A Participative Evaluation of the Rights of Persons with Psychosocial Disability•

Amita Dhanda•

I **Introduction**

Rights are seen as mechanisms of accountability that persons in vulnerable positions possess against holders of power and authority[1]. Human rights discourse can trace its lineages to either the autonomy or the interests' model. Whilst the autonomy model lays stress on choice and self determination the interests' model is more services and facilities oriented[2]. Writing nearly a decade ago[3] on the relevance of the two models to the rights of "persons with mental illness" I had pointed how each of the models constrained the assertion of human rights for "persons with mental illness". The autonomy model carried within it the danger of isolation and neglect and the interests' model could invisiblise the person.

Looking back and reminiscing on the various dialogues one has heard on the "rights of persons with mental illness" one remembers conversations between doctors and lawyers between policing authorities and civil libertarians or even between psychiatrists and anti-psychiatrists. The bearer of the rights that is the "person with mental illness" has been noticeable with her absence. I believe that this absence has significantly influenced perception on the purpose and content of these rights. Illustratively I have in all my writings stressed that as an expression of solidarity I write from the standpoint of "persons with mental illness". However when I perused Principles for the protection of Persons with Mental Illness and the Improvement of Mental Health Care 1991(hereinafter the MI Principles) and used them as an advocacy tool to challenge the disqualifying legal regime which subsists in the Indian legal system I stressed on the fact that the Principles require community living for "persons with mental illness" and to achieve this objective of the Principles it was necessary that " persons with mental illness" possess skills of community living and for that to happen it was necessary to closely interrogate legal constructions of capacity and incapacity. In setting up this argument on the basis of the Principles I glossed over the coercive component of the Principles[4].

• As users and survivors have demonstrated a preference for the term psychosocial disability I have employed the same in this article. Other terms such as " mental illness" " unsoundness of mind" etc have been used in quotes if required to maintain informational accuracy.

• Professor of Law , NALSAR University of Law Hyderabad. The literature search for this article has been greatly facilitated by the support provided to me by the Department of Law University of New South Wales. I wish to thank the faculty of the Department for the same.

[1] P Williams *The Alchemy of Race and Rights* (1993) ; J Feinberg Rights Justice and the Bounds of Liberty Essays in Social Philosophy (1980)

[2] T Campbell et al (ed) *Human Rights : From Rhetoric to Reality* (1986)

[3] Amita Dhanda " Law , Psychiatry and Human Rights" 430 *Seminar* 22 (June 1995)

[4] The gloss is demonstrated by the fact that whilst I bewailed the enactment of section 18 (3) in the Mental Health Act 1987 which allowed a voluntary admission to be converted to an involuntary one I did not take issue with principle 16 (1) of the MI Principles which made provision to the same effect. See Amita Dhanda Legal Order and Mental Disorder 62 (2000)

Significantly when the users and survivors responded to the Principles they gave short shrift to the evocative content of the Principles and fore grounded the forced interventions and the ever present possibility of losing rights. They also questioned the legitimacy of Principles which were finalized without consulting users and survivors[5]. The manner in which the rights discourse can alter if the dialoguing is initiated by users and survivors is again in evidence in the deliberations around the United Nations Convention on Disability Rights. The active participation of persons with psychosocial disability has substantially contributed to active deliberation on an inclusive and unqualified construction of capacity[6] which requires state parties to "recognize persons with disabilities as individuals with rights before the law equal to all other persons"; to " accept that persons with disabilities have full legal capacity on an equal basis as others …and to ensure that where assistance is necessary to exercise that legal capacity : the assistance is proportional to the degree of assistance required by the person concerned and tailored to the circumstances and does not interfere with the legal capacity, rights and freedoms of the person".[7] A similar stress on non discrimination is in evidence in the manner in which the right to liberty and security of person has been asserted. Thus states parties are required to ensure that persons with disabilities "enjoy the right to liberty and security of the person without discrimination based on disability"[8]; "are not deprived of their liberty unlawfully or arbitrarily and that any deprivation of liberty shall be in conformity with the law and in no case shall be based on disability"[9]. These formulations are being highlighted here in awareness of the fact that they are at present only so many recommendations of the Working Group to the Ad hoc Committee. However even as so many recommendations they are ensuring that questions such as legal capacity and liberty are discussed on a common and not a separated platform. Other than the Working Group Report, the various interventions of the World Network of Users and Survivors of Psychiatry and Inclusion International during the third and fourth meeting of the Ad Hoc Committee show that for persons with psychosocial disability guarantees of "non discrimination" "freedom equality and liberty" "support with equal respect and dignity" are non negotiable. They would hold any regime to be disability rights consonant only if it upholds these rights. Insofar as this is how persons with psychosocial disability perceive their own rights, it is my contention that any current day evaluation of their rights should be assessed on the touchstone of these non negotiable guarantees. Hence this article on the rights of persons with psychosocial disability is just such an evaluation of the Indian Legal System.

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[5]The World Network of Users and Survivors of Psychiatry had at its first World Convention in July 2001 at Vancouver rejected the MI Principles as they were formulated without stakeholder participation .

[6] This deduction is being made on the very many advocacy documents circulated by the World Network on Users and Survivors of Psychiatry and by the active participation of the Network's representative in the deliberations of the Working Group.

[7] See article 9 of the Report of the Working Group to the Ad Hoc Committee on a Comprehensive and Integral Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities.

[8] Id art 10 (a)

[9] Id art 10(b)

II **Rights of Persons with Psychosocial Disability in Indian Law**

Upon undertaking a thoroughgoing analysis of the Indian legal order on mental disorder I have found, that irrespective of the justifications proffered, the law was primarily prompted by the need to protect the interests of society[10]. This conclusion has been arrived at on a cumulative assessment of the legislative, adjudicative and litigative choices. The primary concern of legislations is to devise mechanisms to manage what are believed to be the disruptive consequences of mental disorder. The effect of this management on the person whose life and affairs are being managed is not a legislative concern. Thus, for example, the laws of civil commitment allow a person with mental disorder to seek voluntary treatment; but if the same person decides to discontinue treatment contrary to the opinion and advice of the treating doctor, the will of the person is not respected. Instead the relevant statute provides a procedure by which the user's choice can be overruled[11]. Similarly if a person accused of a crime is found to be of unsound mind and consequently unable to instruct counsel it is believed that his right to a fair trial is provided for by postponing the trial[12]. This is believed even when the statute neither specifies the period of postponement nor deals with the other consequences which a protracted trial may have on the life and liberty of the accused[13]. Similarly in ostensible fulfillment of the demands of a fair criminal justice system the defense of insanity is incorporated, which holds criminally non responsible any person who at the time of an offence is by reason of unsound mind unable to know the nature of the act or that it is wrong or contrary to law. However this acquittal on ground of insanity does not result in discharge, as a person acquitted on grounds of insanity could be kept in detention for an indefinite duration at the pleasure of the government[14]. Thus a "person of unsound mind" pays the costs for the induction of this fairness provision by losing both reputation[15] and liberty[16].

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[10] See supra note 4 at 315-19

[11] Section 18 (3) of the Mental Health Act 1987

[12] Sections 328 and 329 of the Code of Criminal Procedure 1973

[13] For example a long postponement could cause the evidence trail turn cold and the witnesses who could testify to the innocence of the accused may get lost. This is especially so because a postponement causes the entire trial to cease whereas fairness would require that at least the trial of facts which determines whether the person did in fact do the act of which he has been charged should continue. It is pertinent to note that such continuance has been provided for in the United Kingdom by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991.

[14] See Section 335 of the Code of Civil Procedure 1973. And for examples of such like indefinite confinement see Veena Sethi vs State of Bihar AIR 1983 SC 339; Moti vs State of Rajasthan (1988) 16 Reports (Raj) 576

[15] The reputation cost is that it is generally believed(as the innumerable cinematic representations show) that persons acquitted on grounds of insanity have it easy where they obtain freedom without having to pay the cost of their actions.

[16] Thomas Szasz " The Insanity Plea and the Insanity Verdict" 40 (3 & 4) Temple Law Quarterly 271 (1967) . Also supra note 4 at 129 -134

The above narration shows that both the procedure of compulsory civil commitment and the preventive detention provisions in criminal law proceed on the presumption that persons of unsound mind are a danger to self or others. It is this presumption of dangerousness which is proffered as the justification for depriving persons with psychosocial disability of their liberty rights. This is done without questions being raised on the factual veracity of the presumption of dangerousness even as a number of studies demonstrate the inadequacies and inaccuracies of the efforts to predict dangerousness and thereon establish that persons with psychosocial disability are no more dangerous than other persons[17]. It also needs to be noted that in devising these procedures the law singles out the risk taking behavior of persons of psychosocial disability, even as they are not the only persons indulging in such like behavior. All this makes for an anomalous and discriminatory legal regime of life and liberty of persons with psychosocial disability.

If the criminal justice system manages the problems of mental disorder by deferment, the civil law resorts to substitution and invalidation. Thus a guardian is appointed for a person who by reason of unsoundness of mind is unable to manage his or her own affairs[18]. If surrogate decision-making is one method of providing protection then the other technique is to invalidate a legal transaction entered into by a person of unsound mind. Both methods have the common consequence that they rendered invisible the beneficiary of the protection.

Thus the Contract Act lays down that a person who by reason of unsoundness of mind is unable to understand the terms of a contract or its effects on his or her interests shall lack legal capacity[19]. The statute envisages that a person who is generally of unsound mind may contract when of sound mind and admits in an illustration that this sound mind could exist even when the person is in a "lunatic asylum"[20]. The statute does not specify the legal status of a contract entered into by a person of unsound mind. However Courts have equated such a contract with a contract entered into by a minor and found it to have no legal validity[21].

This contractual incapacity gets extended to all one time transactions such as transfer, purchase and sale of property[22]. After a lot of back and forth inheritance rights have been conceded[23] but testamentary succession remains problematic[24]. For the ongoing

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[17] In a relatively recent article Thomas R Litwack " Actuarial versus Clinical Assessments of Dangerousness" 7 (2) Psychology Public Policy and Law 409- 443 (2001) has undertaken a comprehensive survey of literature on prediction of dangerousness and highlighted how each of the studies has found a consistent trend of over prediction in assessments of dangerousness. Such a position the author holds " would render assessments of dangerousness of institutionalized insanity acquittees untenable and (unethical)"

[18] Section 50 of the Mental Health Act 1987

[19] Section 12 of the Contract Act 1872

[20] Illustration (a) to section 12 of the Contract Act 1872

[21] Kamola Ram vs Kaura Khan (1912) 15 IC 404 Doulatuddin vs Dhaniram Chuttia(1916) 32 IC 804

[22] See section 7 of the Transfer of Property Act 1882

[23] As the law stands today " persons of unsound mind" are not disqualified from inheriting under any system of law. Disqualifications on inheritance subsisted in Hindu Law and the process of lifting them has been a gradual one. Thus in 1928 the Hindu Inheritance (Removal of Disabilities) Act 1928 provided that a person could inherit if insanity supervened after birth. And only in 1956 section 28 of the Hindu

management of property there are statutory procedures whereby after an extensive inquisition a manager to the property and a guardian to person can be appointed[25].

The incapacity attributed to "unsoundness of mind" is not confined to the economic sphere alone; it also extends to the personal realm. Thus the right to marry is denied to a person who by reason of "unsoundness of mind" cannot comprehend the nature of the ceremony or is unfit to assume matrimonial responsibilities or procreate children[26]. Divorce can be obtained on grounds of unsoundness of mind if the respondent is suffering from a mental disorder of such nature and degree that it is no longer reasonable to expect the petitioner to live with him or her. [27]

To move from the personal to the political, once a person is pronounced to be of unsound mind by a competent court she or he can be denied the right to vote[28] or stand for election or hold and retain office[29]. It is a different matter that despite extensive research it is difficult to discern which court is competent to make such a pronouncement.

Unsoundness of mind thus becomes a construct on which the law hangs its procedures of exclusion, invalidation and substitution. Insofar as the disqualifying regime is not applicable to all "persons with mental illness" and in more recent years there are legislations referring to "persons with mental illness" in a more inclusive manner[30] the aforesaid statement may seem too sweeping in its purport. However before I embark on an analysis of the new legislative order it may be appropriate to dwell on judicial treatment of the disqualifying regime.

Adjudication, as we all know, is a case by case application of the legislative norm. The judiciary contributed its own mite to the "dangerous – incompetent" stereotype of "mental illness" when it has arrived at a finding of legal incompetence only on the basis of a psychiatric diagnosis[31]. The Courts have adopted a more critical approach towards the stereotype, when they have viewed the psychiatric diagnosis as no more than a threshold condition which, can result in a determination of legal incapacity only if the further requirements of the law are fulfilled. Illustrations demonstrating such like

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Succession Act provided that no person would be disqualified from inheriting property on grounds of disease defect or deformity.

[24] Section 223 of the Succession Act 1925 lays down that probate cannot be granted to any person who is a minor or of unsound mind. Section 226 of the Act disallows issuance of letters of administration and section 263 provides that probate or letters of administration maybe revoked if issued to a "person of unsound mind".

[25] Section 50 of the Mental Health Act 1987

[26] Except for Muslim law this disqualification subsists in all other systems of personal law

[27] See section 13(1) (iii) of the Hindu Marriage Act 1955 ;section 27 (1) (e) of the Special Marriage Act 1954 and Section 32 (bb) of Parsi Marriage and Divorce Act 1934.

[28] Section 326 of the Constitution of India and section 16 (1) (b) of the Representation of People Act 1950

[29] For an explanation on the functioning of this disqualification see supra note 4 pp 308-10

[30] For an analysis of these legislations see infra

[31] Supra note 4 records a number of such examples especially in the matrimonial context.

interpretations are specially to be found in cases dealing with criminal responsibility[32] and those pronouncing on divorce on grounds of unsound mind[33]. It has also been seen that Courts have been more empathetic to the concerns of persons with psychosocial disability one, when they find that a person has been wrongfully diagnosed, and two, where they are faced with the woeful conditions in psychiatric institutions. It needs to be noted that Courts comment on the inadequacy of the service from their own perspective[34] ; the perception of person with psychosocial disability nowhere merits attention.

One reason why persons with psychosocial disability are absent from judicial discourse is because of players other than users and survivors activating issues around "unsoundness of mind"[35]. It is claimed that all persons with psychosocial disability are not viewed as incompetent by the law. And the legal provisions are meant to be only applicable to those who have been rendered incapable by their condition. However studies of the litigation patterns show that efforts to obtain a legal determination of incompetence are made for all manners of persons from the eccentric to the non-conforming to the deviant[36]. These efforts (whether successful or not) are continually made because " unsoundness of mind" is equated with incompetence in law and a legally incompetent person is required to live his or her life in accordance with the dictates of others be it family, professional or state. The person's own perceptions, wishes and aspirations are legislated out of existence.

The above analysis shows that the one right that the law confers on persons with psychosocial disability is that a person shall not be found legally incompetent without a judicial determination. All persons with psychosocial disability have not been considered incompetent but this requirement of judicial determination means that the capacity of all persons with psychosocial disability is subject to question. Subsequent to a judicial proceeding a finding of competence may be returned but the challenge cannot be prevented. It is this all encompassing vulnerability which makes the legal construction of capacity discriminatory.

III **Social Action Litigation for Persons with Psychosocial Disability**

The above legislative survey has found the laws relating to persons with psychosocial disability to be in infringement of their constitutional rights of liberty and equality. And yet these legislative provisions have not been subjected to constitutional scrutiny primarily because, as already mentioned, the litigation concerning persons with psychosocial disability has occurred in their absence.

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[32] There is a long line of case law which stresses how legal insanity is distinct and different from medical insanity. Illustratively see

[33] One of the most significant decisions adopting this approach was the ruling of the Supreme Court in

[34] See for example in the Erwadi case the Supreme Court has issued its order on healing places coloured by the disaster at Erwadi. Cruelty of treatment is problematic whether it happens in healing places or in psychiatric institutions however the apex court has not limited its comments to cruelty it has instead ousted all alternative mental health interventions by labeling all of them as cruel. Consequently the court has given short shrift to the opinions of people to the contrary.

[35] For data demonstrating the same see supra note 4 at pp .

[36] Illustratively see cases filed for appointment of guardians to property in supra note 4 at 237-38

With the expansion of the rules of locus standi and the onset of Social Action Litigation the rights of various vulnerable groups have been the subject of contest before the appellate courts. Persons with psychosocial disabilities have also benefited from this development. The social action litigations filed for persons with psychosocial disability primarily focused on the fact of institutionalization. Thus petitions were filed challenging the detention of "insane under trials" or "insane acquittees" for periods longer than for which they could have been punished[37]. There were petitions which questioned the use of jails to house "wandering mentally ill persons",[38] and others which brought to the notice of the court the abysmal conditions prevailing in mental hospitals[39].

These petitions obtained symptomatic relief for individual persons with psychosocial disability but did not address the structural causes of the distress. Illustratively questions were being raised on the periods for which insane acquittees were kept in detention but the fact of detention was not questioned. Similarly anxiety was expressed on the long periods for which "insane under trials" were kept under detention; however the issue of open ended postponement was not questioned. There were no concerns voiced on whether the incapacity to stand trial provisions in its present form furthered fair trial? Similarly the hospital petitions focused on the conditions in specific hospitals without taking issue on institutionalization, forced commitment or treatment. The practice of housing "persons with mental illness" was outlawed, and a detailed program of creating community based services was approved. However in the monitoring follow up the court limited its oversight to maintaining territorial integrity alone and focused its attention on ensuring that persons with mental illness were not housed in jails but shifted to mental hospitals. Consequently States which did not have a mental hospital were pressurized to create institutionalized services. This remedy of establishing psychiatric institutions was suggested as it was seen to be upholding the rights of "persons with mental illness" and such a solution was devised because psychiatric institutionalization was seen as unproblematic.

In making the above proposition this article is not aiming to undermine either the efforts of the Supreme Court of India, the High Courts or the National Human Rights Commission in upgrading the facilities at specific mental hospitals[40]. It is only pointing out that these efforts are symptomatic in impact they cannot usher structural change as they are not addressing structural questions. These social action litigations along with the

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[37] Veena Sethi vs State of Bihar 1982 (2) SCC 583

[38] Sheela Barse vs Union of India WP (Crl) No 237 of 1989

[39] B.R. Kapoor vs Union of India WP (Crl) No 1777-78 of 1983; People's Council for Social Justice and another vs State of Kerala OP No 7588 of 1986; R.C. Narayan vs State of Bihar W. P. No 339 of 1986.

[40] In Aman Hingorani vs Union of India AIR 1995 SC 215 the schemes made by the Union Health Secretary with regard to Gwalior, Ranchi and Agra mental hospitals respectively were adopted by the Supreme Court . In an order delivered on 11.11.1997 in Rakesh Chandra Narayan vs State of Bihar WP (civil) Nos 339/86, 901/93 and 448/94 along with WP (civil) No 80/94 the Supreme Court transferred the supervision of these hospitals to the National Human Rights Commission . The Commission with the aid of a committee of non governmental organizations is making an effort at upgrading the facilities at the various hospitals. In a day long visit at the Gwalior mental hospital in December 2003 I did find an evident improvement in the resources situation but the crusade to obtain transparency and accountability and a rights consonant environment for the inmates seemed an uphill struggle.

interventions flowing from them have extended the fundamental rights jurisprudence to persons with psychosocial disability without interrogating the discriminatory medico-legal policy to which they were subjected.

It is only in 2001 that a petition filed by a psychiatrist[41] on behalf of his patient group has made an attempt to change this trend by challenging the constitutionality of section 81 (2) of the Mental Health Act 1987 which allows a "mentally ill person" to be used for research not directly beneficial to him provided her guardian has consented to such research. The petition also seeks a ban on unmodified electro-convulsive therapy. The petition in the main requires that deprivation of liberty should occur only after the observance of fair process safeguards. It requires that physical restraints should be only used as an extreme measure when required for the safety of the person with mental illness or others, and such restraint should be sanctioned by a Board of a psychiatrist, social worker and a NGO representative. In the same spirit of promoting fair process it requires legal aid lawyers to visit mental hospitals to assist persons with mental illness in their discharge applications.
The petition seems to have an ambivalent stance on guardianship where whilst on the one hand it challenges experimental research on persons with mental illness on the strength of surrogate consent on the other it bewails the absence of guardians and the need to appoint them. The petition in the main is prompted by beneficent motives of good Samaritans, hence speaks of what they believe is needed to uphold the rights of "persons with mental illness". Patient perceptions and aspirations do not find voice in the petition even as it is filed by a patient group. Despite these limitations, the petition is radical in present day India as can be evidenced from the opposition that it has invited both from the Indian Psychiatrists Society and the Association of Indian Private Psychiatrists. Further the petition albeit tentatively has set up a trend for more patient rights sensitive petitions being filed in the Supreme Court. Thus a 2004 petition filed by a disability rights activist[42] asserts that" a patient" has a right to be assisted in the exercise of self determination. It is a different matter that in making its claims the petition heavily relies on the MI principles and accords an uncritical endorsement to them.

The administering of electroconvulsive therapy without anesthesia has been recognized as torture by the European Convention on Protection against Torture[43]. Narrations of users and survivors refer to ECT as unmitigated agony and torture. Questions continue to be raised even on the use of modified electroconvulsive therapy consequently studies demonstrating the ethical and responsible use of the therapy have to be periodically carried out even in developed countries[44]. Use of unmodified ECT is seen to negate the credibility of a country's mental health system[45]. In this situation to refer to unmodified

[41] Saarthak vs Union of India WP No 562 of 2001
[42] Rahul Jani vs Union of India WP (civil) No 118 of 2004
[43] In Hungary since 1994 the collaboration of a specialist in anesthesiology is a legal obligation. " Rates of Electroconvulsive Therapy Use in Hungary" 20 (1) Journal of ECT 42 (Mar 2004)
[44]Grace M Fergusson et al " ECT in Scottish Clinical Practice : A National Audit of Demographics Standards and Outcomes" 20 (3) Journal Of ECT 166 (Sep 2004)
[45] For reports to this effect see Chanpattana Worrawat and Barry Alan " Electroconvulsive Therapy Practice in Thailand" 20 (2) Journal of ECT 94 (June 2004) ; Motohashi Nobutaka and Higuchi " A

ECT as treatment seems like adding insult to injury. The use of unmodified ECT is being defended on the reasoning that if anesthesia was insisted upon then a number of poor persons would be denied this state of art therapy. Surely if the therapy is required and desirable with anesthesia then logically it is anesthesia which should be demanded as a right for poor persons with mental illness considering the right to health has been recognized as a right which flows from the right to life. Yet such an argument has not been made by the Associations of Psychiatrists opposing the petition. It needs to be noted that if unmodified ECT is banned then it will not be possible to administer ECT's in make shift clinics. This would also mean that one of the most expensive therapies would become unavailable to a large number of private psychiatrists because modified ECT cannot be administered by a lone psychiatrist in the privacy of his clinic, As the commercial considerations loom large over the debate I am forced to wonder whether it is these concerns that are prompting the psychiatrists associations support for unmodified ECT.

The Indian Psychiatrists Society in its affidavit informs that unmodified ECT needs to be continued as anesthesia is contra indicated for some "persons with mental illness". It is general medical practice that patients who react unfavorably to one kind of treatment are provided an equally safe alternative. Doctors cannot without the consent of the patient decide on her pain thresholds. Contrary to general medical practice the doctors here are seeking authority to administer a more painful intervention of doubtful efficacy and without the patient's consent. A contention which more than anything else seems to show that the rights which are available to other patients are not available to " persons with mental illness" It is this same unequal treatment which explains how this entire debate is taking place in the absence of the person on whose body the so called treatment is to be administered. The manner in which the Indian Supreme Court resolves this petition shall serve as one more barometer of the state of the rights of persons with psychosocial disability.

IV "**Mental Illness" under the Disability Legislations**

As already mentioned other than the above discussed legislations "mental illness" also finds inclusion in the more recently enacted Disability Legislations. The definition of disability in the Persons with Disabilities (Equal Opportunity, Protection of Rights and Full Participation) Act 1995 includes mental illness[46]. The enactment is an effort to have disability inclusive policies in education[47] and employment[48]. It makes provision for affirmative action programs[49] and social security policies[50] as also physical access to transport and buildings[51].

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questionnaire survey of Electroconvulsive Therapy practice in University Hospitals and National Hospitals in Japan" 20 (1) Journal of ECT 21 (Mar 2004)

[46] Section 2 (i) of the PWDA

[47] Id sections 26-31.

[48] Id sections 32-41

[49] Id sections 42-43

[50] Id sections 66-68

[51] Id sections 44 to 46

The National Trust for (Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities) Act 2000 does not explicitly mention "mental illness". However "persons with mental illness" get included by implication as multiple disabilities is defined to mean the simultaneous presence of any two disabilities included in the PWDA[52]. This law sets up a Trust which could amongst other things support programs for the independent living of persons with disability[53] even as it also specifies procedures for the appointment of guardians for those persons with disabilities who are in need of them[54]. The statute speaks of providing guardianship only if required and only in those spheres where needed[55].

The PWDA applies to "persons with mental illness" however the incapacity regime subsisting in the remaining laws is the stumbling block to persons with psychosocial disabilities obtaining full benefit of the statute. Thus an interrogation of the incapacity regime is required to enable persons with psychosocial disabilities to fully realize the rights guaranteed under PWDA. The ordinary rule of statutory construction is that a later law prevails over an earlier statute. Further a statute has to be so interpreted as to render it workable. Insofar as the PWDA can not work for persons with psychosocial disabilities without the incapacity regime being given a go by it could be contended that the new law has in effect superseded the earlier exclusionary legislative provisions. However without an explicit supersession[56] and in the face of the medicalized IDEAS which has been notified by the Ministry of Social Justice and Empowerment[57] it may be difficult to mount such an argument. Consequently when it comes to accessing the rights guaranteed under the PWDA the position of persons with psychosocial disabilities is to say the least anomalous.

V **Towards a Rights Consonant Legal Order**

As was mentioned in the beginning of this article rights are trumps for the vulnerable[58] and instruments of obtaining accountability from the powerful. Rights have often to be obtained after protracted struggles. Persons with psychosocial disabilities are engaged in this struggle towards the realization of their rights of equality, liberty and dignity. This struggle is primarily being spearheaded by the "discredited"[59] as in a bid to avoid the stigma, exclusion and discrimination confronted by the "discredited" the

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[52] Section 2 (h) NTA
[53] Id section 11 (2) (a)
[54] Id section 14
[55] Id section 14 (3)
[56] It could be contended that supersession is implied in section 72 when it lays down that the provisions of the Act are in addition to and not in derogation of any other law, rules , orders or instructions issued or enacted for the benefit of persons with disability.
[57] This notification has been issued by the ministry on 27.2.2002
[58] R Dworkin Taking Rights Seriously (1977)
[59] Susan Stefan " 'Discredited' and 'Discreditable' : the Search for Political Identity by People with Psychiatric Diagnosis" 44 William and Mary Law Review 1341 (Feb 2003)

“discreditable” wish to pass off as non disabled. The discreditable show that the exclusion requires persons to live a lie to not acknowledge a disability because of the manner in which a person with disability is treated upon disclosure.

The point being made is that a rights consonant legal regime has to make the bearers of the rights central to the discourse. As things stand this is not the situation for persons with psychosocial disability. For that half promise to be rendered whole it is imperative that there are moves in the law to recognize the equal status and capacity of persons with psychosocial disability. Though there are legal sites which can enable the creation of a non discriminatory legal regime for persons with psychosocial disability, no such regime at present exists. The possibilities of making these moves seems dismal if even those who are voicing concern for the rights of “ persons with mental illness” are doing so with paternalistic motivations.

In this situation, the Convention on the Rights of persons with Disability provides opportunity to initiate a suitable forward looking discourse on the rights of persons with psychosocial disabilities. It is appropriate to clarify that I am not proposing a special rights regime for persons with psychosocial disability. Rather, I am highlighting the possibilities that the Convention has opened up for adopting a Disability Rights Regime which would acknowledge, amongst others, the deprivations endured by persons with psychosocial disabilities, and recognize rights which would prevent future denials. This expectation stems from the fact that disability discourse is about accepting diversity and acknowledging difference in such manner that place is made for the part within the whole.

Persons with psychosocial disability are seeking a right not to be discriminated on the basis of disability. It is pertinent to note that in asserting equality of rights, users and survivors are not denying the need for support. However their contention is that these needs of support should again not be seen as peculiar to persons with psychosocial disability, rather this need is an inevitable consequence of human interdependence. Legal recognition to the norm of supported decision-making would mean that that whilst the provision of support would not nullify the decision, at the same time the supporter will not turn decision-maker. Mechanisms such as advance directives and powers of attorney could be other legal devices to deal with the more non communicative phases of the human condition.

If acknowledgement of equality before law and legal capacity is one limb of the rights regime sought by persons with psychosocial disability; recognition of the right to liberty and protection from compulsory treatment is the other limb. It may be pertinent to note that though compulsory institutionalization has been most pervasively practiced against persons with psychosocial disabilities the deprivation is not confined to them, and custodial care has been an oft resorted method for dealing with persons with disabilities. Hence if the problem of forced interventions is addressed in an article of the Disability Convention the life and liberty concerns of all persons with disability would be addressed.

The explicit ouster of coercion from treatment should assist in rectifying the balance of power and make for greater parity of relationship between doctors and patients. It would also assist in making the therapeutic relationship more dialogical than authoritative. The introduction of such a change in doctor –patient relationship would, I hope, not just benefit persons with disabilities but would lead to a culture of medical responsiveness which would be extended to all recipients of care and treatment. It may be appropriate to clarify here that the freedom of medical professionals to develop treatments is not being questioned but the regimen by which such treatment is administered is being scrutinized. Hence what is being asserted is the freedom of choice, the right to be informed and a participative regime of treatment.

In this context it may be appropriate to note that the interventions of the Indian government in the Convention deliberations have been primarily aimed at saving the existing legal order whether it is guardianship or compulsory treatment. The government claims that the situation on the ground dictates its approach. But a Convention is not (as is being oft reiterated in the deliberations of the Ad hoc Committee) about settling a program of action but about agreeing to a set of principles. Further it is not making law for here and now it is also setting direction for the future. And these future directions have to be necessarily aspirational if present limitations are to be overcome. If the text of the Convention saves the existing restrictions then it not only legitimizes the present deprivations but also closes the door for change in the future. Whilst pragmatic considerations may guide the implementation of program under the Convention these considerations cannot and should not guide the adoption of principles and norms. This is because whilst an implementation compromise may result in some present deprivation, a normative compromise hocks the future. It is this future compromise which has to be averted if the deprivations of rights that blight the life of persons with psychosocial disabilities today are not to hamper their tomorrow.