

## *Involuntary Admission and Legal Capacity*

The trajectory of Mrs. A's illness is an example of a case of involuntary admission and treatment, which could amount to torture and cruelty according to the Convention of Rights for Persons with Disability (CRPD). A's diagnosis of unipolar depressive disorder, shortly after the birth of her second child, met with her mental health care needs being addressed by a community centre for a long period of 20 years. However, on developing symptoms that were not the 'norm' for her, she was met with a typical medical response: even with the local mental health centre coming making three home visits, Mrs. A non-compliance to the medication was met with restraint and involuntary admission.

One of the evident issue from Mrs. A's treatment is that despite mental health care being available at the local community level, it is not a guarantee of quality mental health care, as listed in Article 25 of the CRPD. Based solely on Mrs. A's refusal to the medical treatment, she was involuntarily admitted to a general hospital. Her personhood is not considered valid for the medical dealing with her illness and her anger at this forced admission is not taken into account. It only gets worse from this point onwards; she was put under high doses of medication, her sedation was further met with restraint. Her anger which remained unaddressed was termed as another 'symptom' that justified their actions. As we see, the restraint is only removed every 12 hours and is continued for 4 days. To no surprise, the treatment results in resuscitation manoeuvres being unsuccessful and the coroner later reports thrombo-embolism of central pulmonary artery due to immobilization.

Mrs. A's case is a clear violation of Article 15 which states the freedom from torture or cruel, inhuman degrading treatment and punishment. The State Parties have taken away her right to free and informed consent to treatment and not provided for mechanisms to provide 'effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.'

This is further highlighted in the report on torture and other cruel, inhuman and degrading treatment or punishment by the Special Rapporteur, which cites many such similar instances of abuse that people with mental illness have to experience. Not only are persons with mental illness segregated from the society into institutions, mostly against their will or without free and informed consent, they are subjected various forms of seclusions and restraint. The lack of reasonable accommodation in detention facilities may increase the risk of exposure to neglect, violence, abuse, torture and ill-treatment.<sup>1</sup>

The report also reiterates an absolute prohibition of torture contained in the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, article 7 of the International Covenant on Civil and Political Rights, and article 37 of the Convention on the Rights of the Child, is reaffirmed in the Convention on the Rights of Persons with Disabilities.

According to the Article 14, of the CRPD establishes liberty and security of person by stating that the State Parties are to ensure that persons with disabilities: 'are not deprived of their liberty

---

<sup>1</sup> Mendez, J. (2008). Report of the Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment.

unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.<sup>2</sup>

The case study is also an example of Mrs. A not being permitted to access her right to live in the community, as established in the Article 19 of CRPD. While health services were being provided to her in an accessible and affordable in a community area, the services were not of a quality standard with the absence of safeguard frameworks for her protection. More importantly, the treatment meted out to Mrs. A goes against Article 12 which recognizes the equal right to enjoy legal capacity in all areas of life, such as deciding where to live and whether to accept medical treatment.

*If this scenario had occurred in the Indian context*, it would not have been very different from what Mrs. A. experienced. Even though India has ratified the CRPD, the current web of laws (since mental illness is covered in more than one law) does not recognize the right of persons with disability to have legal capacity. The Mental Health Act, 1987<sup>3</sup>, primarily focuses on the procedural issues of admission to the hospital facilities, extending itself to allow for involuntary admission.<sup>4</sup> The discharge procedure makes it difficult for even a 'voluntary' user to come out of the facility. It has also been observed that more long stay users in the facilities are determined by their socio-economic conditions and not due to their mental illness.

Our current laws adopt a substitute decision making process, and like in the case of Mrs. A, the health care providers would not have sought the support of the caregivers, the other mental health professionals she had been interacting for 20 years, to think of alternatives to her forced admission or to de-escalate her distress. Involuntary admission would have been the first resort in the Indian context with no legal safeguards or provisions to protest against this. In India, persons with mental illness do not possess civil and political rights such as the right to vote, right to marry. Assuming a lack of 'capacity', persons with mental illness are victims of 'benevolent and protective' behaviour which denies them their right over their illness and their mind and body.

*Suggestions in the legislation against involuntary admissions* would need to begin with recognizing that people with disabilities do retain legal capacity. The State needs to provide for supported decision making. The new Mental Health Care Bill is scheduled for its approval makes provisions for advance directives which are one step towards promoting supported decision making. However, the other laws such as the Disability Bill need to rethink guardianship as a provision for persons with mental illness, which takes away the civil, legal and political rights from people.

Apart from providing quality care that is affordable and accessible, there needs to a shift towards thinking away from the purely symptomatic medical model. A move towards accepting the socio-cultural basis of illness will help in community care (including housing, employment opportunities) addressing mental health care needs which need not translate to tertiary level of care.

---

<sup>2</sup> Article 14, 1b, Convention of Rights for Persons with Disability.

<sup>3</sup> <https://sadm.maharashtra.gov.in/sadm/GRs/Mental%20health%20act.pdf>

<sup>4</sup> Section 19 of the Mental Health Act, 1987: Admission of Mentally Ill Persons under Special Circumstances

Legal capacity to users of mental health care will allow for persons with disabilities to protest against involuntary admissions and have a say in their own treatment. There is a need to make provisions for the safeguard and grievance redressal at the mental health care settings. Archaic, colonial laws need to be made way for free and informed consent for persons with disability. Training mental health professionals and non-mental health care professionals into understanding the need and importance of supported decision making, legal capacity allow for reducing forced treatments.

Recognizing that there might a section of population that might not have a trusted person for supported decision making, the State needs to make provisions for the same. The legislation clearly needs to state the person's will and preference cannot be ignored and where it cannot be expressed, the person can be aided by a set of people to support their needs. The Indian context has the value of a family and caregivers who can be a part of the supportive process. However, should the person with disability opt not to have the family member as their trusted support, there should be provisions made to accommodate their needs.