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MENTALLY CHALLENGED PERSONS AND HUMAN RIGHTS ASPECTS- AN ANALYSIS

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Abstract

This study delves into the intricate relationship between mentally challenged individuals and their human rights, with a focus on the unjust treatment they often face. Despite the fundamental nature of human rights, which guarantee all persons basic rights and freedoms individuals with mental disabilities continue to the marginalized and stigmatized. This analysis explores the concept of mental health disorders, including their classification and definition, and examines how they intersect with human rights principles. By investigating the duties of governments to respect and protect the rights mentally challenged persons, this research aims to shed light on the critical importance of recognizing and addressing the rights of this vulnerable population. Ultimately, this study seeks to contribute to a deeper understanding of the human rights aspects of mental health, promoting more inclusive and equitable society for all

Key Word: Mentally Challenged, Human Rights, Disability, Mental Health, NHRC

Introduction

The fundamental nature of human rights, serve as a basis to challenge unjust treatment of people with mental disabilities. Human rights, afford all persons fundamental rights and freedoms and place duties on government to respect them. Rather than focusing on personal obligations, classic understandings of human rights center on a government's duty to respect rights and freedoms.

Mental health disorders and mental illness can be found all around us. Mental illness is physical brain disorders that profoundly disrupt a person's ability to think, feel and relate to others and the environment. What is pertinent for modern society is an understanding that mental illness is as significant as physical illness. This article will analyze the nature and meaning of mental disorder and it will discuss the definitions as to who is mentally disordered or insane and its classification.

Mental illness represents a range of diverse conditions where serious infringement of human rights can occur from deprivation of a person's dignity and right to life, to complete denial of the right to lead a fulfilling life. If the rights of the mentally ill are to be assured and protected, several players from diverse areas of society need to play an active role. In this aricle, we examine the specific role of the judiciary in addressing

some of the critical mental health care needs of the country and highlight the landmark role of the National Human Rights Commission (NHRC) in addressing and being a part of mental health change in the country.

Nature of Mental Illness

The law has long kept 'mental illness' in its backwards. Many judges and commentators believe that in using the term 'mental decease' the law embraces a medical concept. If true, this would furnish an example of the law's inertia in the face of change because the law would be embracing an absolute nineteenth century concept.

In the nineteenth century, physicians employed the term 'insanity' to refer to a physical disease of the brain. They believed the strange hallucinations and emotions of the insane were caused or accompanied by anatomical or physiological changes in the 'insane' brain when the Courts and legislators of that era employed such words as 'insanity' or mental 'disease', they adopted the medical usage. For example the 1890 Washington State Civil Commitment Statutes employed 'insanity' to refer to a medical disease. Similarly, New Hampshire treated the existence of criminal insanity as a question of medical fact. This medical definition of criminal insanity was at least understandable when physicians still believed medical 'insanity' had a physical referent.[1]

But the medical fact approach to insanity makes no sense in modern legal usage since psychiatrists have abandoned it; physicians no longer speak of 'insanity'.[2] In its place they use "psychosis" or potentially broader terms such as 'mental disease' or 'mental illness', 'emotional illness' or 'mental derangement' or 'mental disorder' although these terms seem to assume an identifiable underlying abnormality physicians do not now believe they have any definite referents.

In fact, psychiatrists generally have concluded that such phrases as 'mental illnesses' are relatively useless as medical terms. Psychiatrists still employ the words ' mental illness' but do so not to describe a medical condition but rather to achieve social purpose. Thus 'mental illness', even though it no longer has an accepted medical meaning, is not in linguistic limbo. People employ 'mental illness' for its rhetorical power. They use it in achieving social objectives such as suggesting dangerousness and placing the labeled person in the same social role as the physically ill. When psychiatrists or layman say that either alcoholism or homosexuality is a 'disease' they consciously or unconsciously attempt to influence society's reactions to alcoholics or homosexuals. They are using the lable 'disease' to make social, political and moral judgments that society should relegate alcoholics and homosexuals to the sick role. The sociologist Talcott Persons sees the mentally sick role as characterized by a disturbance in a person's capacity to perform other social roles.[3]

Although 'insanity' and 'mental disease' have died as medical concepts, thus legal ghosts still haunt us. For example the term 'mental disease' is present in legal insanity defense standards. Similarly the term is sometimes a part of the various incompetency tests. The legal concept which originally was pinned to the historical medical concept is left with no valid definition in medical terms. Nevertheless, Courts and

[1] James H. Hardisty "Mental Illness : A Legal Fiction" (1973) 48 *Wash. L. Rev.*, p. 735 Available at http://www.heinonline.com visited on 28th June 2012

[2]. "Insanity" is a "vague, legal term for the psychotic state, now obsolete in psychiatric usage." *American Psychiatric Glossary* , 2nd ed., (Washington DC: American Psychiatric Association, 1964), p.39

[3] *Supra* note 1, p. 738

legislatures have generally not furnished any legal definitions of the term except for a few circular ones trial judges in effect instruct juries to determine whether the defendant has a 'mental disease' but leave the term undefined. Many judges and legislators fail to realize that 'mental disease' no longer has an accepted psychiatric meaning. Thus Courts inadvertently let each testifying psychiatrists listen to his own drummer in defining what the law means by mental disease. In turn psychiatric witnesses often assume that 'mental disease' is a legal term since they know it has no accepted medical meaning.[4]

The legal difficulties created by the phrase 'mental illness' make its continued legal usage questionable. It has no accepted medical meaning and, there are not even medical guidelines for establishing such a meaning. Legal usage of this phantom concept exausbates many problems surrounding psychiatric legal proceedings. It aggravates inter professional confusion since lawyers assume 'mental illness' is a medical phrase while testifying doctors define it by reference to legal objectives.[5]

Defining Mental Illness

In the past ignorance resulted in many prejudices about all terms of mental illness. Such strange behavior was considered to be due to possession by evil spirits. Today, we know that mental illness is just like any other illness. Mental illness is both preventable and curable. Mental disturbance is more often caused by wrong attitudes or by dwelling on negative illogical and self-defeating thoughts. In a majority of cases all the symptoms can be brought under control just as in the case of diabetes, hypertension etc. In many cases a total cure too can be achieved, most mental illness can be cured or controlled in less than 90 days and the patients continue to keep well with medication.[6]

A narrow definition of mental illness would insist upon the presence of organic disease of the brain, either structural or biochemical. An overly broad definition would define mental illness as simply being the lack or absence of mental health- that is to say, a condition of mental well being, balance, and resilience in which he can both withstand and learn to cope with the conflicts and stresses encountered in life.[7] . A more generally use full definition than either of the above is that a mental disorder is an illness with significant psychological or behavioral manifestations that occurs in an individuals and that is associated either with a painful or distressing symptom, with impairment in one or more important areas of functionary or with both. The mental disorder may be due to a psychological social, biochemical or genetic dysfunction or disturbance or a combination of these factors in the individual.[8]

Mental disorder has been defined clinically, perhaps tautologically, perhaps simplistically, as a disorder that presents with mental signs and symptoms. And there is a further fundamental problem namely whether mental disorders are indeed distinct from physical disorders Reputable opinion would argue not. Indeed Kendell a former President of the Royal college of Psychiatrists has argued that 'if we do continue to

[4] *Ibid*
[5] *Ibid*
[6] Virupaksha Dattahreya Gounda "*Mental Health Services- Need for Expansion*", (2008) 13 XI *AIR*, p. 195.
[7] *The New Encyclopaedia Britannica*, vol- 23, 15th ed., (Chicago: William Benton Publisher, 2002), p.841
[8] *Ibid*

refer to 'mental' and 'physical' illness we should preface both with 'so-called', to remind ourselves and our audience that there are archaic and deeply misleading terms.[9]

Thomas Szasz raises the question as to whether there is such thing as mental illness and decides in favor of its nonexistence. Szasz feels that for the sake of clarity people who speak of mental illness is usually diagnosed when an individual's behavior deviates from certain legal, psychosocial or ethical norms and that these deviations are expected to be correctable by medical action.[10]

The word 'insanity' has no technical meaning in law or in medicine. The word insanity does not connote any definite medical entity. It is solely a legal and a sociological concept, used to designate those members of the society who are unable, on account of a mental disease, to adapt themselves to ordinarily social requirements, so that the community compulsorily segregates them and takes away their rights as citizens. Insanity is thus seen to be a social inadequacy and medically it takes the form of a mental disease.[11]

The basic definition of mental disorder in U.K. is 'mental disorder means mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability if mind'. But there is a strong criticism of the definition is that it is being too open ended and vague and thereby giving too much scope to the medical profession.[12]

According to USA mental illness means 'a psychiatric disorder which substantially disturbs a person's thinking, feeling, or behavior and impairs the person's ability to function.'[13] There is no simple definition of mental disorder that is universally satisfactory. This is partly because mental states or behavior that are viewed as abnormal or unacceptable in one culture may be regarded as normal or acceptable in another, and in any case it is difficult to draw a line clearly demarcating healthy from abnormal mental functioning.[14]

Classification of Mental Diseases

Accepted international classification of psychiatric disorders, namely the WHO'S Inter Classification of Disease, Edition 10 (ICD 10) and the American Psychiatric Association's Diagnostic and Statistical Manual 4th Edition (DSM IV) is frequently resorted classifications.[15] ICD 10 has 17 categories of disease, with mental and behavioral disorders being but one of these categories it adopts a multi-axial approach. DSM IV relates only to those disorders treated by American psychiatrists and clinical psychologists and is a product of the work of those professional bodies. It adopts a multi axial approach.[16] But both ICD 10 and DSM IV encourage the presumption that a disease is present, even if it has not yet been identified. Both classificatory systems, as

[9] Jill Peay, *Mental Health and Crime*, 1st ed., (New York : Roultedge., 2011), p. 19

[10] Szasz T.S., *The Myth of Mental Illness*, ed., (New York: Hoeber-Harper, 1961), pp. 41-42

[11] Modi's, M*edical Jurisprudence and Toxicology*, 22nd ed., (New Delhi : Butterworths., 1999), p.609

[12] *Mental Health Act, 1983*, Sec. 1(2).

[13] W.J. Curran and T.W. Harding ,*The Law and Mental Health: Harmonizing Objectives,* (Geneva :World Health Organization's, 1978) p.143

[14] *Supra* note 7

[15] American Psychiatric Association, The Diagnostic and Statistical Manual of Mental Disorders (Fourth edition) DSM-IV (1994); World Health Organization, International Classification of Diseases, Glossary and Guide to the Classification of Mental Disorder in accordance with the Tenth Revision of the International Classification of Diseases (ICD-10) (1990).

[16] DSM IV, as a multi-axial diagnostic tool, has five axes; the first relates to clinical disorders and the second to personality disorders and 'mental retardation'. The fourth axis relates to psychosocial and environmental problems: the potential for diagnosis confusion with this system is inherent. ICD 10 is a uniaxial system, in that each diagnosis is classified under only one parent code, which ensures statistically that each patient is only diagnosed under one coding classification. Different kinds of errors will arise here.

is revealed by their not infrequent revisions, lane been subject to clarification and extension. One illustration of this would be the emergence of social anxiety disorder not officially recognized until 1980, this disorder only achieved an adequate definition in the 1987 revision of DSM; yet now social anxiety disorder is reported in the US to be the third most common psychiatric diagnosis after alcoholism and depression.[17] Following is the classification of mental diseases.[18]

1 Organic Mental Disorders

This category includes both those psychological or behavioral abnormalities that arise from structural disease of the brain and those that arise from brain dysfunction caused by disease outside the brain. There are several types of psychiatric syndromes that arise clearly from organic brain disease, chief among them being dementia and delirium. Dementia is a gradual and progressive loss of such intellectual abilities as thinking, remembering, paying attentions judging and perceiving, without an accompanying disturbance of consciousness. Delirium is a diffuse or generalized intellectual impairment marked by a clouded or confused state of consciousness, an inability to attend to one's surroundings, difficulty to attend to one's surroundings, difficulty in thinking coherently, a tendency to perceptual disturbances such as hallucinations, and difficulty in sleeping. Amnesia means gross loss of recent memory and time sense without other intellectual impairment is another specific psychological impairment associated with organic brain disease.[19]

2 Mental Retardation

Mental sub normality is used here to describe a condition of retarded incomplete or abnormal mental development present at birth or early childhood and characterized by limited intelligence. Severe sub normality is a state of arrested or incomplete development of mind, which includes sub normality of intelligence and is of such value or degree that the patient is incapable of leading independent life or guarding himself against serious exploitation or will be so incapable when of an age to do so this group includes those who were previously termed 'idiots' and 'imbeciles'.[20]

Mental Retardation is a condition which occurs either before, during or after birth. This is due to damage or arrestment of the development of the baby's brain as a result of which the brain develops more slowly and does not function as well as the brain of other children of the same age. So the mentally retarded child learns slowly and with greater difficulty and behaves like a much younger child than other children of the same age. As she mentally retarded child grows older his/her body usually grows in size like other children of the same age. But the brain develops slowly and does not function as it should at a given age. The slowness of the child becomes more noticed as the child grows and is unable to cope with what is happening around him/her.

From the earliest days of the twentieth century, researchers have divided persons with mental retardation by etiology. In applying his developmental approach to mental retardation, Zigler specified two

[17] Whether depression, social anxiety disorder and mere shyness are truly distinguishable is subject to debate: indeed, the medical treatment for each can be much the same. See Hortwitz A., Wakefield J., *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder*, ed., (New York: Oxford University Press, 2007), p.46

[18] *Supra* note 11, p. 616

[19] *Supra* note 7, p. 845

[20] *Supra* note 11, p. 616

groups: one of persons with familial retardation, the other of persons with organic retardation.[21] Persons with familial mental retardation show no clear organic cause for their mental retardation. But persons with organic mental retardation, by contrast, shown one of several hundred pre-, peri-, or postnatal etiologies that are associated with impaired intellectual and social functioning.[22]

Mental Retardation is not an illness. It cannot be cured by medicines. It is a permanent condition that means, a mentally retarded child grows up into an adult with mental retardation. But depending on the training, opportunities and experiences given to the child, a mentally retarded child will learn and perform at his/her best.[23]

3 Mood Disorders

These disorders are usually restricted to just two abnormalities of mood depression and elation or mania. The recent trend is to classify mood disorders into:

3.1 Depressive Disorder

Depression is characterized by a sad or hopeless mood, pessimistic thinking a loss of enjoyment and interest in one's usual activities and past times, reduced energy and vitality, increased fatigue, slowness of thought and action, change of appetite, and disturbed sleep.[24]

3.2 Bipolar Disorders (Maniac Depressive Psychosis)

Bipolar disorder is used for a group of mental illnesses with primary disturbances of affect i.e. the mood varies between extreme poles of cheerfulness and sadness. The illness has second characteristic of periodicity. The third characteristic is returning to normally from attack, without impairment of mental integrity. In practice, one finds that single attack, without impairment of mental integrity. In practice, one finds that single attack of mania or single attack of depression can occur. It occurs in persons predisposed to mood disturbances.[25]

4 Schizophrenia

Kraepelin in 1896 named this disease dementia praecox. In 1911, Eugen Blenler introduced the term 'schizophrenia' which literally means disintegration of mind.[26] Individual with schizophrenia exhibit a wide variety of symptoms thus although different experts may agree as to whether a particular individual suffers from the condition, they might disagree about which symptoms are essential in clinically defining schizophrenia Five major types of schizophrenia are recognized by the DSM-IV: the disorganized type, the catatonic type, the paranoid type, the undifferentiated type and the residual type. Disorganized schizophrenia is characterized by inappropriate emotional responses and by incoherent thought and speech. Catatonic schizophrenia is marked by striking motor behavior, such as remaining motionless in a rigid posture for hours

[21] Zigler E."Familial Mental Retardation: A Continuing Dilemma", (1967) 155, *Science*, pp. 292-298

[22] Jacob A. Burack, Robert M. Hodapp, Edward Zigler, *Handbook of Mental Retardation and Development*, 1st ed., (New York: Cambridge University Press, 1998), p.9

[23] *Understanding Mental Retardation and Genetic Counselling : A Hand Book for Community Health Workers and Social Workers*, Published by UNICEF and CAMHADD , 1989, p,10

[24] *Supra* note 7, p. 847

[25] *Supra* note 11, p. 621

[26] *Ibid.*, p.623

or even days, and by stupor or mutism. Paranoid schizophrenia is characterized by the presence of prominent delusions of a persecutory or grandiose nature. The undifferentiated and residual types are marked by the absence of these distinct features; the residual type is, moreover, a less severe diagnosis.[27] In schizophrenia of more insidious onset and milder presentation, there is an accompanying decline in social functioning and competence.[28]

5 Personality Disorders

Personality is the characteristic way in which an individual thinks, feels and behaves, it accounts for the ingrained behavior patterns of the individual and allows the prediction of how he will act in particular circumstances personality embraces a person's moods, attitudes and opinions and is most clearly expressed in interactions with other people. A personality disorder is a deeply ingrained. Long –enduring, maladaptive. And inflexible pattern of thinking, feeling, and behaving that either significantly impairs an individual's social or occupational functioning or causes subjective distress.[29]

Individuals can succeed with extremes of personality dimensions in other walks of life, without engaging in the dangerous behavior seemingly associated with a disordered personality, or in anti-social behavior generally. Or at least in anti-social behavior as it is conventionally conceived.[30]

6 Neurotic Stress- Related and Somatoform Disorders

It includes (a) anxiety disorders. Anxiety is defined as a feeling of fear, dread or apprehension that arises without a clear or appropriate justification. (b) Obsessive-compulsive disorder. In this condition an individual experiences obsessions or compulsions or both. Obsessions are recurring words, thoughts, ideas or images that, rather than being experienced as voluntarily produced, seem to invade a person's consciousness despite his attempts to ignore control or suppress them. (c) Posttraumatic stress disorder: In this condition symptoms develop in an individual after he has experienced a psychologically traumatic event. The traumatic events can include serious automobile accidents, rape or assault, military cannibal, torture, incarceration in a concentration or death camp, and such natural disasters as floods, fires and earthquakes. (d) Somatoform disorders: In these conditions the physical symptoms of the person suggest the presence of organic disease, but no such organic disorder can be found upon physical examination and investigation and instead there is evidence that the symptoms are caused by psychological factors. The production of these symptoms is not under voluntary control. (e) Dissociative disorders: A dissociative disorder is a syndrome in which one or a group of mental process are split off, or dissociated, from the rest of the psychological apparatus so that their function is lost, altered or impaired. In dissociative disorders there is a sudden, temporary alteration in the person's consciousness, sense of identity or motor behavior. There may be an apparent loss of memory of previous activities or important personal events, with amnesia for the episode itself after recovery.[31]

[27] *Supra* note 7, p. 846
[28] Herschel Prins, "Mental Abnormality and Criminality- an Uncertain Relationship", (1990) 30(3) *Med. Sci. Law*, p. 251
[29] *Ibid.*, pp. 849-850
[30] *Supra* note 9, p. 32
[31] *Supra* note 7, pp. 848-849

Causes of Mental Disorder

Very often the etiology or cause of a particular type of mental disorder is unknown or is understood only to a very limited extent. No single theory of causation can explain all mental disorders or even all those of particular types, and moreover, the same type of disorder may have different causes in different persons. For mental disorder the causes are sometimes known and sometimes not known. For example, personality disorder has widely been held to be causally related to dangerousness, and particularly the antisocial/psychopathic variants of personality disorder.[32] The major theoretical and research approaches to the causation of mental disorders are treated below:[33]

1 Heredity

Organic explanations of mental illness have usually been genetic, biochemical neuropath logical, or a combination of these. Or knowledge, regarding the role that heredity plays in the causation of mental disease is incomplete.[34] The study of the genetic causes of mental disorders involves both the laboratory analysis of the human genome and the statistical analysis of the frequency of a particular disorder's occurrence among individuals who share related genes – i.e. family members and particularly twins. In twin studies the frequency of occurrence of the illness in both members of pairs of identical (monozygotic) twins is compared with its frequency in both members of a pair of fraternal (dizygotic) twins. A higher concordance for disease among the identical than the fraternal twins suggests a genetic component. Such studies have demonstrated a clear role for genetic factors in the causation of schizophrenia when one parent is found to have the disorder the probability that his children will develop schizophrenia is at least 10 times higher (about 12 percent risk probability) than it is for children in the general population (about a 1 percent risk probability).

Genetic factors seem to play a less significant role in the causation of other psychotic disorders and in personality disorders however, studies have demonstrated a probable role for genetic factors in the causation of many mood disorders and some anxiety disorders.[35]

2 Psychogenic Causes

Unsuccessfully repressed mental conflicts are considered a very important causative factor. Generally speaking, the conflict is between the individuals instinctual desires, motives or wishes on the one hand, and his ideals, cultural and ethical codes, his conditioned disposition to adhere to customs and conventions as laid down by the social group to which he belongs and the others. When his efforts to re council these conflicting strivings fail, it can result to tension and anxiety. The person, in order to avoid these painful situations, may resort to various mental mechanisms to build defenses round it. This may then produce various types of mental symptoms.

[32] Howard R. "How is Personality Disorder Linked to Dangerousness? A Putative Role for Early- Onset Alcohol Abuse", (2006) 67 *Medical Hypotheses*, p. 703

[33] *Supra* note 7,p. 843

[34] *Supra* note 11, p.614

[35] *Supr*a note7, p.843

3 Environmental Factors

Freudian theory views childhood as the primary breeding ground of neurotic conflicts. This is because children are relatively helpless and one dependent on their parents for love, care, security and support and because their psycho sexual, aggressive and other impulses are not yet integrated into a stable personality framework. Given a plastic mind and being in the closest association with the parents during this period the personality development will be influenced by the attitude of parents. It the parental attitudes are faulty, like overprotection, rejection, over-strictness, unnecessary and unfavorable comparisons with other brothers and sisters, an unhealthy personality is developed, which is vulnerable to stress and strain of life. Children are thus subject to emotional traumas, deprivations and frustrations which they lack the resources to cope with and which can become grounds for intra psychic conflicts that are not resolved but rather merely held in abeyance through repression, producing insanity, unease, or guild and subtly influencing the individuals developing personality, interests, attitudes and ability to cope with later stresses.

4 Organic Causes

Organic diseases which may cause or which may be associated with mental symptoms are any chronic debilitating sickness, cerebral hemorrhaged, fevers, toxemias due to various causes, additions like alcohol, opium, pethidine, etc. head injury, arteriosclerosis senile degeneration, advance cardio-renal disease, myxoedema, pernicious anemia, etc.

5 Precipitating Causes

Domestic difficulties, financial and business worries, frustrations, and disappointments in the sexual sphere, unsuitable job, unemployment death of relative, etc, are other exciting or precipitating factors.[36]

Mentally Challenged and Human Rights

According to Gewwirth, human beings have rights to ‘freedom’ and ‘well-being’ because they are the generically necessary conditions of agency. ‘Well-being’ includes such physical and psychological necessities as life, health, physical security, and mental equilibrium. Freedom may be ‘positive’ or negative. Negative freedom is defined as the absence of coercion or constraint imposed on the individual by other people, preventing the individual for doing what he or she wants to do. Positive freedom, on the other hand, may be defined as the ability to make effective choices about one’s own life.

Rights are not only negative people also have ‘positive rights’ such that others have duties to take action to promote their positive freedom. Since the conditions of positive human freedom can only be effectively provided by people working together, it follows that there is a moral duty to support just institutions ones which promote and foster the equal rights of people to maximum positive freedom.

The just institutions required by rights theory include a fair legal system which as effectively as possible protects and pursues everyone’s right to maximum positive freedoms.[37]

[36] *Supra* note 11, pp.614-615

[37] A, Gewirth, *Reason and Morality*, ed., (Chicago: The University of Chicago Press, 1978), p. 67

Fundamental Relationship between Mental Health and Human Rights

Mental health and human rights are powerful modern approaches in advancing human well-being. The three relationship between-mental health and human rights are (a) mental health policy affects (b) human rights violations affect mental health and (c) positive promotion of both mental health and human rights are mutually reinforcing. The first relationship is that mental health policies, programs and practices can violate human rights.[38] Though the expression of 'voluntarism' and 'non-coercion' said in mental health policy but quite essentially involves the exercise of governmental power like power to restrain to treat to deprive individuals of basic rights of citizenship e.g. voting, access to the courts and controlling personal and financial affairs.[39] The power of government to regulate mental health may be exercised beneficially for the welfare of the individual family and society. However government authority by its very nature affects a variety of personal interests such as autonomy, bodily integrity privacy, properly and liberty. These interests can give rise to human rights claims when power are exercised arbitrarily discriminatory or in the absence of a fair process.

The second relationship between the two approaches is that human rights violations adversely affect mental health.[40] The mental health effects on seven human rights violations, such as torture, rape, genocide and inhuman and degrading treatment, are obvious and inherent severe abuses of human rights result in serious, life-long mental suffering-not only by the individual, but often the family, community and even future generations.

The third relationship between the two approaches is that mental health and human rights are inextricably linked.[41] Mental health and human rights are complementary approaches to the betterment of human beings. Similarly human rights are indispensable for mental health because they provide security from harm or restraint and the freedom to form and express beliefs that one essential to mental well-being.[42]

Rights of Psychiatric Patients

It is unfortunately by no means uncontroversial to claim that psychiatric patients have full human rights. Gewirth somewhat insensitively refers to 'the insane and other such mentally deficient persons' and states that they are not fully agents and therefore not possessed of full human rights.[43] This is illogical since his argument establishing human rights and duties does not in any way depend on people possessing these abilities 'in full', but works just as well provided they act or wish to act for only purpose. This would seem to include just about any human being who is not actually brain dead or in a persistent vegetative state.

[38] Jonathan M. Mann , *"*Health and Human Rights*,"* (1999) 7 *Health and Human Rights*, pp. 11-14

[39] Larry Gostin, " Human Rights in Mental Health: A Proposal or Five International Standards the Importance of Voluntary Admission to Mental Hospitals and Noting the Based Upon the Japanese Experience", (1987) 10 *Int'l J.L. & Psychiatr*y, pp. 358-60.

[40] *Supra* note 38, pp. 14-16

[41] *Ibid*., pp.16-18

[42] Eric Rosenthal & Leonard S**.** Rubenstein, "International Human Rights Advocacy under the Principles for the Protection of Persons with Mental Illness," (1993) 16 *Int'l J.L. & Psychiatry*, p. 268

[43] Michael Cavadino " A Vindication of the Rights of Psychiatric Patients", (1997) 24(2) *Journal of Law and Society*, pp. 238-240

If psychiatric patients do have human rights, then-morally, if not under existing law-most fundamentally they have the equal right to maximum positive freedom. It follows that they have both 'negative rights' not to have their negative freedom infringed and 'positive rights' to be helped in ways which will increase their abilities to control their own lives, including access to facilities which they may voluntarily avail themselves of which may have the effect of improving their mental and physical health.[44]

Indian Position

The National Human Rights Commission (NHRC) was established on 12th Oct, 1993 under the legislative mandate of the Protection of Human Rights Act, (H.R. Act) 1993. Over the years the Commission has endeavored to give a positive meaning and a content to the objectives set out in the Protection of Human Rights Act, (H.R. Act) 1993. It has moved vigorously and effectively to use the opportunities provided to it by the Act to promote and protect human rights in the country. The purpose of the enactment is laid down in the Preamble of the Act i.e., it provides for the establishment of a NHRC, State Human Rights Commission (SHRC) in States and Human Rights Courts for better protection of human rights.[45] The definition of human rights under the Protection of Human Rights Act 1993 limits human rights strictly to the fundamental rights embodied in Part III of the Constitution, which are enforceable by the Courts in India.[46] So the definition, limits the scope of the functioning of the NHRC. A pertinent question naturally arises here; why was the Commission established for the protection of fundament rights when they are being constitutionally guaranteed and are enforceable by the Courts? It appears that the main purpose of the enactment was to provide a better protection of human rights.[47]

Judicial Intervention:

Public Interest Litigations are used for the protection of mentally ill people *Veena Sethi v. State of Bihar*[48] was the first decision in this regard. The Petitioner questioned the system of care of mentally ill people in mental health institutions through a letter that some prisoners, who had been 'insane' at the time of trial but had subsequently been declared 'sane', had not been released due to inaction of the state authorities, and had remained in jail for 20 to 30 years. The Court directed them to be released forthwith, considering the requirements of protection of right to life and liberty of the citizen against the lawlessness of the State.[49] In *Rakesh Chandra Narain v. State of Bihar*[50] the Supreme Court laid down a number of guidelines for Ranchi Mental Hospital to improve the infrastructure and other facilities. In *S. R. Kapoor v. UOI*[51] the case was filed to question the pathetic condition at the Mental Hospital Shahdara and the Court ordered for a detailed enquiry through an expert committee. The Committee's suggestion for change pertained to several areas of hospital functions like diet, personal hygiene, and admission and discharge procedures. In May 1989, the Supreme Court decreed that hospital be developed on the lines of National Institute of Mental Health And Neuro

[44] M. Cavadino, "Community Control?", (1991), *Journal of Social Welfare and Family Law*, pp.488-489

[45] D. Nagaraja and Pratima Murthy, *Mental Health Care and Human Rights*, 1st ed., (New Delhi, NationalHuman Rights Commission, 2008), p.249

[46] *Human Rights Act ,1983* Section 2(d)

[47] See. http://shodhganga.inflibnet.ac.in/bitstream/10603/6653/12/12-chapter%204.pdf

[48] A.I.R. 1983 SC 339

[49] *Ibid*

[50] A.I.R. 1989 SC 348

[51] A.I.R. 1990 SC 752

Sciences, (NIMHANS) Bangalore. This lead to the establishment of the Institute of Human Behavior and Allied Sciences (IHBAS) at Shahdara. Similar judgments were made in response to the public interest litigations with respect to the mental hospitals at Gwalior, Agra and Tezpur.

Right of Speedy trial:

In *Hussainara Khatoon v. Home Secretary Bihar*,[52] it was held by the Apex Court that "right to a speedy trial, a fundamental right, is implicit in the guarantee of life and personal liberty enshrined in Article 21 of the Constitution" These principles were reiterated in *Abdul Rehman Antulry v. R.S. Nayak*[53] in which detailed guidelines for speedy trial of an accused were laid down even though no time limit was fixed for trial of offences.[54]

These notwithstanding, a number of cases have come to light where mentally ill persons who have been facing trial for an offence have been undergoing incarceration for long periods till their flight and predicament surfaced through public interest litigation and much needed relief was provided by the Supreme Court. In the case of *Chandan Kumar Bhanik v. State of West Bengal*[55] the Supreme Court observed. "Management of an institution like the mental hospital requires flow of human love and affection, understanding and consideration for mentally ill persons, these aspects are far more important than a routinized, stereotyped and bureaucratic approach to mental health issues."

In *Sheela Barse v. Union of India*[56] and others was filed in 1989. This case was with regard to the illegal and unconstitutional practice of locking up non-criminal mentally ill persons in jails of West-Bengal. The Court appointed a Commission in 1992 to evaluate the situation. The report highlighted the problems in providing effective mental health services to the mentally ill in jails, lack of human resources, and lack of supervision of care, absence of adequate range of treatment services. It recommended the moving out of the mentally ill in prisons to the nearest place of treatment and care. In its judgment, the Supreme Court held that such a practice of keeping the non-criminal mentally ill in prisons contravened Article 21 and 32 and ordered that such person be examined by mental health professionals and on his advice sent to the nearest place of treatment and care.[57]

The Supreme Court again examined the matter and laid down some rules for administration of mental hospitals. It was *In Re: Death of 25 Chained Inmates in Asylum Fire in Tamil Nadu and another v. Union of India and Others*, [58] where 25 mentally challenged patients housed in a mental asylum at Ervadi in Ramanathapuram district in Tamil Nadu virtually charred to death. The patients couldn't escape the blaze as they had been chained to poles or beds. On the basis of a submission note of the Registrar about the tragic news published in all leading dailies, the Supreme Court took suo moto action in this incident. Notices were issued to the Union of India and to the State of Tamil Nadu. Subsequently, the Court directed the Union of

[52] A.I.R. 1979 SC 1369
[53] 1 SCC 225 (1992)
[54] *Supra* note 16, p.25
[55] Supp(4) SCC 505 (1995)
[56] (1993) 4 S.C.C. 204.
[57] *Ibid*
[58] (2002) 3 S.C.C. 31.

India to conduct a survey on an all-India basis with a view to identify registered and unregistered 'asylums' as also about the state of facilities available in such asylums for treating mentally challenged.

Meanwhile, more PIL's followed *Erawadi*. The Delhi-based NGO 'Saarthak' filed a PIL in October 2001 calling for a ban on the practice of physical restraint and administering unmodified' or 'direct' Electro Convulsive Therapy, i.e. ECT without anesthesia. Action for Mental Illness (ACMI) an advocacy organization for families, caring for family members with mental illness filed another PIL before the Court emphasizing the importance of family members and thus underrepresentation in decision regarding the care of the mentally ill. This PIL highlighted the need for a short term emergency plan for mental health care in view of the gross mental health manpower deficits, need for a psychiatrist to manage district level services, short-term training in psychiatry for general practitioners, integrating the family and community model into institutional care, due representation to families in processes of revising mental health legislation, due weightage to families in decisions regarding treatment, safeguarding the rights of the mentally ill, addressing issues of guardianship, inclusion of mental illness under the Persons With Disabilities Act, 1995 and Rehabilitation Council India Act, 1992 and formulation of guidelines for research involving the mentally ill.[59]

National Human Rights Commission Initiatives:

The NHRC is mandated under section 12 of the Protection of Human Rights Act, 1993 to visit Government run mental health institutions to 'study the living conditions of inmates and make recommendations thereon'. Besides discharging this specific responsibility, the Commission has been, right from its inception giving special attention to the human rights of mentally ill persons because of their vulnerability and need for special protection. The Commission's role in complementary to that of the judiciary.

In *Upendra Baxi v. State of U.P and Others*[60] the Supreme Court requested the NHRC to be involved in the supervision of mental health hospitals at Agra, Ranchi and Gwalior. The Commission on its part conceptualized and translated to a 'Quality Assurance in Mental Health' as the end product of this marathon action research project with the following outputs.'

a) Existing status of mental health hospitals, failing and inadequacies.
b) Comprehensive recommendations to achieve the object of ensuring quality mental health care in the country.

The Outline of recommendations

The Commission recommended:[61]

a) Immediate abolition of cell admissions.
b) Gradual conversion of closed wards into open wards.
c) Construction of new wards of shorter capacity for use as open wards.
d) Streamlining admission and discharge procedure in accordance with provisions of the Repealed Mental Health Act, 1987.
e) Up gradation of investigation facilities.

[59] *Supra* note 16, pp.71-72
[60] AIR 1987 SC 191
[61] *Supra* note 16, pp. 27-28

f) In-service training of all staff members.
g) Providing each patient a cot, mattress, pillow, bed sheet and adequate clothing for change.
h) Improving supply of water and electricity.
i) Ensuring supply of nutritive food of 3000 kilo calories per day to each patient.
j) Developing occupational therapy facilities.
k) Improving recreational facilities.
l) Developing rehabilitation facilities including day care centers.

Since June 1999, when the Quality Assurance in Mental Health report was released the Chairperson, core member in charge of mental health and other members as also Special Rapporteurs have been regularly inspecting and reviewing the activities of all the 37 mental health hospitals. A numbers of qualitative changes and improvements in the overall work environment, management and quality of treatment in there hospitals have taken place as a result of these visits inspections and reviews. The human rights dimension of mental health as occupied the pride of place in all these visits, reviews and inspections.

Mental Health Care Act-2017

India, as a signatory to the United Nations Convention on the Rights of Persons with Disabilities 2006, scrapped the Mental Health Act of 1987 and established the Mental Health Care Act of 2017, marking a significant departure from the previous legislation. The MHCA 2017 has instilled optimism in the realm of mental health, incorporating provisions that can significantly enhance the mental health system.

The primary objectives are to ensure accessible, affordable, and high-quality mental healthcare, reduce stigma and discrimination, advocate for community-oriented healthcare, and empower individuals with mental illness.

This Act, effective from May 29, 2018, signifies a substantial transition towards a more inclusive and supportive framework for mental healthcare in India.

The Mental Health Care Act of 2017 in India aims to decriminalize attempted suicide, ensure access to mental healthcare services, safeguard individuals with mental illness's rights, establish Central and State Mental Health Authorities to supervise services, allow advance directives for treatment preferences, oversee mental health institutions, and outline the roles and obligations of mental health professionals. The Act also establishes authorities to supervise mental health services and enforce the Act, ensuring individuals have the right to secrecy, dignity, and minimal restrictive care.

The Mental Health Care Act, 2017, in India faces several challenges, including inadequate infrastructure, a shortage of mental health practitioners, financial constraints, ongoing stigma and understanding, complexity and ambiguity, regulatory challenges, restricted access to care, excessive focus on institutional care, lack of integration with general healthcare, monitoring and evaluation systems, training and capacity enhancement, and human resource management issues. These issues highlight the need for addressing implementation issues, increasing resources, and enhancing knowledge to ensure the Act's efficacy in advancing mental healthcare in India. The Act's implementation is hindered by a lack of mental health infrastructure, particularly in rural areas, and by a lack of adequate workforce. Additionally, the Act may reinforce institutional care at the

expense of community-based care. Furthermore, the Act's implementation and management are hindered by insufficient training and capacity-building initiatives for mental health practitioners.

Efficient Execution of Mental Healthcare Act, 2017

• Enhance mental health infrastructure: Improve hospitals, clinics, and community-based services.
• Enhance workforce development: Train and recruit mental health professionals.
• Promote awareness and education: Initiate public awareness campaigns.
• Integrate mental health services: Incorporate mental health services into primary healthcare.
• Advocate for community-oriented care: Advocate for rehabilitation initiatives.
• Implement comprehensive monitoring and evaluation systems.
• Ensure financial support and resource distribution: Ensure sufficient financial support for mental health services.
• Educate law enforcement and judiciary: Inform them of the Act and mental health concerns.
• Engage NGOs and private sector: Partner with entities to enhance mental health services.
• Mitigate stigma and discrimination: Establish activities to reduce discrimination.
• Utilize technology: Utilize telemedicine and digital platforms for improved access to mental health care.
• Conduct research and gather data: Guide policy and service development.
• Build capacity: Implement training programs for mental health professionals and stakeholders.
• Implement grievance redressal mechanisms: Handle grievances related to mental health treatment.

By executing these recommendations, India can successfully actualize the objectives of the Mental Healthcare Act, 2017, and enhance mental health results for its populace.

Conclusion

In India there is no effective implementation of the mental health provisions. Apart from a few public interest litigations there has been no public interest shown in this area. The NHRC report reveals the worst situation prevailing in mental hospitals. If there is an effective implementation of the law and effective supervision by the board of visitors, the situation can be improved. The quickest and dramatic changes in this area, especially in institutional setting could be achieved by PIL within its limits the judiciary is performing a fair role for these downtrodden people.

With reference to the NHRC it can play the role of a promoter, facilitator and catalytic agent as also a watch dog. It cannot, however, substitute the primary role or mandate of State Governments to ensure mental health as a matter of human right to every individual. Besides, it is not one department but a host of departments and agencies who are stakeholders in the process. NHRC has, however, adopted a totally open, transparent and participative style of monitoring the pace and progress of activities in the hospitals keeping the human rights dimension uppermost in view. It has hitherto used monitoring as a tool of correction and promotion of human rights of the mentally ill persons.