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AUTISM – A SOCIO LEGAL STUDY OF MENTAL HEALTHCARE LAWS IN INDIA

SUBMITTED BY

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LIST OF ABBREVIATIONS

ABBREVIATIONS	FULL FORM
A.S.D	Autism Spectrum Disorder
AFA	Action for Autism
ABA	Applied Behavioral Analysis
CDC	Centre for Disease Control
DSM	Diagnostic and Statistical Manual
GAPH	Global Autism Public Health
GRAND	Global Research in Autism and Neurodevelopment
INSAR	International Society for Autism Research
MR	Mental Retardation
UN – CRPD	United Nations Convention on the Rights of Persons with Disabilities
WHO	World Health Organization
IMHA	Indian Mental Healthcare Act
RPDA	Rights of Persons with Disabilities Act
WHO-RB	World Health Organization Resource Book
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
KSHRC	Karnataka State Human Rights Commission
NCCMH	National Collaborating Centre for Mental Health

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INTRODUCTION

Autism spectrum disorders (ASDs) are a group of neurodevelopmental conditions that pose a serious public health challenge on a global scale. Both the patient and their loved ones suffer from the disease's hallmark social and communication difficulties, as well as the patient's confined and repetitive conduct.¹ One in every 160 children will be diagnosed with ASD, leading to 7.6 million DALYs (years of life lost due to disability).² One in every 150 children nowadays is diagnosed with autism, making it one of the most prevalent childhood diseases in the contemporary period. It's the second most common developmental impairment, behind mental retardation.³ Autism is a lifelong neurological disorder with no known cure. The presence of the three main criteria for autism spectrum disorder (ASD) at the age of three is considered mandatory for a diagnosis. Communication issues (both verbal and nonverbal) and preoccupation with restricted, repeated interests are two examples of such traits.⁴

1.1 HISTORICAL PERSPECTIVE

I. Psychiatrist Eugen Bleuler coined the word "autism" in 1908. He used it to describe a schizophrenic patient who had withdrawn into his own world. Bleuler used the term "autism" to describe an extreme form of self-admiration and isolation. The Greek word "autós," which means "self," was the inspiration for the term. Hans Asperger and Leo Kanner were early researchers on the disorder. In the 1940s, they each pursued their own projects. Kanner identified seriously afflicted individuals, whereas Asperger portrayed youngsters with exceptional abilities. For the following three decades, doctors continued to find value in their perspectives.

Leo Kanner first described autism as a developmental disorder of the brain in 1943.⁵ II. In his seminal book, *Autistic Disturbances of Affective Contact*, Kanner identified a separate population of kids who lacked the capacity to form close relationships with others, responded poorly to disruptions in their routines, and had unusual language and verbal development. Since these children's "autism" or self-centeredness was identified

¹ C. Lord, E. H. Cook, B. L. Leventhal, and D. G. Amaral, "Autism spectrum disorders," *Neuron*, vol. 28, no. 2, pp. 355–363, 2000.

² WHO, *Autism Spectrum Disorders & Other Developmental Disorders. From Raising Awareness to Building Capacity*, WHO, Geneva, Switzerland, 2013.

³ Centre for Disease Control and Prevention, 2007; Autism Society of America.

⁴ Autism Society of America, n.d.; National Institute of Child Health and Human Development, 2005; U.S. Government Accountability Office, 2005.

⁵ Jacobson et al., 1998; Corsello, 2005.

as their main shortcoming, the names "autistic" and "autism" started to be used to describe their condition. Similar patterns were quickly seen in kids all throughout the globe.⁶

- II. In order to diagnose someone with autism, experts look at their behaviour to see whether they have problems with social relationships, communication, and a variety of interests and hobbies. It's supported by the DSM-V, the manual that outlines mental disorders. Autism disease is characterised by abnormal or impaired social interaction and communication skills and by a very narrow range of interests and activities. This sickness may manifest in a broad range of ways, depending on the person's chronological age and developmental stage. Childhood autism, early infantile autism, and Kenner's autism are further names for the condition..
- III. In 1944, Hans Asperger worked alone to conduct an investigation of a group of children. His progeny were true to Kanner's descriptions. The children he interviewed, however, did not exhibit any signs of echolalia or any other kind of language delay. He also observed that many of the children lacked adequate fine motor skills and were generally awkward.
- IV. In the 1950s and 1960s, the medical community usually assumed that autism was the result of emotionally distant or indifferent parents. Mothers of autistic children have been unfairly blamed for their children's condition for decades.
- V. Some medical professionals in the 1960s started to question this belief. Dr. Rimland's 1964 evaluation of the literature firmly placed autism in the realm of the biologically based disorders. This disproves the prior argument that mothers are emotionally distant and indifferent.⁷
- VI. Little was understood about autism and what it included when it was first reported. According to Turnbull and Turnbull⁸, "early interventions were the exception, not the rule. Placement in private programs was encouraged because it relieved the school of any responsibility for serving children whose families were able or desperate enough to pay for private school opportunities." It was common practice to tell parents there was nothing they could do and suggest they place their kid in an institution that offered nothing more than shelter and sustenance.
- VII. In his study, Freeman⁹ explains the impact of this childhood diagnosis. The intensity of

⁶ Freeman, 1997, p. 641.

⁷ National Alliance for Autism Research, 2005.

⁸ Turnbull, H.R & Turnbull, A.P. (2000). Free appropriate public education: The law and children with disabilities. Denver, CO: Love Publishing Company.

⁹ Freeman, B.J. (1997). Guidelines for evaluating intervention programs for children with Autism.

the symptoms vary depending on the patient's age and developmental stage, much as with other pediatric disorders. Because of this, autism affects individuals of all ages. Although autistic traits may present themselves in varying degrees or even vanish entirely at different times, autism is a lifelong condition. The majority of people with autism will need ongoing social care owing to their disability, yet autistic people have a normal life expectancy. Freeman also discovered that the prognosis for children with autism has altered significantly since Kanner's original studies in 1943, making an early diagnosis of autism critical. An improved quality of life throughout the course of a person's lifetime is possible with early diagnosis of autism and subsequent access to suitable therapies. In addition, parents get support when their kid is given a diagnosis. Parents may now have some insight into their child's struggles and direct therapy more effectively with the help of this label.

1.2 WORLD WIDE SCENARIO

The incidence of autism spectrum disorder (ASD) has dramatically increased. ASD instances are projected to have increased significantly over the previous 40 years, reaching 52 million cases globally as of 2010.

The Queen Mother The resolution to establish World Autism Awareness Day was first proposed by Sheikha Mozah bint Nasser Al Missned, the wife of His Highness Sheikh Hammad Bin Khalifa Al Thani, and adopted by the United Nations General Assembly in 2007. On April 2, people all around the world unite to bring attention to autism spectrum disease (ASD). A panel of experts convened by the United Nations General Assembly on World Autism Awareness Day 2016 concluded that "a special place for children and adults with ASD and other neuro developmental disorders is at the core of the UN Sustainable Development Agenda and in the implementation of the Sustainable Development Goals."

Around the world, there have been several projects aimed at increasing knowledge about ASD and improving care for individuals who have the disorder.

The worldwide Autism Public Health (GAPH) effort was started in 2008 by Autism Speaks, a renowned advocacy group with headquarters in the US, with the goal of raising worldwide awareness of ASD and advancing research, education, and service provision. Several international monies have now been obtained as a result of the interest in international research

on ASD at the International Society for Autism Research (INSAR) meetings.

A resolution passed by the WHO Executive Board in April 2013 called for the treatment of ASD to be coordinated. In both Europe and North America, a number of parent advocacy organisations have grown to be quite powerful.

In July of 2014, the World Health Organization (WHO) conducted a conference in Geneva, Switzerland, that was sponsored by Autism Speaks and focused on parent skills training for caregivers of children with developmental disorders. Meetings were held at following INSAR gatherings to discuss how to improve research and services in regions with limited resources. These efforts established a bridge between the agenda for ASD and neurodevelopmental disorders with goals of combating discrimination, inequality, and the neglect of the most vulnerable members of society. In addition, Qatar is home to many promising ASD initiatives.

As a part of the Autism Europe initiative, the European Parliament officially approved the Written Declaration on Autism (written declaration, under Rule 136 of the Parliament's Rule of Procedure) in September 2015. The letter encouraged all EU countries to adopt a comprehensive, coordinated approach to meeting the immediate needs of the 5 million EU individuals affected by ASD and the difficulties they and their families face on a daily basis. Public health measures on the consequences of autism spectrum disorder and other neurodevelopmental issues are still not widely implemented outside of HICs, despite great advances in the prevention and treatment of infectious diseases. (2002) (Mohammed Elsabbagh) There is a significant knowledge gap between evidence and action in the treatment of persons with ASD and other neurodevelopmental disorders in LMICs. As a result, in 2014, international organizations in the field of child neurology co-hosted a global workshop, which was attended by representatives from 14 different African countries. One of the major consequences of this meeting was the creation of a virtual ASD network for Africa called Global Research in Autism and Neurodevelopment (GRAND). Health Care System Worldwide. Autism and Neurodevelopment Around the World. For instance, the Global Mapping Project for Autism Spectrum Disorder and Neurodevelopmental Disorders has been made possible thanks to support from the Shirley Foundation in the United Kingdom.

A National Autism Working Group was set up in 2015 inside the Ministry of Public Health. Participants include educators, administrators, psychologists, speech-language pathologists, occupational therapists, developmental pediatricians, and, most importantly, family members

from around the country. This committee's job is to create a nationwide strategy for autism by focusing on six key areas: public education and outreach; early detection and screening; diagnosis and assessment; therapies; school services; and transition to maturity. The World Health Organization was instrumental in shaping the National Autism Plan that would be implemented by the year's end. The Qatar Biomedical Research Institute (QBRI) is now undertaking the nation's first research on the incidence of ASD to better understand the demand for services, and a state-of-the-art school for children with ASD, the Renad Academy, will soon open in Qatar.

The economic impact of ASD in the United States (US) alone was estimated at \$268 billion in 2015, based on direct medical, direct non-medical, and productivity costs; this sum is expected to climb to \$461 billion by 2025.4 Individuals with ASD and other neurodevelopmental problems, as well as their loved ones and caretakers, experience major reductions in quality of life.

Autism is not presently treatable. Modern treatments aim to alter developmental trajectories favorably and direct children toward a more neurotypical outcome. Since ASD is essentially a lifelong condition, services from the social, educational, and health sectors must be integrated. While some kids and teenagers may grow up to be adults for whom the label is no longer applicable because of a perceived improvement in symptoms or a result of therapy.

1.3 INDIAN SCENARIO

When compared to the amount of literature on autism that has been published in developed nations like the United States and Europe, less is known about autism in developing nations. Over 70 papers, chapters, and books are available on the issue from India alone, making it the developing country with the most research publications. Despite the prevalence of references like "probably one of the initial attempts in Indian literature to describe and discuss" the condition, it seems that many of these publications are passing unrecognized by Indians. Smaller, unpublished studies have also been conducted, with the national autistic group Action For autistic playing a role in some of them. This section will provide a quick overview of the autism movement in India and the research conducted there. In 1944, a Viennese doctor called A. mentioned autism in the scientific literature of India. In Darjeeling, where Ronald is employed. In the same year that Kanner's seminal work was published, Ronald offered a broad

review of how to identify and address "abnormal children" across a spectrum of causes, kinds, and treatments. In 1959, the word "autism" made its debut in Indian writing, and during the course of the 1960s, it appeared in another half-dozen publications. The medical establishment knew very little about autism beyond this. A small number of clinics in India began identifying autistic children in the late 1970s. Many older adolescents and young adults who were diagnosed with autism in the mid-1990s could be traced back to only a few specialists, and those who had acquired their diagnosis prior to 1980 had done so while living overseas (Daley, 2004). Diagnosis relied heavily on the expertise of individual doctors, and institutionalized medical knowledge lagged far behind. Few people were aware of autism's existence; in fact, the illness was not even included in most medical encyclopedias until recently. Some professionals' 'awareness' of autism started to increase gradually from the early 1980s forward, at which point they were aware of the condition's presence. While experts had some familiarity with the topic, that familiarity was clouded by the mistaken idea that autism was a mental disorder or a sort of mental retardation. This is not meant to indicate that autism is 'inferior' to mental retardation or psychiatric diseases; rather, it is intended to emphasize how this mistake has stopped people with autism from receiving the therapy they need. Autism in India has had a period of increased activity beginning in the late 1980s and continuing to the present day. Like in many other nations, India's educated middle class became aware of autism with the release of Rain Man and the film's subsequent Oscar win in 1988. At around the same time, a few parents in India started spreading autism awareness by writing for newspapers, talking to schoolchildren, and organizing events. Action For Autism (AFA) was started in 1991 by a parent who, together with a few other concerned parents, saw a need to advocate for autistic children and adults and their families. Open Door was established as an autism-specific school in 1994. Action For Autism (AFA) established a year-long, full-time teacher education program in Delhi in 1994. In order to keep members updated on recent research and provide a platform for open dialogue, AFA has now begun publishing the journal Autism Network. The next step was a year of training provided by the Karnataka Parents Association for Mentally Retarded Children (KPAMRC) in 1996. In October of that year, AFA organized and led a delegation of Indian parents of autistic children to meet with the Secretary of Ministry of Welfare to advocate for autism to be included in the Persons with Disabilities (Equal Opportunities, Full Participation, and Protection of Rights) Bill. Meetings with the Joint Secretary of the Ministry of Welfare, the Minister of State

for Health and Family Welfare, and the Lieutenant Governor of Delhi occurred in the months that followed. Action For Autism and the Rajiv Gandhi Foundation began their public-awareness campaign in May of 1998. More than a thousand pediatricians registered with the Indian Academy of Paediatrics around the nation received packets of information about autism as part of this effort. The campaign resulted in a dramatic increase in referrals from pediatricians. Asha, Ashiana, Communication DEALL, Development Centre for Exceptional Children, Priyanj, and We Can are just a handful of the schools and organizations that have been serving those with autism since the late 1990s. Mumbai is home to "Forum for Autism," a parent support organization. The first in a series of ongoing programs, Action For Autism hosted a training in 1998 led by a visiting foreign specialist. In an effort to raise public consciousness of autism, a number of pieces were published in the media between 1998 and 1999. *Beyond the Silence: my life, the world, and autism* was written in 2000 by a young man with autism named Tito Mukhopadhyay from Bangalore. Between the ages of eight and eleven, Tito wrote the book that would make him and his mother famous throughout the world. In 1998, AFA reached out to the RCI to discuss the need of creating a program to educate educators on Autism Spectrum Disorders. After years of work, RCI finally offered a special education diploma in 2003, and it focused on autism spectrum disorders. Autism Society West Bengal, Jyot in Goa, CATCH in Bhubaneswar, and Pathways in Pune were just few of the newer Parent organizations for autism that had emerged at this time. There are around 20 tiny schools in India that focus on educating autistic children at the time of this writing. Due to the proliferation of online listservers, the autistic kid exodus from India has spread to dozens of nations. These landmarks attest to the rapid development of autism awareness in India over the last decade. The fields of diagnosis, therapy, education, parental participation, careers, human resource development, and law are only few of the places where progress has been made. The following status report on autism in India, albeit limited in scope, will attempt to provide readers an idea of the disorder's prevalence and social and cultural setting in India.

Getting a proper diagnosis has long been a struggle for Indian parents of children with autism. Autism diagnoses were rare before to the 1980s. Exceptions apart, most of the time it was doctors in another country that made the diagnosis for a kid. Only a small percentage of physicians, even in major cities, could correctly diagnose autism in a kid until around twenty years ago. Autism was not often discussed amongst medical professionals, and thus, many

physicians were unfamiliar with the word since it was seldom included in medical textbooks. There was usually a lot of room for improvement even in the available data on mental impairment. Many parents of children with mental retardation said they were promised by physicians that their kid will be "okay" in time, according to research compiled by the NGO Jan Madhyam in the late 1980s. In many cases, the physicians had not officially provided a diagnosis, but the campaign helped the family grasp their child's situation. Given this context, it is not surprising that many medical professionals claim to be unfamiliar with autism. Regardless, medical professionals lack the specialized training necessary to detect autism at an early stage, when treatment is at its most effective. Pressures of 'early schooling,' the trend of enrolling children as young as two and three in preschool and kindergarten, started to affect autism diagnosis in the 1980s. When exposed to other kids, developmental gaps were more apparent. It was common practice for schools to notify parents that their kid did not 'like listening to tales,' despite the widespread belief that doing so would bring them great delight. It may be noted by teachers that a certain student did not participate in group play or that he or she constantly moved about the classroom. The fact that generally developing children may sometimes show the same behavioral features that lead to a diagnosis of autism, such as delay in the development of speech, 'shyness,' irritability, and so on, may be a contributing cause to the delay in diagnosing autistic children. A parent may have brought their kid to a pediatrician because of the school's concerns, only to be told that their child was just "slow." Most people would trust the pediatrician's assessment and hope for the best. Those who don't feel pleased by this reassurance can take the unusual step of seeing a psychologist, where they might hear that their kid is "mentally subnormal." As a result, some parents would take their kid to a psychiatrist, only to be informed that their hyperactive youngster had attention deficit disorder and needs to be medicated. They may have began a revolving door of hunting for the right label for their child's condition after months of sedation and insufficient improvement. Despite the existence of institutions like the National Institute for the Mentally Handicapped in Secunderabad, the regional Spastics Societies, and Action for Autism in New Delhi, there are presently no direct connections to these groups because of India's sheer size. For recommendations, parents may ask their child's pediatrician, psychiatrist, or psychologist, read reviews online, watch television, or check the newspaper. Often, crucial time is missed before families with autistic children learn that there is a national organization dedicated to helping

them. Early intervention, especially intervention between the ages of birth and four years, has been shown to be successful in the case of autism, making an accurate diagnosis vital. Autism may be diagnosed as early as 18 months of age if medical practitioners are familiar with the diagnostic criteria. Diagnostic and Statistical Manual, Fourth Edition (DSM IV) and International Classification of Diseases, Tenth Revision (ICD 10) have harmonized their criteria for the diagnosis of pervasive developmental disorders and are now the most popular diagnostic tools used in India. Although it was not designed to do so, the CARS is often used in diagnostic settings. The child's progress in the areas of development most affected by autism, including communication, sociability, and restricted and repetitive behaviors, is the most crucial information one can acquire to aid in forming a diagnosis of autism. There is no definitive test for PDD and no one defining trait or set of behaviors that must be present to make a diagnosis. But there are other characteristics and habits that seem to be more universal. Traditionally, a group including a psychiatrist, psychologist, special educator, etc. would make an autism diagnosis. This is the case with many bigger institutions. The majority of diagnoses in India, however, are made by a single doctor. Professionals providing medical or rehabilitative treatment or training, such as pediatricians, psychiatrists, clinical or developmental psychologists, special educators, and speech therapists having expertise dealing with autistic children. Since the point of diagnosis is to provide the kid the care he or she needs, it's OK if the diagnosis comes from anywhere as long as the kid gets the help he or she needs without delay. At the moment, diagnosis is conducted mostly in urban areas and isolated regions around the nation where a qualified expert is accessible. Generally speaking, diagnosis does not apply in rural or small town settings.

Over the course of four decades, the disability rights movement (DRM) in India has grown and changed dramatically. Disabled people's rights were first advocated for in the early 1970s, although at the time, the movement was still in its infancy. There was a wide dispersion in the requests made by different organizations and people.

In the 1980s, advocates for people with disabilities began to unite under a single banner to advocate for their shared interests. During this decade, several nongovernmental organizations (NGOs) entered the disability sector, which boosted DRM efforts. The Persons With Disabilities (Equal Opportunities, Protection of Rights, and Full Participation) Act, 1995 (or PWD Act) was approved by the government after a number of petitions and demonstrations, and

it set aside 3% of government jobs for people with disabilities. As a result, 1995 is now seen as a watershed moment for the DRM, marking the start of a new age in which people with disabilities were given more representation in the workplace and in the public sphere.

The Convention on the Rights of Persons with Disabilities was established in 2006, making it a millennial initiative. India joined this treaty in 2007 by signing and ratifying it. By that time, organizations focused on disability rights were calling for a rise in the quotas set aside for people with disabilities. The Union Government of India drafted a disability law in 2012, and after minor revisions, it was introduced to parliament the following year. The Rights of Persons with Disabilities Bill, 2016 finally passed both chambers of parliament last Thursday, after been pending for more than three years. More than 26 million people in India who have disabilities are eagerly awaiting the bill's passage into law.

Prior to the 1970s, persons with disabilities were often excluded from society and treated poorly because of their condition. To put it frankly, and this may be politically inappropriate, people with disabilities in India were regarded like garbage. These individuals were often categorized as either beggars or, more positively, musicians. The system itself viewed these individuals negatively; they had no value to society and their problems were ignored as a result. There was a widespread belief that someone's crimes in a prior life were to blame for their current infirmity. Because of this absurdity, India suffered from a wide range of injustices.

In comparison, developments in the Western world at this period were swift and dramatic. After gaining traction in the 1950s, the disability rights movement in the West finally began to seriously challenge governments in the 1970s. Such needs were only beginning to surface in India. People with disabilities were not always given the respect they deserved, even in supposedly enlightened Western cultures. It had been less than 30 years since Adolf Hitler's effort to exterminate the crippled population of Germany on the grounds that he saw no economic value in them.

When thousands of World War II veterans returned home with various infirmities, a shift began in the West. The DRM may trace its origins back to these troops, and they had some measure of success in securing their rights due of the widespread respect in which combat heroes are held.

Nothing of the kind occurred in India. The majority of Indian society's aid to the country's handicapped was seen as charity rather than the provision of legal rights. It wasn't only the handicapped individual themselves who faced discrimination; their family did as well. As a

result, many families rejected their handicapped relatives, and disabled children were often abandoned in institutions. The stigma of being disabled was quite harsh.

Throughout the 1970s and 1980s, the DRM was mostly a fight between a small group of rebels and the larger establishment. Few families could or would provide for their "differently-abled" children, thus there were very few of them. Since this was never a very compelling story, the media was likewise silent on the matter.

Politicians didn't see protecting handicapped people's rights as a priority. People with disabilities were not counted as a "vote bank" since they had no say in the matter. The DRM was not led by a single person, as were the caste movements and the women's rights movements. The lack of leadership delayed the movement's progress for a long time.

People who were born with disabilities were also given a different level of respect than those who acquired their disabilities as a result of an accident. Throughout the 1970s, nongovernmental organizations (NGOs) around the country survived on grants from outside and donations from the country's wealthier citizens. Non-governmental organizations (NGOs) headed by parents or professionals dominated the disability sector. They each operated independently of one another, with no communication between them. Most NGOs exclusively served people with specific impairments, such as those who were deaf or hard of hearing, or who had intellectual disabilities.

Baba Amte, a well-known social crusader, devoted his life to helping those who were afflicted with leprosy and living in poverty. He was a major character who encouraged many others to advocate for this cause. As a consequence, more and more individuals have stepped forward to join DRM after comprehending its significance.

In the 1980s, the welfare model was replaced by the developmental model, signaling a change in the policy framework. During this time period, handicapped people who had previously been seen as charity beneficiaries were given opportunities to take part in shaping the future. At the end of the 1980s, people also started focusing on disability from a medical perspective, with the goal of reducing suffering through medical treatments, medical equipment, and technical assistance in order to make the lives of disabled people "normal." However, these ideas were only practiced by a small subset of the society that was educated, aware, affluent, and progressive.

When the United Nations declared 1982–1993 to be The Decade of Disabled Persons, the

conversation about rehabilitation's ultimate aims shifted once again. In 1986, the government of India established the Rehabilitation Council of India to oversee and standardize the country's many rehabilitation training policies and initiatives. The Mental Health Act (1987) was enacted the very following year. The Mental Health Act is a piece of civil rights law with a primary emphasis on establishing minimum requirements for inpatient care in mental health facilities.

During its whole (1941–1971), the Indian census did not inquire as to anyone's disability status. As a result, the census did not include people with disabilities until the 1980s. Unfortunately, the 1981 census only asked about three different forms of disability. Disabled people were again excluded entirely from the 1991 census. As a consequence, more and more people with disabilities in India are pushing to be counted in the next national census.

Long-term activism paid off in the form of a last-minute inclusion of a question on disability in the 2001 census questionnaire. The enumerators reported that 2.1% of the overall population is made up of PWD with just rudimentary knowledge and skills. India has officially acknowledged the existence of its 21 million PWD population. However, only five categories of people with disabilities were covered in the census, and this did not include those with mental or intellectual impairments.

The number of people with disabilities reported in the 2001 census has been widely disputed by advocates for people with disabilities for a variety of reasons, including the omission of numerous disabilities and inadequate training of enumerators in identifying people with disabilities. Despite the widespread belief that India has the highest proportion of people with disabilities in the world, the reality is that many other nations, including even industrialized ones like the United States, Britain, Australia, and New Zealand, and even some of India's neighboring countries, have a significantly larger rate. Clearly, a lot rides on the definition of impairment.

Over 26.8 million individuals in India have some kind of impairment, according to the 2011 census.

It's 2.21 percent of the total population. A total of 14.9 million men and 11.8 million women are handicapped in the nation, with 18.6 million PWD living in rural regions and 8.2 million in urban areas. Opponents of the proposed rise of PWD reservations from 3% to 5% point out that the number of handicapped persons who were born that way is declining, especially in light of medical advances, while the number of disabled individuals who acquired their disability later

in life is rising. Human traffickers abduct healthy individuals (often children) and disfigure them such that they can never work again in any capacity other than begging.

In response to these needs and those of the general public, the Union Government adopted a National Policy on Disability in 2006. Education, employment, support services, access, social security, etc. were all covered by an all-encompassing national strategy on disability.

This approach, too, required significant revision in light of the UN Convention. Disabled people's civic and political rights are little mentioned in national policy. While some Indian governments have already implemented policies to aid people with disabilities, the vast majority have not done so

MENTAL HEALTH CARE IN INDIA

It is much easier to take advantage of and violate the rights of those who struggle with mental health issues. There must be safeguards in place to protect them against abuse by anybody in society, whether it be relatives, caretakers, medical personnel, friends, neighbours, or even the police. The first step in providing care that is both compassionate and effective must begin with legislation. The human rights of the poor, the marginalised, and the vulnerable are better protected as a result. This is a sign of a culture with strong values, morals, attitudes, culture, traditions, customs, ambitions, and practises, since it demonstrates concern for the well-being of its handicapped and marginalised inhabitants. To ensure the well-being of its citizens, every society requires regulation in a number of different sectors, and mental health care is no exception.

2.1 MENTAL HEALTH IN INDIA

With a population of more than 1.25 billion, India is the country with the second-largest population in the world, behind China. According to UN projections, India's population will reach 1.5 billion by 2030, surpassing China's in 2022.¹⁰

Major depressive illness is the primary cause of years spent with a handicap in India, while anxiety is the ninth most common reason.¹¹

It is estimated that just over one in ten people in India have a mental health issue, one in

¹⁰ "United Nations Department of Economic and Social Affairs, Population Division. World population prospects: the 2015 revision: key findings and advance tables" (New York: United Nations Publications; 2015).

¹¹ "Global Burden of Disease Study 2013 Collaborators. Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013", *Lancet*. 2013;2015(386):743–800.

twenty people suffer from depression, and 0.8% have a “*common and severe mental disorder*”.¹² Mental disease affects a staggering number of people; estimates place the number of those suffering from schizophrenia at 2.5 million, bipolar affective disorder at 8.8 million, anxiety disorders at 36.8 million, and alcoholism at 13.4 million.¹³ In 2013, mental, neurological, and drug use disorders were responsible for little under 31 million disability-adjusted life years (DALY). Of them, 1.7 million were affected by schizophrenia, 1.8 million by BPAD, 11.5 million by depression, 3 million by alcohol and drug abuse, and 1.8 million by dementia.¹⁴ The highest prevalence of mental illness is seen in males aged 30-49. Only 10% of Indians with mental health issues get evidence-based therapies, despite the high prevalence of mental disease in the country.¹⁵ Due to inadequate financing for mental, neurological, and drug use diseases, treatment gaps of more than 70% exist. In 2011, India spent 4.16% of its GDP on healthcare, with 0.06% of the amount designated nationally for outpatient psychiatric services.¹⁶ When compared to the worldwide average of 6.5 beds per 100,000 people in need of mental health care, India's rate of 2.15 beds per 100,000 is much lower.¹⁷ In an effort to ensure that more individuals obtain good quality healthcare, funding is being expanded. India is implementing a variety of programs to meet this high demand, narrow the treatment gap, and reduce the DALYs lost due to mental, neurological, and substance use problems. These efforts need to be supported by clear, realistic, and robust mental health legislations.

Protecting the rights of persons who are getting mental health care is of paramount importance, and laws relevant to this field are essential to doing so. As a result, many individuals in these countries do not have access to safe, effective, person-centered mental health treatment. The effects on one's private, professional, and family life are far-reaching.¹⁸ India was a pioneer in the developing world in attempting to move the treatment of persons with mental illness from asylums to community-based therapies until the lack of established rules and regulations and a lack of community-based services made this impossible. To bring mental health legislation in line with international human rights standards, India has emerged as a global leader. Here, it is hoped that the right laws and

¹² Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, et al. National Mental Health Survey of India, 2015 2016: prevalence, patterns and outcomes. Bengaluru: National Institute of Mental Health and Neuro Sciences; 2016.

¹³ Baxter AJ, Charlson FJ, Cheng HG, Shidhaye R, Ferrari AJ, Whiteford HA. Prevalence of mental, neurological, and substance use disorders in China and India: a systematic analysis. *Lancet Psychiatry*. 2016;3:832-41.

¹⁴ Charlson FJ, Baxter AJ, Cheng HG, Shidhaye R, Whiteford HA. The burden of mental, neurological, and substance use.

¹⁵ Murthy RS. Mental health initiatives in India (1947-2010). *Natl Med J India*. 2011;24:98-107.

¹⁶ World Health Organisation. Mental health atlas 2011. Geneva: World Health Organization; 2011.

¹⁷ Murthy P, Kumar S, Desai N, Teja B. Mental Health Care in India—old aspirations, renewed hope. Report of the Technical Committee on Mental Health. New Delhi: NHRC 2015.

¹⁸ World Health Organisation. Mental health action plan. Geneva: World Health Organization; 2013.

their timely implementation would lead to effective mental health services. The World Health Organization (WHO) hopes that by 2022, half of the world's countries will have updated their mental health legislation to meet international standards. Since many countries need to update their laws dealing to mental health, India's intended amendment and its execution would be highly essential to many other countries, especially those that have also signed the UN Convention on the Rights of Persons with Disabilities (UN-CRPD). Originally published in 2006, the UN-CRPD entered into force in 2008. Since then, almost 160 countries have ratified it.¹⁹ In 2007, India formally joined the UN Convention on the Rights of Persons with Disabilities.

2.2 CHALLENGES TO MENTAL HEALTH CARE IN INDIA

International treaties like the CRPD and the ICESCR constitute "hard" international law that have legal force in the nations that have ratified them. Despite the fact that all international agreements have clearly stated monitoring systems, it must be recognised that the international community only has a limited number of measures at its disposal to make ratifying nations adhere to these accords. 'Name and shame' is a major component of monitoring, which is fundamentally voluntary. In other words, nations willingly submit to convention-based monitoring procedures.

Only if these treaties and covenants are really put into practise in nations will they actually help real people. This necessitates multi-tiered initiatives inside nations. Some nations (including India) need legislative action to incorporate convention-based rights into local law. Financial and human resources, among others, are needed to put these agreements into action. Convention implementation may need either more people or more training for the current workforce. Awareness and sensitivity training regarding the rights guaranteed by this agreement are also necessary. Concerns concerning the applicability of rights established by international agreements may arise among stakeholders and the general public. If these conventions are to be put into action and their intended beneficiaries' lives are to improve, then these issues must be resolved.

The CRPD has also brought about a 'paradigm shift' in the way people with mental illnesses are seen by society, which has important implications for mental health treatment. This paradigm shift from 'objects of charity' to 'subjects with rights' poses a serious threat to the

¹⁹ Steinert C, Steinert T, Flammer E, Jaeger S, "Impact of the UN Convention on the Rights of Persons with Disabilities (UN-CRPD) on mental health care research—a systematic review", BMC Psychiatry. 2016;16:166.

current status quo in mental health treatment. Another paradigm change, this one particularly difficult for mental health practitioners schooled in the medical model of disability, is the movement from a medical to a social perspective on impairment.

2.3 HEALTH AS A FUNDAMENTAL RIGHT

To ensure social fairness, peace, and growth; to defend individual rights; and to promote national welfare are fundamental goals of India's fundamental legislation, the Constitution. The Constitution guarantees citizens right to medical care. They are not reasonable since they violate Chapter IV's Directive Principles of State Policy (DPSP) - Articles 42 and 47.²⁰



²⁰ Part IV, Constitution of India adopted on 26th November 1948.

Art 47 - “Duty of the State to raise the level of nutrition and the standard of living and to improve public health - The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and of drugs which are injurious to health.”

The aforementioned Arts serve as guidelines for the State to follow in its pursuit of improved living conditions for its residents. It also demonstrates the state's recognition of the connection between health and factors like diet, working circumstances, and maternity leave. Although the DPSP used in the previous sentence provide strong support for the right to health, this is not, of course, a promise. Individuals need a well-defined right to health in order to have it enforced and for wrongdoers to face retribution. The right to health has been construed broadly by the Indian judicial system. By filing lawsuits in the public interest and by filing lawsuits in response to individual claims against the State for health care and other benefits. This has resulted in an extensive body of case law in India covering a wide range of health-related topics. The Supreme Court of India has ruled that all doctors, whether employed by the government or a private clinic, have a duty to provide immediate medical care in life-threatening situations.²¹ Art 21 was interpreted to include a right to health care in later instances.

- Right to health as a fundamental right in *Vincent v. UOI*²² was accepted by the apex court by the statement, “A healthy body is the very foundation for all human activities.” Because of this, it is the responsibility of the government in a welfare state to guarantee that circumstances that are favourable to a healthy lifestyle are established and maintained. In a similar vein, Art 21 places a responsibility on the state to protect the right to life of each and every individual.
- In today's society, the courts' primary responsibility is no longer to serve as the guarantors and guardians of the unalienable rights of citizens; rather, they are now now authorised to go farther and provide compensating relief in cases that fall within the public law jurisdiction.

The First landmark in the Indian human rights jurisprudence was articulated in *Rudul Shah v. State of Bihar*²² in which it was held that, “the compensatory jurisprudence for the infraction of Art 21 occurred.”

²¹ Parmanand Katara., v. UOI. AIR 1989 SC 2039.

²² Rudul Shah v. State of Bihar AIR 1983 SC 1086.

- In *Bandhua Mukti Morcha v. UOI*²³, the SC has held, “the Right to Life includes, the Right to live with dignity.”
- It is acknowledged that the Right to Health is fundamental to human life and, as such, is a crucial component of the Right to Life in *CERC v. UOI*²⁴.
- In *Francis Coralie v. Union of Delhi*²⁵, it was held, “the right to life does not mean a mere animal like existence but a more meaningful life, a life of physical and mental integrity.”
- Further in, *State of Punjab v. Mohinder Singh*²⁶, additionally, The right to health care has been described as "fundamental to the right to life." There is a violation of Art 21 of the constitution when the state government refuses to give medical assistance because there are not enough beds available at the government hospital. *Paschim Banga Khet Mazdoor Samiti v. State of West Bengal* addressed this problem of insufficient medical care²⁷. Therefore, it is of the utmost significance to protect and preserve human life. It is the responsibility of the government hospitals that are operated by the state as well as the medical officers who are working there to provide medical help in order to save human life. If a government hospital fails to give timely medical care to an individual who is in need of such treatment, this is a breach of the individual's right to life, which is protected by Art 21.
- The Court also mandated that basic healthcare facilities be furnished with emergency medical equipment. Additionally, it was decided in this judgement that the State's inability to fulfil its constitutional duty cannot be excused by a lack of funding. Similarly, in *Mahendra Pratap Singh v. State of Orissa*²⁸, the court had said, "In a country like ours, it may not be possible to have sophisticated hospitals, but definitely villagers can aspire to have a Primary Health Centre within their limitations."
“Further enhancing the timely intervention by medical professionals” has been clearly stated in *Parmanand Katara v. UOI*²⁹. It declares that all doctors, whether working for a government hospital or not, have a professional duty to provide medical care when it is needed in an emergency scenario with the necessary skills to safeguard life. The doctor's professional and ethical commitment to care for the patient has now become a requirement of law.

From what has been said, it should be clear that the Indian Constitution protects the

²³ Bandhua Mukti Morcha v. UOI AIR 1984 SC 802.

²⁴ Consumer Education and Resource Centre v. UOI AIR 1955 SC 636

²⁵ Francis Coralie v. Union of Delhi AIR 1981 SC 746.

²⁶ State of Punjab and Others v. Mohinder Singh AIR 1997 SC 1225.

²⁷ Paschim Banga Khet Mazdoor Samiti v. State of West Bengal AIR 1996 SC 4.

²⁸ Mahendra Pratap Singh v. State of Orissa AIR 1997 Ori 37.

²⁹ Parmanand Katara., v. UOI. AIR 1989 SC 2039.

fundamental human right of every citizen to the highest attainable standard of physical and mental health. The right to life is the right to a healthy, happy, and respected existence. Being an animal is more than simply a way of life. All rights not specifically enumerated in Article 19 of the Constitution fall under the umbrella of "personal liberty," which is the absence of any kind of bodily restraint on an individual. The right to health care includes guarantees of availability, accessibility, acceptability, and equality.³⁰

Right to mental health care:

A fair level of entitlement to health treatment must be provided through laws addressing mental health issues. Reasonable degree of health care means:

- a) Simple access to healthcare that is integrated with primary care and provided at the community level;
- b) Free supply of necessary pharmaceuticals - The least amount of necessary medications must be stated and made constantly and uninterruptedly accessible without charge;
- c) Acceptability: Services must adhere to medical ethics and be suitable for the client's culture;
- d) Quality - medical facilities and services ought to be high-caliber and suitable from a scientific standpoint.
- e) Accessibility of emergency care at the primary medical facility

Sadly, the law around mental health has disregarded the need of therapy. If there is no health care available, the state must provide for its citizens. The National Mental Health Programme was created in 1983 but has never been carried out. This effectively deprives millions of individuals of their basic human right to get medical treatment. Many explanations have been offered for the absence of action. Inadequate funding and a lack of political will are the two most prevalent. By establishing a legal framework for the execution and enforcement of the National Mental Health Programme's aims, mental health law may be useful. This law marks a paradigm change in the way mental health is addressed since it has the capacity to push decision-makers and others who have been unwilling to pursue the desired policy to do so.

³⁰ D. Nagaraja D, S.B. Math, "Health as a Fundamental Right: National Mental Health Programme initiative" In, MENTAL HEALTH; HUMAN RIGHTS. Eds. Prof Pratima Murthy and Prof Nagaraja

SOCIAL, ECONOMIC, CULTURAL AND RELIGIOUS **CHALLENGES OF MENTAL ILLNESS**

Being disabled is a social issue. Although ASD, like any condition, undoubtedly comes with its own unique set of difficulties or impairments, social, economic, and cultural variables significantly influence how affected people and their families perceive ASD. Additionally, as ASD influences behaviours and social interactions, societal perceptions of and responses to ASD are particularly important.

In her art piece "Fieldwork on Another Planet," sociologist Chloe Silverman explores the social construction of autism and stresses the significance of conceiving ASD in terms of the social environment in which the disease arises. According to her, "Individuals with autism whose life histories suggested the most resilience and best overall quality of life were often those who, rather than being independent, benefited from accommodations in their surroundings and a complex network of social and family supports" are among those who "are affected and most adapt in response to the disability and to an often hostile society that makes few provisions for full-time caregivers." To successfully serve persons with ASD and those who care for them, a supportive, motivating, and empowering social environment must be created.

However, stigma and a lack of knowledge can make it difficult for those with ASD and their families to get resources or feel fully integrated into their communities. On a social level, disability must be seriously addressed.

According to renowned Indian disability researcher and activist G.N. Karna, terms such as "impairment," "disability," and "handicap" are commonly used interchangeably despite their distinct meanings. The World Health Organisation (WHO) defines each of these phrases very specifically.... Disability means limits affecting, totally or partially, to satisfy the requirements of a normal person, whether such limitations are the consequence of congenital impairments or physical impairments. Alternatively, "handicap" refers to "the socially disadvantageous situation arising from the cumulative effects of impairment or disability and society's response."

In other words, disabilities (whether physical, mental, or cognitive) become severely limiting when society as a whole fails to accommodate people who live on the margins. Furthermore, if disability is a social issue, then the answers must also be social.

Although it is difficult to correctly determine the exact incidence of the illness due to its frequent under-diagnosis and under-reporting, it is believed that roughly 2 million individuals in India have some type of ASD. As in any poor country, life with ASD is difficult for many in India.

3.1 LACK OF APPROPRIATE AND AVAILABLE RESOURCES:

With the proper support and tools, many persons with ASD will surely be able to live happy lives and integrate into their communities. Proper support networks and education are essential for parents coping with the additional stress of raising a child with ASD.

It may be almost impossible for parents to have their children diagnosed, treated, or educated in many parts of India due to a lack of necessary resources, much alone find suitable support systems for themselves. While the national government has implemented programs that have ranged in efficacy to address a number of health issues, such as TB and hunger, it has not been successful in ensuring that individuals and families living with ASD are given the proper treatment.

Even while the new laws guaranteeing that parents of autistic children won't have to move for government job are good, they are just inadequate. Additionally, a disability certificate must first be acquired in order to be eligible for the few government benefits that are granted. Before acquiring a handicap certificate, children must undergo a battery of examinations at a government hospital. This waiting period might stretch for weeks or months. The whole procedure could be quite upsetting for a child with ASD.

Large mental institutions in India, which serve a small portion of the population, are the only places where there are psychiatric beds available. There are only around 35,000 psychiatric beds in India, which is woefully insufficient. There is a lot of stigma coming from these institutions. For the purpose of identifying the gaps in these facilities and the changes that have place over a decade, two assessments of mental hospitals were conducted in 1998 and 2008³¹. These reviews show that these facilities need to be improved, and coordination with

³¹ NHRC. QUALITY ASSURANCE IN MENTAL HEALTH. New Delhi: NHRC; (1999).

primary healthcare providers is necessary to enhance community mental healthcare. On the one hand, India has around 3500 psychiatrists, which is much too few for its 125 crore people. It is unfortunate that there aren't enough clinical psychologists, psychiatric social workers, or psychiatric nurses since they are essential members of the team. This has been emphasized in the WHO Atlas³² which highlights the low number of mental health professionals in India. Given the prevalence of mental illness, these numbers are cause for concern. It is estimated that there is a nationwide shortage of psychiatrists of around 77%. One psychiatrist per one hundred thousand people is the target ratio of psychiatrists to the population. The current ratio of psychiatrists to people in need is very low, at about 0.3 per lakh. Undergraduate medical students' lack of exposure to psychiatry is another significant gap. The lack of money for mental health services is another obstacle. Even though the NMHP was established in 1982, insufficient money was allocated in the three Five Year Plans that followed. A sizeable sum of Rs 280 million was only made accessible in the Ninth Five Year Plan, and it was then greatly increased to around Rs 1,900 million in the Tenth Five Year Plan. However, the corresponding State Governments did not make full use of the allocated monies. Because of the seeming indifference of governments and the lack of political will, it is difficult to reach the unreachable in the field of mental health in India. The following difficulties in mental healthcare in India were highlighted in the World Mental Health report of 2001, according to Professor Murthy SR, the former Chief Editor of the World Health Organization.:

- a. There is a significant "unmet need" for mental healthcare.
- b. The general public has a limited grasp on the idea that psychological suffering necessitates medical attention.
- c. Resistance to the use of cutting-edge medicine to treat mental illness.
- d. Public health services face shortages in mental health specialists and infrastructure.

3.2 EDUCATIONAL CRISIS:

The scarcity of supports for students with ASD is also evident in the classroom. Despite the fact that many children with ASD may succeed academically with the right help, there is a dearth of

³² WHO. MENTAL HEALTH ATLAS. Geneva: World Health Organization (2005).

resources designed specifically for them. Public and private schools often lack the resources and supports necessary to accommodate students with autism spectrum disorder (ASD).

The lack of adequate funding affects special education institutions as well. The requirements of a child with ASD might be very different from those of a kid with Down syndrome or Cerebral Palsy, yet most special educators are not qualified to deal particularly with ASD.

Many parents have stepped up to the challenge of teaching their own children and other children with ASD since there are so few suitable educational options available for this population.

Services for people with ASD are almost nonexistent, even if they are scarce for children with the disorder. Although ASD lasts a lifetime, many more opportunities close to those who have it after they are no longer in school.

3.3 DISCRIMINATION AND STIGMA:

Stigma and discrimination against those who suffer from mental illness may have far-reaching consequences, including in areas like job, education, marriage, and housing.

In order to prevent the distress that comes with the fear of rejection from family, friends, and society, people with mental illness sometimes avoid or refuse consultation or treatment from mental health experts for fear of being classified as having a mental disease.

The stigma and prejudice faced by those seeking mental health treatment have been identified as significant obstacles in a number of studies.³³

To better understand the nature, direction, and severity of discrimination reported by people with schizophrenia, a landmark study was published in *Lancet* by researcher Thornicroft and his colleagues (2009), with participation from 27 countries, including India. There were 732 people interviewed in-person for the study.

Negative discrimination, however, was reported by 47% of participants when it came to establishing or maintaining friends, 43% when it came from family members, 29% when it came to getting or retaining a job, and 27% when it came to personal or sexual relationships.

72% felt they needed to hide their illness because they feared discrimination in the workplace, training/education, and romantic relationships.

When asked whether they had ever encountered prejudice, almost a third of individuals said

³³ N.N.Wig. Stigma against mental illness. *INDIAN J PSYCHIATRY* 39:187-9 (1997).

they had feared they would..³⁴

3.4 CAUSATION THEORIES OF MENTAL ILLNESS:

Many people, both educated and nonliterate, attribute mental disease to supernatural forces. As a result, the collective worldview has a direct bearing on people's propensity to seek assistance when they need it. Lack of education on mental health and sickness is also a significant barrier to getting help for those who need it.³⁵

It is ingrained in Indian religion, culture, and tradition for those struggling with mental illness to seek spiritual solace in temples and mosques. Many factors, including ignorance, poverty, lack of education, cultural biases, and a lack of statutory community-based mental health services, might contribute to this mindset. Families of "patients" are often seen bringing them to the temple in hopes of finding a cure for them. It is very uncommon for patients and their loved ones to spend many weeks or months at the temple.³⁶ Guests are welcome to participate in temple pujas (prayer services) and other duties like as cleaning the temple grounds, watering the plants, and making offerings to the deity throughout their stay. Treatment is delayed and existing treatments are underutilised because of such blind practises. Over 90% of individuals in a 2004 research by Srinivasan and colleagues had a disease duration at initial encounter of more than 2 years, 70% had a duration of more than 5 years, and over 25% had a length of more than 10 years.³⁷ Not only does this prolong the course and poor outcome of the illness, but it also places a significant burden on the family. but it uses up the family's meagre resources trying to care for the ill.³⁸

3.5 INHUMAN RELIGIOUS AND CULTURAL PRACTICES:

A petition was filed with the National Human Rights Commission (NHRC) in August 1998

³⁴ G.Thornicroft et al. INDIGO Study Group. Global pattern of experienced and anticipated discrimination against people with schizophrenia: A cross-sectional survey. LANCET 373:408–15 (2009).

³⁵ R.S.Murthy. Mental health initiatives in India (1947–2010). THE NATIONAL MEDICAL JOURNAL OF INDIA 24:98-107 (2011).

³⁶ R.Raghuram et al. Traditional community resources for mental health: A report of temple healing from India. BRITISH MEDICAL JOURNAL 325:38–40 (2002).

³⁷ T.N.Srinivasan et al., Duration of untreated psychosis and treatment outcome in schizophrenia patients untreated for many years, AUST NZ J PSYCHIATRY 38:339-43 (2004).

³⁸ R.S.Murthy et al. Community outreach for untreated schizophrenia in rural India: A follow-up study of symptoms, disability, family burden and costs. PSYCHOL MED 35:341–51 (2005).

stating that the Sultan Alayudeen Dargah in Goripalayam, close to Madurai, was keeping people with mental illness in shackles and a small, cramped room. The Commission requested information from the local District Collector. The Collector had verified that there were around 92 mentally ill individuals residing at the Dargah, having been brought there by family members who believed in the Dargah's healing abilities.³⁹The matter was examined by the Commission in February of 1999. About 500 patients/devotees were residing on the Dargah campus, according to the report published by the Commission. Approximately 75% were Hindu and 25% were Muslim. There were chains on around one hundred patients. The inmates were housed on verandas and thatched shelters. The investigation noted that Dargahs, or institutions, where the mentally ill were chained and maintained in the hope of a religious cure existed in various parts of Tamil Nadu. The Commission therefore concluded it was necessary to have a Committee led by Dr. K.S.Mani of Bangalore investigate the situation in more depth. According to the Committee's advice,

- i. Patient treatment cannot and shouldn't resemble treating livestock. A licenced psychiatrist must be in charge of admission and discharge; the Dargah cannot be trusted with either task.
- ii. Patients' drug use should be closely monitored.
- iii. Institutionalisation should only last a short time, and there should be resources available for a rehabilitation plan, with a focus on getting enough social support from family members.
- iv. Families should get health education about the ailment and be aware of its causes rather than being allowed to leave patients in the Dargah and leave.
- v. The living circumstances in the Dargahs need to be greatly improved, and they shouldn't be permitted to stay that way.
- vi. Facilities for early diagnosis and routine treatment of mental diseases should be available in certain State regions.

The Commission evaluated and approved the Committee's report on January 3rd, 2001, and ordered the Government of Tamil Nadu to execute the recommendations right away and submit a compliance report as soon as possible. The Tamil Nadu Government's compliance was being awaited by the NHRC. On August 6, 2001, in the very same State, the Erwadi event took place. A fire at a religious institution in Erwadi claimed the lives of 28 people. Erwadi, located not far from Ramanathpuram, is home to a mosque revered by Muslims.

³⁹ <http://nhrc.nic.in/dispatch.asp?fno=538>.

People from all across the nation brought their sick loved ones here in the hopes that the Dargah's mystical abilities would restore their sanity. In the guise of 'driving out the evil spirit,' those with mental illness were often caned, lashed, and beaten over the course of the 'therapy. They spent the day shackled to trees with heavy ropes. They were chained to their beds each night. All 28 people could have fled the conflagration if they hadn't been restrained by their chains when it started. Possible outcomes that result from a lack of standards, monitoring procedures, and accountability In spite of the NHRC's advice, we remain vulnerable to calamities, as illustrated by the tragic event at Erwadi in Ramanathapuram.⁴⁰ All parties involved must work together to prevent a recurrence of this horrific disaster.

3.6 ROLE OF MEDIA

Without a doubt, the mainstream media has contributed to the rise in autism spectrum disorder (ASD) awareness. Both *Barfi* (2012) and *My Name is Khan* (2010), both from India, have protagonists who have autism spectrum disorder. Initiatives for Autism Positive portrayals of persons with ASD are definitely vital, however the authenticity and sensitivity with which these films depict ASD or disability in general is up to debate. Television has also helped spread the word about autism spectrum disorder. The Indian talk show "Aap ki Antara" set aside three minutes at the conclusion of each episode to have families of children with autism spectrum disorder (ASD) discuss their experiences. Initiatives for Autism Of course, certain social or economic groups may gain the most from such information, but they are less likely to be reached by mainstream media like cinema or television. Although there has been a rise in public understanding of ASD, it has been gradual, and much more work still to be done.

⁴⁰ Erwadi Tragedy. Appendix-H. in S. P. Agarwal MENTAL HEALTH; AN INDIAN PERSPECTIVE 1946– 2003. Directorate General of Health Services, Ministry of Health & Family Welfare, India (2004).

LEGAL PERSPECTIVE AND PROVISIONS

It is possible, and perhaps even likely, that people with mental illness are more vulnerable to being abused and having their basic rights violated. A safeguard must be in place to reduce their susceptibility to abuse at the hands of loved ones, caretakers, professionals, friends, other citizens, and law enforcement. Legislation is an essential first step towards ensuring universal access to high-quality, affordable health care that is delivered promptly and with compassion. It also helps protect the rights of marginalised groups and those who are otherwise powerless. Respect and care for the disabled and the disadvantaged are hallmarks of a civilised society, as are morality, culture, tradition, aspiration, and practises. The primary goals of mental health law should be to protect, advance, and improve the lives and mental health of its residents. The importance of mental health treatment is bolstered by the indisputable fact that all societies need laws in a variety of areas to ensure the security of their citizens.

4.1 LAW AND POLICY RELATING TO MENTAL HEALTH CARE IN INDIA

Mental health care legislation is an area of law that focuses on the requirements of persons with mental illness or at risk for developing one, as well as their carers. The scope of this includes both areas of common law and statute law. Rules for mental health care should include not just treatment but also promotion and rehabilitation. Thus, legislation is needed to end discrimination against those who suffer from mental diseases. Discrimination has far-reaching effects, takes various forms, and is pervasive. Stigma and prejudice may be barriers not just to receiving proper medical care, but also to other elements of one's life, including employment, education, marriage, and housing. Due to these restrictions, it may be more difficult for such people to integrate into mainstream society, which may make them feel more alone and exacerbate their symptoms.

The laws governing mental health across the globe are examined in order to take into account the numerous suggestions and guidelines, and they primarily address:

- a. The rights of those who are mentally ill (including the right to care),
- b. The standard of care
- c. The use of financial and administrative cost-control methods, as well as consumer

engagement and input in the organization and planning of mental health services.

There are two approaches to mental health legislation:

- a. An all-encompassing single-legislation strategy for addressing people with mental illness
- b. A scattered approach is one that doesn't use a single law but instead puts mental health measures into other laws that are relevant. For instance, general laws about health, jobs, housing, and criminal justice may include mental health-related rules.

In India, the overall approach to regulations governing mental health is a bit unclear. India has several medical legislation as well as a scattered approach. When comparing the three strategies—comprehensive, scattered, and mixed—the mixed strategy seems to be superior to both the comprehensive and the dispersed method. A comprehensive single legislation could encourage stigma and discrimination, but fragmented systems may make it impossible to adequately address all rights and legal concerns relevant to individuals with mental disorders. The complexity of law may be difficult for people to explain and comprehend in a scattered manner. However, the integrated method efficiently addresses significant concerns in one comprehensive law, including as admission, treatment, discharge, research, and guardianship, as well as other pertinent topics in different other laws

4.2 INDIA'S MENTAL HEALTH LEGISLATION:

Three Acts pertaining to mental health were approved by the British colonial administration in 1858, establishing the country of India's first mental health law:

1. “The Lunacy (SCs) Act,
2. The Lunacy (District Courts) Act and
3. The Indian Lunatic Asylum Act.”

Mental health care legislation is an area of law that focuses on the requirements of persons with mental illness or at risk for developing one, as well as their carers. The scope of this includes both areas of common law and statute law. Rules for mental health care should include not just treatment but also promotion and rehabilitation

Thus, legislation is needed to end discrimination against those who suffer from mental diseases. Discrimination has far-reaching effects, takes various forms, and is pervasive. Stigma and prejudice may be barriers not just to receiving proper medical care, but also to other elements of one's life, including employment, education, marriage, and housing:

1. “it gave more emphasis to legal consideration rather than medical care;
2. its position on the family was criticized; and
3. it failed to make provisions for home-based treatments, among other matters.”

Additionally, the 1987 Act did not comply with the UN-CRPD when it was issued in 2006 from the standpoint of international law.

As a result, India recently updated its mental health laws with a much-anticipated new law. The Mental Healthcare Bill, 2016, was overwhelmingly approved by the Rajya Sabha, the upper chamber of the Indian Parliament, on August 8, 2016. The stated aim of the Bill was “to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfill the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto.” This has now been adopted as the IMHA which received the assent of the President on 7 April, 2017.

4.2.1 IMPLICATIONS OF LEGISLATION

In India, there have been considerable improvements in the laws governing mental health. These accomplishments include laws, customs, and precedents. Legislations with direct implications (extensive coverage) and those with indirect implications (only pertinent subjects are addressed) may be distinguished.

Those legislations which have **direct implications** on persons with mental illness are:

- a. “Mental Health Act, 1987 (Mental Health Act, 1987)
- b. Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation Act, 1995 (Persons with Disability Act)
- c. National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 (National Trust Act, 1999).”

Legislations which have **indirect implications** on persons with mental illness are as follows:

- a. “Narcotic Drugs & Psychotropic Substances Act, 1985 (NDPS 1985)
- b. Rehabilitation Council of India Act, 1992 (RCI 1992)
- c. Human Rights Act 1993 (HRA 1993)
- d. Juvenile Justice (Care and Protection of Children) Act, 2000 (JJA 2000).
- e. Protection of Women from Domestic Violence Act, 2005 (DMV 2005).”

Procedures under the criminal and civil codes, the Indian penal code, and case laws all play significant roles in preserving the rights of people with mental illnesses, both directly and indirectly.

Although the aforementioned laws claim to preserve and advance human rights, they fall short of what is necessary in practise. These laws are difficult to apply because of many flaws and obstacles.

4.3 PERSONS WITH DISABILITIES ACT, 1995

When it finally went into effect on February 7, 1996, the Persons with Disabilities Act (Equal Opportunities, Protection of Rights, and Full Participation) 1995 (Act 1 of 1996) had been enacted by both chambers of Parliament on 22nd December 1995.

The 74 total provisions of this Act are divided into 14 chapters.

The passage of this law marks a watershed moment and is a giant leap forward in the fight for disabled people's rights and their inclusion in every aspect of national life and progress. Education, employment and vocational training, job reservations, research, and the building of a human resource pipeline are all covered by the Act, as are other preventative and promotional components of rehabilitation. It also includes provisions for the handicapped, such as insurance for disabled employees and the building of accessible housing for those who need it most. Mental illness-related impairments have been recognised, although they still do not have the same rights as other disabilities. The idea of amending this law has been actively discussed.⁴¹

Critical Evaluation: The Individuals with Disability Act, (PWD 1995) was created to guarantee that individuals with disabilities are not discriminated against, that their rights are upheld, and that they may take part completely in all aspects of society. It is generally

⁴¹ <http://www.un.org/disabilities/countries.asp?id=166html>

believed that the prevalence of mental problems in the Indian population, which is estimated to range from 6-15%, significantly increases the chance of serious impairment. Disorders of the mind account for half of the top 10 causes of disability, including serious depression, alcoholism, schizophrenia, bipolar affective disorder, and obsessive-compulsive disorder. Any family might be hit hard by the loss of a breadwinner due to mental illness.

The already challenging lives of people with mental illness are exacerbated by the increased poverty prevalence among them. The promised mental health and social services, however, have not been provided.

By recognising persons with disabilities as "subjects" with rights and the ability to express those rights, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) symbolises a "paradigm shift" in worldwide views and practises towards people with disabilities.

After signing the CRPD in March 2007, the Republic of India approved it in October 2007. India must respect the convention's guiding principles on a global scale. As a result, the PWD Act, 1995 has to be revised quickly to conform to the CRPD.

In a nation like India, mental health care is not a top priority for the government. Disability law is crucial in protecting the rights of people with mental illness. The main goal of this law is to ensure that people with disabilities have the same rights as everyone else, and even more. It is also essential in regulating the conditions under which people with mental health problems get treatment and protecting their human and constitutional rights.⁴²

Discrimination with regard to employment: Chronic mental illness causes an invisible handicap that has a significant negative effect on family members and the community. Policymakers discriminate even when it comes to mental illness and employment. On the one hand, they acknowledge that disability is a result of mental illness. On the other side, people also think they won't be able to do anything if there is a high degree of mental impairment. There are no accommodations for people with particular mental disabilities under the PWD Act. The PWD Act must be changed in order to treat people with mental illness properly; otherwise, the legislation fosters discrimination.

Rehabilitation of mentally ill patients: For more than 30 years, the WHO, the UN

⁴² D. Nagaraja D, S.B. Math. "Health as a Fundamental Right: National Mental Health Programme initiative" In, MENTAL HEALTH; HUMAN RIGHTS.

Convention on the Rights of Persons with Disabilities, as well as many other international organisations, have promoted community-based rehabilitation.⁴³ Unfortunately, despite its importance, mental health patient rehabilitation has received little attention.

Dual registration: The Mental Health Act of 1987 regulates institutions that provide mental health care, including mental hospitals, psychiatric nursing homes, private general hospital psychiatry centres, and convalescent homes (rehabilitation centres). The basic requirements for convalescent institutions that prioritise rehabilitation and community reintegration should be the same as those for mental hospitals that specialise in the treatment of severe mental illness and disruptive behaviour. The Mental Health Act of 1987 and the Disability Act of 1995 both require these facilities to register and get licences. Due to the need for dual registration, no new facilities for mental health rehabilitation may be established. Therefore, it is crucial that they each have their own definition under the Mental Health Act, and that the applicable minimum standards be set in accordance with the kind of therapy they provide.⁴⁴

Lack of rehabilitation centers for persons with mental illness: Each state should create at the county level halfway houses, vocational training centres, social skills training centres, cognitive retraining centres, childcare facilities, and long-stay institutions for the aim of providing rehabilitation for individuals with mental illness.

Certification of the disability for mental illnesses: As per the gazette notification, disability certificate can be issued for any mental illness.

In several Indian states, disabled people's eligibility for assistance is determined in part by how much money they bring in each year. Disabled people's rights should not be contingent on their capacity to earn a certain amount of money, hence this barrier must be eliminated.

The Disability Act should set a timetable for both medical experts granting certifications and government agencies delivering promised aid. It's important to make it clear why you're not qualified to get a certificate.

⁴³ S.B.Math, C.N. Maria. Stigma haunts persons with mental illness who seek relief as per disability act 1995. INDIAN JOURNAL OF MEDICAL RESEARCH.134;128-130 (2011).

⁴⁴ <http://siteresources.worldbank.org/DISABILITY/Resources/2806581172671461088/CommunityBas>

By expanding its coverage to include people with mental illness, the PWD Act, 1995 became a watershed piece of legislation at the time. In order to safeguard, promote, and fulfil the Rights of people with mental illness, however, the aforementioned problems must be addressed as soon as possible by suitable changes. The PWD Act of 1995 falls well short of the requirements of the UN Convention on the Rights of Persons with Disabilities (UNCRPD). Therefore, in 2009, the Ministry of Social Justice and Empowerment began the process of modifying the PWD Act, 1995.

4.4 THE RIGHTS OF PERSONS WITH DISABILITIES BILL, 2014

A committee, led by Smt. Sudha Kaul, was formed to write a bill to alter the Persons with Disabilities Act of 1995. The 2011 Legislative Draught was handed in to the Ministry. Then, the Draught was sent to the appropriate Cabinet departments and eventually made its way to the individual states. It was introduced in the Rajya Sabha on February 7, 2013 by Minister of Social Justice and Empowerment Mr. Mallikarjun Kharge.

1. “The Persons with Disabilities (Equal Opportunities, Protection of Rights, and Full Participation) Act of 1995 is repealed by the bill. The purpose of the Rights of Persons with Disabilities Bill was to formalise India's commitments under the UNCRPD.”
2. “This bill tries to make a paradigm shift from:
 - a. Charity model to Rights based model and
 - b. Medical model of disability to Social model of disability.”
3. A "person with disability" is defined under the law as an individual who has a mental, physical, intellectual, or sensory impairment that substantially limits his or her capacity to fully and equally participate in society. (Bill, 2014) Disabled People's Legal Protections. The bill also broadens the scope of what constitutes a handicap to include 19 different medical issues:
 1. “autism;

2. low vision and blindness;
3. cerebral palsy; deaf blindness;
4. hemophilia;
5. hearing impairment;
6. leprosy;
7. intellectual disability;
8. mental illness;
9. muscular dystrophy;
10. multiple sclerosis;
11. learning disability;
12. speech and language disability;
13. sickle cell disease;
14. thalassemia;
15. chronic neurological conditions; and
16. multiple disability.”

People who have at least 40% of any of the aforementioned impairments are considered to have benchmark disability.

The proposed legislation guarantees that people with disabilities will not be treated differently because of their impairment. Disabled people have the right to be safeguarded against cruel or degrading treatment, as well as to receive equal protection and safety in times of danger, armed conflict, humanitarian catastrophes, and natural disasters.

Within five years after the National Commission for Persons with Disabilities formulating laws, all currently constructed public buildings must be made handicap accessible. No business will be permitted to erect a structure, get a completion certificate, or be permitted to inhabit a building if it does not comply with the rules established by the Commission.

The Bill opens up opportunities for persons with disabilities in areas such as general

education, vocational education, and business ownership. All government-funded universities and those receiving government funding must set aside at least 5% of their seats for students with qualifying impairments.

Both the national and state governments must designate positions in organisations under their control as being reserved for people with standard disabilities. Persons or groups of people with at least 40% of any disability must occupy at least 5% of the available positions.

According to the Bill, the reserve must be calculated based on the total number of openings in a cadre's strength.

The measure also covers and takes into account legal capacity in order to comply with UNCRPD Art. 12 of the Convention. Equally as with all other people, people with disabilities have the right to own, inherit, and manage real estate as well as their financial affairs.

Additionally, specific guardianship arrangements are developed for people with mental disease. According to the Bill, a district court may provide guardianship to a mentally ill individual if it determines the person is incapable of caring for himself or making legally binding judgements. Additionally, the guardianship's nature is described.

The bill also prohibits undergoing any medical operation that results in infertility on a person with a handicap without that person's free consent.

The Bill requires the federal and state governments to create, respectively, the National and State Commissions for Persons with Disabilities.

Experts will make up the Commissions, and they will have to

- (i) note any laws, regulations, or plans that go against the Act;
- (ii) look into issues involving the denial of protections and rights applicable to people with disabilities,
- (iii) keep an eye on how the Act is being put into practise and how the money that governments provide to help the handicapped is being used.

When comparing the UNCRPD with the Rights of Persons with Disabilities Bill, 2014, it is evident that the bill's drafter went above and above to be inclusive and to comply with the CRPD's requirements.

4.5 THE RIGHTS OF PERSONS WITH DISABILITIES ACT 2016 (RPDA)

The Persons with Disability Act (1995), which the IMHA amended, was superseded in 2016 by the Rights of Persons with Disabilities Act (RPDA). The President of India approved the RPDA on December 27, 2016, and it, like the IMHA, makes it clear that its goal is to implement the UN Convention on the Rights of the Child.

People with mental illness have legal protections for many of their social and economic rights, and the RPDA, which is supplementary to the proposed IMHA, codifies such protections. Respect for difference and acceptance of people with disabilities as part of human diversity and humanity, equality of opportunity, accessibility, equality between men and women, respect for the evolving capacities of children with disabilities, and respect for the inherent dignity of all people are all emphasised.

Two main concerns have been raised about the RPDA.

1. First, in several crucial ways, it seems to be out of sync with the IMHA.
2. Secondly, it is debatable whether the RPDA's broad character permits it to handle the unique difficulties caused by mental illness.

The IMHA doesn't directly address many of the social rights or discrimination issues stated in the UN-CRPD or the WHO Resource Book on Mental Health, Human Rights, and Legislation (WHORB), which supports this criticism.

4.6 NATIONAL TRUST FOR WELFARE OF PERSONS WITH AUTISM, CEREBRAL PALSY, MENTAL RETARDATION AND MULTIPLE DISABILITIES ACT, 1999

A national organization for the welfare of persons with autism, cerebral palsy, mental retardation, and multiple impairments must be established, according to NTA 1999. There are 36 parts and 9 chapters in this Act.

1. The Act mandates:
2. promotion of care-related policies,
3. Protection of those with certain impairments in the case of their parents' death,
4. methods for appointing trustees and guardians,
5. assistance to recognized groups that provide the families of the handicapped need-based services during times of hardship.

Where individuals with intellectual, severe, and numerous impairments are unable or unwilling to advocate for themselves, this Act promotes and supports the development of Parent's Associations..

The appointment of guardians for the care and proxy decisions of the incapacitated has been cited as a major criticism of the National Trust Act. This debases the individual and runs counter to the objective of promoting their empowerment, equality, rights, and full involvement. While it's true that everyone should have the freedom to make their own choices, it doesn't imply they don't need any kind of guidance or support. Making a choice should be more of a "shared" or "assisted" or "informed" affair. Patients are more likely to feel empowered when they have both ownership and accountability (in the form of guardians). No way is this a kind of delegated "decision making." Providing protection/care/support in the absence of family member(s) is unquestionably a benefit to mentally ill patients and their family members.

The provision of assistance for those with mental illness under this statute, however, met with opposition. It was suggested that people with mental illness consult the section of the Mental Health Act of 1987 titled Judicial Inquiry into the Possession of Property, Custody of the Person, and Management of Property by a Person Suspected of Having a Mental Disorder.

Compared to the NTA1999, procedure, the guardianship process under this act is exceedingly time-consuming and requires a lengthy, unpleasant court process. Therefore, the Mental Health Act must be appropriately updated if people with mental illness are to be included under the National Trust Act.

4.7 THE MENTAL HEALTH ACT, 1987

The Indian Lunacy Act, 1912 was replaced by the Mental Health Act (MHA), which was passed in 1987 and went into effect in 1993. It's been described as”

“An Act to consolidate and amend the law relating to the treatment and care of mentally ill persons, to make better provision with respect to their property and affairs and for matters connected therewith or incidental thereto.”

THE CHALLENGES IN MHA, 1987

Hospital Standards: The Mental Health Act (MHA) is proactive in its pursuit of optimal

minimum criteria for mental institutions, but its implementation is constrained by a lack of funding. The current situation makes it impossible to have only one certified psychiatrist on staff for every 10 beds. Individuals who do not need hospitalisation but who nevertheless cannot be cared for at home may be placed in a convalescent home. In contrast, the terms "convalescent home," "psychiatric hospital," and "psychiatric nursing home" are all used interchangeably in the MHA. This means that the same basic requirements for psychiatric facilities also apply to rehabilitation centres. Because of the difficulty in maintaining these ideally low standards, individuals working in nursing homes and rehabilitation facilities have voiced their displeasure. The art piece "Rights body raids drug rehab centre" was featured in the March 28, 2012 issue of the Deccan Herald. A former police sub-inspector claimed he was kidnapped and "detained" at a drug rehabilitation institution in Bangalore, prompting the Karnataka State Human Rights Commission (KSHRC) to conduct a search. The KSHRC police conducted a search warrant at the rehabilitation centre after receiving a complaint. The KSHRC team discovered approximately 54 individuals during the raid, all of whom were living in a single, undersized home with no access to basic services. However, officials at the Centre insist that all of the residents there freely checked themselves in to overcome their substance abuse and alcoholism.

S.R. Nayak, head of the Karnataka State Human Rights Commission (KSHRC), led a team that stormed Sumana Social Service Centre⁴⁹, an alcohol and drug rehabilitation clinic run out of a chicken farm in Avalahalli, Bangalore. Three farm buildings held over a hundred individuals, mostly women and children, and some of them claimed to have been beaten, undressed, and humiliated. The inhumane conditions of the center's management and administration were exposed in the raid. There were maybe sixty individuals sharing a bed. The facility's prisoners shared a single "unhygienic" lavatory. It would have been impossible to keep animals in such conditions. Some of the prisoners spent more than three years inside the facility. No qualified medical professionals or mental health professionals were available to help them. In violation of the Mental Health Act of 1987, it also housed people with mental illness.⁴⁵

Unfortunately, there are very few de-addiction and mentally ill rehabilitation centers across the country run by the government. This leaves the people helpless and hopeless too as a significant proportion of private rehabilitation centers are reported to be notorious for making profit at the cost of human rights and values.

⁴⁵ Torture at rehabilitation centre. Available online at <http://archive.deccanherald.com/Content/Nov122008/city20081112100326.asp>

Exclusion of government mental hospitals: Government mental institutions are not eligible for MHA licenses, and MHA does not enforce the minimal requirements at these facilities. This is a significant flaw in the Act. Many public interest lawsuits have been filed against government hospitals due to their subpar quality of care.⁴⁶ Therefore, it is important to think about the impoverished patients of these government mental institutions and the situations they face. The National Human Rights Commission's 1999 study, titled "Quality Assurance in Mental Health," provides a clear explanation of this. However, the National Human Rights Commission (NHRC) now has responsibility for overseeing and improving government-run mental facilities.⁴⁷

Review procedure under MHA 1987 for involuntary admission into closed ward: The Indian Constitution is the highest law of the land, and it protects the rights of all Indian people. No individual should be deprived of his or her life or personal liberty, unless in accordance with 'process provided by law,' as stated in Article 21, Right to Life and Liberty. Therefore, if there is no "procedure established by law," placing people with mental illness in a locked ward is a breach of their right to life and liberty at any facility where this occurs. Current MHA (1987) review and appeal procedures place mentally ill individuals in the path of the court system, which is already stretched thin.

Only in accordance with the law, and without being arbitrary, unjust, or irrational, may limitations be placed on basic freedoms. Only the "procedure established by law" may be used to violate Art 21 (Right to life and personal liberty). The law must be just, fair, and reasonable, and the legal process must be scrupulously adhered to.⁴⁸ An incident, where a reception order was issued without proper examination caused severe distress to a French citizen in Tamilnadu.⁴⁹ Roger Vandenbyvanghe, 61, arrived in India in January 2008. When he first arrived, he could never have imagined that the cops would make his life so terrible. In order to get Matha Amritandamayi's blessings, he traveled to India. His visa and passport were in good standing. The expiration date of his visa was 6.8.2008. He misplaced his clothing, personal papers, and other items, including his passport. He was monolingual in the French language. He also had trouble talking to other people. The lanes of Kanyakumari District have become his own maze. He was penniless and had to rely on charity to survive. At the same time, the District Collector of Nagercoil summoned a conference after learning

⁴⁶ Human rights panel raids alcohol rehabilitation centre'. Available online at <http://www.hindu.com/2011/03/09/stories/2011030967470300.html>

⁴⁷ Deccan Herald, published on March 28, 2012 an Art titled 'Rights body raids drug rehab centre' Available online at <http://www.deccanherald.com/content/144346/rights-body-raids-drugrehab.html>

⁴⁸ Gopalan A.K., v. State of Madras. SCR 88. 1950. ; Maneka Gandhi., v. UOI. AIR 1978 SC 597.

⁴⁹ 49Nathalie Vandenbyvanghe v. The State Of Tamil Nadu, 2008 (Madras High Court).

that people with mental health issues were being seen at transit hubs like train stations and bus stops without any official reception orders being in place. Those with mental health issues in Nagercoil Town and Kanyakumari Township were discussed, and a plan was made to safely transport them to the Institute of Mental Health in Ayanavaram, Chennai.

The police in Nagercoil, Tamil Nadu, encircled 115 people on July 9, 2008, filing complaint Cr.No.800 of 2008 under Section 23 of the Mental Health Act, 1987. The 115 patients that were brought in front of the medical team included the French national in question. The medical staff confirmed that he was manic-depressive (Mood Disorders). Certificates of comparable kind were given for the remaining 114 people.

Form-5 was also used to deliver the reception orders. All 115 patients were transported to Chennai per the reception instructions and checked at the Institute of Mental Health in Kilpauk.

The detenu was placed under surveillance for a week. According to the Institute of Mental Health's observation report from Chennai-10, Mr. Roger Vandenbyvanghe did not show any signs of abnormality or psychopathology during the whole ten-day observation period.

His daughter became concerned when dad failed to return to his own country before the visa's expiration date. The French embassy told her that her father had been admitted to the Mental Health Institute in Chennai when she inquired about him. The petitioner was taken aback by the news since her father did not suffer from mental illness. So, she flew to Chennai to bring her dad home with her. Her attempt to have her father released from the hospital was denied. Her father, she said, was being held against his will by the medical staff. This habeas corpus petition was submitted by her as a result.

The Madras High Court was unhappy with how the police, the medics, and the learned judicial magistrate handled this group that seemed to be powerless but was nonetheless entitled to human rights protections. Medical certifications and reception orders issued by the learned Judicial Magistrate were criticized by the High Court.

The court said that people with mental illness have the same rights to a dignified existence and to the protection of the law as everyone else. Some lower-level judges may be under the impression that only procedural law is binding in their courts. The time has come for them to alter their perspectives. They were equally responsible for ensuring the plaintiffs' constitutional rights were upheld. Their regular duties must not conflict with their legal responsibilities under the Constitution. "It is evident that on the part of Judicial Magistrate No.II, Nagercoil, he had not applied his mind to examine the persons produced before him

under Section 24 of the Mental Health Act, 1987, but had mechanically passed the reception orders," the court said.

Detenu Mr. Roger Vandenbyvanghe was ordered released by the court. Regrettably, only the courts may hear appeals of decisions made under the Mental Health Act of 1987. It's common knowledge that legal proceedings are time-consuming, expensive, and tiresome. Patients at psychiatric facilities lacked ready access to any of the MHA's required review processes.

Therefore, it is fair to characterize the involuntary admission mechanism outlined in the MHA (1987) as arbitrary and unreasonable. This is a major flaw in the law.

Failure of implementing system in MHA: Numerous times, concerned family members have gone to the local police station to ask for assistance in getting a troubled individual to the hospital. Without giving them a second consideration, their demands are disregarded. Finally, vulnerable family members are sometimes compelled to report the mentally ill person for minor offenses like assault, property damage, theft, robbery, and so on. In such cases, law enforcement officials detain the mentally ill individual, file a FIR for the minor offence, and detain them in court custody for an extended period of time without providing any treatment⁵⁰. The existing MHA 1987 makes it incredibly difficult to get a reception order.

Guardianship of mentally ill patients: A person of unsound mind may be unable to take care of his own financial and legal matters. Therefore, the MHA allows for the appointment of guardians for those with mental illness and a manager to handle their property. This regulation, however, is too strict and complicated. This problem has to be simplified and dealt with in the same way that the National Trust Act of 1999 does.

Licensing authorities: The MHA does not specify the expertise or credentials of the inspector. For this reason, it must be revised such that a medical practitioner, and ideally a psychiatrist, serves as the licensing authority conducting inspections.

Mental Health Authority: Twenty years after the MHA 1987's passage, only five of the country's fifty State Mental Health Authorities are fully operational. Lack of human and financial resources is the primary cause of non-implementation. When it comes to the distribution of funds for Mental Health Authorities, there is either no mechanism in place or MHA remains mute.

Poor knowledge and implementation: The fact that not all members of the court and law enforcement are familiar with its existence is one of the key reasons why the MHA is not being fully enforced.

⁵⁰ Sheela Barse., v. UOI. 1995 SC.

The officer in charge of a police station is responsible for safeguarding anyone within the station's jurisdiction whom he or she has probable cause to believe is dangerous due to mental illness and for making the necessary arrangements for the admission of stray mentally ill patients to a mental hospital. There is little hope for a turnaround in the situation very soon in the absence of concerted efforts to raise public awareness. Human rights and mental health advocacy are therefore still a pipe dream for the mentally ill.

UNADDRESSED ISSUES BY MHA, 1987

Substance Dependence: Children, individuals with substance use disorders that cause significant behavioral abnormalities, and incarcerated people are all eligible to be treated at specialized mental hospitals and psychiatric nursing homes. Family members of addicts often push for their loved ones to get treatment and rehabilitation against their will. However, there is no mention of admitting and treating those with chemical dependency who reject treatment due to a lack of behavioral change in the MHA's guidelines.

Death of mentally ill patients inside the hospital: Death rates are higher for those with mental illness than the general population. Suicide rates are around ten times as high among those with mental health issues like depression or schizophrenia as they are among the general population. However, MHA does not deal with the problem of a patient dying while in custodial care for mental illness. Understanding the circumstances and resources available in these mental institutions is essential before making any decisions about the death of mentally ill persons.

Psychiatric Emergency Services: Unfortunately, MHA (1987) does not include any standards for the provision of ambulances for emergency crisis intervention to assist families caring for a family member with a mental illness. When faced with a mental emergency, many primary care physicians are hesitant to treat or act. Such patients are often sent to higher institutes without even conducting an examination.

The Supreme Court of India has ruled that all doctors, whether employed by the government or a private clinic, have a duty to provide immediate medical care in life-threatening situations.

Choice of treatment: When a very sick patient declines well-established treatment procedures like medicine or modified electroconvulsive therapy (ECT), MHA (1987) is silent on the permission for treatment and the approach to be used. For patients who are unable to provide permission, several institutions have developed their own policies, which may be challenged in court. Involuntary admittance is different from forced treatment. It is necessary

to define forced therapy and to detail its practice.⁵¹

Media and mentally ill patients: The media, including television, movies, newspapers, and so on, continue to exploit people with mental illness for sensationalist purposes by depicting them as dangerous, violent, a serial murderer, stupid, criminal, or caricatures. Stigma and unfavorable public opinions persist in part because of such portrayals. This derogatory portrayal of anyone with mental illness ought to be prohibited and punished. There is no mechanism in MHA for punishing those who do such severe harm to the mental health of the general public.

Non Inclusion of Complimentary Alternative systems and Faith healing centers: According to the epidemiological data that is currently available, between 0.6 and 1.2% of people who are severely mentally ill need to be institutionalized or receive inpatient treatment, and between 6 and 7% need professional mental health help at any one time. A severe bed shortage has been caused by the nation's 40,000 mental institutions. As a consequence, individuals have turned to faith healing clinics and religious healing facilities for assistance with issues including ghost possession, demon possession, karma, and more. By teaching and training them, there is an urgent need to create an innovative paradigm that integrates complementary alternative systems and faith healers into the mainstream of delivering mental health treatment.

On the one hand, MHA struggles to meet the requirements in mental institutions. The rights of people with mental illness are being violated, however, by uncontrolled complementary alternative systems, faith-healing facilities, and religious healing institutions. Examples include the recent burning to death of mentally ill persons in Ramanathapuram's Erwadi after the thatched shelters in which they were tied caught fire⁵³. The public and private sectors must thus work together to provide long-term care for people with mental illness for the simple reason that governmental organizations cannot possibly provide for the demands of such a large population on their own. Therefore, for the long-term treatment of mentally ill patients, the minimal norm should be modified and new criteria should be developed in collaboration with private psychiatrists.⁵²

States' responsibility for caring for persons with chronic resistance to treatment:⁵³ State governments have not yet set up any long-term care facilities for those who have shown persistent resistance to treatment for mental illness or who are homeless and travelling the

⁵¹ Parmanand Katara., v. UOI. AIR 1989 SC 2039.

⁵² 53Erwadi Tragedy. See Appendix-H in book titled 'Mental Health; An Indian Perspective 1946– 2003', Eds S. P. Agarwal., Published by Directorate General of Health Services, Ministry of Health & Family Welfare, India. (2004).

⁵³ S.B. Math et al. Psychiatric epidemiology in India. INDIAN JOURNAL OF MEDICAL RESEARCH.126;183-192(2007).

nation. These people are usually abandoned at beggar homes or left to their own devices. The MHA has been mute on the matter.

Rights of the person with mental illness in custodial settings: The Act's main goal is to defend the rights of people who are mentally ill wherever they are. Similar to that, under the amended Act, patients with mental illnesses in any facility providing custodial care, such as a jail, juvenile detention center, etc., must be monitored. In other cases, persons with mental illnesses were kept in mental institutions for more than 50 years before they were finally released thanks to the intervention of the Honorable SC of India. The new proposed law must solve these problems.

Certificates and mentally ill persons: Family members of mentally ill people often take advantage of the medical certifications for their own gain. Doctors have been hounded by relatives of mentally ill patients seeking certifications under the Right to Information Act. Unfortunately, throughout the whole procedure, the rights of the mentally ill patient are infringed. The current MHA does not handle this certificate problem.

Enumeration of rights and responsibilities of the person with mental illness: Because of their increased susceptibility to abuse, stigma, and prejudice, people with mental health conditions should be afforded special legal protections. Right to be treated in the least restrictive environment, right to a safe and hygienic environment, right to communicate, right to free legal aid, right to he/she/it's own body, right to he/she/it's own privacy and confidentiality, right to information, right to family, right to be treated in the least restrictive environment, right to food, right to clean drinking water, right to be free from physical restraint, right to be free from cruel and degrading treatment, People with mental illness must also abide by the regulations of care facilities like hospitals and nursing homes.

Enumeration of rights of families and the care-givers: The mental illness of a loved one may have ripple effects across the family. Numerous studies reveal that family carers of persons with serious mental illness encounter major pressures, a somewhat high burden, and limited help from other State actors such as mental health experts, law enforcement agencies, executives, etc. People's reactions to a family member's mental illness may run the gamut, from uncertainty and shame to rage and denial to shock and depression to feelings of guilt and responsibility.

Sadly, due to stigma and prejudice, many families give up their own social and professional activities when a member develops a mental illness. Despite the fact that families in India are the main care providers, MHA 1987 does not address these concerns. In India, the state has had a relatively little role in delivering care up to this point.

MENTAL HEALTH CARE BILL 2013

In 2013, a new Mental Health Care Bill was launched, signaling a transition from perceiving those with mental illness as dependent on institutional care to seeing them as fully autonomous individuals deserving of respect and legal standing in their own right. Since India signed the UN Convention on the Rights of Persons with Disabilities in 2006, attitudes have changed. Custodial care under the Indian Lunacy Act of 1912, therapeutic treatment under the Mental Health Act of 1987, and rights-based laws under consideration for the future all make up India's mental health legislation.

The Statements of Objects and Reasons for the Bill declare that the government ratified the UN Convention on the Rights of Persons with Disabilities in 2007. The nation's laws need to be updated to comply with the Convention. A new Bill was submitted to accomplish precisely that since the present law does not go far enough to protect the rights of those who are mentally ill or to promote their access to mental health care. The key provisions of the Bill are:

Rights of persons with mental illness: The legal right to access publicly run or supported mental health care and treatment programmes belongs to every person. Access to high-quality, fairly cost therapies is a requirement of the right to mental health care. People with mental health conditions have the right to equal treatment, protection from cruelty and humiliation, access to legal representation and their medical records, as well as the ability to express concerns about the calibre of the care they get from mental health specialists.

Advance Directive: A person with mental illness has the legal right to choose a representative and make prior decisions about his treatment, including who he would want to make decisions for him in the case of a mental health crisis. An advance directive is only legally binding if it has been certified as legitimate by either the Mental Health Board or a registered medical practitioner. If a mental health practitioner, family member, or caretaker has concerns about an advance directive being followed, they may file a petition with the Mental Health Board to review the directive, make changes, or even have it revoked.

Central and State Mental Health Authority: These administrative bodies must: “(a) register, supervise, and maintain a register of all mental health establishments; (b) develop quality and service provision norms for such establishments; (c) maintain a register of mental health professionals; (d) train law enforcement personnel and mental health professionals on the provisions of the Act; (e) receive complaints about deficiencies in the provision of services; and (f) advise the government on matters relating to mental health.”

Mental Health Establishments: Every facility providing mental health care must be approved by the appropriate Central or State Mental Health Authority. The Bill lays out the requirements that a facility must meet before it may register with the appropriate authorities, and it also details the steps that must be taken while admitting, treating, and discharging patients suffering from mental illness. When a person with mental illness is eligible for admission to a mental health facility, he or she should be given the opportunity to make the choice unassisted whenever feasible.

Mental Health Review Commission and Board: The Mental Health Review Commission is a quasi-judicial body that will be charged with reviewing the usage and procedure of advance directives and providing advice to the government on protecting the rights of persons with mental illness. With the backing of state governments, the Commission must set up Mental Health Review Boards in each state's judicial districts. The Board will have the authority to (a) register, review, amend, or revoke an advance directive; (b) appoint a nominated representative; (c) adjudicate complaints regarding deficiencies in care or services; and (d) accept and rule on applications from a mentally ill person, his nominated representative, or any other interested person challenging the decision of the medical officer or psychiatrists in charge of a mental health establishment.

- **Decriminalising suicide and prohibiting electro-convulsive therapy:** The Indian Penal Code exempts anybody who has attempted suicide from prosecution on the grounds that they are deemed to be mentally ill at the time of the attempt. Only when muscle relaxants and anesthesia are used is electro-convulsive treatment permitted. No minors may participate in the treatment.

The Bill lapsed due to the dissolution of the Lok Sabha.

MENTAL HEALTH CARE BILL 2016

In August of 2016, the Bill was reintroduced with 134 revisions by the 16th Lok Sabha, which is governed by the National Democratic Alliance (NDA). Because of these changes, the original Bill no longer reflects the spirit of the United Nations convention and has a completely different purpose, structure, and set of provisions. Concerns have been raised concerning the feasibility of the goals after the revisions made to the UPA-II Bill.

I offered four significant revisions during the March 2017 Lok Sabha debate on the reintroduced Bill, all of which served to clarify and enhance its provisions by updating the Bill's definitions. Both chambers of Congress approved the revised legislation, and it was

signed into law by the president to become the Mental Health Care Act of 2017.

The Mental Healthcare Act's proposed regulations have been drafted and made available for review. Gathering feedback from interested parties and subject matter experts is required by law, but the ministry is under no obligation to approve and execute the resulting regulations.

Experts and NGOs in the field of mental health launched public conversations with the ministry of health and family welfare to highlight gaps in the proposed legislation. I'll go through some important factors the ministry should think about in order to make sure this kind of law fosters an environment where people with mental disabilities are given the care they need.

4.8MENTAL HEALTH CARE ACT 2017

The Mental Health Care Act of 2017 was signed into law on April 7th, 2017, and it officially went into effect on July 7th, 2018. The first paragraph of the law referred to it as "An Act to provide for mental healthcare and services for persons with mental illness, and to protect, promote, and fulfill the rights of such persons during delivery of mental healthcare and services, and for matters connected therewith or incidental thereto." The Mental Health Act, 1987, which had been in effect since its passage on May 22, 1987, was repealed in its entirety by this new law. Mental illness is to be defined "in accordance with nationally and internationally accepted medical standards as may be notified by the Central Government." No person or authority should identify another as a person with mental illness unless in direct connection to the provision of services for the treatment of such disease, according to the Act.

SALIENT FEATURES

The Mental Healthcare Act of 2017 intends to decriminalize suicide attempts by requiring the government to provide options for rehabilitation to those who have made an attempt rather than prosecuting or punishing them.

In accordance with the Convention on the Rights of Persons with Disabilities and its Optional Protocol, the Act aims to fulfill India's international commitment.

It seeks to empower people with mental illness, breaking with the Mental Health Act of 1987 in the process. The 2017 Act acknowledges the agency of individuals with mental illness, enabling them to make choices about their health as long as they receive the necessary information.

The Act strives to protect the rights of those who have mental illnesses, as well as their access

to care and treatment without prejudice on the part of the government. Additionally, as is the case for the treatment of physical illnesses, insurers are also required to provide medical insurance coverage for the treatment of mental illness.⁵⁴

The Mental Health Care Act of 2017 has provisions for registering institutions involved in mental health and for regulating the industry. In order to prevent anybody with a mental disease from having to travel far for treatment, these measures include the need for the building of mental health facilities throughout the nation as well as the formation of a regulatory agency known as the mental health review board.

The Act has limited the use of electroconvulsive treatment (ECT) to only being used in emergencies and in conjunction with anesthesia and muscle relaxants. Additionally, it is now against the law to employ ECT as a treatment option for kids.

The Mental Health Care Act of 2017 has also pledged to battle stigma of mental illness and has specified certain methods on how to accomplish the same, as well as outlining the duties of other authorities, such as the police, with regard to persons with mental illness.

4.9 Guardian and Wards Act

A guardianship application for a person under the age of eighteen years may be filed under the GWA.⁴ Such an application can be for the guardianship of the minor or his/her property or a combination of both. Under the GWA, the District Court mainly considers the following factors: “(1) the welfare of the minor; (2) the age, sex and religion of the minor; (3) character and capacity of the proposed guardian, and his/her nearness as kin to the minor; (4) existing/previous relation of the proposed guardian with minor and/or his/her property; and (5) the preference of the minor, if he/she is capable of making an intelligent decision.” Since matters of succession and guardianship are governed by personal laws, related legislations may be applicable. For instance, in the case of Hindu minors, the Hindu Minority and Guardianship Act, 1956 (HMGA) is relevant as it brings personal law into the fold of the aspect of guardianship. The HMGA also treats the welfare of the minor as the paramount factor in deciding guardianship applications.

However, it does classify two further types of guardians mainly, (1) natural guardians (parents); and (2) testamentary guardians (persons appointed to be guardians by the parents in the event of their demise). This supplemental procedure of appointing testamentary guardians under the HMGA is further accepted by a committee constituted under the NTA, when appointing a

⁵⁴ The Mental Health Care Act, 2017.

guardian for a person with special needs under the age of eighteen years. Further, the process of application of guardianship under the GWA/HMGA is wide in scope, as it allows foreign nationals to apply for guardianship of a minor with special needs, unlike in the NTA, wherein foreign nationals are barred from applying. There is, however, no personal law of guardianship applicable to minors of other faiths, such as Christians, Parsis and atheists.

The GWA is the guiding law when considering applications of guardianship for individuals with special needs of such other faiths. Thus, any person desirous of being a guardian (for instance, a relative or a friend), can apply to the court requesting to be appointed as the guardian of the individual with special needs. In relation to the duties of the guardian, the "guardian of the person" must look after health, education, and maintenance of the minor. On the other hand, the "guardian of the property" must handle the minor's property as a prudent person would handle his or her own. Such a guardian needs the court's previous approval before they may sell, give, or mortgage their ward's immovable property. The guardian acts in a fiduciary capacity and not that of an agency in relation to his/her ward. The guardian may be removed through the declaration of the court, by resignation or through automatic cessation, which would include events such as death of guardian or the person with special needs ceasing to be a minor.

JUDICIAL PRONOUNCEMENT AND GOVERNMENTAL SCHEMES

5.1 JUDICIAL PRONOUNCEMENT

On December 4, a SC panel made up of Chief Justice Dipak Mishra, Justice A.M. Khanwilkar, and Justice D.Y. Chandrachud ordered the state of Uttar Pradesh to outline how it intends to implement the RPWD Act's (RPWD Act) provisions on inclusive education. These comments were made in response to a PIL that Rajneesh Kumar Pandey had submitted, asking the court to order the UP government to hire additional special educators for children with disabilities. This is a substantial change from the strategy used by the court in its ruling on October 27, 2017. The court had previously said that it was "impossible to think" that children with impairments could get an education in regular classrooms and that they should only be educated in special schools.

A deeply flawed approach:

The court's October 27 order revealed a deeply retrograde view of disabled people's abilities, despite the fact that both domestic and international legal instruments now acknowledge the proposition that inclusive education is crucial in preparing children with disabilities for adulthood. The Supreme Court's statement that it would be "impossible" for people with disabilities to attend regular schools ignored the thousands of regular schools around the nation that are dedicated to making the educational experience completely accessible for their students with impairments. If this rule were strictly enforced, it would send a message that the nation's 12 million handicapped children are not welcome in mainstream classrooms.

Section 16 of the RPWD Act mandates that all publicly sponsored or accredited schools must offer equal educational opportunities for students with disabilities. The responsibilities of the relevant government in this respect are laid forth in Section 17, including the necessity to develop centers for teacher preparation and make suitable adjustments to the curriculum and assessment system to accommodate students with disabilities.

The Supreme Court's ruling from October 27 mischaracterizes the Act since it makes many allusions to "special schools" whereas the Act clearly provides that children with "benchmark disabilities" have the opportunity to attend a "special school" if they so desire. Therefore, it is very clear that the Act mandates the government to create and support the same "inclusive education system" that the court found to be impossible.

Therefore, it is encouraging that the court has decided to reevaluate its prior ruling in light of the RPWD Act's perspective.

Inclusive education: An exception or the norm?

Although the Supreme Court's recent interest in inclusive education is promising, the justices don't appear ready to fully grasp how transformative this strategy may be. At least two signs point to the court maintaining both an inclusive education option and a special education default. First, contrary to what it indicated in its judgement, the court did not create a mainstream school delivering inclusive education on December 4; rather, it formed a two-person committee only for the inspection of special schools. This demonstrates how "special schools" continue to be the focus of any court intervention while inclusive education is now

relegated to the burdensome position of judicial afterthought.

Second, the court indicated in its ruling from October 27 that it was not defining the word "disability" in accordance with the Act. In contrast, pupils "who suffer from blindness, deafness, autism or such types of disorder may be required to have separate schools with distinctly trained teachers," the court emphasized that certain physical problems may not necessitate admittance to special schools. The RPWD Act does not specify a minimum standard that must be fulfilled in order for a student to qualify for inclusive education. As a consequence, the court established erroneous categories that are not permitted by law and restricted access to inclusive education to a tiny group of people with disabilities who do not have conditions like autism, blindness, or deafness.

The way forward

The United States Supreme Court (USSC) ruled earlier this year in *Endrew F. vs. Douglas County School District* that every individual education plan (IEP) must be "reasonably calculated to enable a child to make progress appropriate in light of the child's circumstances" in order for the child to be eligible for special education services in a regular school setting. Because "receiving an instruction that aims so low would be tantamount to (the disabled children) sitting idly, awaiting the time when they are old enough to drop out," the court ruled that an Individualized Education Program (IEP) that assures minimal participation is not enough.

The Indian Supreme Court might rule one of two ways in the end. Alternatively, it might adopt the position articulated in its October 27 judgement and fail to institutionalise the assurances of inclusive education enshrined in the RPWD Act, as did its American equivalent. Assisting the former would help make the right to inclusive education meaningful and real for children with disabilities, while the latter would transform the promises under the RPWD Act into nothing more than a hollow promise and 'parchment barrier' to discriminatory conduct by mainstream institutions.

The Supreme Court of the United States ruled decades ago in *Brown vs. Board of Education of Topeka* that public schools are inherently unequal, and hence the "separate but equal" idea does not apply to them. The Supreme Court's October 27 opinion not only implied that the

notion of "separate but equal" stood on its own, but also attempted to revive that long-debunked doctrine.

In light of this, the court's decision to reevaluate this approach in its opinion released on December 4 seems promising. The court ruled in a recent judgement on December 15 that the approach of all educational institutions towards students with disabilities must be informed by the unexceptionable principle that no child is 'ineducable,' inasmuch as every disabled child, when provided with appropriate support systems, has the ability to learn. We can only hope that these recent developments signal a sea change in the legal system's appreciation of disabled people's abilities.

In *Seema Lal v. State of Kerala*, there is widespread exploitation of therapy services across Kerala, as well as reports of parents being overcharged, allegations of abuse, and violations of children's rights. It is determined that the Government should intervene by building model centers across Kerala in order to lower the prices and act as a role model for similar centers. The Kerala Social Security Mission will develop plans to establish at least one such center with financial support from the government, with an eye toward income generation at the centers, since the Finance Department has placed restrictions on providing necessary human resources even on a contract basis.

Case law from *Pradeep Kumar Shrivastava v. CBI* established certain protections for individuals with disabilities under Title II of the Americans with Disabilities Act. Section 3 ensures that these individuals are treated fairly and are able to live their lives with respect and dignity. The government in question has a responsibility under Section 4 to ensure that women and disabled children enjoy the same legal protections as everyone else. Section 16 mandates that schools assess kids for learning impairments, help those with disabilities succeed academically, and track their participation, achievement, and graduation rates. This assistance should be offered in settings that encourage the full academic and social participation of persons with disabilities. Section 17 also requires schools to conduct surveys every five years of all enrolled students to assess whether or not their unique needs are being met; to hire and train teachers who are fluent in sign language, among other things, to work with children with intellectual disabilities; to encourage research to improve education; and to take any other steps that are deemed appropriate. Section 24 provides social security to enable

the appropriate government to establish the necessary programmes and schemes to safeguard and enhance the rights of individuals with disabilities, provided that it has the requisite financial means to do so. In addition, Section 27 required that rehabilitation services and programmes, especially in the areas of health, education, and employment, be made available to individuals with disabilities by the appropriate Government and local authorities. Section 28 mandates that the government fund disability-related research and development projects. High OA-2233/2017 support may be offered to any person with a baseline handicap using the method described in Section 38. The Sections that were just stated make clear what this law's intentions are. The overall goal of the law is to provide all available assistance to people with disabilities, especially in the areas of their education and health care, as well as to create an environment that allows them to live with dignity. Parents and other family members who support or help a disabled person are included in the concept of "care-giver." The term "high support" refers to the intensive physical, psychological, and other supports that must be given to people with benchmark disabilities on a daily basis in order for them to eventually be able to make their own decisions, pursue education, find employment, etc. "Inclusive education" refers to a method of instruction that is appropriately modified to satisfy the educational requirements of students with disabilities. The phrase "person with disability" refers to someone who has a chronic physical, mental, intellectual, or sensory impairment that prevents them from fully participating in society. Even though the policy decisions dated 06.06.2014 and 17.11.2014 were earlier in time than the Right of Persons with Disabilities Act, which came to be enacted in 2016, nonetheless the aim and object of the OA-2233/2017 above policy decisions is same as the enactment. It would not be incorrect to say that the policy decision of the Government has been adopted in the form of the enactment. The policy was a solemn commitment of the State and its functionaries towards persons suffering from disabilities, including autism spectrum disorder, and after the 2016 Act, it now becomes the statutory obligation of the State to provide the support system to the persons with disabilities, including high support wherever required. In order to provide the support system to the disabled, the role of the care-giver cannot be ignored. The definition of care-giver under Section 2(d) includes the parents. Even otherwise, the parents being responsible legally, socially and morally to their minor children, have to be given due and required support to

enable them to provide support system to their disabled children for their rehabilitation, including their education, health care and environment etc. It is on the basis of the aforementioned parameters that the validity of the impugned transfer of the applicant is required to be addressed. Undisputedly, the child and the wife of the applicant are disabled persons. They require special attention, high support, medicare, social and physical support even for their day to day activities. The applicant is the sole member in the family who is to provide them such kind of support and is thus a 'care-giver'. The OA-2233/2017 transfer policy of the Government is meant for the Government servants whose circumstances are normal and not extraordinary. Here is a case where the applicant has extraordinary, rather abnormal circumstances. His request for transfer cannot be looked into under the normal circumstances. Special circumstances exist and have to be addressed differently. Special disease requires special treatment.

The Division Bench of the Madurai Bench of the Madras High Court had made the following observations in the case of K.R. Raja v. Union of India and others while examining a writ under Article 226 of the Indian Constitution to issue a Mandamus to ensure the inclusion of children with disabilities under the Right of Children to Free and Compulsory Education (RTE) Act 2009:-

“5.The petitioner's learned counsel emphasized that the Rights of Persons with Disabilities Act, 2016 (hereinafter referred to as "the Act" for convenience) contains a specific mandate under Section 16 that the relevant Government and the local authorities should make every effort to ensure that all educational institutions they fund or recognize provide inclusive education to children who are differently abled. It is pointed out that from the information secured under RTI, the petitioner has come to know that in several districts, number of differently abled students admitted in private schools is very low and in most cases it is nil. Therefore, it is submitted that the Court should intervene and issue appropriate direction.”

In *The Child vs State Of Tamilnadu*,⁵⁵ Candidates from all around the country are expected to take the National Eligibility and Registration test (NEET), a highly demanding entrance test. The first reply argues that the occasional instance of bias due to a misapplication of the rules regulating the test is inevitable and should be accepted despite the fact that it is regrettable.

⁵⁵ W.P.No. 24973 of 2022.

Meanwhile, the first respondent is using the knowledge they've gained from running the NEET process to proactively address any issues that came up during the course of the examination. Even if just a few of pupils have been subjected to such unfair treatment, the repercussions are still significant. The statistics have not been shared with the Court. The success of the NEET and, in this instance, the implementation of a binding standard imposed by the Ministry of Social Justice and Empowerment for the benefit of students with disabilities, may determine the whole trajectory of a student's professional life. Throwing up one's hands in despair instead of trying to rectify the wrong inflicted to a student- is no solution for an authority bound by the dicta of law and the Constitution. A judge can't turn a blind eye to the human face behind the numbers, which shows the hopes, dreams, and sorrows of a student and her loved ones. In this case, the appellant is not alleging misfeasance on the side of the first respondent but rather basic carelessness in providing the benefits and protections guaranteed to people with disabilities under the RPwD Act of 2016. The protections given by the law must be implemented, and anybody who violates a student's entitlements must face legal consequences, if the law is to achieve its salutary goal of ensuring the full and equal participation of students with disabilities in society. We cannot have responsibility without accountability, and we cannot have power without responsibility. This demonstrates that the judicial system has always shown compassion for children with disabilities. They have voiced optimism that schools would not abandon youngsters with special needs. Institutions of higher learning have been urged to step up and welcome these kids. Education is the means by which a kid is rescued from the depths of despair and inspired to reach for the stars. The sixth response has not only failed to fulfill this obligation, but they have also dishonored the great Missionary's name and done something very disturbing to their Christian religion.

In *Devidas Loka Rathod v. State of Maharashtra*⁵⁶, has held that: “11. The exemption set out in Section 84 IPC states that an act committed by a person who, at the time of the conduct, was incapable of understanding its nature or that what he was doing was unlawful or against the law due to mental insanity would not constitute an offense. However, Section 105 of the Evidence Act places less burden on the accused than it does on the prosecution to prove their

⁵⁶ (2018) 7 SCC 718.

case beyond a reasonable doubt. According to *Surendra Mishra v. State of Jharkhand*⁵⁷, the accused need merely prove his case by a preponderance of the evidence before the burden of proof shifts to the prosecution to show that the exception does not apply. However, not every single claim of insanity will be accepted. Medical insanity will not be used as the standard of testing; rather, legal insanity will.”.

5.2 GOVERNMENTAL POLICIES AND SCHEMES

Separate law for the persons with ASD

Despite the RPWD Act of 2016 coming into effect, there is a unique institution set up by a national legislation specifically for people with ASD. The National Trust was established under “the National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999, and is a statutory entity of the Ministry of Social Justice and Empowerment, Government of India.”

Health insurance for the persons with ASD

The Niramaya Health Insurance Policy, offered by the National Trust, covers medical expenses up to Rs. 1,000,000 for people with ADS, cerebral palsy, mental retardation, and other disabilities.

Housing for the persons with ASD

The National Trust's GHARAUNDA program offers people with ASD inexpensive, guaranteed housing and minimum-standard care for their whole lives. This difficult problem required a permanent answer, thus GHARAUNDA, an approach to permanent housing and care, was developed. The goals of GHARAUNDA are to ensure that people with autism have access to a reliable, affordable, and continuing supply of high-quality care services for the entirety of their lives, regardless of their financial situation, and to promote assisted living that respects the individual's autonomy and dignity.

Making children with ASD ready for school

Early intervention and support for children with ASD and their families are offered in DISHA Centers. This program covers kids between the ages of 0 and 10. Making the kids with ASD

⁵⁷ (2011) 11 SCC 495; (2011) 3 SCC (Cri) 232.

prepared for school is one of these centers' goals.

Education and vocational training of the persons with ASD

The National Trust's GYAN PRABHA program offers financial aid to people with ASD in an effort to encourage them to enroll in postsecondary and vocational programs.

All children with disabilities between the ages of 6 and 18 are required to receive free education under the RPWD Act of 2016.

Samarth Scheme

This is a plan for long-term (prolonged stay) and short-term (respite care) residential services. There are residential facilities included in this plan. Early intervention, special education or integrated schools, open schools, pre-vocational and vocational training, training that is focused on finding work, leisure, sports, etc. are additional activities.

Niramaya

There is a specialised health coverage plan for those with ASD, CP, MR, and multiple disabilities. No of the nature of the disability, this programme provides full coverage without exceptions or eligibility requirements. An individual of any age may apply for and get insurance coverage of up to Rs. 1 lakh for a single payment. Transportation, in-hospital medical procedures more than once, pre- and post-hospital expenses, cashless hospitalisation at empanelled hospitals, claim reimbursement for outpatient department (OPD) services, and treatment at hospitals not on the insurance company's list of approved facilities are all part of the services provided. Hospitalisation, treatment, and surgical correction are all part of the service package.

Income Tax Concessions

A deduction of Rs 75,000 is permitted for those with disabilities (at least 40%) under Section 80U. A reduction of Rs. 1,25,000 is permitted for those with severe impairments (80% of one or more disabilities). A deduction of Rs. 75,000 (for a person with a disability of at least 40%) and Rs. 1,50,000 (for a person with a disability of 80% or more) may be made under Section 80DD for a person's support, including medical care for a dependent who has a handicap.

Rehabilitation council of India

The Rehabilitation Council of India was incorporated as a society in 1986. The Rehabilitation

Council of India Act was approved by Parliament in September 1992, and as a result, on June 22, 1993, the Rehabilitation Council of India became a formal organization. The Act underwent a complete revision by the Parliament in 2000. This mandate entrusted the duty of overseeing the Rehabilitation Council of India's policies and programs, the rehabilitation and education of people with disabilities, the standardization of courses and a Central Rehabilitation Register for all qualified professionals and professionals working in the field of special education, and the work of registering personnel in a Central Rehabilitation Register. This Act gives the authority to take penal action against those who are disqualified for providing services to people with disabilities. Major General (Retired) Ian Cardozo serves as its current chairman. Its address is B-22, Qutub Institutional Area, New Delhi 110 014. The Ministry of Social Justice and Empowerment of the Government of India establishes a General Council in accordance with subsections (1) and (3) of Section 3 of the National Rehabilitation Council Act 1992. The standardization of training programs and courses for professionals with disabilities, as well as their assessment, are governed by the General Council, which is the organization's highest authority.

The functions are:

1. Standardization and regulation of training courses at various levels in all training institutes across the country.
2. To give recognition to training institutes / universities conducting training courses in and outside the country in the context of rehabilitation of the disabled.
3. Enhancing research in rehabilitation and special education.
4. Maintaining a Central Rehabilitation Register of occupations of persons with valid qualifications in the field of rehabilitation.
5. To encourage the continuation of rehabilitation education programs and for this, work closely with organizations working in the field of disability.
6. To promote ongoing education in the fields of special education and rehabilitation by cooperating with institutions and organizations that support people with disabilities.
7. Acknowledging institutions for vocational rehabilitation as human resource development facilities
8. To register teachers and other staff members who work in centers for vocational

rehabilitation.

9. To provide recognition of affiliated national institutions of disability and higher or apex bodies as human resource development centers.

10. Registration of employees employed by the Ministry of Social Justice and Empowerment at National Institutes and Apex Institutes for People with Disabilities.

The objectives are:

1. Controlling training policies and initiatives in the area of disability rehabilitation.
2. To establish basic requirements for instruction and training of different kinds of professionals and staff who work with people with disabilities.
3. To bring standardization in training courses of professionals working for persons with disabilities. Regulating these standards uniformly across all institutions in the country.
4. To give recognition to institutions / universities offering postgraduate degree / bachelor's degree / postgraduate diploma / certificate course in the field of rehabilitation of persons with disabilities.
5. Delegation of degrees / diplomas / certifications by foreign universities / institutions on reciprocal basis.
6. Upkeep of the Central Rehabilitation Register of professionals and other people with legitimate credentials in rehabilitation.
7. Regularly gather data on education and training in the area of rehabilitation with the assistance of organizations active both in India and abroad.
8. To promote continued education in the fields of rehabilitation and special education via collaboration between domestic and international organizations.
9. The classification of institutes for vocational rehabilitation as manpower development facilities.
10. To register teachers and other staff members who work in centers for vocational rehabilitation.
11. To list employees of the Ministry of Social Justice and Empowerment's top institutions and national organizations.

The Rehabilitation Council of India Act establishes guidelines for the education of professionals in rehabilitation, as well as the establishment of the Rehabilitation Council of

India, which will register professionals in rehabilitation with valid credentials and maintain the Central Rehabilitation Register. The Act acts as a facility for certification and quality control and aims to guarantee that people with disabilities are cared for by certified staff. The Act outlines the Council's composition, membership, and duties in great detail. The acknowledgment of the credentials offered by the university or other institution for professional rehabilitation professionals is one of the most significant aspects of this Act. The Act includes a comprehensive list of accredited rehabilitation credentials as well as course and university names.

In addition, the Act prescribes the rights of professional rehabilitation personnel with recognized qualifications to act as professional rehabilitation personnel in the Government or in any institution from the point of view of office and in any part of the country.

According to the Act, the main functions of the Rehabilitation Council are as follows -

1. Ensuring minimum level of education to recognize rehabilitation qualification
2. Registration of professional personnel in the Central Rehabilitation Register
3. Setting norms of professional code of conduct and removal of names from the Central Rehabilitation Register.

The Rehabilitation Council of India (Amendment) Act, 2000 was introduced to reform the previous Act and improve its implementation mechanism.

Important amendments included in this Act include expanding the scope of work of this Council, through the listening and training of professional rehabilitation personnel and component monitoring of research in rehabilitation and special education. Apart from this, it has adopted the definition of disability given in the Disabled Persons (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 and it is mentioned that the President of the Council has experience in the field of disabilities. The occupant should be a person of professional qualification.

Tamil Nadu CM scheme

The Chief Minister's Health Insurance Scheme will now pay for a variety of treatments for the developmental condition known as autism spectrum disorder. According to J. Radhakrishnan, state secretary of health, autism has not yet been covered by the majority of programs. According to him, the State government is now giving insured families a way to get the

therapy they require for autism for up to Rs. 1 lakh per year. The Institute of Child Health, Egmore (ICH) is the site of the project's pilot. The full autism therapy program, including speech, occupational, and behavioral therapy as well as any required psychiatric care, according to Shanthi Nambi, director of the Institute of Mental Health and a former head of child psychiatry at ICH. She said that parents might utilize the insurance funds to cover their children's special education costs. Every month, a set amount will be given to the parents, who may use it to cover additional expenses like paying the therapist, she said. One in 55 to 70 youngsters, according to Dr. Radhakrishnan, is thought to be on the autistic spectrum, and of them, around 100,000 need extensive treatment. "We will gradually expand it to other centers, both private and government," he added. "The initially approved center is ICH." According to him, this is a part of the health department's aim to increase the CMCHIS's coverage of ailments.

Orunodai 2.0

Orunodoi 2.0 will be introduced by the Assam State government in April 2023, with a goal of serving over 27.61 lakh beneficiaries, including those on the autistic spectrum, etc. It is the Orunodoi Scheme in its improved version. The government pays the beneficiaries in the DBT (Direct Benefit Transfer) manner on the tenth of every month in accordance with Orunodoi guidelines. On April 10, 2023, the government intends to send the first Orunodoi 2.0 payment through DBT. In his speech introducing the 2020–21 budget, former finance minister and current chief minister Himanta Biswa Sarma defined the Orunodoi program as the "foremost bead" of the Ashtadash Mukuta Unnoyonee Maala. Each recipient received Rs 830 per month at first from the government. The sum is now Rs 1,250 per recipient per month after two modifications. A check of the list of recipients from the previous year revealed ineligible recipients in addition to those whose financial circumstances had improved. The eligible recipients were reduced from 19 lakh to 17.07 lakh as a result.

IMPACT OF THE COVID-19 PANDEMIC ON PERSONS WITH AUTISTIC SPECTRUM DISORDER

According to some, the COVID-19 epidemic is "the war of our generation." Millions of families are valiantly fighting war against COVID-19 by overcoming the various difficulties

brought on by social isolation, such as disrupted schedules at work and school, financial instability, and the inability to see loved ones, all of which are made worse by the ambiguity of how long this will endure. For people who suffer from autism spectrum disorder (ASD), these difficulties are probably increased. It may be highly challenging to comprehend social distance, convey pain, and adjust to new routines due to characteristics of ASD, such as poor social and communication skills, repetitive behaviors, and insistence on sameness.

About three-quarters of people in both the autistic and non-autistic or "neurotypical" groups said that the epidemic had caused a rise in their feelings of despair and anxiety. Additionally, compared to neurotypical adults, autistic people reported a larger rise in anxiety and depressive symptoms. This trend is especially concerning since autistic people often have greater rates of anxiety and depression than neurotypical people. The study measured how much or little individuals worry—compared to before the pandemic—about various issues. Adults with autism were observed to worry more than neurotypicals during the pandemic about their pets (if they had any), access to medicine, acquiring food, and properly implementing the guidelines to stop the spread of COVID-19.⁵⁸

6.1 IMPACT OF COVID 19 PANDEMIC ON TEENAGERS WITH ASD AND THEIR FAMILIES

Families caring for autistic teens at home face several additional obstacles as a result of their children's social withdrawal. Teenagers with autism spectrum disorder (ASD) can benefit from a variety of school-based programs, such as special education, behavioral therapy, occupational therapy, speech services, and individual aides. Because many adolescents with ASD already struggle with social and communication skills, the value of virtual delivery of these therapies is limited. Because of this, many parents are balancing the obligations of caring for their own children, teaching their own children in special education, and working from home all at the same time. During times of stress and anxiety, aggressive and self-harming actions might become more common. For persons with Autism Spectrum Disorder (ASD), any event that is 'out of the ordinary' can become an enormous challenge.

Therefore, the need is to acquire certain techniques and ways to help them cope with the outcomes of COVID-19.

6.2 STRATEGIES TO SUPPORT TEENAGERS AND YOUNG ADULTS WITH ASD

⁵⁸ https://www.myscience.org/news/2022/impact_of_the_covid_19_pandemic_on_autistic_adults-2022-ugent

DURING COVID-19⁵⁹

Educate teenagers about COVID-19: It's crucial to teach teens and young adults with ASD about COVID-19 and social withdrawal since misunderstanding may feed worry and terror. Media exposure to COVID-19 might be overwhelming and incorrectly perceived. When addressing COVID-19, the language used should be plain, unambiguous, and appropriate for the person's level of cognitive development.

Keep the routines that you can keep: People with ASD place a lot of importance on routines. While many of our rituals and routines have undergone significant change, others, including mealtimes, bedtimes, and other schedules, may still be maintained.

Create new routines: To assist establish a new normal, it might be beneficial to substitute new habits for the ones that are no longer feasible. These routines should, wherever feasible, include social interaction, entertainment, and physical activity.

Practice old coping skills and learn new ones. Now is the moment to think back on the ways in which the adolescent or young adult has dealt with adversity in the past, and to remind him or her of those strategies. A few examples include conversing to loved ones, partaking in a favorite hobby, or even just listening to some comforting music.

Increase communication. When parents and children live apart, such as in a group home, it's only natural for them to worry about one another. These concerns may be lessened if the staff at the group home is open and communicative with the residents' loved ones about the policies and methods they use to maximize infection control and the residents' progress.

Plan something to look forward to. Families may find it beneficial to schedule celebrations or delayed events since a number of spring activities, such as vacations and family holidays, have been postponed. These gatherings may be planned to give a family something to look forward to while also acting as a potent reminder that this too will pass.

Seek mental health services. It's crucial to seek mental health assistance if your adolescent or young adult is struggling to cope, displaying excessive anger, or hurting themselves. Numerous clinics are still offering telehealth services, such as talk therapy and medication management.

In the current situation, families are removed from education, society, and the daily grind of

⁵⁹ Strategies to support teens and young adults with autism spectrum disorder during COVID-19 by Robyn Thom; Chris McDougle.

work, and we are all leading fairly sedentary lives. This is an excellent chance to learn about family members' interpersonal requirements. If their parents can read their child's nonverbal cues, autistic youngsters may function better. They are also capable of reading parental body language. With autistic children, very nuanced nonverbal communication may help them regain their family-friendly flexibility. Parents may compassionately confront their children's fundamental survival requirements by acting passionately in front of them rather than by instructing them how to do it and without placing any demands on them.

Parents should challenge their children's fundamental requirements in order to include them in daily duties. Participate with them in meal preparation, organisation, cleaning, washing kitchenware, and drying cleaned clothes. Introduce them to the contents and uses of the storage areas.

Help children connect with the objects in their immediate surroundings and their daily function. Additionally, this is the ideal moment for parents to foster stronger bonds with one another and work together to promote their child's overall growth.

The greatest moment to help their autistic kid become autonomous inside and integrate with the rest of the family is now. This will make it more likely that parents will succeed in assisting kids in being more cooperative and obedient at home. Therefore, when we emerge from the lockdown, we can assist them in better understanding the outside world than before.

CONCLUSION AND SUGGESTIONS

7.1 CONCLUSION

People with mental illness are, or may be, more vulnerable to being abused and having their basic rights violated. Discrimination is a daily reality for many people with mental conditions. Abuse, isolation, and the inability to participate fully in social life are all results of discrimination. Discrimination may be fought by direct legislative and policy initiatives.

There must be some kind of safeguard in place to prevent people from being harmed by their own or other people's loved ones, caregivers, professionals, friends, fellow citizens, or law enforcement.

Self-determination is crucial for people to reach their full potential. However, the presumption is made in legal systems worldwide that those with mental illness lack the capacity to make choices and manage their own life. Assuming that persons with mental disorders lack the capacity to make their own choices and the resultant denial of legal competence is the primary bias that generates discrimination in other areas of life.

Stigma and discrimination towards people with mental health issues lead to widespread violations of their human rights. Human rights breaches often include the withholding of legal capacity.

Individuals with ASD and their families face challenges regardless of their financial status or cultural background. However, many individuals with ASD may thrive with the correct care and support. Families coping with autism spectrum disorder (ASD) also benefit from expanded resources and training programs. However, it is frequently not innate cognitive, psychological, or developmental deficiencies but rather social, economic, and cultural variables that make contacts with people with disabilities more challenging.

Managing ASD is quite difficult. There are a number of sociocultural concerns in India that exacerbate the challenges of ASD, especially in some regions.

Despite the need of early treatment and intervention, it is difficult for even the richest metropolitan, highly educated, and socially prominent families to give the attention their children require.

However, families that are low-income, low-education, socially-disadvantaged, or who live in rural areas may have a more difficult time gaining access to treatments and supports for autism spectrum disorder.

Ignorance is another barrier that stands in the way of achievement for persons with ASD. Uninformed parents have a more difficult time understanding and accepting their child's diagnosis, and they are less likely to seek the proper support and aid. From the moment of diagnosis forward, the quality and

availability of ASD resources are severely influenced by the lack of understanding in the medical and educational sectors. They are also less likely to get assistance from friends and family.

Because of the stigma associated with having autism spectrum disorder, many parents are less likely to seek treatment for their child.

When it comes to giving resources, services, and assistance to people who need them the most but don't have easy access to them, non-governmental organizations (NGOs) have been at the forefront of these efforts. This is because the government has not provided enough funding or recognition.

Adequate, accessible, timely, and compassionate health care is only possible with the help of legislation. It also helps protect the rights of marginalized groups and those who are otherwise powerless.

It is indicative of a civilized society that appreciates and cares for its disabled and marginalized citizens, as well as strong values, morals, attitudes, culture, traditions, customs, objectives, and practices. Protecting, advancing, and improving the mental health of the people who would be affected by such legislation should be its top priority. In light of the undeniable truth that every society need regulations with respect to many matters,

The proper laws are necessary to ensure the well-being of a country's people in regards to mental health treatment.

However, Indian law and judicial interpretation discriminate against persons with mental disorders by consistently denying them legal capacity. This keeps them from taking part in society as fully and productively as they are able to. These legal constraints exist with the stigmatizing sentiments held by many in the mental health field.

7.2 CONCLUDING THE MENTAL HEALTH LEGISLATION

In conclusion to the mental health legislations across the globe, we have some common principles engraved in our mental health care legislation, such as:

- A. The core tenet of all mental health laws across the world is the provision of mental health treatment for people with mental illness. When we talk about a person's mental health, we're referring to the wide range of services available to them in order to help them recover and live as independently as possible within their families and communities. Medication, individual therapy, and community supports like self-help groups (those with mental illness assisting themselves and one other) are all part of the treatment process.
- B. The major objective of the mental health laws is to provide treatment in a setting with the fewest restrictions possible. In addition to defending the rights of those who suffer from

mental illness, this aids in their healing. The rule nowadays is that clinical care must take place outside of a hospital, not the other way around.

- C. Treatment of any kind requires informed consent. A patient must provide informed permission before receiving treatment. However, under the mental health laws, a person may be kept in a hospital and provided treatment for mental health without their agreement. Most laws addressing mental health include this clause.
- D. Almost all laws pertaining to mental health include provisions for involuntary admittance; however, there are significant differences in the review mechanisms available, including but not limited to: detention period, frequency of review, appeal procedure, jurisdiction, and type of the review body/board/tribunal.
- E. This independent statutory body's main duty is to safeguard the rights of people with mental illness and to examine the procedures used in the following situations: admission of involuntarily admitted patients; treatment without permission; and execution of advance directives, Nomination of representatives, mandatory community treatment orders, and any violations of a person's human rights while receiving treatment for a mental illness.
- F. The majority of mental health laws make sure that the details of the services obtained are kept private and cannot be disclosed without the patient's consent. However, there are circumstances in which certain data may be disclosed in the public interest without the patient's consent.
- G. The regulation of the mental health industry is one of the law's primary purposes. The law forbids anybody from opening or maintaining a mental hospital or nursing home unless they are in possession of a current license issued by the law. The legislation also specifies the minimal criteria for granting an institution a license. Legislation also covers the subject of mental health practitioners' certification.
- H. Compulsory community treatment orders are allowed under several mental health laws. Many laws do not permit this institution since it infringes upon the rights of patients in the community.
- I. The majority of Mental Health Acts do not address the insanity defence (criminal culpability). Insanity defence cases are typically handled via the criminal justice system. Mental health statutes often encompass the admission, treatment, release, administration of property, patient rights, and review procedure for the loss of liberty during the admission and treatment process.

7.3 SUGGESTIONS

People with mental health issues often face stigma, isolation, and discrimination, as well as being denied or having their work rights severely restricted, being subjected to physical abuse or assault, and being denied access to adequate mental health care.

Care for children, adolescents, and adults with autism spectrum disorder (ASD) and associated neurodevelopmental disorders is a vital area that calls for increased national capacity.

1. Policymakers should target numerous fields to achieve this goal. They need to:

- Increase public understanding of autism spectrum disorder (ASD) and push for earlier diagnosis and treatment so that affected children may get help sooner;
- Provide more training to parents, teachers, and clinicians on the most successful treatments for children with ASD, so that these therapies may be made available to these children;
- Ensure that people with autism spectrum disorder and other neurodevelopmental disabilities have access to public schooling with the intention of full inclusion;
- Provide families of people with autism spectrum disorder (ASD) and other neurodevelopmental problems with the resources they need to provide for their loved ones; and

In order to fully understand the obstacles we confront in treating ASD and other neurodevelopmental disorders, it is important to promote involvement in high-quality research and health monitoring.

2. Empowerment of mental health services:

One method proposed to combat prejudice towards those seeking mental health care is to increase service users' agency. People with mental and psychosocial impairments should be given the opportunity to exercise their legal ability as part of efforts to promote empowerment at the individual level.

3. Certification of Autism

According to the RPWD Act of 2016, the assessment of autism has not yet been made public, and the published disability standards specify certain specialists like "pediatric neurologist," "rehabilitation psychologist," and other similar titles to certify particular disorders.

The problem has grown to be a significant impediment to granting the disability certificate. For certifying impairments that they often treat, several medical specialties have been excluded. For instance, psychiatrists have not been included while evaluating learning disabilities. It is necessary to change the name of the expert and allow the medical authorities to choose the specialist needed for certification so that PwD do not have to travel between cities and hospitals in order to get their disability certificate.

Following specialized training, primary care physicians may now issue numerous disability certificates, which will benefit a lot of impaired individuals in remote regions. However, the disability standards should have also granted private practicing physicians the authority to certify, allowing for proper checks

and balances to address the scarcity of human resources.

4. A check on human rights violation:

One method proposed to combat prejudice towards those seeking mental health care is to increase service users' agency. People with mental and psychosocial impairments should be given the opportunity to exercise their legal ability as part of efforts to promote empowerment at the individual level.

5. Proper and effective implementation of Directive Principles of State Policy:

It is important to create programs that inform parents about the health risks their children face. Using online education, we can make these courses easily accessible. Opportunities for training should vary in difficulty, from teaching people how to talk to the afflicted family member to teaching parents how to deal with their own stress. These abilities not only help kids grow and flourish, but they also let parents relax. Involving families in program decision-making is crucial because it increases buy-in and improves outcomes.

Directors of policy and programs may bolster these initiatives by creating and maintaining institutions (such support groups, family gatherings, and activities) that bring individuals together. When the internet is accessible, family members from different areas may connect online to talk about their worries. This kind of contact is particularly useful in less developed and rural locations, where face-to-face encounters may be difficult.

6. Recognition of legal capacity of people with mental disorder:

In India, people with mental health issues face institutionalized discrimination, most notably in the form of a denial of their legal competence. People with mental illness should be afforded equal protection under the law in India. According to social model theory, people with disabilities should be given the same opportunities as everyone else to participate in communal life.

Supported decision making is an adaptation that helps people with mental illness function legally on par with the general population.

Supported decision making, such as psychiatric advance directives (PADs), may allow people with mental illness make legally binding decisions even if they lack the mental ability to do so due to disease. Thus, the 'personhood' of people with mental problems is acknowledged by a supported decision making paradigm codified in legislation. The acceptance of people with mental illness as fully human is a significant and necessary first step in ending prejudice towards them.

7. Significant Research:

There are major gaps in research as well as in ASD-related resources and services in India. In order to comprehend the experiences of persons with ASD and their families better, there is still more work to be done. Many parents are frustrated by the dearth of resources suitable for ASDs. Therefore, thorough investigation would help us better comprehend their circumstances and enable us to act accordingly.

Government support and funding to Non Governmental Organizations: A variety of non-governmental organizations (NGOs) are striving to raise public awareness of autism spectrum disorder (ASD) and empower people with ASD, as well as educate and assist the people who care for them. Individuals and non-governmental organizations (NGOs), no matter how passionate or devoted they may be, can only do so much without the backing of the government and enough money. There has to be change at the national, policy level to make sure that these NGOs' aims are achievable for the persons and families affected by ASD that they serve.



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