



CENTRE FOR
LAW & POLICY
RESEARCH

CLPR WORKING PAPER 1 / 2012

**MOVING TOWARDS AUTONOMY AND EQUALITY: AN
ANALYSIS OF THE NEW MENTAL HEALTH CARE BILL
2012**

Jayna Kothari and Dharmendra Chatur

ABOUT THE AUTHORS: *Jayna Kothari* (jayna.kothari@clpr.org.in) is Founder / Director of the Centre for Law and Policy Research in Bangalore. *Dharmendra Chatur* is a BA, LLB (Hons.) candidate at Christ University, Bangalore and a Research Assistant at the Centre for Law and Policy Research.

The authors' address for correspondence is: Centre for Law and Policy Research, D6, Dona Cynthia, 35, Primrose Road, Bangalore 560025.

ABSTRACT: *The new Mental Health Care Bill 2012 marks a complete shift from the existing Mental Health Act 1987 from viewing persons with mental disabilities as persons requiring institutionalisation, to persons with autonomy, equal recognition of their rights and full legal capacity. This shift has been in view of India's ratification of the UN Convention on the Rights of Persons with Disabilities 2006 ("UNCRPD"). In this paper, we analyse the provisions of the Bill specifically in the context of the changes in mental health care law that it proposes, keeping in mind the rights to autonomy and equality of persons with mental disabilities. We examine the effectiveness of the changes with reference to the UNCRPD and the United Kingdom's mental health law. We conclude by making certain recommendations where the Bill that do not safeguard the autonomy and equality of persons with mental disabilities.*

INTRODUCTION

India ratified the UN Convention on the Rights of Persons with Disabilities 2006 (UNCRPD) and the Optional Protocol to it in 2007.¹ The UNCRPD's objective is to protect and promote the rights of persons with disabilities from a social model unlike the earlier medical model of disability. It ensures that persons with disabilities become holders of rights rather than being objects of welfare measures and medical treatment (UN et al 2007). To that extent, "the UNCRPD marks a paradigm shift in attitudes and approaches to persons with disabilities and views them not as 'objects of charity', but 'subjects with rights'" (Murthy 2010: 153).

The current Indian law relating to persons with mental illness or disabilities is the Mental Health Act 1987 (MHA) which was enacted to replace the Indian Lunacy Act 1912. Considered to be a watershed moment in furthering the protection of persons with mental disabilities, the MHA, however, had its own shortcomings. It deprived persons with mental disabilities of their legal capacity to make decisions about their life, health care and property and it failed to alleviate social stigma surrounding mental disabilities (Trivedi 2009). Compliance with the UNCRPD warranted recognition of legal capacity of persons with mental disabilities allowing them to make decisions affecting their health and protecting their rights. Moreover, in the existing mental health care law, schemes and initiatives for any benefits were extremely insufficient, limited and scarce (Murthy 2011).

In addition, the existing mental health care system was inadequate to meet the requirements of the UNCRPD. The MHA is focused on the confinement of persons with mental disabilities in mental health institutions while the UNCRPD requires a system that puts the focus on legal capacity of the patient and protection of his/her needs rather than the institutions in which they were treated. The UNCRPD's mandate necessitated expansion of mental health care system beyond hospitals to rehabilitation and awareness, and finally the regulation of mental health care in all settings – whether in hospitals, private or public, non-medical (religious shrines, NGOs, facilities run by public spirited individuals and so on) or through community-based care (Murthy 2010: 153). Therefore, an impetus was provided to ensure access to better healthcare for persons with mental disabilities in furtherance of a rights-based approach to mental disability – which was completely absent in the MHA.

The changes required by the UNCRPD in India's domestic mental disability law are now sought to be achieved by the Mental Health Care Bill 2012 (MHC Bill). In this paper, we review the draft MHC Bill critically. The UNCRPD mandates that States parties should ensure to all persons with disabilities equality of opportunity and accessibility, especially to treatment and care; full and effective participation and inclusion in society; respect for the inherent dignity, autonomy, including the freedom to make one's own decisions, and independence of persons and non-discrimination (UN et al 2007a). We analyse the MHC Bill to check its compliance with the UNCRPD and if it adequately protects, promotes and ensures the human rights of persons with mental disabilities and respect for their inherent dignity.² In two separate parts, this paper examines the issues of autonomy and equality in the context of mental disabilities. In our analysis, we use relevant provisions of the UNCRPD, the UK mental health law as a comparator and additionally highlight the problems with the MHA. Finally, we conclude with recommendations about the MHC Bill and suggest methods to improve its implementation.

THE MENTAL HEALTH CARE BILL 2012

In order to create a rights-based legal framework in compliance with the UNCRPD, the Union Ministry of Health and Family Welfare began a process to amend and possibly repeal the MHA in 2010. A draft Mental Health Care Bill 2010 was placed in the public domain for comments following several public consultations held in Bangalore, Pune, Chandigarh and Tezpur (Dhar 2011). Later, a national consultation with the involvement of many NGOs and civil society groups was held on this draft Bill which culminated in the present MHC Bill that was made public on 01 October 2012. This is expected to be the final draft of the Bill and will likely be introduced in the Parliament in its present form.

The new Bill is much longer than the existing MHA having 16 Chapters and 137 clauses. Before going into the specific aspects of the MHC Bill, it must be noted that the Bill makes new strides in developing an improved definition of "mental illness".

1. *Definition of 'mental illness':*

One of the significant advancement in the MHC Bill is the definition of 'mental illness'. It defines mental illness as "a disorder of mood, thought, perception, orientation and memory which causes significant distress to a person or impairs a person's behaviour,

judgment and ability to recognise reality or impairs that person's ability to meet the demands of daily life and includes mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation".³

This definition of 'mental illness' is a major improvement over the MHA which did not provide any guidance as to what would constitute mental illness – except for stating that a person who was mentally ill was anyone needing treatment and who did not come under the definition of mental retardation. This was clearly from a medical model of disability, while the MHC Bill seeks to understand mental illness from a social model, giving a broad and inclusive definition as to what may constitute mental illness. The failure to define 'mental retardation' in the MHC Bill has been severely criticised because this term is not defined in any other law at this moment (Murthy 2010: 154). Further, such exclusion would leave out persons with mental retardation from the purview of the MHC Bill, and their rights to access to health care, their rights to be treated with dignity, community living and freedom from cruel and degrading treatment, among others, would not be protected.

Clause 3 of the MHC Bill also lays down other criteria for determination of mental illness. Mental illness can only be determined in accordance with national and international medical standards. This clause also provides that a person's mental illness will not be a determinant of his/her social, political, economic, religious, cultural or racial status as well as non-conformity with such beliefs of one's community.⁴ Finally, a person's mental illness will not be conclusive of his/her unsound mind, which is a very significant proposition as unsoundness of mind can only be declared by a competent court and will not depend on a person's mental illness.⁵

Therefore, the definition of 'mental illness' receives a better treatment in the MHC Bill than in the MHA. We will now turn to the two major themes we focus on in our analysis of the MHC Bill – Autonomy and Equality.

2. Autonomy and Equality of Persons with Mental Disabilities in the MHC Bill:

a) Autonomy and Legal Capacity:

UNCRPD: Article 12 provides for 'equality and recognition of persons with disability before the law' and reaffirms legal capacity of a person with mental disability. Article 12 sets out the "right to recognition everywhere as persons before the law",⁶ as well as the recognition that persons with disabilities "enjoy legal capacity on an equal basis with others in all aspects of

life”.⁷ This provision proscribes discrimination on the basis of the mental disability of a person. The Article also makes a paradigm shift from ‘substituted’ to ‘supported’ decision making, thus abolishing any transfer of rights of decision making to another person.⁸

Article 12(4) directs the state parties to provide safeguards against abuse of rights of legal capacity and also establishes rights over property for persons with disabilities. Significantly, it mandates that safeguards must be in place to prevent abuse and ‘ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body’. The safeguards against undue influence and requirement of review of preferences hold relevance for persons with mental disabilities and impose an obligation on state parties to create a system to facilitate such review.

A major contribution of the MHC Bill is that it recognises that every person, including a person with mental illness, will be deemed to have capacity to make decisions regarding his/her own mental health care or treatment.⁹ This enabling provision reaffirms every person’s right and capacity to decide what treatment or care he/she must be subjected to, in compliance with Article 12 of the UNCRPD. To exercise this capacity, such person must have an ability to understand information relevant to the mental health care or treatment (including consequences of making or not making such a decision), retain such information, use or weigh such information to make the decision and communicate such a decision. The decision can be communicated by any means including talking, sign language and so on.¹⁰ Also, if others perceive the decision taken by the mentally ill person to be wrong or inappropriate, then that would not by itself indicate that the person did not have capacity to take such a decision.¹¹

In addition, the Bill gives every person with a right to make an “Advance Directive”,¹² empowering him/her to decide how he/she should and should not be cared and treated for mental illness in the future.¹³ The Advance Directive must be made in writing and must be registered with the jurisdictional Mental Health Review Board (MHRB).¹⁴ It cannot be contrary to any law in force, and can be amended, cancelled or revoked at any time.¹⁵ Also, an Advance Directive will not be applicable to emergency treatments.¹⁶ Every medical officer in charge of a mental health establishment and every psychiatrist treating a mentally

ill person must comply with the advance directive.¹⁷ However, an exception to this enables a relative, mental health representative or care-giver to make an application to the MHRB for review, alteration, modification or cancellation of an advance directive.¹⁸ A legal guardian may make an advance directive for a minor as well.¹⁹

The Mental Health Review Commission (MHRC) has the power to review use of advance directives periodically and make any recommendations thereof. The MHRC may also make regulations or modify procedure for making advance directives in the interest of the rights of mentally ill persons.²⁰ The MHC Bill also lays down an elaborate procedure for registration and revocation of advance directives as well as situations in which such directives can be overridden, which is aimed at preventing any misuse.

Another welcome provision in the Bill is the requirement that all treatments and medical research on mentally ill persons must be done only with their free and informed consent (by giving information about the risks, benefits, alternatives in an understandable language) or with the consent of the State authority, where the person is not capable of giving consent.

United Kingdom's Functional Approach and "Advance Decisions": In the United Kingdom, with respect to the legal capacity of the patients, the UK Mental Health Act 2007 Act provides that, "a person must be assumed to have capacity unless it is established that he lacks capacity".²¹ Only because a person seems to others to have made an unwise decision does not depict his inability to have legal capacity.²² The 2007 Act (UK) opts for what is known as the 'functional approach' which lays down the functional areas of capacity stating that a person is said to be unable to make a decision for himself if he is incapable "to understand the information relevant to the decision"; "to retain that information"; "to use or weigh that information as part of the process of making the decision"; or "to communicate his decision (whether by talking, using sign language or any other means)".²³ The MHC Bill 2012 adopts this functional approach as well.²⁴ Similar to the advance directive of the MHC Bill, the UK law also gives the patients a right to make an 'advanced decision' to refuse future treatment if the patient foresees that he will not have capacity to do so in the future.²⁵ It must be noted that this advance decision can only be made for refusing treatment, whereas the MHC Bill 2012 allows an advance directive for specific methods of treatment as well as non-treatment.²⁶

The Bill also provides for appointment of a nominated representative of a mentally ill person. It lays down the procedure of such an appointment for adults and minors as well as the procedure for revocation, cancellation and alteration of the nomination. The Bill prescribes duties of such nominated representatives. For example, to seek admission or discharge of a mentally ill person, apply to the MHRB for violation of rights under the Bill and so on.²⁷

Admissions, Treatment and Discharge: Along with reaffirming the Autonomy and Legal Capacity of persons with mental disabilities, the MHC Bill makes a significant improvement over the MHA by providing that any person may submit himself/herself to any mental health establishment as an independent patient for treatment for any mental illness. The Bill also provides for a detailed procedure and mechanism for admission, treatment and discharge of various kinds of patients with differing needs of care.²⁸ This is in stark contrast to the MHA, under which a Judicial Magistrate was empowered to decide whether a person is mentally ill and how his/her property must be dealt with. This power came under heavy criticism due to the unguided discretion it placed in the hands of courts to make decisions on behalf of persons with mentally illness without giving any agency to the persons with disabilities themselves (Antony 2009).

United Kingdom's 'Appropriate Treatment' test for detention: On the other hand, in the UK, the Mental Health Act 2007 has provisions for involuntary and compulsory treatment and detention of people who are mentally ill. If in the opinion of medical health professionals a patient ought to be detained “in the interest of his own health, his safety, or for the protection of others” in a hospital, then as a safeguard against potential abuse, an appropriate treatment for the supposed illness must exist if such patients are to be detained. The MHC Bill also has similar provisions with regard to the involuntary detention of a person with mental disabilities. Although the MHC Bill has safeguards as to when a person can be involuntarily detained, unlike in the UK, it fails to provide sufficient safeguards from possible abuse in the form of an ‘appropriate treatment’ test.

b) Equality and protection of rights of persons with mental disabilities:

The MHC Bill brings about a rights-based protection of mentally-ill persons.²⁹ This was never the focus of the MHA,³⁰ and the MHC Bill fills the requirement of the UNCRPD by guaranteeing to all persons the right to access to mental healthcare, and a range of services

for persons with mental illness including shelter homes, supported accommodation, community based rehabilitation; the right to community living, the right to live with dignity, protection against cruel, degrading and inhuman treatment, the right to equality and non-discrimination, the right to information, confidentiality and access to medical records; right to personal communication, legal aid and the right to make complaints about deficiencies in provision of services in addition to other similar legal remedies.

Specifically, in an attempt to prevent any cruel or degrading treatment for persons with mental illness, a complete prohibition has been placed on the use of electroconvulsive therapy (“ECT”) for minors (unless necessary as an emergency measure to save a minor’s life), sterilization of men or women as a mode of treatment for mental illness, and any form of chaining of persons.³¹ Psychosurgery as a treatment for mental illness can only be performed with the patient’s informed consent and the MHRB’s approval.³² However, while prohibiting all the above modes of treatment, the MHC Bill permits ECT for adults with the use of muscle relaxants and anaesthesia. This retention of ECT for adults is severely problematic as the mere use of muscle relaxants and anaesthesia would not make ECT as a treatment any less cruel or degrading. ECT for adults could also have been permitted only with the patient’s informed consent or the MHRB’s approval.

ECT as a method of treatment in the United Kingdom: The UK Mental Health Act 2007 permits a patient with sufficient capacity a right to refuse ECT (shock treatment) and abolishes such treatment when performed without consent. However, it is permitted without consent only when it is absolutely necessary to save the patient’s life or prevent immediate deterioration of his condition in an emergency.³³ In the MHC Bill, however, ECT is a prohibited treatment in emergency situations.³⁴ Surprisingly, although ECT is a prohibited treatment in emergencies for adults, it has been retained as a life-saving measure for emergencies involving minors.

Our suggestion is that ECT ought not to be permitted for adults without permission of the MHRB: The retention of ECT as a mode of treatment in clause 104(1)(a) of the MHC Bill for adults, even if it with anaesthesia and muscle relaxants is cruel and degrading treatment and has been banned in several jurisdictions.³⁵ In contrast, for psychosurgeries, both informed consent of the patient and approval from the MHRB is necessary to deter any abuse of the discretion. However, the same safeguards are not extended to ECT. Further, in clause 103(3), ECT is prohibited as form of emergency treatment. When it is prohibited as emergency

treatment, there is no justification as to why such a harsh and inhuman procedure is permitted otherwise. Therefore, in order to comply with the UNCRPD's mandate of freedom from cruel, inhuman or degrading treatment, ECT must be prohibited. If it is inextricable, then its use cannot be permitted without the permission of the MHRB and the patient's or his/her nominated representative's informed consent.

Finally, mental health establishments can use physical restraints and seclusion only if it prevents any imminent harm to the patient himself or to others and with the approval of the psychiatrist in charge of the patient's treatment.³⁶ To prevent misuse of this provision and protect rights of the mentally ill, the mental health establishments are under an obligation to report all instances of restraint and seclusion to the MHRB on a monthly basis.³⁷ Any research on mentally ill persons must be conducted with their free and informed consent.³⁸

It is for the first time that any law has guaranteed such rights to equality, non-discrimination and the positive rights for provision of basic services to persons with mental illness. In fact, even the Persons With Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 ("PWD Act") does not guarantee such rights to persons with disabilities, and this Bill, if passed may lead to a positive change for the PWD Act as well.³⁹

In furtherance of the protection of equality and rights of persons with mental disabilities, community care as a mode of treatment and rehabilitation has also been recognised by the UNCRPD.

3. *Right to Independent Living:*

Article 19 of the UNCRPD guarantees the right of persons with disabilities to live in the community and to be treated on par with the other members of the community. The impetus to community care formally approves the idea of deinstitutionalisation – with the primary aim of integrating persons with mental disabilities into their community. The UNCRPD provides that the principle of 'least restrictive treatment' ought to be followed in all cases requiring only the most difficult cases which have no reasonable effective alternative to be confined to psychiatric hospitals with in-patient treatment. The out-patient treatment is encouraged and can be most effective where the patient has a support system of family and friends who are willing and able to meet the needs of the patient. Further, Article 19(c) provides for non-

discrimination between people with disabilities and the general population in the matter of access to community services and other facilities.

Our suggestion with regard to community care and independent living is based on the scope of Article 19 of the UNCRPD. This Article recognises the equal rights of all persons with disabilities to live in the community, with choices equal to others, and to ensure that they have the opportunity to choose their place of residence, with whom they live, and that they have access to a range of in-home, residential and other community support services, including personal assistance where necessary to support living in the community and facilities to prevent isolation. In comparison, the MHC Bill in clause 19 (2) provides that the appropriate Government shall within a reasonable period provide for or support the establishment of community-based living such as half-way homes, group homes and the like. Nowhere does it provide for a range of living opportunities such as residential support services for persons who would want to continue staying at home, but would require support and assistance for doing so. Further, this clause also does not provide for any definite time frame within which such services would be provided. To comply with the UNCRPD, the clause must have provided that adequate support is available from the government to protect the core aspect of the rights granted in the UNCRPD, that persons with disabilities will have the right to 'live in the community with choices equal to others'.

Other noteworthy provisions of the MHC Bill:

1. *Systemic changes in the mental healthcare system and new forums for complaints:*

The MHC Bill seeks to create various new bodies and completely overhaul the existing mental healthcare system in the country. It provides for the establishment of the Central and State Mental Health Authorities, which would be responsible for the registration and oversight of mental health establishments by laying down minimum standards and a monitoring mechanism to ensure statutory compliance.

The Bill also sets up the Mental Health Review Commission and district-level Mental Health Review Boards (MHRB). The MHRC and MHRB are equipped with several administrative and adjudicatory functions and will form the first level of interaction of any person with mental illness or his/her representative with the mental healthcare system for violation of any of his or her rights. This is a whole new regime when compared to the MHA which gave an unbridled power to the Magistrate in the mental health system, which has now

been reduced to only a few specific cases. With the introduction of these new bodies, for the first time, a person with mental illness can directly approach a forum for protection of his/her rights.

With regard to the forums that the MHC Bill creates, we suggest that co-operation between these forums must be enhanced for effective judicial oversight. The MHC Bill creates MHRBs for judicial redressal of any violations of the Bill. In addition, the Rights of Persons with Disabilities Bill, 2012 (“RPWD Bill”) also creates a parallel system of judicial redressal by creating special disability courts for violations of any rights of disabled persons (including mentally disabled). This parallel system creates several bottlenecks as generally rights of disabled persons are violated in a more systematic way which can usually be characterised by a multiple set of violations in all walks of life. As the MHRB’s jurisdiction is only limited to violations in mental health establishments, the persons with mental disabilities will be forced to approach the special disability courts under the RPWD Bill for any redressal. Although this creation of an effective judicial redressal mechanism is laudable, such multiplicity of forums will only add to further marginalization without sustained co-operation between these bodies.

2. Duties of the Government:

The burden of planning, designing, implementing programs for promotion of mental health and prevention of mental illness, creating awareness about mental illnesses, reducing stigma, sensitizing govt. officials including police officers, implementing public health programs to reduce suicides and other such programs has been placed on the appropriate government.⁴⁰ Insufficient awareness, advocacy and sensitization about mental illness were serious pitfalls of the MHA and this is being remedied by the Bill.

3. Decriminalization of Suicides:

A remarkable provision in the MHC Bill provides that notwithstanding anything contained in the Indian Penal Code 1860 or the Code of Criminal Procedure 1973, a person who attempts to commit suicide will be presumed to have a mental illness and will not be subjected to any investigation or prosecution.⁴¹ In 2011 alone, a staggering 135,585 people committed suicide and this number has increased 25% over the last decade (National Crime Records Bureau 2012). The Bill adopts a beneficial approach towards people who attempt

suicide and casts an obligation on the appropriate government to provide care, treatment and rehabilitation to reduce the risk of recurrence of attempted suicide.⁴²

CONCLUSION

In conclusion, the Mental Health Care Bill 2012 makes significant strides over the MHA bringing about protection of rights and empowerment of persons with mental illness.

However, some crucial issues have been left unaddressed in the bill – mainly the existence of ECT for persons. This needs to be completely banned, as electro convulsive therapy ought not to be permitted as a treatment, if we are to protect the rights to autonomy and dignity of the person with mental illness. Secondly, the provisions in the Bill relating to the rights to community care independent living are not adequate and effective. While it mentions that the Government shall provide community-based living such as half-way homes, group homes, it does not impose a positive duty or a positive obligation on the appropriate government for providing community and independent living arrangements, nor does it set a time frame within which such facilities must be provided. The failure to address these concerns can go to the root of the rights to autonomy of persons with mental illnesses and their rights to live and make choices equally as other persons. These suggestions and recommendations are therefore primarily aimed to ensure that the MHC Bill is fully compliant with the UNCRPD and becomes a workable legislation that protects the rights of persons with mental disabilities comprehensively.

While the suggestions we make are for improvements in the MHC Bill, it will be more effective in its implementation if it is complemented with a National Mental Health Policy and Action Plan, as recommended by the World Health Organization (WHO 2007). Such a policy and action plan may make the goals of the legislation achievable and realistic. Since the Bill places a tremendous infrastructural, financial and human resource burden on the appropriate state government and other governmental authorities, a well-designed and comprehensive Policy and Action Plan would be crucial to operationalise the goals of the Bill. The big task however remains to ensure that the Bill gets passed and we are successful in replacing the seriously outdated Mental Health Act 1987.

REFERENCES

- Antony, James T. (2000): "A Decade with the Mental Health Act, 1987", *Indian Journal of Psychiatry*, 42(4): 347-355.
- Dhar, Aarti (2011): "National consultation on new mental health bill today", *The Hindu*, 21 March 2011.
- Disabled Peoples' International (2006): "Abusive practice of 'unmodified' electroshock treatment abolished at main psychiatric facility of Turkey", 23 November 2006, available at: http://www.dpi.org/lang-en/resources/topics_detail.php?page=557, viewed on 12 January 2013.
- Kothari, Jayna (2012): *The Future of Disability Law in India* (New Delhi: Oxford University Press).
- Mental Health Policy Group (2012): "XIIth Plan District Mental Health Programme: Recommendations to the Planning Commission of India", 29 July 2012, available at: <http://mhpolicy.files.wordpress.com/2012/07/final-dmhp-design-xii-plan2.pdf>, viewed on 14 November 2012.
- Mudur, GS (2011): "Squabbles mess up mental health survey – Foreign experts cherry-pick Indian data to present misleading picture", *The Telegraph*, 12 August 2011.
- Murthy, Pratima (2010): "The Mental Health Act 1987: Quo Vadimus?", *Indian Journal of Medical Ethics*, 7(3): 152-156.
- Murthy, R. Srinivasa (2011): "Mental Health Initiatives in India (1947-2010)", *National Medical Journal of India*, 24(2): 98-107.
- National Crime Records Bureau (2012): "Accidental Deaths and Suicide in India Report 2011", Ministry of Home Affairs, available at: <http://ncrb.nic.in/CD-ADSI2011/ADSI-2011%20REPORT.pdf>, viewed on 13 November 2012.
- Srebnik, DS and JQ La Fond (1999): "Advance Directives for Mental Health Treatment", *Psychiatric Services*, 50(7): 919.
- Trivedi, Dr. JK (2009): "Mental Health Act: Salient Features, Objectives, Critique and Future Directions", *Indian Journal of Psychiatry*, 51: 11-19.

UN, OHCHR and IPU (2007): ‘Why a convention was needed’ in “From Exclusion to Equality: Realizing the Rights of Persons with Disabilities: Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities”, available at: <http://www.un.org/disabilities/default.asp?id=217>, viewed on 24 November 2012.

— (2007a): ‘The Rights and Principles enumerated in the Convention’ in “From Exclusion to Equality: Realizing the Rights of Persons with Disabilities: Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities”, available at: <http://www.un.org/disabilities/default.asp?id=224>, viewed on 24 November 2012.

UNCRPD (2006): UN Convention on the Rights of Persons with Disabilities 2006 (available at: <http://www.un.org/disabilities/default.asp?id=259>); Optional Protocol to the UNCRPD (available at: <http://www.un.org/disabilities/default.asp?id=311>). Both the UNCRPD and the Optional Protocol entered into force on 03 May 2008.

World Health Organization (2007): “Mental Health Policies and Action Plans”, Mental Health Policy, Planning and Service Development Information Sheet, Sheet 1, available at http://www.who.int/entity/mental_health/policy/services/1_MHPolicyPlan_Infosheet.pdf, viewed on 13 November 2012.

NOTES

¹ UNCRPD and the Optional Protocol to the UNCRPD. Both the UNCRPD and the Optional Protocol entered into force on 03 May 2008.

² Article 1, UNCRPD.

³ Clause 2(1)(r), Mental Health Care Bill 2012 (MHC Bill 2012).

⁴ Cl. 3(3)(a) and (b), *ibid.*

⁵ Cl. 3(5), *ibid.*

⁶ Art.12(1), UNCRPD.

⁷ Art. 12(2), *ibid.*

⁸ Art. 12(3), *ibid.*

⁹ Cl. 4(1), MHC Bill 2012.

¹⁰ Cl. 4(1), *ibid.*

¹¹ Cl. 4(3), *ibid.*

¹² For a review of the benefits of advance directives in mental health treatment and care in the United States, *see* Srebnik, DS & JQ La Fond (2009).

¹³ Clause 5(1), MHC Bill 2012. The provision of ‘advance directive’ is similar to Ss. 24-26 of the Mental Capacity Act 2005 (United Kingdom) where a person can make an advance decision to refuse any future treatment. However, the advance directive under the MHC Bill is wider in its ambit and has sufficient safeguards to prevent any misuse.

-
- ¹⁴ Cl. 6, MHC Bill 2012.
- ¹⁵ Cl. 8, *ibid.*
- ¹⁶ Cl. 9, *ibid.*
- ¹⁷ Cl. 10, *ibid.*
- ¹⁸ Cl. 11, *ibid.*
- ¹⁹ Cl. 11(4), *ibid.*
- ²⁰ Cl. 12(3), *ibid.*
- ²¹ Section 1(2), Mental Capacity Act, 2005 (UK).
- ²² S. 2(1), *ibid.*
- ²³ S. 3(1), *ibid.*
- ²⁴ Cl. 4, MHC Bill 2012.
- ²⁵ Sections 24- 26, Mental Capacity Act, 2005 (UK).
- ²⁶ Cl. 5(1)(a) and (b), MHC Bill 2012.
- ²⁷ Clauses 14-17, *ibid.*
- ²⁸ Cl. 94, *ibid.*
- ²⁹ Chapter V, clauses 18-28, *ibid.*
- ³⁰ However the MHA had only one provision providing for protection of human rights of mentally ill persons. Section 81 of the MHA protected a mentally ill person from physical or mental indignity or cruelty during treatment.
- ³¹ Cl.104, MHC Bill 2012.
- ³² Cl.105, *ibid.*
- ³³ S. 58A read with s. 62, Mental Health Act, 1983 (UK).
- ³⁴ Cl. 103(3), MHC Bill, 2012.
- ³⁵ ECT has been banned in several countries such as Slovenia, Turkey etc. Campaigns to ban this are alive in countries such as Canada, Ireland and even India. For Turkey's ban, *see* Disabled Peoples' International 2006.
- ³⁶ Cl.106, MHC Bill 2012.
- ³⁷ *ibid.*
- ³⁸ Cl. 107, *ibid.*
- ³⁹ For a comprehensive account of the effect of UNCRPD on disability law in India, *see* Kothari 2012: 175-199.
- ⁴⁰ Chapter VI, clauses 29-32, MHC Bill 2012.
- ⁴¹ Cl. 124(1), *ibid.*
- ⁴² Cl. 124(2), *ibid.*