Review of questions	New key topics discussed	Group management	Other
1	Introductory questions require revisions -tailor to group	GHPU ECT Governance of the MHCA Resource limitation Stigma Family Assisted decision making Drafting of the MHCA	Discussion of a participant who refused to consent to participate Parties talking over each other	Discussion of language barriers. More care with the set-up of the room and recording. Impact of fans on recording.
2 and 3*	Less need for long introductory discussion	Patient rights Coercion and autonomy Suicide Indian Culture Doctors position in society	Steps to include junior staff	Discussion re inclusion of other mental health professionals Noted my bias that substitute decision making is negative.
4	How do elicit positive view without biasing answers	Traditional medicine practitioners	Hierarchy and power imbalance involving more junior participants	The need to use more direct English

5	Questions functioned well	-	The balance of demonstrating knowledge of the topic but not biasing opinion Seeking the opinion of female participants early on	The need to use more direct English. Noted my bias that coercive measures are negative
6 and 7*	Questions functioned well	-	Interrupting individuals dominating the group	Minimising interruptions
8	Questions functioned well	Military psychiatry	Holding a more nutral stance on the CRPD and the MHCA	
9	Questions functioned well	-	Asking questions about family without pushing a view on autonomy	Timing of questions needs to be adhered to
10	Attempt to focus more on implementation	Corruption	Trying to follow different idea to identify new themes	

11	Attempt to focus more on implementation	-	Shifting to attempting to get more detailed information on common themes	
12	Questions functioned well	-	Shifting to attempting to get more detailed information on common themes	
13	Questions functioned well	-		

*Group occurred back to back and as a result no debriefing occurred between them

MHCA - Mental Healthcare Act 2017

ECT - Electroconvulsive therapy,

GHPU - General hospital psychiatric units

5.4.2 Electroconvulsive therapy

5.4.2.1 Results

ECT was identified as a major topic from the earliest focus groups, eleven of the thirteen groups spontaneously brought up the topic. Discussions relating to ECT reflected some of the most emotionally charged responses in our data. In general, great support was expressed for ECT and concerns were raised about the limitations being placed on its use. One group went so far as to state the provisions relating to ECT as their main reservation to the new Act. Psychiatrists working in rural settings tended to favor more liberal ECT practices; these psychiatrists were, in general, more experienced. Young psychiatrists were often more accepting of the MHCA but still had

significant reservations concerning ECT related legislation. The identified themes and sub themes that directly related to ECT are described in table 5.3 and discussed below. ECT was also prominent in many discussions where it was not the primary topic these themes and sub themes are described in table 5.4 and also discussed below.

Table 5.3: Key themes and subthemes identified from focus groups directly relating to ECT

Theme	Sub-theme	Key quotes
Benefits	Lifesaving nature	‘ECT is a life-saving therapy’ (FG3, M, 8) ‘It works; it works wonders’ (FG3, M, 25)
	Evidence base	‘We have robust data to say that unmodified ECT is safer than modified ECT, which is safer than antidepressants’ ‘We shared that data from our institute that we have been using ECT for the last 60 odd years’ (FG3, M, 8) ‘We have enough scientific database to confirm the point that ECT is good for everybody if done with proper care’ (FG1, M, 30) ‘there is no law that should prohibit or interfere with the scientific decision making process, is what I think’ (FG11, M, 25)
	Vignette or personal story	‘Every time he has mania the only thing he responds to is ECT ... but in a manic phase he will refuse. But after a couple of sessions of ECT he comes back to himself. Nothing works with him except ECT.’ (FG9, M, 10) ‘...I have a 16 or 17 year old who is highly suicidal not cooperative with regard to medication, not eating , refusing to take treatment, getting violent, getting aggressive and I have ECT as an only option. (FG4, M, 17)

	In severe cases	‘We have to take permission from them [Mental Health Review Board] but the patient is violent and highly suicidal it will take a lot, maybe three to four days.’ (FG7, M, 20)
Minors	Prohibition	‘This act doesn’t allow it’ (FG9, M, 40, not working with minors) ‘there is no evidence to ban ECT for children and minors (FG11, M, 20, working with minors)
	MHRB role	‘They have talked about minors. You need to go to the district review board, fine if you win the review.’ (FG6, M, 30, working with minors) ‘The review boards, who knows what they're actually going to advise on what they're actually going to do.’ (FG3, M, 25, not working with minors)
Unmodified ECT (i.e. without muscle relaxant or anaesthetic)		‘Even in a set up like this we have serious problems getting an anaesthetist because there is paucity of anaesthetists’. (FG2, M, 20, works in a rural setting) ‘And we have not seen any significant problems with unmodified ECT. In fact, we can say that in many aspects it is better than the modified ECT’ (FG2, M, 20, works in a rural setting) ‘All the ECT is given in the operation theatre, because there is anesthesia, there is a department that’s no problem. But in some of the places across country, it's difficult.’ (FG10, M, 40) ‘But when they have taken away the direct ECT totally I think that that might limit the practice of ECT in the periphery’ (FG13, F, 29)

Acute setting	Emergency treatment	'Of course there are institutions and there are psychiatrists who do give ECT within the first 24 hours; now under the [new legislation] that cannot happen.' (FG8, F, 24)
	Early in admission	'That is our concern there: that ECT will be less used and particularly when there is a definite need in terms of emergency' (FG2, M, 20, works in a rural setting) 'You can treat for 72 hours and we are not allowed to give ECT in those 72 hours' (FG 9, M, 40)

ECT – electroconvulsive therapy

Table 5.4: Key themes and subthemes indirectly relating to ECT identified from focus groups

Theme	Sub-theme	Key quote
Resource limitation	Professionals	'We are not able to give unmodified ECT. And again we have to beg for anesthetists.' (FG3, M, 8)
	Infrastructure	'We need to improve the resources that we can give those kind of services.' (FG3, M, 8) 'People from remote places are visiting faith healers. First they have to get the proper psychiatrist that would be our first objective' (FG3, M, 8)
	Personal finance	'In many private set-ups if you had an anesthetist for the ECT the expenses or cost of ECT will also be too much.' (FG2, M, 20, working in rural areas) 'They just come have the ECT and get back home, because that was the cheapest' (FG10, M, 40) 'It will not be patient choice it will be recourse driven, its affordability driven. for example, our cost of ECT was x so at the moment you would say modified ECT are given 3x

		because specialist events and the procedure is different’ (FG11, M, 20)
Drafting of the legislation		‘The Act was discussed here before going to the Parliament. This draft was discussed and there was a lot protest. But it was dismissed by giving the reference of UN-CRPD.’ (FG2, M, 35)
Governance of the MHCA		‘Psychiatrists do not have proper representation on any committee, on any board.’ (FG1, M, 30) ‘Medical decisions should be left to medical people’ (FG1, M, 39) ‘Who should be given ECT, who should not be given ECT, this is scientific literature driven, evidence driven, decision which is ratified by our professional body.’ (FG 11, M, 25)
Stigma		With regards to ECT, what has happened in India today..., see the Indian population rely a lot on media and the way things are advertised and shown In movies and poetry. So ... it [ECT] has been very negatively portrayed by the media. So the general mentality of the common lay person is ... it [ECT] is not a beneficial and there is a lot of stigma associated with ECT.’ (FG4, F, 4) ‘They [NGOs and anti ECT lobby] are very against ECT and they have created lots anger about ECT and these patients and families are rejecting ECT.’ (FG 7, M, 20)

ECT – electroconvulsive therapy

UN CRPD – United Nations Convention on the Rights of Persons with Disabilities

NGO – Non-Governmental Organization

MHCA – Mental Health Act

5.4.2.1.1 Themes directly relating to ECT

5.4.2.1.1.1 Benefits for ECT

The views of the psychiatrists we interviewed were highly supportive of ECT. They described their departments as 'ECT friendly' and their use of ECT as 'liberal'. One psychiatrist described his skepticism about ECT prior to starting psychiatry and how his view was changed by the cases he managed. The most commonly occurring statement related to this theme was that ECT was 'life saving'; this was mentioned in 53.8% of the groups. Many groups highlighted the severity and volume of cases they encountered and the long duration of untreated illness. They referenced many anecdotes and shared vignettes in support of ECT but also talked about both published literature and audits carried out at their departments. Exact details of the studies they were referencing were not always clear and findings were often summarized. Overall, focus group participants were highly supportive of the practice of ECT and justified and supported this from multiple different angles.

Patient care was the consistent driving force behind the psychiatrists who opposed the new limitations on the use of ECT. Not only were the treating clinicians aware of their patients need for recovery but there was a strong concern for the financial limitations people were facing. They articulated a strong desire to deliver a 'life-saving treatment' to patients whom they perceived as not having other viable options. Statements typical of their concern included:

'We cannot give unmodified ECT so the brunt [of the negative impact of this] is taken by the patients only' (FG3, M, 8)

And

'Most of us have prevented suicide ... with ECT, but now our hands are tied'
(FG3, M, 8)

5.4.2.1.1.2 ECT in minors

The strongest opposition to the new legislation concerned restriction on the delivery of ECT to minors; this topic often evoked angry statements concerning the MHCA and its authors. Many psychiatrists whom we interviewed practiced ECT in minors. Again,

many offered both anecdotes and research as justification for this practice. The severity of the minors presenting to their services was discussed, with multiple groups describing suicidal or violent individuals with a major mental illness or individuals with catatonia. There was a strong view that the use of ECT in minors is a medical decision and that this should be taken between doctors and guardians. One group (FG11) suggested that this higher level of review where a MHRB's permission was needed was a product of non governmental and human rights based organisations. One focus group (FG13) deviated from the perspective of the others, they reported not being concerned about the provisions as they were not using ECT in minors even prior to the MHCA.

Two distinct sub-themes were constructed from the data which, on examination, might reflect two sides of the same concern. First, many individuals, including senior psychiatrists, incorrectly stated that the new Act introduced a complete ban on minors receiving ECT. This misapprehension was expressed in interviews both before and after the implementation of the MHCA. On further discussion, some believed that this 'ban' was contained within the Act while others acknowledged that ECT in minors was possible (which it is) but that bureaucratic and administrative constraints would amount to a *de facto* prohibition (which they might).

This led on to the second sub-theme: the impact of the MHRBs on the use of ECT in minors. Many psychiatrists were worried about the general level of bureaucracy in India and concerns were expressed about how long it could take to get the MHRB to agree to ECT in a minor. There was also much anxiety among Indian psychiatrists that MHRBs may simply not approve the use of ECT in minors and hence the fact that many psychiatrists believe that the MHCA totally prohibits this practice.

The seemingly arbitrary nature of the cut off at eighteen years arose in multiple groups:

'I don't think someone who's having issues at seventeen, that their diagnosis is going to change at eighteen.' (FG4, M, 17, works with minors)

Another group highlighted how no one would give ECT to a 'nine year old', but in older adolescents there is a grey area. However, whenever the idea of a grey area emerged

its boundaries varied widely; one group discussed a ten year old receiving ECT as a very viable possibility.

Only two groups saw any positive aspect to the limitation of ECT in minors. In that group one psychiatrist mentioned that they felt the MHCA offered a degree of protection. They acknowledged that things can go wrong and felt the review by the MHRB spread the responsibility to some degree:

'I would prefer a judicial review rather than a police review.' (FG6, M, 30, works with minors)

5.4.2.1.1.3 Unmodified ECT

The prohibition of unmodified ECT also produced very strong reactions but there was less of a clear consensus on this issue compared to the issue of ECT in minors. The vast majority of psychiatrists reported never having delivered unmodified ECT; none reported currently delivering it; and many groups welcomed the prohibition. Younger psychiatrists had less reservations about the banning of unmodified ECT. One group highlighted that, while there were many protests against the new MHCA, the UN-CRPD was often quoted as a justification for the changes. In particular, the banning of unmodified ECT was necessary due to the prohibition of torture or inhumane treatment in the UN-CRPD.

Despite this, many psychiatrists argued against the prohibition. Generally, this was argued with reference to emergency cases or clinical circumstances in which muscle relaxants or general anesthesia might be unavailable or contraindicated. Some participants took the case a step further and referred to an evidence base supporting the superiority of unmodified over modified ECT:

'We have robust data to say unmodified ECT is safer than modified ECT, which is safer than anti-depressants' (FG3, M, 25)

and

'As a clinician we favor unmodified'. (FG2, M, 33)

Multiple groups raised the issue of 'anesthetist's availability and cost' as a major driver of unmodified ECT. They highlighted the fact that anesthetists might not be available and that even when they are, their involvement greatly increase the cost of ECT and that this can put it out of the reach of poorer families. These families might opt for unmodified ECT rather than no treatment at all, they said. There was limited consideration given to the complications of unmodified ECT, beyond the short term. Negative long-term complications were not discussed; instead the psychiatrists we interviewed focused on the long term implications of untreated mental illness.

5.4.2.1.1.4 ECT in the acute phase

The delivery of ECT in the acute phase of mental illness was raised in many groups. In a similar manner to the use of ECT in minors, there were two main concerns. The first appeared to come from a misunderstanding of the MHCA and the second related to the potential bureaucratic and administrative delay. First, multiple focus groups were of the belief that ECT could not be used in the emergency setting, in particular in the first 72 hours. This was another area where even senior psychiatrists were unclear about the legislation. However, their concerns about 'emergency treatment' did not correlate with the Act's definition of 'emergency treatment' or with the fact that ECT would indeed be permissible within time-frames that they believed it would not be permitted in.

The second issue related to how long it will take MHRBs to make decisions. There was also apprehension about the appropriateness of MHRB decisions (see below). Psychiatrists in some focus groups were also unclear about their ability to use ECT in an individual admitted on a 'supported' basis (the term used in the Act for admissions without patient consent) and how 'advance directives' and 'nominated representatives' could be used (and if necessary challenged). The potential for MHRB-related delays may be of particular relevance here as these are likely to impact the acute phase disproportionately.

There is also concern that the banning of unmodified ECT was of particular relevance in the emergency setting:

'it is more than harm, it's depriving them of the best treatment.' (FG2, 8, M, working in solely rural setting)

5.4.2.1.2 Themes indirectly related to ECT

In addition to the above, four of the other topics had elements that were indirectly but highly relevant to ECT, these were resource limitation, the drafting of the legislation, the governance of the MHCA and stigma.

Resource limitation was one of the most consistent themes throughout all our focus groups and it arose in relation to almost every topic. There were concerns about the numbers of current professionals including nurses, psychologists, psychiatrists, anesthetists, judges, administrators and individuals for MHRBs. Apprehension was also expressed that there was no additional capacity to train significantly more staff in the near future. The lack of professionals related to ECT in a few ways. The lack of doctors and nurses prolongs duration of untreated illness, increasing the severity of presentations. Many psychiatrists reported that they were seeing sixty to one-hundred patients per day and that there was not the capacity to engage in the procedural work needed to admit supported patients. Psychiatrists were concerned that patients would either end up not being seen due to lack of resources or that psychiatrists would be hesitant to treat individuals as supported patients or deliver ECT if there were so many administrative barriers. A lack of anesthetists was identified by five groups as a reason for not totally prohibiting unmodified ECT. The lack of appropriate individuals to staff MHRBs made psychiatrists uncertain if they will be sufficiently informed to carry out their role.

'We have review boards where the people who will be there have no idea what mental illness is, what mental health is. They will be deciding what kind of treatments will be given to mentally ill patients' (FG3, M, 8)

In addition to a lack of professionals, infrastructural limitations also commonly arose, often this related to a lack of beds, 'half-way homes, sheltered accommodation, supported accommodation' and the 'community based rehabilitation' mentioned in the Act. In relation to ECT, there were concerns that the MHRB would not be fit for purpose and one group suggested that this would make psychiatrists less willing to facilitate supported admissions. The current judicial infrastructure could also greatly delay treatment on occasions where MHRB decisions were challenged. One quote captures the general concerns well:

'The resources are not available and we are tied down by various laws and norms. They are good, definitely they are ideal. But first of all, the platform has to be ready to launch something which is big and ideal.' (FG3, M, 8)

In addition to limitations on mental health resources, the financial resources of patients came up multiple times and was given as a reason for continuing with unmodified ECT as anesthetist involvement commands significant cost. These views on unmodified ECT were more prominent in Bihar and Jharkhand compared to Maharashtra, however they were still expressed by psychiatrists in Karnataka.

Many psychiatrists felt that factors outside of evidence-based medicine were driving the MHCA, this was one of the most common and consistent topics that arose in the focus groups, and it was seen as impacting directly on the issue of ECT. It was also one of the broadest topics. Psychiatrists felt that individuals and bodies with an increasingly social model of mental healthcare had, and would continue to have, substantial impact at multiple levels including the drafting of the legislation, the governance of the MHCA and the perceptions of mental illness and its treatment in the media.

There was much concern about how the MHCA was drafted. One group described the drafters as holding an 'anti-psychiatry' stance. Other groups stated that they and the IPS had very limited involvement in the drafting. The role non-governmental organizations (NGOs) had in the drafting of the legislation was extensively discussed and led one psychiatrist to conclude that:

'The whole process of redrafting was flawed, is what I think. ... if you look at the changes, it was government policy driven but the stake holders, mental health professionals, were totally inadequately consulted ... its largely NGO driven and rights driven, no professional scientific inputs at all. The whole document, the drafting and the process of actually assigning somebody to draft this law itself, is questionable. The person who drafted this law has never been part of this country in patient care, he is not a member of our professional body, he has no clue of the Indian scenario he does not know how to treat a patient in an Indian scenario, and he decides to redraft the law of this country.' (FG11, M, 20)

The mental health professionals we interviewed saw the role of NGOs as mixed: many highlighted good things that they did, but when it came to their influence on ECT in the MHCA psychiatrists were much less positive.

'The NGO lobby was very strong because everywhere outside of hospital, a negative picture of electroconvulsive therapy has been portrayed and they selectively, or maybe deliberately, undermined the positive effect of electroconvulsive therapy'. (FG3, M, 15)

Others explicitly talked about an anti-ECT lobby and their impact on the new legislation, particularly as it applies to ECT in minors and unmodified ECT. This lobby was reported as so strong that one psychiatrist commented on how they were relieved that ECT was retained in the new Act at all. There was an impression in many of the focus groups that the MHCA represents international standards and that it is 'borrowed from established developed nations'; some even went so far as to describe the MHCA as 'un-Indian'.

In addition to the apparent impact of a non-medical model on the drafting of the legislation, psychiatrists were disturbed by how little influence they believe they will have on its governance through the MHRB, SMHAs and the CMHA. They felt, that MHRB's will make treatment decisions that might not facilitate high-quality healthcare provision.

Concerns were raised about the scientific and psychiatric literacy of patients. The time constraints on Indian psychiatrists led some of them to feel that they would not have time to deliver the level of psychoeducation that the new MHCA would require to allow patients to make fully informed treatment decisions. One focus group of psychiatrists expressed concern that there will be ongoing hostility towards ECT from NGOs and that they will attempt to influence patients' advance directives to limit the use further. This was not a view commonly expressed and it was challenged in the one group where it was brought up.

A repeated comment, from multiple groups, summed up the divergent perspectives of psychiatrists and legislators in relation to the MHCA:

'The ground reality is different'. (FG2, M, 17)

5.4.2.2 Discussion

ECT is an increasingly contested treatment internationally. Strong lobby groups continue to oppose its use and many individuals still question its evidence-base (Payne and Prudic, 2009; Read and Arnold, 2017). Our study demonstrates that the changes in India's MHCA will significantly challenge current ECT practices in India in several different ways. Young psychiatrists have been shown to be more accepting and welcoming of the new MHCA in a recently compiled book aiming to create awareness and understanding of the MHCA 2017 (Kalmegh et al., 2018).

Gangadhar et al. (2010) highlighted the large numbers of articles concerning ECT published by Indian psychiatrists. The research presented here provides the context for much of the current Indian research. Indian psychiatrists have extensive experience using ECT and, based on our sample, believe strongly in its effectiveness. The results of studies conducted using large historical data from India make a certain case against the limitations of ECT brought about by the MHCA. However, some of these studies have significant methodological limitations (Ray, 2016). Andrade et al. (2017), for example, retrospectively reviewed 637 patients who received unmodified ECT and reported improvement in over 95% and saw complications in only 11%. While

this study challenged the existing understanding of the prevalence of complications, data collection was not based on a study protocol and there was no control group.

Overall, however, Indian psychiatry is working genuinely hard to clarify and enhance the evidence base for ECT practice in India. Of necessity, this research often has to be based on retrospective studies due to both the new legislation and the perceived urgency to address these issues. While these data-sets have limitations, many psychiatrists are attempting to glean valuable information from them in order to provide their patients with the best standard of care possible.

5.4.2.2.1 ECT use in minors

In our study, identified an inaccurate belief, held by some professionals, that the new Indian legislation fully bans ECT in minors – an inaccurate belief that is also seen in the media (Das, 2017). Under the MHCA, however, the use of ECT in minors is permitted after permission is obtained from a MHRB. Subsection 80(4) states that *‘the Board (MHRB) shall dispose of an application, other than an application referred to in subsection (3), within a period of ninety days from the date of filing of the application.’* Subsection (3) makes no mention of ECT with the result that permission for ECT in minors could take up to three month to acquire from a MHRB and this may well result in a *de facto* prohibition in all but the most severe cases. This appears to accord with what many of the psychiatrists we interviewed felt and with the World Health Organization’s direction that the use of ECT in minors should be prohibited (WHO, 2005).

To understand the concern many psychiatrists have regarding MHRBs, it is important to remember their role. These bodies will greatly influence the place of ECT and treatment in general. If the six board members, only two doctors (one psychiatrist and one medical practitioner) will be on these boards and meetings can continue without either of them, as they require only a quorum of three. Decisions before the board are deemed to be judicial proceedings (MHCA, Subsection 78) although their decisions can be appealed to the State’s High Court (MHCA, Section 83).

There is a paucity of research relating to ECT in minors, but ECT continues to be administered to adolescents in many countries. In light of the stronger emphasis on

certain human rights after the CRPD and the WHO view that ECT in children and adolescents should be banned, it is likely that the practice will become increasingly rare (WHO, 2005; UN, 2006). This provides a compelling reason for psychiatrists who are still engaged in this rare practice to collect routine data so that treatment outcomes can be carefully evaluated.

5.4.2.2.2 Unmodified ECT

The WHO holds the view that unmodified ECT should be banned (WHO, 2005). Indian psychiatrists have long highlighted the need for enhanced evidence around the safe use of unmodified ECT; while the vast majority identify modified ECT as preferable, circumstances have been identified where unmodified ECT may be necessary (Andrade et al., 2003)). In 2012, the IPS, the Indian Association of Biological Psychiatry, and the Indian Association of Private Psychiatry released a position paper on unmodified ECT that questions its negative impacts and advocates for its use in exceptional circumstances (Andrade et al., 2012). The paper lays out six circumstances under which, these groups feel, unmodified ECT may be considered: lack of anesthetic availability, urgent need for ECT that cannot wait for anesthetic review, inability to get intravenous access, contraindication for anesthetic, contraindication for succinylcholine, and inability to afford anesthetic. Some of these topics were discussed in our focus groups too but other concerning reasons also surfaced, such as the use of unmodified ECT to reduce cost to the families of the person receiving ECT.

This 2012 position paper also discusses six studies that support using unmodified ECT, three of which are *Lancet* papers over 35 years old. The other three more recent reports come from India. The paper provides a comprehensive account of the adverse effects of unmodified ECT and states that modified should always be the preference, but it also lays out guidelines that should be followed if unmodified ECT is needed. Indian psychiatrists have, in response, suggested that the benefits of unmodified treatment may be over-stated and the risks under-played (Rajkumar et al., 2007).

Andrade et al., in an article in the *Indian Journal of Psychiatry* (2000), reported a 2% rate of vertebral fracture with unmodified ECT which is significantly lower than

earlier studies which found vertebral fractures in over 20% (Dewald et al., 1954). Tharyan et al. (1993) argued that unmodified ECT may actually be safer for patients due to the complications of general anesthetic with modified ECT. This view aligned with the opinions expressed in some of the focus groups. Other studies have been published in India which support the use of unmodified ECT, albeit with substantial methodological limitations (Ray, 2016).

Consistent with these positions, the IPS submitted a writ petition to the High Court of Mumbai in 2018, arguing that elements of the MHCA '*violate right to equality and consequentially right to life of mentally ill people, as enshrined in the Constitution of India*' (IPS, 2018). This writ has a number of grievances with the MHCA but the primary issue relates to the effect of the prohibition of unmodified ECT in deprived and rural or tribal parts of India which lack resources for anesthesia. A key argument is that the prohibition on unmodified ECT is not evidence-based and they submit articles arguing that there may be evidence for an improved safety profile in unmodified ECT (Andrade et al., 2003; Tharyan et al., 1993).

While there is evidence to support the idea that benzodiazepine-modified ECT may be a safer alternative to unmodified ECT, the IPS writ argues that to ban unmodified ECT in emergency circumstances is '*irrational and arbitrary*' (Shah et al., 2010; Gallegos et al., 2012). This position contrasts strongly with those of the WHO (2005) and, to an extent, the IPS, Indian Association of Biological Psychiatry, and Indian Association of Private Psychiatry, whose 2012 paper highlighted the many risks of unmodified ECT (Andrade et al., 2012). However, the fact remains that many Indian psychiatrists see unmodified ECT as a necessary therapeutic compromise in light of resource limitations on the ground.

5.4.2.2.3 ECT in the acute phase

The Indian Act allows ECT to be delivered in certain contexts without the consent of the individual through a supported decision-making process (MHCA, Section 89(7)) or if they have an advance directive in support of ECT. Confusion and misinformation about the emergency period and when it terminates was apparent in our focus groups as well as the medical literature and the IPS High Court writ (IPS, 2018; Kumar 2018).

The period of emergency treatment ends once the individual is assessed at a mental health establishment (MHCA, Section 94(4)), so the issue of ECT in the emergency phase would only be of concern to psychiatrists if they were delivering ECT outside of established centers or prior to assessing the individual. One of the problems with this issue is the paucity of high-quality research data to support emergency ECT in the first place. Therefore, while the need for emergency ECT is discussed in the literature for a number of indications including catatonia (Gallegos et al., 2012), there is a paucity of studies on this topic, owing to the nature of the patients affected and the infrequency of presentations.

5.4.2.2.4 Themes indirectly relating to ECT

Resource limitation often arose in the context of the discussion about ECT and *vice versa*. India is vast, with a population of over 1.2 billion people, and in the 2017 UN rankings of gross domestic product (GDP) per capita India came 144th. The National Mental Health Survey of India 2015-2016 highlighted the burden of mental health problems in Indian society, as well as the proportion of mentally ill persons who are managed outside of formal psychiatric settings (Gururaj et al., 2016). It estimated that 11% of Indian adults suffer from a mental disorder, of whom the majority do not receive any treatment. The survey estimated that 150 million people are in need of mental health interventions.

In addition to this large treatment gap there are also variations in service availability across the country with especially limited services in rural areas, although the picture is often complicated by the practice of traditional and alternative medicine (Byrnes, 2014; Thirthalli et al., 2016). Financial resources are grossly inadequate with less than 1% of the national healthcare budget spent on mental health. In addition, there are very significant human resource limitations despite the emergence of task-sharing with community based projects which may incorporate traditional practitioners and which need to be scaled up and integrated with national policy (Patel et al., 2016; Thirthalli et al., 2016). These concerns all clearly influenced the views of psychiatrists in our focus groups.

The theoretical underpinning of mental health legislation has been irrevocably changed by the UN-CRPD. Modern psychiatry will have to become increasingly rights-based if it is to concord with it. The drafting of the CRPD mirrored many of the tensions that are seen in the implementation of the MHCA 2017. Strong, well-organized lobby groups pushed for the exclusion of any coercive practices, while medical professionals and other groups attempted to forge a more moderate course (Byrnes 2014; Melish, 2014). In a fashion very similar to what is happening in the MHCA with unmodified ECT, there were petitions right up until the last minute during the drafting of the CRPD for some emergency provisions to be included to allow forced interventions in extreme circumstances (Degener and Begg, 2017). If Indian psychiatrists are concerned that the obligations of the MHCA are the narrow end of the wedge and that further limitations are to come, the CRPD strongly affirms their concerns. As discussed in the preceding chapters, the Committee on the Rights of Persons with Disabilities (2014), which interprets the CRPD, went further by explicitly prohibiting all coercive treatments thus challenging a key aspect of mental health legislation in most countries. Indian psychiatrists have identified their need to become more politically engaged and active in lobbying (Kalmegh et al., 2018).

In the main, the CRPD has greatly supported the rights of individuals with disabilities and has done much to realise positive change. However, the unqualified inclusion of individuals with mental impairments (Article 1) may inadvertently impair the realisation of rights for people with mental illness (Freeman et al., 2015; Applebaum 2019). If psychiatrists are to continue to implement the practices developed under the medical model they will have to learn to communicate their rationale clearly with patients, carers and MHRBs. They will need to become skilled and clear communicators, a difficult skill when, as highlighted in the focus groups, there is extremely limited time with each patient and carer.

5.4.3 Advance directives and nominated representatives

5.4.3.1 Results

All focus groups discussed advance directives and nominated representatives on multiple occasions and these topics often elicited emotionally charged responses. A

wide range of opinions were expressed, with one participant comparing them to opening ‘a can of worms’. Table 5.5 describes specific themes and subthemes that were developed in relation to advance directives and nominated representatives and these are discussed in detail below. Comments relating to advance directives and nominated representatives generally referred to both concepts; we state explicitly (below) where this is not the case.

Table 5.5: Key Themes and Subthemes Identified from Focus Groups Relating to Advance Directives and Nominated Representatives under India’s Mental Healthcare Act, 2017

Theme	Sub-theme	Key quotes
Reasons for opposing ADs and NRs	Imposing external international standards on an Indian context	‘I think that the law-makers or doctors who designed this Act have taken the international standards into consideration while they completely ignored the Indian context.’ (FG5, M, 2) See at any point of time you know there is something that is in the political agenda of the government. So, there was a time when all the UN cry was about autism. ... And, you know, I don't know whether most of the funds were utilised in the proper way. So now it is mental health’ (FG3, M, 25)
	National culture norms which are at odds with ADs and NRs	‘Indian society is still a family-based society; we have very strong family ties. This is not an individualistic society.’ (FG1, M, 30) ‘Ninety per cent of the patients will say, ‘whatever you feel is best, do that for me.’ (FG4, M, 17) ‘In India there isn’t one person’s care, there is a family basically and the family can be the immediate family, extended family, whatever, everybody is treated as one. ... So this whole thing, of you know, having a NR is so not Indian. (FG13, F, 29)

	Individual preparedness and mental health literacy	'Advance directives - I am not against that but we are not prepared for that right now.' (FG1, M, 20) 'To what extent do they really understand and can make an informed decision about when they are well. About what is the treatment that they want when they're not well. I mean as she said this is a very advanced to act for a country like us. There are a lack of safeguards.' (FG8, F, 24)
Logistical considerations that need to be addressed prior to adopting ADs and NRs	Human and infrastructural resource limitations	'The difficulty is how are they going to execute that law. We don't have that kind of infrastructure, that kind of human resources. The law is well written but execution will be an issue.' (FG7, M, 20) 'We don't have the time but we have to do it, it's [document decision making] something that we have to do now' (FG11, F, 2)
	Guidance around capacity assessment	'It should have been included in the Act itself, you cannot have capacity not mentioned, not give any guidelines and then let the Act come into force'. (FG6, M, 30) 'I cannot prove that anybody has no capacity, everybody will have capacity, it will come as an obstacle to any of my treatment decisions. Capacity definitions have to be redefined; the clause has to be redefined.' (FG11, M, 20)
Benefits of introducing NR and AD	Rights-based protections of service users	'The rights of persons with mental illness, they're not at all encountered in the old Act. That is an improvement; advance directives, those things are good.' (FG2, M, 8) '... when it comes to making an advance directive it is necessary that the patient knows about what they are going through, so that itself is one of the initiatives that we feel that the mental healthcare act is has put into place.' (FG12, F, 3)

AD – Advanced directive, NR – Nominated representative

5.4.3.1.1 Reasons for opposing advance directives and nominated representatives

Throughout the focus groups, opposition was raised to the supported decision-making framework facilitated by advance directives and nominated representatives, with psychiatrists suggesting that the 1987 Act should be retained, the current MHCA needs major revision, or that these provisions will simply be ignored. As one psychiatrist put it

'I did not want these issues of nominated representatives or advance directives they look impractical in the current scenario for me' (FG 11, M, 20)

In this theme and its sub-themes we have brought together comments underpinning the view that advance directives and nominated representatives cannot or should not be used, in their current format or until there is a significant societal shift. Three key reasons for opposition were constructed using the data, these related to the international, national, and personal contexts. First, at an international level, participants felt that the MHCA was overly influenced by external agencies, including NGOs, the UNCRPD and the legislation of high income 'western' countries:

'Psychiatrists feel that their concerns have not been given as much importance as the views and opinions of patients, care-givers and NGOs.' (FG1, M, 30)

Participants felt their specific concerns had not been listened to. Some of the principal values of the MHCA were described as 'un-Indian'. Autonomy and individualism in particular were criticised with one psychiatrist describing the new legislation as an 'individual-oriented western paradigm' (FG1, M, 40). Another described how 'individualistic societies probably understand what an advance directive is; it is a very individual perspective. India is a family-based society. We are more culturally integrated than an individualistic society' (FG1, M, 30).

At national level, many questioned the need for ADs and NRs on the grounds that 'in India there is a very patriarchal system. When it comes to the Doctor, he'll say

‘Doctor whatever you feel. Treat me like your son or treat me like your daughter’.

(FG4, M, 17). There was also apprehension about patients’ decision-making:

‘So, who will make advance directives? The patients who are really concerned about their rights. Most of the patients in India have faith in their doctor. They will not make advance directives; only a few patients will and we will have to follow them. Who will be at loss? The patient will be at loss, but at least we are protecting his rights.’ (FG7, M, 12)

Some participants were apprehensive about the potential for non-adherence, refusal of admission and ‘poor treatment decisions’, although others seemed more willing to embrace the uncertainty of collaborative treatment planning. One psychiatrist described it as a ‘double edged sword’. A small but vocal minority questioned the universality of human rights in an Indian context, with one participant commenting that ‘human rights issues are very subjective, very subjective here’ (FG1, M, 20).

All focus groups drew attention to the benefits of family involvement in treatment. Relatives often presented with an individual in crisis and many experienced violence at the hands of their mental ill relative. Many psychiatrists perceived their duty of care as applying to the whole family. One psychiatrist described how social, interpersonal and family bonds can be so strong as to supersede or pre-empt legislation:

‘It is a multi-layered reality. One hardly can deal directly with the law. One has to first of all deal with the family, then the community, caste, then politicians, then the law.’ (FG7, M, 35)

Other psychiatrists were more direct and, in relation to families ‘losing importance’ in relation to caring for mental ill relatives, simply stated ‘it should not be in the Act. Nominated representatives are not our requirement.’ (FG9, M, 40) and another stated ‘we should not have nominated representatives, we have family members’ (FG11, M, 20) While there was a lot of concern about the exclusion of families, one psychiatrist

did imply how that close collaboration with families only exists as far as they are in agreement with medical professionals, they expressed concern that

‘[the MHCA is] going to give so much legal power to the patient and family. I don’t know at what point in time they are going to misuse it, simply because they are not fully aware, you know, we are giving them something that they can’t really use in a very justified sort of way’ (FG13, F, 29).

Participants were also concerned about the ability of individuals to make advance directives and choose nominated representatives, and the fitness of people to serve in that role

‘Some of the families are not aware of technology and science. They believe in faith healers and would take patients to them and would try local remedies.’ (FG4, F, 4)

Many psychiatrists attributed this inability to effectively use the supported decision making framework to a lack of literacy and educational attainment. It was suggested that individuals with higher educational attainment, income and knowledge about mental illness might be in a better position to make advance directives or appoint nominated representatives:

‘Teach our society about mental illness, how it happens and how it is treated, then that person will help us to decide upon their treatment.’ (FG3, M, 15)

Some participants stated that stigma was the key barrier to the use of advance directives and nominated representatives. They saw the need to register advance directives and acquire permission from a nominated representative as a strong indication that the person might become unwell in the future and, therefore, stigmatising. However, there was also an acknowledgement that stigma is declining and awareness increasing. Some participants felt that patients were well informed and made comparisons to other areas of medicine to support this position.

Despite directly enquiring about it, psychiatrists did not address the dissonance between having concern that families are being marginalised while also having concern that families are unqualified to act as nominated representatives. They preferred instead a more informal regulation of this process

'the cultural ethos does not have this ingredient right now in terms of rights. Yes, the right is more disciplined, self-regulated and within the family context or cultural context.' (FG 11, M, 25)

5.4.3.1.2 Logistical considerations that need to be addressed prior to advance directives and nominated representatives

The second theme to emerge related to logistical issues and resource based considerations. In the analysis, consideration was initially given to classifying this as an additional area of opposition to advance directives and nominated representatives, as many of the issues raised were negative. However, the topic differed from the previous concerns as professionals were very open to exploring potential solutions and examining how pitfalls could be avoided. Concerns in the area of logistics were associated with a lack of information and uncertainty rather than a fundamental disagreement with the legislation. For example, where MHRB could not be appropriately staffed, participants discussed the option of phased implementation of the MHCA to facilitate implementation rather than suggesting the idea be abandoned. In relation to advance directives there was concern directed towards the infrastructure rather than the idea itself:

'My concern is that if it [the advance directive] is buried under millions of sheets and pages, to find it at the right time, to get the decision ... this is a very big query for me.' (FG8, F, 24)

The primary logistical consideration was that of resource limitation. This topic was ubiquitous in the discussions and was seen as the central reason why the MHCA would prove challenging to implement. Limitations identified related to human

resources, finance, infrastructure and time. There was particular mention of the lack of appropriately trained professionals, including judges, nurses, social workers and psychiatrists. Individuals in multiple groups identified that the MHCA would shift many decision into a legal setting making infrastructural issues in this area highly significant.

'Now it has gone from the medical bastion to the judicial bastion.' (FG10, M, 32)

Participants were also highly concerned that the MHRBs positions could not be filled with suitably experienced members:

'We have review boards where the people who will be there have no idea what mental illness is, what mental health is. They will be deciding what kind of treatments will be given to mentally ill patients.' (FG3, M, 8)

Many individuals highlighted how hard it was to recruit mental health professionals in the first place and feared that MHRBs would draw from an already under resourced pool. Some groups expressed concern that if MHRBs are comprised of individuals unsuited to or not qualified for the task this could be a potential source of corruption.

The low level of funding for mental health was highlighted repeatedly and the budgetary demands of implementing the MHCA discussed. Participants identified the problems that could arise if an advance directive requested a treatment that was unavailable in the local area or if an individual indicated a preference for a certain hospital or psychiatrist. One participant was concerned that individuals would make advance directives only allowing admission to hospitals that are not registered as mental health establishments because to reduce stigma. Such advance directives could present prohibitive financial implications or insurmountable resource issues. Resource limitations also led to concerns about the proposed system for storing and accessing advance directives. Psychiatrists were apprehensive about the time commitments of more collaborative work and the burden of new administrative procedures.

Assessment of mental capacity was the second major logistical concern. When advance directives or nominated representatives were discussed in the groups, assessment of capacity was often a key point of contention. Perceptions varied on whether there was sufficient guidance on this topic; some participants felt that it was well described in the MHCA while others did not feel that it was sufficiently addressed. The vast majority of participants agreed that the requirement to regularly assess capacity would not be possible within the time constraints they experienced. The frequency of reassessment was also unclear to many. Concerns were raised about individuals' mental capacity to make advance directives and that they may make them while unwell. One psychiatrist suggested that the appointment of a minister for mental health would be helpful in addressing the logistical problems and ensure that appropriate funding was provided.

5.4.3.1.3 Benefits of introducing advance directives and nominated representatives

Under this theme we have brought together comments in support of advance directives and nominated representatives and the potential positive impacts on individuals, carers, and professionals. We have included supportive comments even where there are some underpinning reservations or a perceived need for infrastructural or societal change. Some psychiatrists had more positive views of advance directives and nominated representatives on a theoretical level and felt that this would support individuals in making choices that would be more beneficial to mental health. Advance directives and nominated representatives were seen as part of the overall protection of patient's rights brought about through the MHCA:

'I think for me personally the biggest thing that I like about the act is that it's much more patients centric, it talks much more about patient's rights about their ability to make their own decisions. Including advanced decisions about their future treatment.' (FG8, M, 15)

A minority of participants identified advance directives and nominated representatives as entirely positive and saw potential for them to support patients' rights and realise more patient-centred care. The roles advance directives could play in improving confidentiality and privacy were mentioned, some psychiatrists pointed out that currently information is often shared with the head of the family, this law gives an individual the ability to choose to have information shared with a different family member, or a partner. Some groups saw a particular role for NRs in individuals without a family. While many were concerned about large numbers of patients appointing a highly inappropriate nominated representative, a minority believed very few people would choose to appoint nominated representatives and that those who did would generally have important reasons for doing so.

One psychiatrist identified the tensions that exist between securing rights to autonomy and rights to health and dignity. They were concerned that the autonomy that would be achieved through the MHCA would come at a cost for patients.

'This law is going to ensure that people live in the community without treatment with fullest autonomy and a lot of rights but they never recover, that is not the point in the whole legislation. You have to empower them to live a normal life, this act cannot help him lead a normal life.' (FG11, M, 20)

5.4.3.2 Discussion

The inclusion of advance directives and nominated representatives in the MHCA reflects a clear UNCRPD-driven shift towards supported decision-making and patient-centred treatment, away from substitute decision-making (Committee on the Rights of Persons with Disabilities, 2014; Duffy and Kelly 2019b). The MHCA is a progressive piece of legislation on many levels but our findings highlight some of the complexities of implementation (Duffy et al., 2018; Kalmegh, 2018). While the Act's supported decision-making provisions might not fully achieve the standard proposed by the Committee on the Rights of Persons with Disabilities (2014), they go a long way towards aligning with the UNCRPD itself by taking a moderate approach that also

attempts to incorporate the ground realities of psychiatry in India (Ramon et al., 2016).

Many psychiatrists in this study India-specific reasons why they felt UNCRPD-based legislation could not be implemented but higher income countries have also articulated similar challenges, despite taking less radical steps (Hoffman et al., 2016). Shared decision-making is a new process internationally and its realisation requires training for services users and clinicians everywhere that it is implemented (Ramon et al., 2017).

Ademosu (2018) has described a Eurocentric paradigm in mental health, the colonial resonance of such practices, and the danger of external agencies assuming they know what is best for a culture. Despite these concerns and despite the role that NGOs and the UNCRPD played in the development of the MHCA, much of the impetus for change actually emerged from India and Indian psychiatrists themselves (Rajkumar et al., 2007; Sakar, 2004; Thippeswamy et al., 2012).

5.4.3.2.1 Reasons for opposing advance directives and nominated representatives

It is important to note that evidence suggests that advance directives are unlikely to drastically change treatment practices, as up to 80% of individuals making them opt to follow their doctor's advice (Gowda et al., 2018, Pathare et al., 2015). Two clear inconsistencies arose in our focus groups in relation to this theme. First, some participants felt that advance directives were not needed owing to the expectation of paternalistic care and a willingness among patients to have their doctor decide for them. Second, strong anxiety was expressed that individuals might make advance directives that were not in line with doctors' treatment suggestions. While there may be individuals that fall in to each of these categories, both groups were portrayed as the norm, a position that is internally inconsistent.

The role of a highly involved family in the delivery of care was often put forward as a reason why nominated representatives were inappropriate and unnecessary in Indian society. The converse interpretation – that intense family involvement might make nominated representatives even more important - did not emerge. While Indian

families can play a very strong role in the lives of those with mental illness (Avasthi, 2010; Chavan et al., 2018), and this can often promote their wellbeing, it could also be to their detriment (Mahomed et al., 2019). Moreover, while, in certain regards, the role of the family may be replaced by the nominated representative (Duffy and Kelly, 2017c), family still receive special attention in the MHCA: family members have entitlements to become a nominated representative if nobody else is nominated (Section 14(4)) and they have a right to challenge an acting nominated representative (Section 16). In practice, where advance directives have been made, over 80% of individuals appoint a direct family member as nominated representative (Pathare et al., 2015).

Indian studies of the use of advance directives have shown that 89% to 95.6% of individuals who are capable of making an advance directive are willing to make them (Gowda et al., 2018; Tekkalaki et al., 2018). Two-thirds of patients welcome their use (Gowda et al., 2018). Many opt against receiving physical restraint (62%) or electroconvulsive therapy (47%) in the future (Tekkalaki et al., 2018). Interestingly individuals who have experienced these treatments in the past tend to be more likely to accept them again in the future, although findings are mixed. Treatment choices do not appear to vary significantly with educational status. Finally, there is evidence that the completion of advance directives increases self-efficacy and motivates individuals to make more decisions (Shields et al., 2013), but, even so, the concerns about advance directives are also seen among psychiatrists in high income countries (Gieselmann et al., 2018).

5.4.3.2.2 Logistical considerations that need to be addressed prior to adopting advance directives and nominated representatives

Regarding logistics, India's mental health infrastructure is under-funded and under-developed (Gururaj et al., 2016; Patel et al., 2016). Indian psychiatrists see more patients and have less time to spend with each patient compared to their American counterparts (Wasan et al., 2009). The adoption of a supported decision-making framework will increase time demands on Indian psychiatrists (Inamdar et al., 2016). While it is suggested that advanced directives will improve adherence and reduce

hospitalisation, there is a paucity of high quality evidence for this and it is unlikely that this will offset demands on psychiatrists' time (Campbell and Kisely, 2009).

There are also other unresolved issues. Where advanced directives have been used, carers have expressed concern about individuals' capacity to make decisions (Shields et al., 2016) and illness can impact on content (Gowda et al., 2018). Carers identified two reasons they did not want advanced directives, they felt that they were not useful in bringing additional stability to individuals lives and they questioned the individual's capacity to make decisions. Although this sample was small, they did not identify many of the issues raised by the participating psychiatrists in this study, for example culture, resourcing, or mental health literacy issues. However, both the psychiatrists interviewed in this study and the carers Shields et al. (2013) interviewed, expressed paternalistic views towards individuals receiving treatment. These views were in contrast to those of service users, who strongly wished to be involved in the decision concerning them and who felt equipped to contribute (Shields et al., 2013).

Nominated representatives might provide some of the support needed to maximise decision-making capacity and thus enable universal legal capacity (Kanter, 2015), i.e. through their role in supporting decision making, nominated representatives may allow individuals with challenges relating to their decision making capacity to exercise legal capacity. However, it may also prove necessary for capacity assessments to be carried out at the time of making advanced directives to prevent MHRBs revoking or modifying them, this is suggested in the guidance document on capacity assessment (Expert committee, 2019). The capacity criteria in the MHCA may also be non-concordant with the UNCRPD, as it is argued the concept of 'decision making capacity' is discriminatorily applied to people with disabilities (Committee on the Rights of Persons with Disabilities, 2014). The guidance document on capacity assessment provides evidence for this view (Expert committee, 2019) as eight of the nine contexts in which it suggests assessing capacity, only apply to individuals with a mental illness severe enough to necessitate admission. Others, including the WHO, have called into question the validity of decision-making capacity itself (Szmukler, 2019; World Health Organization, 2019b; Light et al., 2016).

5.4.3.2.3 Benefits of introducing advance directives and nominated representatives

Prior to its implementation there was much anticipation of the potential benefits of the MHCA to the rights of individuals with mental illness (Hoffman et al., 2016; Ramon et al., 2017; Rane et al., 2013). It is unsurprising that psychiatrists see the supported decision-making elements of the MHCA as having the potential to protect individuals rights, as the content of the legislation closely and intentionally aligns with the UNCRPD (Duffy and Kelly, 2020b). In addition to this theoretical perception, clinical research has demonstrated that the provision of CRPD concordant healthcare like that described in the MHCA can benefit patients and cares, and that advance directives and nominated representatives can be effectively utilised (Pathare et al., 2021, Shields et al., 2013).

Much of the earlier commentary in this discussion has called into question the idea that Indian society is not ready for advance directives and nominated representatives. However, while the rights-based nature of the MHCA is self-evident, the key question raised by our focus groups remains unresolved: Is the MHCA realisable and relevant in an Indian context? This is a crucial issue. In practice, it is critically important that mental health legislation is focused on realisation in the real world and not simply focused on theoretically perfect arrangements that do not translate into practice (Sen, 2009). Ostensibly perfect laws that produce bad outcomes are clearly worse than imperfect laws with positive results.

5.5 Strengths and limitations

5.5.1 Strengths

This study captured the views of psychiatrists during a paradigmatic shift in mental healthcare for India. Thanks to the dramatic impact of the CRPD internationally, this is a transition that many other countries may undertake in the coming years.

Consequently, these professionals provide useful information for how this transition can be made in partnership with mental health professionals, rather than marginalising highly experienced practitioners (Hoard and Duffy, 2021). It included mental health professionals working in four different Indian states, and approximately 1% of Indian

psychiatrist participated in our focus groups.

The two individuals leading this work, Dr Richard Duffy and Professor Brendan Kelly, are primarily based in Ireland and are not directly connected with India or Indian psychiatry this presents both advantages and disadvantages. On the one hand, it facilitates a position of equipoise in the focus groups and allows these authors to be more objective about their findings, the removed some potential bias in the interpretation. However, it also means that they lack a practical understanding of this legislation on the ground. The input from the India-based co-investigators and co-authors was invaluable in identifying and addressing some of these gaps in knowledge that arose due to their external perspective.

While we believe we reached theoretical saturation on our focus group data, this is complicated by the evolving implementation of the MHCA. During the most recent focus groups (Dec 2019), the SMHAs had been convened but the hospitals we visited were yet to be allocated MHRBs. This made much of the discussion about the practicalities of the act theoretical. However, while this is certainly a dynamic situation, sampling a wide range of Indian psychiatrists revealed very consistent themes across our work. Small variations in perspectives were seen across geographical regions, but no new topics or themes arose in the later focus groups. This allowed us to explore existing topics in more detail, enhancing the richness of the data.

5.5.2 Limitations

As mentioned above the primary researchers were not directly connected to India. In addition to the benefits this brought, it also had inherent draw backs. The researcher's perspective and experience of norms within European culture and psychiatry were often discussed in the debriefing sessions following focus groups. The researchers attempted to adopt a neutral stance, but no researcher can fully separate from their own cultural context.

The primary limitation of this study is that the questioning route and selection the participants was to facilitate a broader understanding of the MHCA. The aim of the focus groups was not to assess the perspectives of psychiatrists on assisted decision

making or ECT. However, the depth of information that we received on these two topics allowed a targeted analysis to be conducted. Had the focus group been specifically designed to answer questions about these topics more detail may have been provided. Despite this limitation, the broad focus of our groups provided extensive context to the themes analysed.

The focus group participants ideally would have been randomly sampled from an extensive list of potential participants, from a wide range of Indian states. India is a vast country and there are limitations in drawing conclusions from only four states, few of the psychiatrists were working solely in a rural setting, it would be vital to ascertain the perspective of psychiatrists or general physicians working in such a setting. Maharashtra was overrepresented and unfortunately it was not possible to conduct additional groups in Bihar and Jharkhand due to recruitment and logistical issues. While this may limit the generalisability of our findings, large variations in topics addressed were not observed in the different states. The study would have also been enhanced by returning to the same location at two different time points. As it was conducted, it was not possible to identify if changes in perspectives about ECT or assisted decision making reflected psychiatrists views in a given location or if they were evolving as they became more familiar with the MHCA.

It could be argued that individuals who agreed to participate in our study were not a representative sample due to a selection bias. Despite this, strong opinions were acquired from both sides of the debate in our focus groups, some individuals welcomed the new act and espoused its benefits from human rights, while others were highly critical of it. While our participants may represent a more outspoken or extreme cohort, they were not homogenous in their views of the MHCA.

In one of the focus groups there were some challenges with the use of English, on multiple occasions in that group the conversation occurred in a local language and a translation was then provided by one of the group members. This highlighted that how some of the nuance may have been lost due to the focus groups taking place in English.

Overall, while it was important to describe the concerns of Indian psychiatrists as they face into the new legislation, it remains to be seen how this pioneering law will work in practice. The MHCA was yet to be fully implemented at the time of our last

visit (Dec 2019) despite the legislation having come into force in 2018. The MHRBs were yet to be set up and the psychiatrists we interviewed were yet to encounter advance directives or nominated representatives. Concerns raised here may prove to be disproportionate and alarmist but equally unanticipated issues may arise. As one focus group participant put it:

'We don't have experience, yet, let us get experience of all these new provisions.' (FG12, M, 12)

5.5.3 Assessment of trustworthiness and credibility

To address matters relating to trustworthiness and credibility the criteria proposed by Walsh and Downe (2006) have been edited into table 5.6 This includes matters relating to analysis, interpretation, reflexivity, and relevance and transferability. This table highlights that while many steps have been taken to address trustworthiness and credibility, there are methods that could be employed by future researchers to further enhance these.

Table 5.6 Exploration of trustworthiness and credibility of the focus groups with Indian psychiatrists discussing the Mental healthcare Act 2017

Criteria	Strengths	Limitations
Analytic approach appropriate	Approach and justification described Development of coding system discussed. Contextual variables included and discussed, Iterative approach between two researchers appropriately used. Saturation reached.	Research participants had no involvement in analysis.

	Deviant data sought and obtained. Same themes repeated at different sites despite significant differences in the contexts.	
Context described and taken account of in interpretation	Context of data collection described. Iterative approach and separate analyses for each publication demonstrated time 'dwelling with the data'.	More detail on the contexts of the groups could have been provided outside of the objective facts described.
Clear audit trail given	research processes described in methods section.	Themes to focus analysis on not identified at inception of study.
Data used to support interpretation	Notes on emotional content of discussion and individual demographic and professional variables included in the discussion. Discussed how interpretation led to conclusions included.	Discussion of how interpretation led to conclusions could be enhanced.
Researcher reflexivity demonstrated	Debriefing notes on each group made. Attempts made to include all participants. Debriefing notes made including ethical issues after each group and discussed steps take to address them.	Limited documentation for discussion of relationships between researcher and participants during groups. Additional reflection on bias prior to starting study would have been helpful

		but was considered once groups started. Difficulties addressing the hierarchical structure in Indian psychiatry may have limited the views of junior focus group members.
Relevance and transferability evident	Limitations discussed. Findings resonated with knowledge and experience, and interpretation made sense when reading transcripts and reflecting on groups.	Limited pre-existing theories existed to link with collected data.

Adapted from Walsh and Downe (2006)

5.6 Conclusion

The focus group element of this research provided a useful context to inform the black letter component of this thesis. Concerning the two areas in which analysis was focused this research identified that ‘the ground reality is different’, there is a significant divide between the legislation in theory and how it is practiced. This has not been helped by delays in the formation of MHRBs.

Key overarching themes include the dangers and consequences of resource limitation at both a financial and a human resource level. This has echoes of a prior period of transition in psychiatry, where asylums were opened as a humane response to sick houses and destitution, but quickly due to underfunding and mismanagement, they undermined the rights of the individuals they sought to serve. Failure to fund this act appropriately could equally have a detrimental impact on individuals with mental illness.

The second area of concern that spans both topics presented here, but that arose in other topics that we did not analyse in this thesis, relates to the discordance

between the CRPD and Indian culture. It remains under debate whether the MHCA represents a step towards the realization of non derogable rights for individuals with mental illness in India or the imposition of western culturally discordant values. This is a larger question for the CRPD as a whole.

Many groups highlighted the disconnect between the legislation as it stands on paper and how it is realized in practice. To quote one of the focus group participants,

'Are they really going to be able to do it, is it all on paper?' (FG 13, P3)

This significant divide may have been exacerbated by the manner in which the MHCA was implemented, the fact that the legislation was brought into force without the necessary infrastructure in place, has led to psychiatrist becoming accustomed to practicing a truncated MHCA. It may prove challenging to address this should sufficient infrastructure be forthcoming.

6. Summary of findings

6.1 Context

The WHO has recently recognized legislation as a powerful tool for facilitating healthcare, across medicine psychiatry has the longest standing relationship with the legal field and is well placed to harness it as a tool to help people suffering with mental illness. Although, it should be noted that the relationship between psychiatry and the law has not always been an entirely positive one. The publication, and near universal ratification, of the CRPD since 2006, has brought about the most significant revision of mental healthcare since the advent of psychotropics. The CRPD seeks to put the individual receiving treatment and their wishes at the center of care. The text of the CRPD would greatly limit involuntary care, however the Committee on the Rights of Persons with Disabilities and WHO's QualityRights initiative are determined to take this a step further, seeking a total prohibition on all involuntary care. This affirmation of an individual's mental capacity irrespective of their mental state is an area of grave concern for many psychiatrists, who see this as a potential route to criminalization, marginalisation and untreated illness rather than an opportunity to realise greater autonomy and quality of life for individuals with mental illness. These concerns have been expressed in the medical literature and many of these were echoed by the psychiatrists in this study.

With a population of over 1.3 billion, India's mental health legislation is likely to be one of the most influential documents for individuals with mental illness in the world. India's mental health legislation was long overdue a review, the Mental Health Act, 1987 was originally drafted in 1950 and this legislation would have needed extensive revision to make it concordant with the CRPD. Many countries have opted to make minor adjustments to their mental health laws, in a tokenistic acknowledgment of the CRPD. India by contrast took the bold step of writing two pieces of legislation, the RPWDA and the MHCA, that from their preambles explicitly seek to concord with the CRPD. In addition to being concordant with the CRPD, India also provided its citizens with a justiciable right to mental healthcare. These ambitious steps prompted this research project, as if successful India's legislation will become the template for

countries seeking to realise the CRPD, and if elements of it are unsuccessful, they may highlight components of the CRPD that are impractical or that may have unintended negative consequences.

6.2 Black letter analysis summary

The WHO-RB was recently withdrawn by the WHO, in line with the Committee on the Rights of persons with disabilities and the UN's special rapporteur on torture, they are pursuing a total prohibition on coercion, involuntary treatment, and substitute decision making within mental healthcare. Within the WHO the QualityRights initiative is driving this, consequently its documents make no reference to protections that should exist for people receiving involuntary treatments. However, many jurisdictions, including India, have retained contexts in which involuntary treatment and substitute decision-making can occur and so this study opted to compare the MHCA to the WHO-RB checklist.

India's legislation was concordant with 64% (112/175) of the WHO-RB checklist items, (50.9%) 89 were addressed in the MHCA. Eleven of the non-concordant items were well justified in their deviation, often providing individuals with additional rights more in line with the CRPD. Many elements of the MHCA and the RPWDA drew phrases from the WHO-RB verbatim. This level of concordance significantly surpassed the levels seen in the handful of other countries where this kind of analysis has occurred. The WHO-RB acknowledges that not all of its items need to be addressed in legislation, consequently this reflects excellent alignment with the checklist.

Some of the concerning omissions included, the insufficient protections concerning limited guardianship in the RPWDA, patients being treated in the community under advanced directives, non-protesting patients and long-term independent (voluntary) patients. The act could also be strengthened with enhanced protections for women and minority populations. There are some areas where it appeared that the non-concordance was due to an intentional opaqueness that was potentially present in an attempt to be concordant with the CRPD, while still permitting a degree of involuntary care. This is particularly evident in relation to the

interaction between capacity and the role of the nominated representatives and may also be behind the lack of guidance concerning limited guardianship in the RPWDA.

The alignment of India's legislation with the CRPD was in many ways the most consequential element of this project, this is the component that is of most relevance to researchers outside of India. Due to the legal obligations that the CRPD places on ratifying nations, there will be increasing pressure to revise mental health laws to give greater weight to patient autonomy and preference. India's attempt to operationalise the CRPD in its legislation, and this project's analysis of their attempt, will hopefully highlight the merits and pitfalls of such a process.

In order to align with the CRPD, the MHCA created the construct of nominated representatives and advance directives, it placed these at the center of the act. The RPWDA has limited guardianship in place of nominated representatives, but the protections surrounding this are poorly described. However, there is no RPWDA equivalent of an advance directive which may represent a major omission, as advance directives under the MHCA only relate to mental healthcare decisions. The nominated representative facilitates a supportive decision-making framework, in place of the substitute decision making model that was present in the 1987 Mental Health Act. However, pragmatically the MHCA acknowledges situations where the nominated representatives may have to offer very high levels of support approaching 100%. This is a highly pragmatic tool that prevents individuals being deprived of treatment due to their mental capacity being temporarily compromised. Building on the role of the nominated representative, the MHCA also has replaced involuntary with supported admissions, in these individuals with impaired mental capacity can exercise their legal capacity and receive treatment despite not being able to provide full and informed consent.

Overall, there were high levels of concordance with the CRPD. Despite this, there were a few areas where there were notable omissions. Political rights, liberty of movement and nationality require extensive legislative change if they are to concord with the CRPD. Many areas that were well addressed will need to have more details provided in policy or state level legislation as practical details were often absent. In some areas, questionable concordance with the CRPD in the Indian legislation reflected a progressive desire to provide high quality mental healthcare (e.g. in

relation to research). In addition, some of the omissions from the legislation have moved certain controversial topics outside the RPWDA and the MHCA into policy documents (e.g. limited guardianship and assessing mental capacity). Involuntary admission, involuntary treatments, restraint and emergency treatments have been retained although they seek input from nominated representatives in an attempt to shift the process from a substitute to a supported decision-making paradigm.

Probably the most contentious Article in the CRPD in terms of mental health legislation is Article 12 which relates to 'Equal recognition before the law'. Where practices might appear to contravene the CRPD, multiple protections have been put in place, chiefly mediated by MHRBs. Areas of non-concordance are generally the product of efforts to balance competing CRPD rights with each other, and this balancing act is often directly reflected in the text of the MHCA.

6.3 Focus group summary

Indian psychiatrists tended to be critical of the MHCA, while some could identify positive elements about the new law, many more expressed their concerns. The professionals interviewed in this study were highly critical of the drafting process and the individuals who drafted the act, they felt that they either had not been consulted or if they had, that their concerns had been ignored. Some identified the CRPD and human rights-based agenda as driving the legislative change. The first key concern that ran through many of the topics that were analysed, was that the mental health practitioners interviewed felt that many elements of the MHCA were a poor cultural fit with Indian society. They identified difficulties with the perceived marginalisation of families, the emphasis on autonomy, and the reduced role for psychiatry in the administration of the MHCA. The final point was compounded by the perception that there was poor mental health literacy in other professions, people receiving treatment and their carers.

The second overarching concern related to resource limitations. These deficits were identified at almost every level. Staffing levels were described as inadequate, this related mostly to mental health professionals but was also described in the judiciary and the police. As a consequence of this, psychiatrists often did not

have the time to give an individual receiving treatment the time the MHCA would require. Facilities were described as lacking, in particular step-down and rehabilitation services.

In relation to ECT, psychiatrists were highly supportive of the practice and were unhappy about its use being limited in minors, without anaesthesia or in the emergency setting. Interestingly it was often psychiatrists not working in rural settings who felt that psychiatrists in these settings needed to be able to give unmodified ECT, and psychiatrists not working with children who wanted ECT to be accessible to minors. In relation to advance directives and nominated representatives, psychiatrists had a wide range of reasons for opposing their use. They had multiple logistical reasons for being concerned about their use but some were supportive of their introduction.

In relation to ECT and assisted decision making, some of the views of the psychiatrist were under pinned by misunderstandings of the act or a preconceived idea about the type of decisions MHRBs would make. Their views were often supported by very vivid anecdotes or unpublished research done locally. However it was very clear in all the interviews that their desire to be allowed to use coercive measures was motivated by a desire to help their patients and families.

6.4 Future research

There are three key areas that would benefit from future research stemming from this thesis:

- An evaluation of the legislation in terms of the QualityRights initiative would be helpful in identifying areas where additional protections could be identified and human rights abuses addressed. This could utilise the WHO QualityRights tool kit (2012), themes three (capacity) and four (freedom from torture) will be of particular relevance as India negotiates the relationship between capacity, nominated representatives and supported treatment. The up scaling that Pathare et al. (2019) proposed of their research could be an excellent compliment to this project.

- Assessment of the perspective of psychiatrists once the act is fully implemented would be highly informative. Delays in implementing the legislation have delayed such research, but it is a necessary part of assessing the impact of the legislative changes into the future. Quantitative data collected through the excellent network of the IPS could prove a valuable source for this research. Repeating the focus groups prior to the first revision of the MHCA or five to ten years after its full implementation could also be highly informative. This would offer a useful contrast to the data presented here.
- This thesis is lacking the perspective of individuals receiving treatment or their caregivers. This would be very useful in contextualising the findings of the research to date. Part of this would be achieved through utilising the QulaityRights tool kit as suggested above. But specific research focusing on the questions raised by this research would be highly informative, this could build on the work of Pathare et al. (2015). For example, examining patients relationships to their families or their reflections on assisted decision making tools. Too often no voice is given to individuals who benefited from restrictive treatments, while individuals who had a negative experience exert disproportionate influence (Degener and Begg, 2017; Melish, 2014).

6.5 Conclusion

India has taken a very bold step in writing legislation that is explicitly compliant with the CRPD. In doing so it has also provided a justiciable right to mental healthcare to more than a sixth of the world's population. If fully realized, this will transform how those with mental illness are treated in India, and hopefully serve as a template to other countries seeking to enact CRPD concordant legislation. India's legislators have expertly negotiated the intricate balance between competing rights while keeping the legislation centered on the individual receiving treatment and attempted to maximize their autonomy throughout. While it could be argued that it falls short of being concordant with the Committee on the Rights of Persons with Disabilities interpretation of the CRPD, it is pragmatic and does not elevate the right to autonomy above all other rights. Much more in keeping with Indian culture, the pursuit of autonomy is held in tension by a desire to realise the rights to health and active participation in family and community.

India's legislation should serve as a wake up call to many countries who have only made tokenistic gestures in bringing their mental health law in line with the CRPD. Until a jurisdiction can demonstrate a mental health law that is fully concordant with the UN Committee on the Rights of Persons with Disabilities' interpretation of the CRPD, the Indian legislation will remain the gold standard.

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