

COMMENTS

Does “supported decision-making” in India’s Mental Health Care Bill, 2013, measure up to the CRPD’s standards?

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Abstract

The Convention on the Rights of Persons with Disabilities (CRPD) requires States to replace their mental health laws based on substitute decision-making for persons with mental health issues with laws based on the supported decision-making paradigm. However, the exact scope of the CRPD’s mandates is currently under debate, especially in the case of persons with very high support needs. The Mental Health Care Bill, 2013, introduces supported decision-making in India in the form of advance directives and nominated representatives. This article discusses how far the Bill measures up to the CRPD’s standards and highlights some of the difficulties when the support needs of the person are very high.

Introduction

The Mental Health Care Bill, 2013 (1) was introduced in the upper house of India’s Parliament on August 19, 2013 (2:p 1). The Bill attempts to align and harmonise Indian law with the human rights framework laid down under the United Nations Convention on the Rights of Persons with Disabilities (CPRD) (3), which India ratified on October 1, 2007 (4). This article argues that the Bill attempts to ensure the full and effective participation of persons with mental illness in their healthcare, treatment and decision-making on their management, on an equal basis with others, through the provision of supported decision-making mechanisms. However, the Bill comes up against certain problems, particularly when the individual in question has a very high need for support. At present, demands are being made in many countries for a review of their national mental health laws in the light of the CRPD’s mandates. As such, the Bill can offer constructive guidance to

other States seeking to revise their mental health legislations. It can also serve as a reminder to policy-makers that supporting the decision-making capabilities of persons with mental disabilities is a complex and evolving process.

The Bill seeks to replace India’s Mental Health Act of 1987 (MHA) (5), the current legislation on the subject. Overall, the premise of the MHA is the paradigm of involuntary admission of and substitute decision-making for persons with mental health issues, which can eviscerate their legal capacity. Worse, it is not uncommon to hear stories of people who have been abandoned by their relatives and friends to languish in mental asylums for years, with almost no contact with the outside world and no prospect of ever being able to participate in social activities (6,7), a scenario facilitated by the framework of the MHA.

This article centres around two main questions. First, what are the CRPD’s standards for supported decision-making in mental healthcare? Second, do the supported decision-making mechanisms introduced in the current draft of the Bill meet those standards? Part 1 begins with a description of some challenges associated with the current model of substitute decision-making in mental healthcare. Part 2 sets forth the CRPD framework and the role of supported decision-making as envisaged by it. Part 3 discusses various models of decision-making under the Bill. Part 4 examines the relevant provisions of the Bill in the light of the framework set forth in the CRPD with a view to answering the question of whether the mechanisms of supported decision-making in India’s Mental Health Care Bill, 2013, measure up to the CRPD’s standards.

1. Substitute decision-making and mental disability law

Under the MHA’s framework, the admission and treatment of persons with mental health issues is routinely authorised either without their personal consent or with the consent of their substitute decision-makers, which can include formal guardians, relatives, friends and others (5). This evisceration of legal capacity is often carried out on the ground that persons with mental illness lack the mental capability to make decisions on their own health and well-being.

The practice of involuntary care and substitute decision-making in health-related matters is contrary to the notion of delivering healthcare services on the basis of a patient’s informed consent, long considered to be one of the

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cornerstones of ethical healthcare. Coercion and substitute decision-making in mental healthcare are but one example of a plethora of instances – of which guardianship is the chief one – in which the autonomy of persons with mental disabilities is violated because of the paternalistic presumption that they cannot make rational decisions because of their mental health issues. In consequence, mentally disabled persons are stripped of their right to decide, and individuals are appointed to act on their behalf to protect them from “poor” decision-making.

Substitute decision-making regimes constitute an almost ubiquitous and rationalised justification for denying the legal capacity of persons with mental illness. As a result of these regimes, persons with mental disabilities have very restricted access to various services, opportunities and choices which are routinely available to other members of society. Further, they may become dependent on substitute decision-makers for the most basic and the most intimate aspects of their lives.

Within the context of mental healthcare, decisions made by a substitute can directly affect the physical as well as mental integrity of the person. Psychiatric medications have the capacity to alter a person’s moods and thought processes and can thus affect their identity in a fundamental way. As such, treatment without consent may even amount to torture or cruel, inhuman or degrading treatment in accordance with the current human rights standards (8: p10).

The practice of substitute decision-making in mental healthcare can also be deemed discriminatory because the general right of patients to receive treatment only on the basis of free and informed consent is universal. Indeed, other persons – meaning those who are supposed to have adequate “mental capacity” – have almost absolute control over their health-related decisions. Thus, it is axiomatic that the wishes of a mentally competent person regarding what should and should not be done to their body must be respected, even if those wishes are found to be outright irrational (9).

The critics of an autonomy-based model of patients’ rights are concerned that the law relating to informed consent leans too heavily in favour of the personal autonomy of mentally ill patients at the expense of other equally laudable goals, such as beneficence (10) or collection of public health data. Yet, these very critics do not object to the complete deference afforded by the law to the personal autonomy of other patients. By contrast, the MHA derogates the power of decision-making from persons with mental illness on the ground that they lack capacity, even if it ultimately results in the violation of their personal autonomy. These widely accepted discriminatory practices of substitute decision-making in mental healthcare and the domestic laws that authorise these practices are now being scrutinised under the human rights framework laid down under the CRPD. This framework is discussed below.

2. CRPD framework and the role of supported decision-making

Although the human rights framework laid down under

previous core human rights treaties was equally applicable to persons with disabilities (PWDs), these persons continued to be denied those rights all over the world. Thus, the CRPD was adopted to re-emphasise their human rights and fundamental freedoms (3: Art 1). The framework of the CRPD attempts to address the discrimination faced by a variety of PWDs in one human rights instrument. The main challenge before the States Parties is to apply the common CRPD framework to a diversity of PWDs in such a way that “all persons with disabilities” enjoy their human rights on an equal basis with others. This point is important while considering the right to consensual medical treatment because many States are currently finding it difficult to apply the CRPD’s mandates regarding the right to autonomous decision-making on an equal basis with others to persons with severe mental health issues.

There are several articles in the CRPD which are relevant to the issue of consensual treatment of PWDs. Article 25 (d) expressly mandates States Parties to require health professionals to provide care of the same quality to PWDs as to others, including on the basis of free and informed consent (3). Article 12 (3) obligates States Parties to take appropriate measures to provide PWDs with access to the support they may require in exercising their legal capacity (3). Article 14 (1) (b) declares that the existence of a disability shall in no case justify a deprivation of liberty (3). Article 15 enjoins that no one shall be subjected without their free consent to medical or scientific experimentation as part of a prohibition on torture or cruel, inhuman or degrading treatment (3). Article 17 protects PWDs’ right to respect for their physical and mental integrity on an equal basis with others (3).

The exact scope of interpretation of these CRPD provisions is in the process of evolving. The CRPD does not provide criteria for determining whether persons with mental health issues may ever be treated without their personal consent on grounds of mental incapacity, risk or danger. Some States Parties (11, 12) and commentators (13) argue that such criteria, even in limited circumstances, must be read into the CRPD for the protection of those persons or of others. Australia (14) and Norway (15), for example, have already made interpretative declarations to that effect. In stark contrast, the CRPD committee has categorically rejected the position taken by States on this issue, first in its General Comment No 1 on Article 12 (16), and then in its Guidelines on Article 14 (17). In both instances, it has maintained that any medical intervention, under any circumstance, which does not have the informed consent of those individuals, violates their human rights.

The committee also prohibits the denial of legal capacity on the basis of an alleged lack of mental capacity and opposes mental capacity assessments – whether on the basis of the status approach (on the basis of the diagnosis of an impairment), the outcome approach (on the basis of a decision made by a person that is considered to have negative consequences), or the functional approach (on the basis of a perceived or actual deficiency in a person’s decision-making skills) – for any purpose whatsoever, deeming that the concept of mental capacity “is not, as is commonly presented,

an objective, scientific and naturally occurring phenomenon" (16: p 4).

Many States Parties (18) and commentators (19,20) agree with the general proposition that they must recognise the equal legal capacity of PWDs, including that of persons with mental illness, to make decisions regarding consent to medical interventions. If PWDs need support to make decisions on granting or refusing consent, then such support must be made available to them so that they can exercise their legal capacity on an equal basis with others. Some States have also taken steps to include formal support mechanisms, such as advance directives, in their legislations to allow mentally ill persons to exercise their legal capacity with the help of support (21:s 24–26, 22). However, some States continue to disagree with the CRPD committee on two main points.

First, contrary to the position taken by the CRPD committee, a number of States argue that substitute decision-making and treatment without consent cannot be completely ruled out in the case of certain mentally ill persons. They argue that treatment without obtaining personal consent is inevitable in those extreme cases in which the will or preferences of the person cannot be determined even after exhausting all the means available (11, 12); or in which the person is acting in ways that are blatantly contrary to their interests and/or carry the risk of serious consequences to their health (11: p 2); or in which the decisions made by the person are based on misperceptions of reality due to psychosocial impairments that are causing danger to the self or others (12: p 3). The CRPD committee suggests that in these cases, the decisions can be made by another person but they must be in accordance with the "best interpretation of will and preferences" of the mentally ill person rather than their presumed "best interests" (16: p 5).

Second, these States and many commentators do not view mental capacity assessments based on the functional approach as being discriminatory towards persons with mental illness (23:p 4). This is reflected in the attitudes of the healthcare professionals involved in situations requiring consent. State laws thus continue to pin the right to consensual medical treatment to the actual or perceived functional capacity of a person (21: s 2, 3). Some commentators claim that functional assessment of mental capacity has a role to play in determining the form of support required or in gauging the adequacy of the existing support mechanism (23: p 5). The CRPD's shift from substitute decision-making models to those based on the supported decision-making paradigm needs to be considered in the light of this ongoing debate.

3. The Mental Health Care Bill and models of decision-making

The Bill envisages four different mental healthcare and treatment decision-making systems in the context of persons with mental health issues. First, it clearly retains substitute decision-making in two situations: admission, treatment and discharge of minors; and emergency situations. Decisions regarding a minor's mental healthcare and treatment are

always to be made by their nominated representative (1: s 96). Similarly, treatment in emergency situations has been made subject to the consent of a nominated representative, when the patient is available. When the nominated representative is not available, a registered medical practitioner can proceed without obtaining consent (1: s 103). Emergency situations are those situations in which it is immediately necessary to prevent death or irreversible harm to the health of the individual in question, or to prevent serious harm to the person or to others, or to prevent serious damage to property when the person's behaviour is believed to flow directly from their mental illness (1: s 103[1]). However, issues pertaining to substitute decision-making in the treatment of minors and in emergency situations are beyond the scope of this paper, and are highly specialised areas of mental health law.

Second, it is envisaged that most of the time, persons with mental illness shall make independent decisions regarding their admission, treatment or discharge, without support. Section 94 (2) of the Bill provides that "[a]ll admissions in the mental health establishment shall, as far as possible, be independent admissions except when such conditions exist as make supported admission unavoidable". There is no need for the consent or presence of a nominated representative or a relative or caregiver for the admission of an independent patient to a mental health establishment (1: s 95[6]). Section 95 (5) provides: "[a]n independent patient shall not be given treatment without his informed consent". The Bill envisages independent decision-making *sans* support when the mentally ill person is not a minor, is acting of their own free will, without any duress or undue influence, and when they have the capacity to make decisions on their mental healthcare and treatment with minimal to no support from others in such decision-making (1: s 94,95).

Third, for those who require support in making decisions regarding admission, treatment or discharge, such support can be provided in the form of advance directives and/or nominated representatives. Section 98 (6) of the Bill provides: "Every person with mental illness admitted under this section shall be provided treatment after taking into account (a) an advance directive, if any; or (b) informed consent of the patient with the support of his nominated representative, subject to the provisions of sub-section (7)."

Finally, although the Bill makes an attempt to shift to a supported decision-making regime, it also attempts to address situations in which the decision-making abilities of the person are so severely impaired that they are unable to make an autonomous decision despite the provision of all the existing support mechanisms. The position adopted under the Bill is akin to the stand taken by some of the States and commentators in their submissions to the CRPD committee on the Draft General Comment No 1, wherein they have advocated the use of substitute or facilitated decision-making models to deal with these rare cases. As such, the Bill has departed from the absolutist approach of the CRPD committee, which requires "both the abolition of substitute

decision-making regimes and the development of supported decision-making alternatives”, and which reiterates that “the development of supported decision-making systems in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with article 12 of the Convention” (16:p 6).

4. Does India’s Bill measure up to the CRPD’s standards?

The treatment of persons with high support needs is the main area of disagreement between the CRPD committee and many of the States Parties. Although it remains to be seen whether the decision-making models proposed under the Bill necessarily violate or actually comply with the CRPD’s framework, the Bill has promising and troubling ramifications for the scope of the right to consensual medical treatment of mentally ill persons that may serve as a useful example for other States in the process of revising their mental health laws. At this stage, it would be useful to highlight some of the difficulties faced by law-makers in dealing with the borderline cases. Recent discussions on the provisions of the Bill can shed some light on the complexity of this issue.

Advance directives

Section 5 of the Bill gives patients the right to make an advance directive in respect of decisions related to their mental health and treatment. Section 10 makes it incumbent on mental healthcare professionals to propose or administer treatment to a person with mental illness in accordance with a valid advance directive made by them, subject to Section 11. In ordinary situations, barring the circumstances mentioned in Section 11, registered medical practitioners and psychiatrists must be held to be bound by the content of advance directives, in accordance with Section 10.

However, under Sections 98 and 99, there appears to be some uncertainty regarding the role of advance directives in the admission of persons with mental health issues with high support needs. Under both these sections, healthcare professionals are to “take into account” the advance directives made by the person concerned before they are admitted. Does this mean that healthcare professionals will always be bound by the contents of advance directives in accordance with Section 10? The overall tenor of Sections 98 and 99 suggests otherwise.

Sections 98 and 99 are to be used for admitting persons who have a mental illness of such severity that they have been acting violently, or show an inability to take care of themselves, are unable to make decisions related to mental healthcare and treatment independently, and require high support in making those decisions (1: s 98, 99). However, before any decision is made regarding admission to a mental health establishment, the health professional has to take into account the advance directive to decide whether admission is the least restrictive alternative in the circumstances (1: s 98[6],99[11]). Thus, the language of Sections 98 and 99 gives the impression that an

advance directive is just one of many factors to be considered before admitting a person with mental health issues with high support needs. It appears that in some cases, the past wishes of the person, contained in a valid advance directive, may be ignored if the presence of other factors enumerated under Sections 98 or 99 makes it necessary to do so. For instance, if a person who has been acting violently under a psychotic delusion that he is eliminating evil from the world has written an advance directive saying that he/she does not wish to be admitted in a mental health establishment, will his/her advance directive always be followed? It seems that if the case falls under Section 98 or 99, that person could be admitted to a mental health establishment in spite of the advance directive, if that is the least restrictive alternative in the circumstances. Thus, for the purpose of admission under Sections 98 and 99, the wishes of mentally ill persons as expressed in their advance directives may not always prevail.

Although the use of supported decision-making mechanisms in the form of advance directives may be restricted in the example mentioned above, the person still has support available to him/her in the form of a nominated representative. However, supported decision-making through a nominated representative is also problematic in “hard cases” involving persons with high support needs.

Nominated representative

Under both Sections 98 and 99, the application for admission to a mental health establishment has to be made by a nominated representative. The nominated representative is also authorised to provide temporary consent to treatment under these sections if the person admitted under any one of these sections requires “nearly hundred per cent support” from his/her nominated representative in making a decision regarding treatment (1: s 98 [7],99[12]). When the decision to be made by the nominated representative is based on the will and preferences of the person with mental illness, there is relatively little conflict. However, there are times when the person concerned is opposed to being admitted to a mental health establishment or his/her wishes cannot be ascertained even after all possible means of support have been exhausted. Does decision-making by a nominated representative amount to substituted decision-making in these cases? In any case, does the decision-making model envisaged under Sections 98 and 99 comply with the CRPD framework? How far does the “best interpretation of will and preferences” paradigm (16: p 5) replace substitute decision-making in the presumed “best interests” of persons with mental illness in the current draft of the Bill?

The Bill addresses this problem by providing that in most cases, the nominated representative will be appointed by the mentally ill persons themselves and the nominated representative is *supposed to consider the current and past wishes, life history, values, cultural background and best interests of the person with mental illness, and give particular credence to the views of the person, to the extent that the*

person understands the nature of the decisions (1: s 17[a] [b]) (emphasis added).

At first glance, the Bill seems to live up to the CRPD committee's expectations, ie all forms of support must be based on the will and preference of the person, and not on what is perceived as the objective best interests of the person (16: p 7). The Bill intends to give primacy to the will and preference of persons with mental illness, as opposed to their putative best interests, to protect them from paternalistic decision-making. However, this approach is likely to fail when the past wishes of those persons are not known or when their life history, values and cultural background guide the nominated representative in different directions. Thus, perhaps, the Bill requires the nominated representative to also consider the best interests of the person when his/her past wishes, life history, values and cultural background are unable to give any definitive guidance.

Although the Bill intends to strike a balance between what the person wants and what is best for him/her, it may give rise to another risk. The concept of best interests is shaped and influenced by the social, political, economic, cultural and historic contexts. This has a special significance in mental healthcare because mentally ill persons can be easily thought of as not being capable of knowing what is in their best interests. When the person's will and preferences are not known, the concept of best interests is susceptible to be used merely as a pretext to override the decisions of the person that one considers inappropriate or wrong.

Association between mental and legal capacity

The Bill endeavours to ensure that legal capacity is not denied to persons with mental health issues on the basis of mental capacity assessment, by providing: "All persons with mental illness shall have capacity to make mental healthcare or treatment decisions but may require varying levels of support from their nominated representative to make decisions." (1: s 4[1]) However, the Bill does not eliminate mental capacity assessments from its framework, as required by the CRPD committee.

Like many modern legislations on the subject (22:s 3[1]), the Bill provides for mental capacity assessment using the functional approach (ie assessment of the abilities to understand, appreciate and communicate treatment-related information) (1:s 4[1]). The current draft of the Bill has no express provision creating the presumption of capacity. However, on the recommendation of the Parliamentary Standing Committee, the Government of India has agreed to modify the relevant section [Section 4 (1)] to create such presumption (2:p 29). Yet this is a rebuttable presumption and still requires a mental capacity assessment that could result in the conclusion that a mentally ill person lacks mental capacity in a given situation. In the overall scheme of the Bill, the conclusion that a person lacks mental capacity does not necessarily mean that substitutes should make decisions on his/her behalf because the Bill provides for support

mechanisms in such situations.

Mental capacity assessments, however, can also be used to determine whether or not support should be provided to persons with mental health issues. For example, under Section 6 of the Bill, a valid advance directive can be made only if a medical practitioner certifies that the person making it has the capacity to take decisions related to mental healthcare and treatment when making the advance directive (1: s 6[1] [b]). The medical practitioner's decision as to whether the person has the capacity will depend on mental capacity assessment, in accordance with the functional approach adopted under Section 4 (1) of the Bill.

In this context, the Bill could have opted to provide for a supported decision-making mechanism to help the person with mental illness make an advance directive. Under Paragraph 29 (i) of General Comment 1, "The provision of support to exercise legal capacity should not hinge on mental capacity assessments; new, non-discriminatory indicators of support needs are required in the provision of support to exercise legal capacity." (16: p 7) Section 6 (1) of the Bill could be re-examined from this perspective.

The functional approach adopted under the Bill may cause another problem. Under Section 11, the Mental Health Care Board has the power to uphold, modify, alter or cancel the advance directive. One of the grounds on which this can be done is if the person is deemed not to have had the capacity to make decisions relating to his mental healthcare or treatment at the time when the advanced directive was made (1: s 11[2] [d]). Thus, even though the Bill does not deny legal capacity on the basis of mental capacity assessments, it can restrict the use of supported decision-making systems (namely, advance directives), which can result in the denial of legal capacity in some cases.

The link between mental and legal capacity can also create problems at the stage at which an advance directive is sought to be implemented, especially if mental capacity is defined in terms of a functional approach. This is because even when a person with mental illness is adjudged to have lost capacity using a functional approach, they can still express their wishes. Those wishes can be radically different from their past wishes as conveyed in the advance directive. This discussion is particularly relevant in conditions such as bipolar disorder, which is characterised by extreme mood swings (24). In such cases, it is difficult to decide which wishes are "authentic" wishes. This issue can become critical if the treatment is administered against the present wishes (whether authentic or not) of the person concerned. According to Section 5 (3), "An advance directive made under sub-section (1) shall be invoked only when such person ceases to have capacity to make mental healthcare or treatment decisions and shall remain effective until such person regains capacity to make mental healthcare or treatment decisions." Further, according to Section 5 (4), "Any decision made by a person while he has the capacity to make mental healthcare and treatment decisions shall override any previously written advance directive by

such person." Therefore, as soon as the person's ability to "understand and appreciate" is impaired, their present wishes cease to matter and their past wishes (ie those expressed in the advance directive) begin to overtake those. This happens without further inquiry into what the person really wants. At present, neither General Comment No. 1, nor the Bill provides a satisfactory answer to this ethical dilemma.

Mental incapacity law and the Rights of Persons with Disabilities Bill, 2014

Although a detailed analysis of the Rights of Persons with Disabilities Bill (PWD Bill), 2014 (25) is beyond the scope of this article, some of its relevant provisions are discussed below because they have a direct bearing on the decision-making mechanisms provided for under the Bill. The PWD Bill was introduced in the Rajya Sabha on February 7, 2014 to give effect to India's obligations under the CRPD (26). The PWD Bill was intended to replace the existing Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (PWD Act).

The PWD Bill also recognises the right of PWDs to exercise their legal capacity with the help of support, if necessary. However, Section 13 of the Bill provides for limited or plenary guardianship only of those mentally ill persons who have been declared "incapable of taking care of themselves and of taking any legally binding decisions on their own". In particular, the power of a plenary guardian extends to "taking all legally binding decisions for the mentally ill person". The PWD Bill further provides that the decisions of the mentally ill person have no binding force in law during the subsistence of the guardianship and that the guardian is under no legal obligation to consult the person or determine their will or preference whilst taking decisions for them.

The above provisions of the PWD Bill are supposed to override the decision-making models envisaged under the Bill. Therefore, a guardian appointed under the PWD Bill can make decisions on behalf of a mentally ill person without consulting them or without taking into account their will and preferences while taking decisions. Consequently, the provisions regarding guardianship under the PWD Bill can suspend the supported decision-making models proposed under it.

The provisions regarding guardianship, and especially those pertaining to plenary guardianship seem to be in direct violation of the CRPD's philosophy. These provisions strip mentally ill persons of their decision-making power, which results in the denial of legal capacity. The PWD Bill recognises 19 types of disabilities, but the provision of plenary and limited guardianship is applicable only to persons with mental illness. In that sense, the PWD Bill allows discrimination against persons with mental illness as against those with other types of disabilities. The provisions for supported decision-making under the PWD Bill might become irrelevant if the Bill is not modified to remove guardianship from its purview.

Conclusion

The Mental Health Care Bill proposes a shift from traditional substituted decision-making models to ones based on supported decision-making paradigms in mental healthcare, as required by the CRPD. As such, the Bill takes the first step towards removing a legal barrier to the full and effective participation of persons with mental illness in decisions affecting them. However, it rejects an absolutist interpretation of the provisions of the CRPD by allowing treatment without the personal consent of the patient in rare cases, and adopts a legal framework which takes account of the realities in India.

In addition to discriminatory laws, the mentally ill face huge socioeconomic and attitudinal barriers which hinder their participation in decisions affecting them (27, 28). The Bill attempts to restore autonomy in decision-making to persons with mental illness in matters related to their mental health treatment. However, this objective will not become a reality unless the existing barriers are identified and removed at the ground level.

According to a WHO report, in 2011, the mental health expenditures by the health department/ministry were only 0.06% of the total health budget (29: p 1). Further, the majority of primary healthcare doctors and nurses have not received official in-service training on mental health during the past five years, and officially approved manuals on the management and treatment of mental disorders are not available in the majority of primary healthcare clinics (29: p 2). There is thus a severe dearth of outpatient, inpatient and rehabilitation facilities to cater to India's huge population.

At present, India lacks adequate infrastructure and trained manpower to deliver mental health services of good quality (30). Supported decision-making systems will increase the burden on the healthcare sector. Even if the support is made mandatory by law, there is no guarantee that there will be enough trained staff available at the ground level to ensure the full and effective participation of the mentally ill in their treatment, healthcare and decision-making regarding their mental health on an equal basis with others. In a country like India, perhaps it would be worth recognising, strengthening and integrating informal support mechanisms in the framework of the formal mental healthcare setting to overcome the socioeconomic barriers, which is what the Bill attempts to do.

In India, the family members of the person with mental illness play a vital role in all decisions concerning their ill relative (31). If the family members are formally appointed as nominated representatives of the patient to assist in the decision-making process, they could feel empowered and could also be held accountable for their role. In the present set-up, the formal role of family caregivers is limited to making requests for involuntary admission and giving proxy consent to the patient's treatment. The Bill provides a legal framework in which it is possible to enlarge and regulate their role. It also allows mentally ill persons to appoint nominated

representatives who are not related to them. This provision can create a lot of friction between patients' relatives and their nominated representatives (2: pp 12,32). The Bill does not address this problem, but for the new law to function smoothly, it needs to be handled sensitively at the point of delivery of mental healthcare services.

The Bill has evoked contrasting reactions. Some experts have opined that it is not in harmony with the CRPD insofar as it denies mentally ill persons the autonomy to decide to leave the institution if they are not satisfied with the treatment (2: pp 9,11). On the contrary, many psychiatrists believe that the Bill, in fact, bestows too much decision-making power on the patient. Under the framework of the MHA, the psychiatric profession has traditionally played a very dominant role in patients' decision-making with regard to their treatment. The supported decision-making mechanisms introduced in the Bill attempt to restore autonomy in decision-making by patients. As such, the Bill challenges the existing power structure in the current mental healthcare set-up. There are already signs that many psychiatrists are opposed to this change on the ground that it hinders the patient's timely recovery (33). The president of the Indian Psychiatric Association (IPS) opposed the supported decision-making mechanisms in the Bill on the ground that they were alien to Indian culture. The IPS advocated a family-oriented model, in which a family member may provide substitute consent on behalf of the person with mental health issues, whenever required (2: p 12). If the Bill is to function smoothly, these attitudinal barriers need to be addressed through dialogue and sensitisation.

It is in this environment that the shift from substitute decision-making models under the MHA to supported decision-making systems under the Bill has to take place. To facilitate the transition of the mental healthcare system established under the MHA to one that would be based on CRPD's values, the Ministry of Health and Family Welfare, Government of India held consultations for three long years with various stakeholders, including caregivers, users and activists, over several drafts of the Bill (34). During this period, the authors of the Bill endeavoured to reconcile the different approaches and views of different groups of stakeholders towards substitute and supported decision-making. For all practical purposes, this reconciliation can be achieved only gradually.

However, in General Comment 1, the CRPD committee has declared in absolute terms that "the rights provided for in Article 12 apply at the moment of ratification and are subject to immediate realisation. The State obligation, provided for in Article 12, paragraph 3, to provide access to support in the exercise of legal capacity is an obligation for the fulfilment of the civil and political right to equal recognition before the law. 'Progressive realization' (art 4, para 2) does not apply to provisions of Article 12." (16: p 7) By contrast, some academics have argued that the requirements of support mechanisms laid down in Article 12 are subject to progressive realisation (35: p 8).

At present, it is hard to predict when this Bill will finally become law. It was sent to the Department - related

Parliamentary Standing Committee on Health and Family Welfare. In its 74th Report (2), the Standing Committee made many recommendations to the government. Most of the recommendations were readily accepted. The Bill has at least managed to initiate a debate around mental health issues in India. Finally, in social debates, the right questions are being asked about honouring the rights of and responsibilities towards persons with mental illness, even if the answers to those questions remain uncertain.

The CRPD requires States Parties to remove barriers to the full and effective participation of persons with mental illness in their decision-making. Of these barriers, legal barriers are the most problematic because they legitimise social and attitudinal barriers. Therefore, revising outdated mental health laws is an important step towards securing the human rights of persons with mental illness. The experience of CRPD-inspired legislative attempts, such as the Bill, can throw light on the complexities of the CRPD's mandate and the ethical dilemmas involved in the treatment of persons with mental illness. These attempts may be used by other countries while revising their own laws.

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