

**UNDERSTANDING MENTAL DISABILITY IN INDIA:
DISCOURSES, INSTITUTIONS AND POLICIES**

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In partial fulfillment of the requirement
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MASTER OF PHILOSOPHY

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DECLARATION

I declare that the dissertation entitled **UNDERSTANDING MENTAL DISABILITY IN INDIA: DISCOURSES, INSTITUTIONS AND POLICIES** submitted by me in partial fulfilment of the requirements for the award of **Master of Philosophy** is my original work. It has not been previously submitted for any other degree of this University or any other university.


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CERTIFICATE

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CONTENTS

ACKNOWLEDGEMENTS	i
LIST OF ABBREVIATIONS	iii
INTRODUCTION	1
CHAPTER 01: UNDERSTANDING DISABILITY.	10
CHAPTER 02: MENTAL DISABILITY IN COLONIAL INDIA	26
CHAPTER 03: ACTS, POLICIES AND INSTITUTIONS IN INDIA AFTER INDEPENDENCE	43
CONCLUSION	74
APPENDIX I	
APPENDIX II	
BIBLIOGRAPHY	

LIST OF ABBREVIATIONS

CIP:	Central Institute of Psychiatry
PWD Act, 1995:	Persons with Disabilities Act, 1995
NGOs:	Non-governmental Organization
UPIAS:	Union of Physically Impaired Against Segregation
WHO:	World Health Organization
ICIDH:	International Classification of Impairments, Disabilities and Handicaps
ICF:	International Classification of Functioning, Disability and health
ICD:	International Classification of Diseases
UNCRPD:	United Nations Convention on the Rights of Persons with Disabilities
EIC:	East India Company
ILA:	Indian Lunacy Act
UDHR:	Universal Declaration of Human Rights
IPS:	Indian Psychiatric Society
MH'87:	Mental Health Act 1987
NCRB:	National Crime Records Bureau
CBR:	Community Based Rehabilitation
DDRC:	District Disability Rehabilitation Centres
DEIC:	District Early Intervention Centres
MHCA'17:	Mental Health Care Act, 2017
MHRB:	Mental Health Review Commission
MHRC:	Mental Health Review Commission
ECT:	Electroconvulsive Treatment
CLPR:	Centre for Law and Policy Research

GMCH:	Government Medical College and Hospital
IHBAS:	Institute of Human Behaviour and Allied Sciences
IPHB:	Institute of Psychiatry and Human Behaviour
HMH:	Hospital for Mental Health
RMH:	Regional Mental Hospital
RINPAS:	Ranchi Institute of Neuro-Psychiatry and Allied sciences
NIMHANS:	National Institute of Mental health and Neuro- Sciences
DIMHANS:	Dharwad Institute of Mental Health and Neuro- Sciences
MHC:	Mental Health Centre
GMHC:	Government Mental Health Centre
NHRC:	National Human Rights Commission
PDH:	Psychiatric Disease Hospital
SHRC:	State Human Rights Commission

INTRODUCTION

The Indian disability rights movement is marked by three phases: the initial phase between the 1970s and 1980s can hardly be considered a movement. While this period was marked by various Civil Rights movements and Anti-Establishment movements based on the rights to dignified life, in various parts of the world, it started rather late in India. Within India, the concerns were mostly charity based advocated by NGOs and unlike other movements, a unified leadership was rather missing. Mental disability was nowhere to be seen emerging as a category advocating for its rights as part of disability rights activism.

With the shift towards policies based on developmental model in late 1980s, the disability concerns began to focus on medical approach and treatment. The establishment of Rehabilitation Council of India in 1986, followed by enactment of the Mental Health Act, 1987 set a watershed beginning for persons with mental disabilities. However, the act had many loopholes and could not be implemented properly.

The 1990s marked a thrust with movement's shift from social welfare concerns to demand for recognition of human rights. The movement began to acquire a collective shape with increased involvement of international groups. The enactment of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, in 1995, further facilitated towards rights based entitlements to persons with disabilities. A remarkable feature of the Act was that mental illness and mental retardation were formally recognized as disabilities. The Act was however based on medical standards of diagnosis and not on social responses.

Till the 1990s, persons with mental disabilities remained excluded from the disability rights groups owing to the different medical nature of their disabilities (Mehrotra 2013, 101). A major turn took place with the enactment of the National Trust for welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999, for persons with developmental disabilities.

The third phase of disability rights movement began in 2000s and continues till present. This era brought about major advancements within disability rights activism.

In 2006, National Policy Statement was launched. The ratification of the UNCRPD titled the Indian disability policies completely on rights based framework. In 2014, National Mental Health Policy was launched which acknowledged the loopholes present in the State practices in the policies meant for people with mental disabilities and recognized the need to address stigma, discrimination and oppression through promotion of rights based policies, awareness programmes etc. The PWD Act 1995 was revised as RPWD Act 2016 and Mental Health Act 87' was replaced with Mental Health Care Act 2017.

The first two mentioned above, does not explicitly comprehend any Indian mental disability discourse other than establishing mental disability legible to be entitled and purviewed within the disability legislations and policies. The third Act begins possibility of Construction of a separate mental disability theorization. However, none of the legislations focus on abolishing discriminatory laws in the Indian Constitution. So, mental disability as a conceptual issue apart from those based on state practices remains more or less undiscovered.

The Indian State practices are still welfare based on medical diagnostic labels. This is also reflective in the policies formulated. People with Mental disabilities have so far been unable to move out of its psychiatric label as social and political identities. While almost all the legislations and policies plead for the safeguard of rights, none of them have advocated for political rights of persons with mental disabilities.

Article 326 of the Indian Constitution bars voting rights of persons with 'unsound mind'. This is retained by the Representation of People's Act 1950, which proposes for the disqualification and removal from the electoral roll on the grounds of 'mental unsoundness'. None of the Social Justice provisions enshrined in the Constitution, explicitly advocate for 'disability' among other marginalities. The Article 15 and 16 does not specifically abolish 'disability' as a ground for discrimination. As Kannabiran puts, traditionally disability has long been considered to be an index of marginality (Kalpna Kannabiran, 2012, p.86)

Practically, disability remains the most marginalized even among other marginalities.

RESEARCH OBJECTIVES:

- This study attempts to grasp and present an explicit comprehensive understanding of mental disability in India;
- The study examines existing theoretical discourses on disability in general and mental disability in particular;
- Taking cues from post-modernist and post-colonial traditions, this study examines and collects colonial discourses on mental disability.
- The study then intends to present 'mental disability' as conceptualized by the Indian state, reflective through its legislations and policies.

LITERATURE REVIEW:

Michael Oliver argues that the issue of disability has been given scant attention in academic circles and only within the disciplines of medicine and psychology has disability been afforded an important place. He stresses the need for other social science disciplines to take over the issue of disability towards constructing a social theory of disability. Oliver, further, argues that there remains a silence on the history of disability and even if it exists, it is in terms of medical advances. He situates disability as an individualized and medicalized problem within the capitalist societies, but, at the same time he denies the universality of existence of disability as individual and medical problem in all forms of societies both historically and contemporarily. Drawing upon anthropological material, Oliver suggests that the current dominant conception of disability is related to both economic and social structures and to central values of particular societies.

While Oliver situates the problem of disability mostly in the context of post-capitalist societies of Britain and the United States, this also holds true to Indian society to a larger extent. As when one looks at the history of disability in India, particularly, the social responses towards mental illness, it is predominantly in terms of medical advances. Although, Oliver does not explicitly mention post-colonial societies like India, Nevertheless, he does not universalize disability as an individual and medical problem. I want to proceed further to explore as how mental illness has been

historically perceived in societies like India, which Oliver's work does not mention. Secondly, he is optimistic for the redressal of disability problems through International Disability Movements emerging from new social movements.

Nussbaum argues that classical social contract thinkers have failed to include and imagine people with physical and mental impairments as participants in the choice of political principles. For such people with impairments and disabilities, who are fully capable of participating in political choice, this denial of basic choice seems to be a flaw from the point of view of justice, Nussbaum argues. The fact that they are not included in the group of choosers means that they are not included in the group of those for whom principles are framed. So, people with impairments and disabilities are not primary recipients of justice and this also has consequences for the treatment of people with impairments and disabilities in the society and therefore, also for equal citizenship.

The social justice and fundamental rights provisions of the Indian Constitution also does not give explicit attention to disability as a form of social oppression. I think disability as a form of oppression and marginalization should be given serious attention as it has both physical and social presence unlike other forms of social oppression which are socially constructed. Within the problem of disability, I find the issue of mental illness as one of the most non-lucid category and I tend to propose that apart from distortions arising from social contract traditions, the subtle attention to disability as marginalisation and oppression within the social justice provisions can also be attributed to this sub-category of mentally ill.

Dhanda's work is a rights based analysis of laws for persons with mental illness thereby explaining interaction between law and mental illness which is otherwise conventionally perceived in medical terms. Dhanda mentions that any transaction be it a contract or marriage etc., has both physical and mental elements and presence of both are required to decide upon the legal validity of transaction presence of both of these elements is required and it is where mental illness becomes an impediment to mental capacity, thereby rendering moral authority of transaction invalid. So, Dhanda argues that there exists an inverse relationship between legal capacity and mental disorder. To render a transaction invalid the scale of mental incapacity has to be judicially determined.

Dhanda suggests that law has two functions- Maintenance of order and protection of vulnerable sections of society. The former can be infringed by the manifestations of mental illness and therefore, there are regulatory and disciplining institutions to control such manifestations, which Dhanda claims is the second mode of legal interaction in this sphere. With respect to the latter, mentally ill people being prone to vulnerability and exploitation, protection of persons with mental disorder is another task that the law performs in relation to mental disorder.

The Indian Legislature, Dhanda argues, attempts to provide this protection in three ways:

- By denying legality to legal transactions involving a person of unsound mind;
- By freezing legal proceedings till the person of unsound mind regains sanity (mainly in criminal proceedings);
- By allowing someone else to represent the interests of a person of unsound mind.

Dhanda does not go into the debate of what constitutes law for persons with mental illness, but only explains various forms of state-made law i.e., legislations, subordinate legislations and judicial decisions. She argues that interaction between law and mental illness involves various actors-principal actors like legislators, judiciary and the executive; family members, institutionalizing forces like the police and medical experts. Dhanda puts that this also shows how society and medical actors use the legal provisions relating to mental illness.

The scale of mental capacity has to be determined by court. In the legal scenario, a continuous comparison between the social, legal and medical perceptions of mental disorder comes to the fore. But the authority of final determination remains with the court. Dhanda puts that in this context it is appreciable that legal norms may or may not be in conformity with social or medical norms.

Dhanda argues that public discourse on mental illness to the extent of insanity brings to the fore three representations of the condition: dissent, deviance and disorder. Insanity as dissent and deviance have rhetorical potential and can be used to create

political space for persons with mental illness, while mental illness as disorder reflecting bio-medical take where the consent and cooperation of the person is required serves the interests of the sufferer. Personal autonomy to the sufferers again depends upon the scale of mental incapacity. So, it is here that the legal construction of insanity assumes crucial significance.

The colonial narratives on the practice of psychiatry remain centered on the asylum practices. The colonial discourses on mental disability measures its evolution through the lens of asylums. The history of establishment of mental asylums in Medieval England was also superimposed on India. Michel Foucault attributes the discovery of institutional confinement to the seventeenth century Europe when 'deviants' were segregated and confined. He called this the 'great confinement'. Foucault argues, this became a practice to serve the interests of market society separating productive from the unproductive. The unproductive were to be institutionalised and trained under calculated constraints into a productive body. According to Foucault, medicine and psychiatry were the facilitators to promote market based social structures, to segregate productive from unproductive. Foucault adds anti-psychiatric essence to the concept of mental disability and completely denies any individual experience of disability in general. However, biological existence and physical presence of mental disorders in addition to psycho-social factors cannot be denied.

David Wright argues that history of psychiatry only provides a partial understanding of the asylums. He agrees that the patterns of psychiatric development show that asylum structures and practice of psychiatry in colonies were replication of such practices in their colonizer countries. He, however, totally disagrees that proliferation of asylums was what Foucault has called 'the great confinement'. Wright further says that, this was not the case as asylum represents only a small fraction of persons with mental disabilities admitted to asylums and most of them receiving treatment within families, which remains lost in most of the existing scholarly discussions. According to him, confinement was related to the pressures of industrialization on families to load off their care burden of unproductive members.

Waltrud Ernst puts that through the establishment of asylums, the Colonial British government succeeded in drawing allegiance from the Indians to have social and political control over them in the guise of the humanitarian agenda to serve. She

argues that the asylums were the sites of race and class hierarchy. Ernst mostly focuses her analysis on European patients and does not offer much on Indian patients and Indian experiences.

RESEARCH QUESTIONS:

- Why Social Science academics have failed to take up 'mental disability' within the disability discourse?
- Do colonial discourses reveal a state-subject relationship between the British State and the India?
- Are people with mental disability adequately represented in India?
- Do the Indian State policies adequately reflect the needs of persons with mental disabilities?

HYPOTHESIS:

The understanding of the phenomena of mental disability by the Indian state is flawed and the institutions and policies to deal with the issues of persons with mental disabilities have not delivered to address this question.

METHODOLOGY:

This work has undergone discourse analysis of primary sources such as reports, legislative acts, data, policies and programmes as well as secondary sources. Analytical and historical method has been followed to approach the texts. A qualitative interview of few psychiatric professionals was conducted at the Central Institute of Psychiatry (CIP), Ranchi. The interview pertained to queries regarding the process of implementation of mental health legislations, involuntary admission and rehabilitatory aspects of treatment.

Limitations: This work acknowledges the restricted access to the data and subject under study. Further, this work limits itself to exploring a larger picture of the existing scenario. There is a lack of in-depth study on the established theoretical and historical discourses in this study due to paucity of time.

CHAPTER OVERVIEW:

The first chapter attempts to establish co-relation between mental disorder and disability based on their common experiential terrains. It argues that mental disorder is a part of disability discourse based on three commonalities- based on common social welfare entitlements, their external pathologically imposed identities and social responses generating common stigmatised, oppressive and discriminatory experiences. To justify that mental disorders are outcome of social factors, the next section discusses social theory of mental disability which suggests that mental disability and social structure share an inverse relationship with each other. The disparities in social advantages based on the social distributive structure create social hierarchies. The individual belonging to the lower hierarchy stands more chances of mental disability due to limited access to social resources and redressal mechanisms.

The social capital theory illustrates how mental health is inextricably linked to access to social resources and networks. This theory establishes that mental disorders also arise and are influenced by social interaction, a premise suitable enough to consider them as part of disability discourse. Based on this presumption, the next section looks at three definitions of disability- The WHO's definition, which provides separate definition of impairment, disability and handicap; The ICF definition, which is similar to the 10th Revision of the ICD and contains information on diagnosis and health condition, but not on functional status. Critics of the ICF model have argued that it is a new medical model which focuses on individual impairment rather than the environment attributing to disability; the third definition is specific to India, provided by the PWD Act, 1995, which enlists seven categories of disability including mental illness and mental retardation. Apart from the legal entitlements and provisions, this Act does not offer much for the theoretical understanding of mental disability.

The academic deficiency on separate theories of mental disability engages the next section to look at the three theories of disability- the individual model of disability, the social model of disability and the cultural model of disability. The first chapter attempts to investigate and explore varying theorizations on disability primarily with the objective to trace whether there exists theoretical discourse on mental disability.

The second chapter explores the mental disability discourse in the colonial period. The first section of the chapter discusses mental disability discourse in ancient period and medieval period which suggests that mental disability was conceived as to be belonging to spiritual and family domains. The second section of the chapter narrates conceptualization of mental disability within the colonial Government's practices. The third section presents a brief account of development of psychiatry in medieval England to show how similarities existed between psychiatric patterns in India and England. The fourth section shows inside the asylum practices between the period of 1858 till 1912. The last section discusses the Indian Lunacy Act of 1912.

The first part of the third chapter begins with the discussion of first mental health act of Independent India- The MHA '87, followed by the PWD Act '95 and National Trust Act, followed by the UNCRPD and then the MHCA'17. The second part of the chapter analyses policies and institutions based on the study of recent reports by the NHRC and Human Rights Watch reports to show how it exists in the present scenario.

CHAPTER 01: UNDERSTANDING DISABILITY.

The chapter does not attempt to re-define different sub-categories of disability, for disability as a single theoretical discourse has so far marked its absence in the social sciences. It tries to trace different conceptualizations about disability analysing their impacts on the lives of the disabled. This is an attempt to look at the theoretical understanding of disability to get a comprehensive idea of the subject.

It is to mention that although mental illness remains recognized as one among the seven listed disabilities under the *PWD Act,1995*.The Act as a whole highlights very little of mental illness as a disability and only represents the provisions of the *Mental Health Act,1987*. The very understanding of mental illness is more by its exclusion rather than explanation. Additionally, pathological diagnostic labels have marked its identity, and there have been little attempts to rediscover mental illness within the general discourse on disability. The chapter tries to establish relationship between mental disorder and disability based on the experiential commonalities. The last section looks at mental disability from a sociological approach examining how social positions, structures and the means of production are causal factors in affecting mental health both at the individual and system level. The section attempts to trace how externalities shape mind and society relationship. The purpose of the chapter is to present an extensive picture of mental distress and impairment as disability within the disability discourse.

Within the Indian popular discourses too, there are multiple terminologies, often derogatory, on mental disability – *pagal*, *moorkh*, *mand-buddhi* etc. (Ghai 2015, 82).These discourses reify able-bodied norms meant to determine the characteristics of disability. The creation of identities based on such social meanings reveal a certain politics of language use which decides the social positioning of such identities. Ghai argues that this makes a serious impact on the lives of disabled people (Ghai 2015, 82). The meaning associated with each of these terms governs the representation of persons with disabilities within the socio-economic distributive system and decides the shape of politics.

The academic language discourse too, while maintaining cautious attempt, not to offend the sentiments of people with mental disabilities, have unconsciously added to

their stigmatization with the use of euphemistic terms. These terms induce unintentional discriminatory social positioning of people with mental disabilities by stereotyping their identities. Most of the official terms like- *differently-abled, people with special needs, divyang* etc., meant to preserve dignity of individuals, only add to their stigma. These terminologies unintentionally provoke ‘able-bodied’ and ‘normality’ norms. These tend to subdue personality and individual experiences under a collective identity formation. This is, however, a common disabled experience in general.

In a survey conducted in Britain by OPCS in 1986 (M. Oliver 1990, 07), such reductionist impository deterministic methodology was followed. Few of the questions asked in face to face interview have been listed as follows (M. Oliver 1990, 07):

Can you tell me what is wrong with you?

Are your difficulties in understanding people mainly due to a hearing problem? Did you move here because of your disability?

Does your disability affect your work in any way at present?

The nature of this interview process presents interviewer as the expert (Oliver 1990,07) and the participant as object of his oppression. This process makes person believe that his problems are due to his own functional impairments and not due to the failure of society to address his difficulty.

According to the *Union of the Physically Impaired Against Segregation (UPIAS)*, it is the society which disables by unnecessarily isolating and excluding persons with disabilities from full participation in society. This is what makes them an oppressed group in society. However, ‘people with disabilities’ has remained a preferred terminology within the formal structural systems that work with people with disabilities and also within most advocacy and political organizations in India. The reasoning behind this is that the person with disability is a person first, and the disability is her/his personal experience. It is a mode of fighting against the stigma of disability and re- emphasizing the humanity, wholeness and normalcy of the person

Disability has never been a uniform and single category. It encompasses a variety of human conditions and thus, is a diversity in itself. Generally the answer to the question of 'who is disabled?' is always thought upon from the vantage point of *able-bodiedness*. In India too, disability does not connote a single or unified definition as is evident from different social responses and practices in different cultural contexts. Social sciences so far do not have a very good reputation in critically examining disability as opposed to able-bodied norms. Nevertheless, the importance of defining disability cannot be denied for the following reasons: As W.I. Thomas (1966) says, "If men define situations as real, they are real in their consequence (cited in Oliver, 1990, 02). Likewise, Oliver argues, if disability is seen as a tragedy, then people with disabilities would be treated as its victims, and this treatment is most likely to get transformed into policies for their social welfare (Oliver, 1990, 02). He further suggests that within a society any object is judged and conceived by the social meaning assigned to it (Oliver, 1990:02). In other words, when disability is seen as a situation, then disabled people would be seen from the vantage point of consequential effects of that situation. And these consequential effects are reflected in policies made for these people. So, a proper definition of disability is much needed, for it impacts the lives of disabled people directly. Also, as Oliver suggests, this links both theory and practice of disability, which more or less remains subdued in the dominant discourse on disability politics in India.

Disability has been a historical determining tool to segregate social and political productivity and un-productivity by assigning certain fixed disabled collective and individual identities. This acquires a very important role in the modern industrial societies. Gradually, this process became convenient and legitimate with the aid of clinical and medical expertise. This is reflective of the ideological construction of disability in the context of the rise of capitalism and the emergence of medical model of disability in the post-capitalist period.

Thirdly, need for the definition of disability arises from the 1950s upsurge of identity politics. There was an increasing consciousness that to address certain social problems, those problems must be reformulated. In the West, *disability* as an identity poses against the notions of *able-bodied* norms. However, in India political discussions on disability within the larger discourse on identity politics still remains

on the margins except some organizations preferably NGOs, working for the advocacy of social welfare concerns of persons with disabilities.

Disability has been framed differently in different countries and cultures as well as in the field of academics. Some view disability as a biological defect while others see it as a human rights and social problem. Anita Ghai (2015) argues that in any subject area, the definition of the problem affects what solutions could be sought and how (Ghai 2015, 74) . What she argues is similar to what has been already mentioned above as the perception of disability in terms of its consequential effects on those who are disabled. Ghai puts that “The definitions of disability assume significance as these are important in diagnosing a particular condition as belonging to a specific category, which can have far reaching consequences in shaping the identity of those subjected to its ramifications“ (Ghai 2015, 76). There are different types of disabilities-some are inborn, some are acquired, some are physical, some are intellectual; then there are 'hidden' or 'invisible' disabilities. In India, access to State welfare requires a medical certificate indicating the percentage of impairment issued by an authorized State board. Once a medical label of disability is sanctioned, it imposes on individuals their particular social identity in popular discourse. The external labelling of identities generates an internal disabled experience. Oliver and Barnes(1998) suggest that definitions of disability can be divided into two categories: firstly , official definitions developed by professionals and academics; secondly ,definitions based on the personal experiences of the disabled people (Oliver and Barnes 1998). When an externally imposed fixed conceptualization of disability is established, it becomes very difficult to accommodate varying expectations of people who undergo different disabled experiences. Like, in India, during the 1981 census, only three types of disability was included, the Census 1991 included only disability with total incapacitation and so, even people with severe impairments were excluded and thus, these censuses revealed a very low incidence (Disabled Persons in India: A statistical profile 2016). So, this manifests the casual concerns of government towards people with disabilities in understanding them, figuring them out and making suitable policies for them.

In India, these medically diagnostic labels guide the lives of the persons with disabilities. These labels qualify them have access to social welfare entitlements.

However, it also reduces them to disrespect and sub-human treatment and restricted access to several opportunities. Diagnosis gives central importance to pathology, pressing for clinical and medical expertise. This establishes a professional-patient relationship, inducing *categorization*. This produces an official designation where-by one category is assigned greater value over the other. Apart from a medical process, diagnosis becomes a system of analysis of people's lives based on the expertise of professionals, and this eventually excludes the patient in determining who they are, gradually erasing their recollection of disabled experiences. They, begin to internalize and accept pathological 'identity' imposed on them by professionals. While disability manifests varied interactions and patterns of mind and body, labelling them as one can be catalytic in the exclusion and isolation of people from mainstreams of society. In the context of professional certification of disability by the state, Stone, 1986 argues that "the concept of disability by the state is fundamentally the result of political conflict about distributive criteria and the appropriate recipients of social aid" (Stone 1986,172 quoted in Oliver,1990).

Ghai draws on Salifos-Rothschild, who posits, "A serious overall curtailment of option occurs when professionals adhere to a stereotyped role for...[people with disabilities], which, like sex-appropriate roles, offers a single appropriate model of thinking and behaving for the...person and precludes a whole range of 'inappropriate' options, regardless of the individual's abilities, talents, and inclinations" (quoted by Ghai 2015,80). This kind of classification system affixes deterministic beliefs which suggests that the needs and behaviour of individuals can be understood by the groups they fall in (e.g. disabilities, gender, caste, race, etc.) (cited by Ghai 2015,80). Identification, therefore, becomes central to classification (Ghai,2015,80). The classification institutions comprise of social institutions such as social welfare departments, rehabilitation councils. These institutions force people with disabilities to social exclusion by assisting them adjusting to 'normal' norms of the society. This classification accrues them a transfixed collective recognition with very little scope for their personal aspirations.

The term 'castification' describes this exclusion of minorities while assigning them a social status based on deterministic standards. Some of the difficulties faced by people with disabilities are also attributes of castification process enforced by social

institutions through medical deterministic standards. This process sees people with disabilities as somebody 'less-human'. The classification assigns deterministic standards to the definition of disability which labels people with disabilities as less capable or less human. This generates stigma(Goffman,1963) among the people with disabilities, which again poses serious implications in their unification as a political identity. Ghai argues that “disability primarily signifies exclusion, which is, produced through a shifting, interconnected web of linguistic, legal, medical, political, social, economic structures” (Ghai 2015, 81). Disability is different from other forms of social categories in that it has to be certified and variations that disability cause are seen as deviance. This precludes a basis on which it must be based. In general discourse, the notion of 'able-bodiedness' or 'normalcy' decides representations of disability.

DEFINITIONS OF DISABILITY:

I shall mention three definitions of disability out of which the first two definitions have been acknowledged globally while the third one specifically relates to the Indian context. Mental disability as such, has not been defined specifically in the first two of the definitions, except the third one, which enumerates mental illness and mental retardation as among seven listed disabilities. This section then, presupposes that mental disability also could be looked at through the definitions explained below. The definitions are as follows:

The World Health Organization's (WHO) definition:

The WHO introduced *International Classification of Impairments, Disabilities and Handicaps* (ICIDH)(WHO,1980 also cited in Oliver 1990). This provides separate definitions of impairment, disability and handicap which are as:

Impairment- Impairment is any loss or abnormality of psychological, physiological or anatomical structure or function (WHO 1980).

Disability-Disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being (WHO 1980).

Handicap- A disadvantage for a given individual, resulting from an impairment or disability that limits or prevents the fulfilment of a role for that individual (WHO 1980).

The WHO definition seems somewhat close to individual or medical classifications of disability-handicap. (Oliver 1990, 04) In doing so, it conserves the notion of impairment as abnormality in function, disability as not being able to perform an activity considered normal for a human being and handicap as the inability to perform a normal social role. Oliver argues that the WHO definition re-establishes 'normality' criterion for deciding what is disability, while, ignoring context based differences at the same time(Oliver 1990, 04). This definition takes environment for granted even though the handicap is no longer considered to be within the individual. As long as the environment consists of social roles that are considered to be normal, the inability of the individual to live up to the requirements of these roles puts her in a disadvantaged position and thus creates a handicap. In this way, the medical approach is conserved since changes must be brought to bear on the individual rather than the environment.

What gets wrong with the medical approach to disability? Medical people tend to see all difficulties solely from the perspective of proposed treatments for a patient without recognising that the individual has to weigh up whether this treatment fits into the overall economy of their life (Brisenden1986, 176 also cited in Oliver 1990). Hence, medical approach produces definitions of disability which are partial and limited and which fail to take into account wider aspects of disability. Also. this approach tends to ignore questions about quality of life. The WHO definition present disability as a static condition and suppress its experiential and situational components. These definitions medicalize and individualize the problems of disability and the policies framed. The WHO definition had been extensively used in areas such as rehabilitation, education, statistics, policy, legislation, demography, sociology, economics and anthropology. This definition, however was revised and a new definition was introduced termed as International Classification of Functioning, Disability and Health (ICF).

The ICF definition:

This classification is similar to the International Classification of Diseases(ICD) 10th Revision, which contains information on diagnosis and health condition, but not on functional status. The ICF is structured around the following components- body functions and structure; activities and participation (Ghai 2015,86). The ICF has developed from the International Classification of Impairments, Disabilities and Handicaps (ICIDH), which was criticised for not allowing the measurement of environmental and social barriers and facilitators in the process of disablement. Critics of the ICF model have described it as the ‘new medical model’ with an emphasis on the individual and the impairment rather than the disabling environment. This model sets standards for all individual social, economic and political activities. In the context of India, power of setting standards has primarily remained in the hands of those who were non-impaired. Therefore, this standardization could misrepresent people with disabilities. Disability KaR paper provides a critique which argues that ICF represents a little more than medical model thinking guised in the language of a social model.

The third definition is provided by the Indian Government Act entitled ‘Persons with Disabilities Act (equal opportunities, protection of rights and full participation)’,1995. This act lists seven categories of disabilities, which are as follows:

- Blindness
- Person with low vision
- Hearing impairment
- Mental retardation
- Locomotor disability
- Mental Illness
- Leprosy cured

Before this definition came into being, the Rehabilitation Council of India Act, 1992 had a different set of definitions. With increasing social visibility, Rehabilitation issues in the medical model were re-thought as the Persons with Disabilities (PWD) Act, 1995, passed by the Parliament of India. Though mental illness was a part of the equal opportunities act, not much has been discussed and implicated in the act. Many other categories such as cerebral palsy, autism etc. were not taken into consideration

in this act. The National Policy for Persons with Disability was announced in February 2006 which carried good stipulations but without any second thought about financial resources. This policy recognizes the need to replace the earlier emphasis on social rehabilitation but, it lacks clear roadmap, list of priorities to be implemented in practice. With the ratification of UNCRPD on 01 October 2007, the Government of India is obliged to ensure adherence to its provisions and amendment of various national acts which will be discussed in detail in the third chapter.

MENTAL DISORDER WITHIN DISABILITY DISCOURSE:

The disability movement is scattered in its opinions when it comes to the issue of including mental disorder and mental impairment within its discourse. Even most of the significant texts on disability have elucidated too little on this part of discourse highlighting its individual medical aspect rather than one based on a shared disabled experience. As Beresford posits, “There does not seem to be any clear agreement in disability discourse whether or not madness, distress and psychiatric system survivors are part of the discussion” (Beresford 2000, 168). This obscurity in agreement can be related to different experiences of individuals with mental impairments from individuals with other disabilities. Many mental disorder survivors do not consider themselves as individuals with disability. For them, disability remains an outcome of medical intervention in their distress (Beresford 2000, 169). They tend to conceive themselves as normal and reject genetic and biological elucidations of disorder and distress. In other words, disability represents the visible domain of impact of a particular distress on the individual’s body. A similar thinking guides individuals with other types of disabilities who can visualise it only in its physical and permanent impacts. As Kim Hewitt puts, the status of mental illness as a physical illness still remains foggy despite advancements in diagnosing its physical manifestations (Hewitt 2006, 155). She further suggests that there exists no universal etiology of mental illness and its understanding as a function of relationship between mind and body varies in different historical, cultural and social spaces.

Despite varied opinions and confusions owing to the fluid ramifications of mental disorders making it difficult to fit within the disability discourse, it cannot be denied that common experiences do shape their existence. Both individuals with mental disorders and individuals with other forms of disabilities are recognized by common

pathological theorizations imposed on them externally; they are bestowed a particular category which shapes their personal as well as collective identities. For e.g., within the policies and legislations they fall under social welfare provisions. As Colin Barnes, 1999 has pointed, “The original definition of impairment was limited to physical conditions, it was later expanded to include all impairments- sensory and intellectual. This was in recognition of the fact that all physical conditions have psychological implications and that all intellectual impairments have physiological consequences. Also, that these labels were imposed rather than chosen and that they were politically and socially divisive” (cited in Beresford 2000,169). This is very clearly evident that both individuals with mental distress and individuals with other disabilities undergo same forms of oppression, humiliation, discrimination and deprivation of their basic rights. So, they have in common- their ‘disability’.

SOCIAL THEORY OF MENTAL DISABILITY:

According to sociological thinking, mental disability and social structure are causally linked. The mental disability and social structure share an inverse relationship with each other. The social structure characterized by social divisions and social hierarchies created by unequal socio-economic status, caste, class and gender, race etc., divisions are intrinsically linked to arousal of mental disabilities. Many of the sociologists contend that individuals occupying higher social strata within the structure of society have better health than those assigned lower social stratification (Peng 2009, 86).

The theory of social causation suggests that people belonging to the lower social strata in a given society are more likely to show higher probability of mental distress than those who are positioned at upper hierarchy. Individuals suppressed to lower social hierarchies have lesser access to personal, social, political and economic resources and are prone to traumatic and hard exposures to circumstances. The limited means to resources makes it difficult for them to cope such circumstances, thereby, affecting their mental well-being (Peng 2009, 87). Governing social structural arrangements initiate such situations which disturb mental intactness at the individual level.

The theory of fundamental causes proposed by Link and Phelan (2005) (cited in Peng 2009, 88), emphasizes the idea that distal or indirect factors which are structural or social in nature, for e.g., socioeconomic status which includes money, power, social

networks, political influence, education etc., are the fundamental cause of disparities in disability among different social hierarchies. These distal factors influence and operate proximal and immediate factors for e.g., lack of means to treat mental distress due to limited access to social and structural resources. The proximal factors directly interact at the level of individual influencing his/her mental health.

The social stress theory similar to the social causation theory propounds psychological stress initiated by disparities in social structural arrangements are responsible for gradual arousal of mental disorder in individuals. The stress or a series of stressors are one of the channels through which social positioning affects mental health.

The stress operates both at the individual and group level. At the individual level, an individual's own experiences, traits, social position decides the presence of stress. At the group level, it can be triggered by a group's social positioning within a social arrangement. For e.g, inequalities in distributive system produces unequal social structures, which arouses stress both at the individual and group level. Aneshensel contends that two major pathways linking structure with stress are exclusion from full participation in the social system and participation which yields nothing beneficial to them (cited in Peng 2009, 90). At the individual level, the importance of social positioning and social structures in explaining mental disability in theories of social causation, theory of fundamental causes and social stress theory has been articulated in social capital theory. At the system level, this has been well explained by the theory of political economy of health, which is a Marxist recapitulation on health and disability.

How social capital influences mental disability?

Robert Putnam defines 'social capital' as "the networks, norms and social trust that facilitate coordination and cooperation for mutual benefit". (Putnam 2000). Disability can shape people's lives in ways which blocks social capital growth. Social capital is created through *participation* in networks and groups, but the experience of disability infringes this capability mainly through social isolation. Mental disability being accrued the most stigmatized and demanding status, impedes social capital growth to its worst. Another aspect of social capital is *reciprocity*, facilitating mutual exchanges of benefits, which is less likely to be in practical mentally disabled existence. *Trust* is

another key aspect which is very unlikely to be exchanged owing to traumatized and oppressive experiences of individuals with mental disabilities. Another key aspect *social norm* defines the membership in building social capital. Mental disability remains the most challenging historical impediment to social mainstreaming. It becomes extremely difficult for individuals to overcome their particular experiences and demands of disability for social inclusion.

Lacking or limited social capital denotes lesser access to social resources to have a strong social positioning. Social capital is a characteristic of healthy communities. All the theories mentioned above can be best elucidated with the concept of social capital which apparently shows a triangular relationship between social networks, social positioning and healthy existence at the individual level.

The Marxist sociological thinkers concede that mental disability outcomes at group level can be best contemplated by the theory of political economy of health. This theory claims that higher occurrence of mental disability among disadvantaged social groups is the outcome of unequal income distribution and control over social resources. This distribution is guided by the control over the means of production which determines 'class' distinction of each group within the system. At the system level, a group which does not control the means of production be it material, social, political and cultural is, the non-capitalist, non-propertied class, subject to domination by the capitalist class which owns the means of production and therefore resources. The exclusionary and exploitative nature of systemic arrangement exposes the chances of psychological distress among the lower hierarchies with limited resources to address it. This theory is analogical to understanding relationship between disability and social status in hierarchical societies based on other differences like caste, race, gender, sexual preferences, etc.

THEORIES OF DISABILITY:

While the academics extensively engaged itself with identities such as race, gender, caste, religion etc., engagement with disability has remained at margins. This is to say that in depth study of disability both as experiential and theoretical conceptions has remained under-covered in the discipline of social sciences.

However, it cannot be denied that problems with the theorizations of disability are multiple. Disability as a category is a diverse association of different categories. It, thus, becomes very difficult to comprehend them theoretically as one category, for some disabilities are either congenital or acquired; physical or intellectual; temporary or lifelong. However, Ghai argues that while acknowledging qualitative differences, too much fragmentation must be avoided for the sake of formulating a disability theory (2015, 223).

Within the Indian context, disability theory and politics of disability are at margins and therefore, have not really been adopted into practice. Within the common discourse, disability has been theorized in terms of medicalization and social models.

The Individual Model of Disability:

This model assumes that disability is an objective condition in the form of physical, intellectual or emotional deformities within an individual. This locates the problem of disability within the individual situating the problems arising from functional impairments of the individual. The response this model poses is in terms of medical cure, solely dependent on the person affected by disability. Within India, where resources to cure disability are limited, disability reduces the affected person to his particular impaired identity (Ghai 2015, 226). Thus, medical model has failed to understand disabled people as more than their specific problems. This model empowers able-bodied norms and perspectives of viewing disability through non-experiential terrains by assigning fixed identities to disabled people. This inflicts a sense of viewing disability as 'personal tragedy' among the disabled. Personal Tragedy theory of disability (Oliver, 1990) underlines the medical conceptualizations of disability that disability is a personal tragedy of the individual, arising out of his/her own bodily or mental defects and not due to the failure of society to address his/her needs through appropriate human support and accessibility. This understanding forces disabled people to attempt hard to adapt to normalcy either through adjustment, concealing one's disability to avoid stigma arising out of it. This makes it difficult for the people to recognize their specific experience and subsumes possibilities of alternative narratives to arise as a political identity.

The idea of 'normalcy' inculcates unrealistic expectations among the disabled causing more damage to the sense of self (Ghai 2015,229). In this process, oppressive structures of society do not get recognized and so this model is self-harming to people with disabilities. In fact, Oliver (1990) insists that there is no such medical model of disability. Rather, it is an individual model which is based on medicalized aspect.

Social Model of Disability:

The social model of disability arose as a protest against the medical model. A major proposition of this model is that the problem of disability is to be located within the society, and as already mentioned above, the problem is not the individual impairments but the failure of society to recognize needs of the disabled. This model was carved out of the experiences of the disabled and their reservations against the definitions proposed through able-bodied perspectives. This model asserts that while impairment may be an individual condition, disability is the outcome of oppressive conditions imposed by the society over people with disabilities (Finkelstein1980,47). This theory re-formulates disability as one of the human experiences.

However, the kind of institutionalization that the West had undergone arising out of medical model, was not popularly accepted in India. Family is still central in providing support to its members with disabilities. Family provides identity and sense of security to its members. So, in India disability is still an issue within the private domains. However, the treatment members with disabilities receive at the hands of society, depends on the socio-economic positioning of the family, as will be discussed later in this chapter.

Social models, however vary depending on the type and concerns of society. In some societies, they are involved in structural concerns while in the other they are concerned with identity formation.

Cultural Model of Disability:

Cultural model of disability suggests that the experiences of people with disabilities and their restricting limitations cannot be conceptualized universally but varies from society to society as well as historically. The social disabilities of individuals and groups are peculiar to the social conditions of the particular societies concerned

(Oliver1990,18). So, one can say that the individualised view of disability in modern industrial societies is not universal, this can be agreed about societies like India where the disability is not medicalized to the extent the West has been. These variations are dependent on factors like social obligations towards the disabled, the type of social structure, economy, political system etc. However, so far none of the scholars have provided a comprehensive framework to explore and integrate variations among different cultures and implicit theories of disability are the only theories available to look at the cultural conceptions of disability. I have mentioned these theories based on the framework provided by Michael Oliver, *The Politics Of Disablement*,1990.:

The first implicit understanding of disability comes from the work of Evans-Pitchard (1937), which suggests that in societies overruled by religions and magic, disability is most likely to be perceived as punishment by the divine. The problem with this explanation is that it views religious or magical beliefs as the sole determining factors in defining disability and the treatment disabled receive (M. Oliver 1990).

The second understanding is based on the work of Turner (1967) who develops the concept of liminality. The sick person lives in a state of social suspension till he/she gets better. The disabled spend their lifetime in similar suspension as undefined, ambiguous people(Murphy,1987:117 cited by Oliver,1990:20). Oliver locates two problems with this explanation-Firstly, disabled people are not placed at margins in all societies; secondly, this idea shifts attention away from the physical and social differences harming disabled people and rather creates a sense of metaphysical 'otherness' among them(Abberley,1988:306 cited by Oliver,1990:20).

The third understanding of disability states that in societies where people struggle for economic survival, the weak and disabled members are not considered as productive and are subject to subhuman treatments (M. Oliver 1990)

Most of the cultural discussions on disability are based on the framework derived from the perspectives of health and illness and disabled people have been commonly perceived as deviants and incompetents. The cultural understanding of disability has not moved far beyond these. Oliver says that disability as a category is culturally produced and socially structured. A comprehensive disability theory could then be constructed on the common experiences of the disabled in different spaces and time.

CONCLUSION:

The disability discourse in India suffers from theoretical deficit. This exists as a static and essentialist concept mainly within the private domains. Despite advancements in disability policies, the concerns still remain confined to the issues of care, support, accessibility. The idea of 'dependency' is conserved thus. Disability as a representative identity for a group of people with specific experiences so far remains at margins. This is partly because in-depth and critical inquiry into disability is absent. The theoretical and experiential discourses on disability must be linked to frame a theory of disability specific to the Indian experience. While acknowledging that disability is a diverse category and different sub-categories within this reflect dissimilar experiences, nevertheless a common link of 'human essence' could be drawn to bring these together. I suppose this may help develop framework to deconstruct the existing notions of 'normalcy' and towards its re-construction encompassing all sorts of human existence.

CHAPTER 02: MENTAL DISABILITY IN COLONIAL INDIA

This chapter attempts to explore colonial discourses on mental disability in India reflected from the practices of the colonial psychiatric practices as established by the British Government in India. The chapter begins with presenting a brief scenario of mental health practices in pre-colonial India. The next section discusses the development of modern psychiatry in medieval England and tries to trace if there exists any relationship between patterns of development in England to that in India. The chapter then proceeds to look at the Indian asylum practices to explore and present a social and political picture of asylum between 1858 till 1912 drawing on the details and excerpts provided in Anouska Bhattacharya's extensive work. The last section of the chapter discusses The Indian Lunacy Act, 1912.

The central focus of the chapter is to collect a concept of mental disability by tracing colonial discourses on mental disability. This is supposed to examine whether there exists any distinct Indian discourse on mental disability relevant for the next chapter.

MENTAL HEALTH PRACTICES IN PRE-COLONIAL INDIA:

Ancient India:

The discourse on mental disability has been existing since Vedic times in India, according to many historians. *Atharvaveda* (1200-1000 BCE) carries the earliest record of narratives on madness in India (Pinto 2017, 35). Madness in this period, was associated with curse of gods or to demonic possessions. The treatment suggested was medication, prayers and restraints.

The *Ayurveda* tradition prescribed medicine, offerings and prayers as part of its treatment procedure to cure insanity. The tradition practised the science of medicine along with spirituality.

The *Charaka Samhita* (1000 BCE) provides a detailed account on insanity and its treatment procedures. This text lists presence of some exogenous and non-exogenous factors as to be prime causes of insanity, exogenous factors comprising of abstract factors like demonic possessions, gods and other supernatural beliefs; while non-exogenous factors related to somatic and behavioural patterns.

The common form of treatment included a combination of prayer and medicine, confinement was prescribed for violent patients; different forms of ritualistic lifestyle and moral values were included as part of treatment during the Ancient Indian period. The broader argument here is that even though mental health practices were community specific, nevertheless, an Indian discourse on mental disability existed much before the colonial period (Pinto 2017, 35).

The Medieval India:

The medieval period records some historical evidences of the presence of some primordial form of mental institutions like *Shahdaula's Chauhas* at *Gujarat* and in *Punjab* (Shaw cited in Sharma and Varma 1984, 295), at *Dhar* in *Madhya Pradesh* under the supervision of physician *Maulana Fazulur Hakim* (Sugandhi cited in Sharma and Varma 1984, 295). There are also references of presence of asylums in the period of *Muhammad Khilji*(1436-1469 A.D.) during the fifteenth century.

However, the family was the central domain of patient care and treatment and hospitalization was rare throughout the medieval period.

THE MENTAL HEALTH PRACTICES IN COLONIAL INDIA

The concept of institutional confinement of insane or lunatics was not in practice in pre-colonial India and only came to be established after the arrival of the British East India Company in 1600 (Jarret n.d., 07). The institutionalization of mentally ill in the mental asylums by the British initiated the onset of psychiatry as practice in India. Shridhar Sharma suggests that early mental institutions in India were established to cater for European patients (Sharma 2008, 110). Mental asylums in India were a British idea. Since, these institutions were of British origin, they also reflected ideas and concepts prevalent in the Contemporary England in particular and Europe in general.

There are ideological disputes among scholars regarding the British intention to establish asylums in India. Some argue that these establishments were erected for the general treatment and betterment of colonial subjects, while others like Waltrud Ernst argue that these establishments were constructed to gain moral allegiance from Indians to have control over them through such structures of discipline and humanistic

gestures. Racial theory of British supremacy and eugenics remained central to the practice of psychiatry in India. This is evident from the fact that there existed separate asylums for the Europeans and the Indians. Even inside the Indian asylums caste, class inter-sectionality seemed to dominate the practice of psychiatry which will be discussed later in the chapter.

To facilitate the development of Western psychiatry in India, the British began to de-historicise and de-value the traditional Indian therapeutic practices as primordial and barbaric (Pinto 2017, 41). These practices were eventually, de-legitimized and practitioners criminalized and penalized to proliferate the development of psychiatry in India.

In the medieval England (1050 – 1485 A.D.), during the late 14th Century A.D., England's first mental institution emerged from *Bethlehem Hospital*, later to be known as *Bedlam*, near the city of London (Jarret n.d., 07). *Religious Charities and missionaries emerged as pioneers in the emergence of hospitals caring for the sick and disabled during this period.* Before the medieval period, the disabled population lived among their communities and were being cared by their families.

By 1403, patients with 'mental illness' or commonly called 'lunatic' patients formed the majority of Bethlehem's inmates.. The demographic study of the inmate population reveals that patients mainly belonged to poor social and economic backgrounds, the marginalised, lonely, destitutes, conceived as threats. *During this period, there is no evidence of professional psychiatry as a means of treatment, rather, punitive mechanisms along with spiritual practices were preferred as part of treatment: "'Chains, manacles, locks and stocks' appear in the hospital inventory from this time- the stock of the corporal punishment was believed to induce recovery in some cases- and isolation was seen as a means of enabling a person to 'come to their senses' At the same time attendance on and compassion towards people afflicted by madness was a religious imperative"* (Jarret n.d., 10).

A vast majority of mentally ill population remained outside institutions within their respective communities. *After the establishment of Bethlehem hospital, the idea of specialised institution came into being in England in naïve Foucauldian sense at least* (Foucault 1965).

In the medieval period itself, a primordial conception of mental illness as a certain form of category *under legal jurisdiction somewhat emerged*:

“From the 13th Century onwards, the King held rights and duties over ‘natural fools or idiots’ [...] He would have custody over their property and assets but also a duty to ensure they were properly cared for. Special ‘inquisitions’ were held by officials in front of country juries, to determine a person’s mental status. In the early 16th and 17th Centuries, the law would consider them as incapable to reason and a Court of Words would allocate responsibility for management of their affairs.” (Jarret n.d., 11,17).

Mental illness in the Sixteenth and Seventeenth Century England could be characterized by the onset of its medicalization. During this phase, mental illness marked itself getting transformed eventually into a medicalized proficiency from a subject under religious and traditional domains. In 1547, Henry VIII transferred the regulation of Bethlem Hospital in London to the Corporation of London, thereby transforming it as a Civic institution from a religious one. The new governors of the hospital enacted a stricter admission policy, admitting only those prone to cure, as well as threat causing to self and others (Jarret n.d., 17).

In 1619, Helkiah Crook became the first medically qualified ‘keeper’. His appointment marked the beginning of medical skill as a criterion for the appointment of medical officer and medical staff in Bethlem Hospital. His medical qualification set him apart from other staffs. His appointment demonstrates that gradually the treatment of mental illness was establishing itself as a medical skill, Thus, consistently shifting away from the notches of traditional and religious practices. Although, he was dismissed in 1633 on the grounds of Corruption and mal-administration by an inquiry by Royal Commission in 1632, nevertheless, he made a long lasting influence (Jarret n.d., 17).

Even with the onset of medical institutionalization of mental illness during the Sixteenth and Seventeenth Centuries, only a handful of patients preferred institutional care and most of them relied on their respective families for care. Even they preferred traditional forms of treatment over medical services by an ‘expert’¹, probably due to two reasons : firstly, out of economical incurring as most could not afford the services

¹ Expert, here refers to a person specialized in medical skills

of professionals; secondly mental illness was still perceived as a supernatural, divine curse, or demonic convulsions (Barnes 1991) suitable to be treated by a range of traditionally skilled practitioners like astrologers, witch-hunters, charmers, clergy etc. One such account mentions about Richard Napier who was a clergy man, medical practitioner as well as astrologer based at Buckinghamshire in England between 1597 and 1634. He treated patients suffering from self-harming and suicidal tendencies, mood disorders, talkativeness, 'hatred of spouse', sexual disorders etc through spiritual and traditional remedies (Jarret n.d., 17,18). So, alternative forms of treatments also existed apart from institutional confinements. In the Eighteenth Century England, mental disability came to be seen as a condition of diminishment in reason rather than as a supernatural or divine bane or spirit possessions. Though, the older existing idea did not fade away completely, however, its importance got subsumed under the new idea. *This established a belief that mental disability could be remedied through moral treatment and a disciplined lifestyle* (Jarret n.d., 23).

The Eighteenth Century England also witnessed an increased growth in the number of asylums country wide , which was instigated by a voluntary asylum movement based on a belief that the 'disabled and the mentally ill could flourish in healthy, clean institutional settings' (Jarret n.d., 21). Some of the hospitals which were established during this period were Bethel Hospital (1712) in Norwich, St. Lukes, some small scale asylums with a capacity of 100 people, in places of Manchester (1766), Newcastle (1767), York (1777) and Liverpool (1792). In 1796, the York Retreat was established by the Quaker Community which was a regime in itself (Jarret n.d., 21,22). These asylums were ordered and managed. Apart from these voluntary institutions, there were private madhouses and private homes to take care of the mentally-ill who could afford them. *Voluntary asylum movement shifted the conception of care from a medicalized one towards a more 'humane' means i.e. based on compassion, humanity and pity. Though, in-famous allegations of asylums as an epicentre of corruption, mis-management and cruelty also remained vocal even in this period.*

The Private Madhouse: One of the distinguishing features in the development of mental institutions in eighteenth century England was the rise in the growth of private madhouses. With growing scientific attitude towards conceiving madness associated with a loss of reason and not as a causality of supernatural calamity, madness,

gradually began to find its place within domains of care mostly in familial set-ups rather than a situation of social isolation in segregated institutions. Private madhouses could provide such ambience with calculated constraints even for the vigorous and threat-causing patients. In these houses, patients could keep their personal attendants. This is important to mention here that economic wellness guided access to facilities: there were separate arrangements for private patients and paupers, by charging smaller private rooms at higher prices and larger dormitories accommodating pauper and lunatics together. By the end of the eighteenth century, the number of such officially licensed private madhouses had grown to forty-five (Jarret n.d., 23). There are also references of inhuman treatment of pauper lunatics in some of the madhouses. In 1763, *The Gentleman's Magazine* condemned many such acts which were routinely practiced in some of the madhouses (Jarret n.d., 23). At Lainston House near Winchester, paupers were kept chained in filthy conditions in stables; this was closed in 1847 for mistreating pauper lunatics (Jarret n.d., 23).

With the enactment of Regulation of Madhouses Act in 1774, the otherwise flourishing practice of madhouses began to decline (Jarret n.d., 18). This Act introduced a licensing system to keep a check on the unlawful detention of non-lunatics by quell or through family conspiracies. With the growth of the state-owned asylums in the nineteenth and twentieth century, private madhouses took hind stage as institutions for the care of mentally-distressed in England.

In the nineteenth century, revolutionary transformations brought about by the industrial revolution in England also influenced its asylum system. The nineteenth century asylums were located in countryside landscapes away from the bustles of population within highly segregating giant walls. The asylums enclosed farms, workshops, lawns, sports grounds and a cemetery. Some asylums even had their own railway stations and fire brigades (Jarret n.d., 29). *The Bulider' Magazine* in 1892 reported: "From any of the great main lines of railway which run through the shire, a traveller will be sure to spy in some comparatively secluded position, a great group of buildings, which by their modern air...their tall chimney stacks and...their bulky water tower, seem to belong rather to the busy towns than to county seclusion" (Jarret n.d., 28).

The nineteenth century was characterized by a transition from community- care system to institutionalized segregation. The notion of ‘able-bodiedness’ began taking centre- stage in diagnosis and segregation of mentally- abnormal from rest of the population. This, further, marked a transition in the nature of workhouses from humanistic to one based on punitive work mechanisms, particularly after the enactment of Poor Law Act in 1834.

With this Act, 350 pauper workhouses were constructed at an average distance of twenty miles from each other. By the early nineteenth century, there was a remarkable increase in intake of lunatics in both county pauper asylums and workhouses. By 1900, more than 100,000 lunatics were occupants in 120 county pauper asylums and 10,000 were in workhouses (Jarret n.d., 28). Asylums emerged as prominent spaces for cure of mentally ill and community care within families and friends did not remain as much popular as it used to be earlier. From 1808, parliament authorized publicly funded asylums for pauper lunatics and twenty more asylums were built. From 1845 onwards, building asylums was made mandatory in each county and a Lunacy Commission was established to regulate the same. By the end of the century, as many as 120 asylums housing more than 100,000 people existed in England and Wales (Jarret n.d., 29).

The twentieth century society in England was very much influenced by the science of ‘eugenics’, based on belief that abnormal or defective members of a population would cause general decline of its race unless kept controlled, segregated and sterilized from the normal. In words of Julian Huxley, secretary of the London Zoological Society and Chairman of the Eugenics society, in 1930, “What are we going to do? Every defective man, woman and child is a burden. Every defective is an extra body for the nation to feed and clothe, but produces little or nothing in return” (Jarret n.d., 34)

The politics of the period was based on the issues of racial supremacy and thus, defectives- both physical and mental posed a challenge towards the quest for racial supremacy and human perfectionism in twentieth century England. This triggered various structural and institutional transformations. One such measure was constructing a range of colonies in rural settings to segregate mentally deficient from the rest of the population.

The 1913 Mental Deficiency Act played a critical role in carrying forward the idea of eugenics towards achieving human perfectibility in the twentieth century England. This act established that mental deficient patients must either be closely monitored within the communities² or segregated or kept in ‘mental deficiency colonies’ in an isolated scattered environment (Jarret n.d., 36). Mentally deficient people were further graded based on the extent of their respective disabilities. Each colony was further sub-divided into detached ‘villas’, housing up to sixty people and a central administrative block separated male and female villas. The children, the adults, vigorous patients and idiot patients were also segregated from each other; working patients were provided with cooking and heating facilities. All together a single colony housed between 900 to 1500 people (Jarret n.d., 36). These villas also had children’s school, staff quarters etc. and other basic amenities that leave was not required. Most patients performed daily chores and colonies ran their own expenses through dairy and agricultural sell. These colonies survived till 1990s (Jarret n.d., 36).

Post second world war era, particularly the year 1945, marked the beginning of the decline of asylum era. The Victorian notion of asylum in segregated rural settings came to an end. This was initiated by public condemnations of abusive and inhumane practices on these institutions. The 1981 Care in the Community Green Paper indicated the end of the asylum and promoted community-care system (Jarret n.d., 40,41) of treatment.

A significant number of people with mental disabilities came back to mainstream living through a new range of day-care homes, rehabilitation centres and community care. Although the asylums in England occupy 140 years of disability history, nevertheless in its imperial colonies, the same idea of asylum and specialized institutions were superimposed and continue to be in practice till date. This chapter tends to explore how far the asylums and institutions for mentally-ill in colonial India reflected the asylum culture of England, its imperial colonizer. The next chapter goes on to explore whether these trends still continue to take hold in the mental health policies of post-colonial India or not. This chapter limits this study till colonial period in India

² Even though the number of disabled people grew in the first half of the twentieth century still a significant population remained within communities. People classified as mentally deficient, when un-institutionalized, were kept in community under Government supervision.

THE DEVELOPMENT OF PSYCHIATRY IN INDIA:

The development of modern psychiatry in India stands parallel to the establishment of mental institutions in India. The establishment of lunatic asylums as specialized institutions to segregate insanes and mentally disabled from rest of the population was typically British in character. The establishments of mental asylums began in India with the arrival of the British East India Company in 1600 A.D. to cater to European members of the Company who developed mental distress due to the warm Indian climate. Gradually, the number of mental asylums began to rise in India and in the long run, these institutions became objects of colonial disciplinary power as what Foucault would suggest (Foucault 1975). Psychiatry as professional medical practice was not common in early asylum phase in India and only with the introduction of phrenology and scientific education as part of 1858 colonial reforms did it begin to acquire space within asylums. So, the development of psychiatry goes hand in hand with the evolutionary developments in asylum structures in colonial India. Thus, it would not be wrong to conceive both of these synonymous to each other.

As many historians have argued that mental asylums were built to protect the community from the insane and not for the cure of the latter. So, the insanes were segregated in such institutions much on the lines of asylums in England in highly segregated army barracks and dilapidated buildings with high walls located away from cities.

First Phase of Psychiatric Development: The first mental hospital was established at Calcutta by one surgeon, Dr. George M. Kenderline. However, this asylum could not be recognised by Medical Board as he was earlier dismissed from service for neglect of duty in 1770 (Sharma and Varma 1984, 296). In 1817, this hospital was taken care over by Surgeon Breadmore behind the Presidency General Hospital housing around fifty to sixty European patients. The East India Company (here onwards EIC) paid a rent of 400 rupees to a private lunatic asylum under the charge of Surgeon William Dick. On April 15, 1795 another asylum was founded at Monghyr (now Munger district in Bihar) for the insane EIC soldiers. In 1794, the first mental hospital in South India was established at Kilpauk, Madras. In Bombay the first mental hospital was established in 1745. With the political developments of the time shaping Company's policies, we find the concentration of initial asylum developments mainly at Bombay,

Calcutta and Madras Presidencies. In 1806, a mental hospital was established at Colaba. In 1821, a lunatic asylum was established at Patna on Lower Road. In 1855, a lunatic asylum was established at Murli Bazar.

Method of treatment: There are references of treating admitted patients in such asylums through Opium, Morphia(Calcutta asylum). Hot bathes and use of leeches for sucking blood to control periodic temper have also been mentioned. The Dacca asylum boasts of using 'music' as a form of treatment to calm down patients (Sharma and Varma 1984, 297).The use of psychiatric skills as the form of treatment does not appear anywhere during this period.

Second Phase of Psychiatric Development: Until 1857, there were no significant developments in the number of lunatic asylums except in the three major cities of Calcutta, Bombay and Madras. The transfer of power from the EIC to the British Crown in 1858 marked a significant phase in the development of Indian psychiatry with the enactment of first pan-India Lunacy Act, Act No. 36 in 1858. This was the first official lunacy legislation in India. The Act proposed for the establishment of mental hospitals, admission of patients and guidelines for treatment of patients. Under the Act several asylums were built in India:

North India: Punjab (1840) by John Martin Honigberger. With the annexation of Punjab by EIC in 1849, Dr. Smith, the first Civil Surgeon at Lahore took the charge with twelve epileptics and idiots admitted in the asylum (Sharma and Varma 1984, 298). By 1863, the number of patients increased to 283 after which the asylum was renovated by 1900 for efficient run (Lodge Patch cited in Sharma and Varma 1984, 298).

Central Provinces: Jabalpur (1866), Brar (1866), Benares (1854), Agra (1858) and Bareilly (1862) (Varma 1953 cited in Sharma and Varma 1984, 298).

South India: Within Madras Presidency, at Waltair (1871), Trichinapally (1871), Madras City(1871). The hospital at Madras City was established for 145 European and Indian patients. Within Bombay Presidency, Colaba (1865),Poona(1865), Dharwar (1865), Ahmedabad (1865), Ratnagiri (1865), Hyderabad in Sind(1865). Colaba had a capacity for Europeans with over 285 beds and Ahmedabad had 180 beds by 1872. (Sharma and Varma 1984, 298)

East India: Bhowanipore in Calcutta, Patna, Dacca, Berhampore, Dullunda in Calcutta and, Cuttack.

Third Phase of Development: The early twentieth century marked significant shifts in the asylum administration system in India. Those major transformations have been enlisted as:

Transfer of charge of supervision of mental hospitals from the Inspector General of Prisons to Civil Surgeons;

Specialists in psychiatry to be appointed full-time officers in mental hospitals;

To have a central provision for all lunatic asylums across India(enactment of the Indian Lunacy Act,1912);

Establishment of new mental hospitals with improvement of existing hospital conditions (Sharma and Varma 1984, 298).

Under the new legislation, Indian Lunacy Act, 1912 Central European Hospital was established at Ranchi on 17th May, 1918. In 1920, the names of all mental asylums in India were changed to mental hospitals. The Indian Lunacy Act, 1912 will be discussed in the later section of this chapter.

THE ASYLUM PRACTICES:

Within a native asylum, lower staffs like attendants, cooks, washer men, janitors were mostly Indians, while the administrative positions were held by the British. The Indian keepers and staffs doing daily chores of asylum were in immediate contact with admitted patients there. The administrators exercised an indirect control over the asylum inmates and it were these lower staffs who practically regulated direct supervision over the asylum affairs. Anouska Bhattacharya in her thesis argues that this system of asylum management permitted for the intermingling of local ideas with western psychiatric practices within the native asylums of India from the period between 1858 till 1912 (Bhattacharya 2013, 80).

The arrangement of patients and staffs within the asylum too, reflected the cultural, social, religious and economic determinants of contemporary Indian society at large.

The British psychiatry had generated a new knowledge of the ‘Indian Mind’. It had formulated different diagnostic levels for the mental capacity of Indians based on their socio-cultural and economic alignments. British psychiatry during this phase of its development had little to do with treatment skills, rather it was merely an instrument of diagnosis to segregate and confine natives (Kim Wagner cited in Bhattacharya 2013, 80).

Such social compositions of asylums could be well understood from the following excerpt borrowed from Bhattacharya’s work (2013) based on information from certain annual reports, notes and letters in the archives. This excerpt presents an array of social participants involved in asylum affairs. The excerpt quotes the remarks made by Dr. Tressider in 1872, The Inspector-General of Hospitals in Delhi revealing the identities of those who had been recruited:

“In place of the discharged [*Jemadar*], I have appointed a man called [*Peer Bux*], a very respectable [*Mahomedan*], who is especially valuable, as he has a certain amount of medical knowledge from having been a [Native Doctor] in [the community] [...] Mr. Gilson [the *Darogah*] whose exceeding care, judgement and kindness would if lost to the Asylum, be ill compensated for by the services of a [Native Hospital Assistant]” (Bhattacharya 2013, 81) .

The above excerpt reveals different ranges of asylum staffs – *Jemadar*, Native Doctor, *Darogah*, Native Hospital Assistant. The newly appointed ‘*Jemadar*’ is a ‘*Mahomedan*’ named ‘*Peer Bux*’ as the above excerpt suggests. Apart from this, the excerpt suggests that this newly appointed *Jemadar* has medical knowledge due to his experience as a ‘Native Doctor’ serving the ‘Community’ i.e., the Indians. We can get an idea from above remarks of Dr. Tressider that indigenous medical skill was also considered for the treatment in asylums.

In addition to them, some other actors were also associated with the asylum, performing specific business. These were asylum keepers, attendants who were indigenously known as *wallahs* (Bhattacharya 2013, 82). Bhattacharya writes, ‘ The Pagla wallahs, the men who worked in the asylum as attendants (wallah as “keeper”), the *chai wallahs* who visited daily, and those men and women who visited the asylum from the local community. There was a great deal of discussion about these wallahs in

the official, sub-official and local literature. Most of the discussion revolved around their recruitment, their pay and the kind of work they should be expected to do. With an asylum community so extensive and variable, these discussions did not always reach a conclusion, and many negotiations took place' (Bhattacharya 2013, 82,83).

Regarding *chai wallahs* (tea sellers), Bhattacharya writes, 'The chai wallahs visited asylums and other institutions (prison, banks, courtrooms) on a regular basis, carrying tea and gossip; their innocuous roles in society meant they were able to traverse very disparate spaces, such as private homes and official buildings without causing offense.[...] Some of the chai wallahs had more access to the asylum than most of the British staff, they also penetrated their services to more private spaces like patients' rooms and asylum's courtyard. They brought local newspapers, exchanged news, discussed issues and took messages' (Bhattacharya 2013, 82,83).

Mr. R.D. O'Callaghan, the Inspector General of Hospitals, Lucknow, wrote a letter to his friend:

"How talkative are the wallahs when they come with their tea. Even though I understand only limited Hindustani, they talk as if I am an old friend...One wallah has improved his English immeasurably through our daily interactions. He told me about the construction of a new madhouse to the North, whose establishment would take funds away from our great public asylum...[which] already provides an important custodial role for the very vulnerable insanes in this country" (Bhattacharya 2013, 83,84).

The above excerpt suggests that these local actors permeated the space of colonial institutions like asylum and were a source of important information circulated through gossips and informal often friendly interactions. So, the asylum during this phase was not necessarily a strictly isolated site, rather a comparatively permeable space penetrated by ideas and actions of both the British and local stakeholders.

There are also references of provision of allowing extra attendants on patients' or at their relatives' expenses in asylums. The asylum administration would not pay for their salaries and other expenditures; however, they would be allowed to stay with the patients who they attended to. Often, these private keepers and attendants were dealt with hostility by their official counterparts. The unwanted presence of extra attendants

would often result in lack of space and accommodation within asylums. Apart from them, families and friends of patients would also stay. The administration showed unwillingness to interrupt in microspheres of asylum and thus, the immediate direct power to manage asylums vested with local keepers and attendants. By 1910, the Government of India ‘officially’ allowed entry of local communities into asylums (Bhattacharya 2013, 89). As such this could be meant that colonial state was not as reluctant to devolve power to Indians when it came to managing affairs at the ground level.

Post 1857, the new Government of India shifted its policies from that of the earlier administration, though the aim was same i.e., the consolidation of power and expansion of empire in India. In the due course, a necessity to understand the Indian Mind was felt. To procure such knowledge gathering, the British state encouraged Indian participation in its administrative affairs. Through social communication and gossips with local communities, the State would try to gather political intelligence from them (Bhattacharya 2013, 89). Asylums were one such sites, sites of information exchange.

The Indian subordinate staffs influenced the routine practices within asylum. The superintendents also relied on them. The British administrators rarely interrupted in the Indian ritualistic domains until it was pertinent to do so. So, they had to rely on their Indian subordinates in managing such affairs. The following excerpt again borrowed from Bhattacharya’s work shows the extent to which the British administrators paid heed to their subordinates:

In 1869, Dr. F. Payne, the Superintendent of Dullunda wrote in ‘Annual Commentary on Bhowanipore’, [a Lunatic Asylum in Bengal] : “ Babu Nibaran Chandra Banerjee is well-qualified in his task of cooking the daily meal, which the lunatics gladly receive each day in the courtyard. Old Babu has often suggested we reduce the quantity of spices we provide our lunatics, leading as it does to violence and intractable danger for the others and in the town... Babu’s suggestion is both less expensive and, it seems, efficient in reducing the maniacal nature inherent to the lower castes... We no longer purchase the *Pagli spice* [sic], much to the dissatisfaction of our peons, who regularly used it to flavour their foodstuffs” (Bhattacharya 2013, 91).

Payne's letter reveals three different ideas presented by three different actors: Old Babu, the Peons and Dr. Payne. Dr. Payne represents the colonial State, he accepted Old Babu's suggestions of reducing spices in the food. By accepting his recommendations, he decentralized his authority by vesting it with his subordinate staff. While this excerpt informs nothing regarding Old Babu, except that he was a cook by profession and not a student of Western medicine. That maniacal nature was inherent to lower castes and reducing spices in food could control insane behaviour were his personal beliefs shaped by highly-ritualized Indian way of living and caste-class consciousness of the time. Not much is mentioned about the peons in the excerpt. This excerpt yet again manifests that asylum management was an assimilated affair of both the British and Indian ideas, in other words, this was a 'hybridized' (Bhattacharya 2013, 91) system of management. Thus, during the period from 1858 till 1912, Indian asylums were not necessarily an impermeable segregated system of management but a hybridized system of administration.

The story, however does not end here. Dr. Payne's agreement to Old Babu's suggestion sparked resentment among the spice vendors of the market who otherwise were used to make significant profits by supplying spices to asylum (Bhattacharya 2013, 92). The *Anandabazaar Patrika* (Anandabazar Patrika, 14 December 1869) (Bhattacharya 2013, 92) reported a riot in the local market near Dullunda in 1869 caused by Dr. Payne's decision. Spice-vendors were also upset that associating lunacy with spices would also discourage general people from purchasing spices. One group of vendors demanded for the British authorities to purchase their spices in order to compensate for the loss they incurred (Bhattacharya 2013, 92).

Back home, Old Babu's family lost their services due to social boycott. As a representative of colonial impartiality and ruling class, Dr. Payne was asked to intervene by both Old Babu as well as local spice vendors. Chaos arising outside asylum made its place into asylum. The Dullunda asylum did not remain untouched by local politics.

Beside these actors, asylums were influenced by administrators and officers who managed them sitting far behind through official modes of communication. The most common of such interactions mostly related to issues of patient or staff transfers. Records at National Archives of India show up to 100 lunatics being moved either

voluntarily or involuntarily every year of the 1880s (Bhattacharya 2013, 97). Lack of space within asylums and request by relatives for transfer to asylums in vicinity of homes of patients were the main reasons for patient transfer.

2.5. THE INDIAN LUNACY ACT, 1912:

By the late nineteenth century and early twentieth century, the growing public concern about the condition of mental asylums triggered by rising political awareness and nationalistic sentiments among the Indian masses persuaded the British Government in India to have a central supervision of mental asylums in 1906 and later the enactment of the Indian Lunacy Act in 1912 (ILA, 1912, hereafter) (Jiloha 2007, 70).

The ILA, 1912 was meant to serve two purposes:

- Protection and refuge to ‘incapables’;
- Protection of society from insanes. (Channabasavanna 1985, 179)

This Act brought about major developments in the field of psychiatry in India. The provision of voluntary admission was introduced, Lunatic asylums were renamed as Mental hospitals in 1922; officers with specializations in psychiatry were to be appointed as superintendents in mental hospitals. However, *detention* still remained much emphasized practice, whereas, *rights* of the mentally ill were overlooked and sub-due. The marginal development of psychiatry could be attributed as one of the reasons for custodial confinements of mentally ill. The ILA, 1912 was enacted to legitimize such admissions and confinement of mentally ill in India.

CONCLUSION:

The Indian discourse on mental disability existed since pre-colonial times, but the official concept of institutional care was first introduced by the British with the enactment of first legislation on mental health in India, the Indian Lunatic Asylums Act 1858 against the background of reforms after transfer of power to the British Crown in 1858. The asylum practices in India developed on the same lines as that in medieval Britain. The asylum development appear synonymous to the growth of psychiatry in India. During the first phases, the medical proficiency was at margins and confinement was preferred, as well as asylums were sites of information exchange

and indigenous practices of treatment and a prototype of larger society with the presence of different actors within it. However, with the gradual growth of professional psychiatry, asylums became more and more impermeable to external actors, particularly after the enactment of ILA, 1912. The period from 1912 till 1947 records very little regarding the internal practices within asylum. To sum up, the colonial narratives reveal master- subject relationship within the mental disability discourse. The Foucauldian concept of disciplinary power and knowledge of the body is reflective of this period. The negligible accounts of patient narratives other than those mentioned in the official archives, in-discriminatory reduction of all forms of mental disorders as 'lunacy' subject to custodial confinement manifest such colonizer-subject relationship. The next chapter shall look into post-colonial laws, acts ,policies and institutions to derive understanding of mental disability.

CHAPTER 03: ACTS, POLICIES AND INSTITUTIONS IN INDIA

AFTER INDEPENDENCE

PART I

After the enactment of *Universal Declaration of Human Rights*(UDHR) by the United Nations General Assembly in 1948, India became a signatory to it. This raised a concern to replace ILA 1912 and draft a new mental health Act in concordance with the UDHR (Narayan and Shikha 2013, 178). The Indian Psychiatric Society (IPS, hereafter) submitted its first draft on new Mental Health Bill in 1950, but it was only on 22nd May, 1987 that the Bill was enacted as Mental Health Act 1987 ,a long gap after government began initiating its process of enactment since 1978. The Act, however, could only be implemented on 01 April 1993 as The Mental Health Act(Act 14 of 1987).

THE MENTAL HEALTH ACT, 1987 (ACT NO. 14 OF 1987):

Definition: 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 Mental Health Act 1987) .

The MHA '87 is divided into ten chapters and ninety-eight sections:

	CHAPTER	DESCRIPTION
01	CHAPTER 01	Mentions title, extent, commencement and definitions of the Act
02	CHAPTER 02	Provides guidelines for the establishment of mental health authorities both at the Central and State level
03	CHAPTER 03	Lays down guidelines for the establishment of psychiatric hospitals and psychiatric nursing homes. Also mentions guidelines for the provision of licence to establish psychiatric hospitals and psychiatric nursing homes by the licensing authority, inspection of psychiatric institutions and treatment of out-patients
04	CHAPTER 04	Provides guidelines for admission and detention procedures in psychiatric hospitals on three basis: on voluntary basis(Part I), under special circumstances(Part II) and on reception

		orders[Part III(A.B.C.D)]
05	CHAPTER 05	Deals with inspection (Part I), discharge (Part II), leave of absence (Part III) and removal of mentally ill persons (Part IV)
06	CHAPTER 06	Deals with judicial inquisition regarding mentally ill persons possessing property, his custody and management of his property
07	CHAPTER 07	Lays down instructions for the financial maintenance of mentally ill persons in a psychiatric hospital or psychiatric nursing home
08	CHAPTER 08	Provides instructions for the safeguard of human rights of mentally persons
09	CHAPTER 09	Deals with penalties and procedures against breach of rules of the Act
10	CHAPTER 10	Deals with miscellaneous provisions such as bonds, report by medical officer, Government pensions for mentally ill, legal aid etc.

MAIN FEATURES OF THE ACT:

The Act marks a departure from the ILA, 1912 by defining mental illness in a comparatively progressive manner, with more focus on treatment and care rather than on custody (The Mental Health Act 1987).

The Act proposes for the establishment of Mental Health Authority at both the Central and State levels to regulate and supervise and advise on mental health matters (The Mental Health Act 1987).

The Act lays provisions for the protection of human rights of persons with mental illness. This is one of the revolutionary provisions mentioned in the Act as human rights of mentally ill patients were never taken care of in the earlier colonial Acts (The Mental Health Act 1987).

Provisions of penalties in case of violation of the rules of the Act (The Mental Health Act 1987).

Simplified admission and discharge procedures with provisions for admission of minors with mental health problems (The Mental Health Act 1987).

This Act excludes people with intellectual disabilities from the category of mentally ill (The Mental Health Act 1987).

3.0.1. DISCONTINUITIES WITH ILA, 1912:

MHA'87 makes a significant departure from ILA, 1912 through the changes and/or inclusions of the following provisions:

In the use of terms: Some derogatory terms used in the ILA,1912 have been replaced by certain acceptable terms in MHA'87- 'lunatic' by 'mentally ill', 'criminal lunatic' by 'mentally ill prisoner' and 'asylum' by 'psychiatric hospital/ nursing home'. An important shift from the earlier Act is that persons with intellectual disabilities(earlier called as mentally retarded) have been excluded from the purview of the Act (The Mental Health Act 1987).

Establishment of Authority: The Chapter II of MHA'87 calls for the establishment of Mental Health Authorities both at the Central and the State level to regulate functioning of mental health institutions within India. By doing this decentralization, the Act aims to ensure better and efficient management of mental health system within India. However, this was not the case with the ILA, 1912 which called for a central supervision of mental asylums in India (The Mental Health Act 1987).

Admission procedures: MHA '87 carries comparatively simpler admission procedures than the ILA 1912. While the earlier procedures of admission continue, a new form of admission procedure has been added i.e., Section 19(Chapter IV). This section proposes for non-involvement of judiciary to admit an un-consenting patient for a period of ninety days supported by two medical certificates. This provision is particularly helpful during emergency when patient requires immediate treatment but is unable to give consent. Along with this, MHA '87 also establishes that approval of members of Board of Visitors is not mandatory to admit voluntary patients (The Mental Health Act 1987).

Human Rights of the mentally-ill: Chapter VIII (Section 81) of the MHA '87 explicitly calls for the protection of human rights of the mentally-ill. The provisions include dignified treatment without causing any physical or mental violation; persons undergoing treatment cannot be used for research purposes unless the research is of

direct benefit to the person for the purpose of treatment or diagnosis, or the person or his/her guardian(in case of minors or person incapable of giving consent) has given a written consent; No letters of communications by or to mentally-ill persons can be obstructed, confined or destroyed (The Mental Health Act 1987).

3.0.2. EVALUATION:

The Act does not define mental illness categorically; rather it considers any sort of mental disorder in need of treatment excluding intellectual disabilities (named earlier as mental retardation) as mental illness. It seems ironical, that despite fulfilling qualifications of mental deficit, it has been dislocated from the jurisdiction of the Act. This has alienated a large number of severely affected people from the care and treatment benefits.

While licensing(Chapter III) (The Mental Health Act 1987) (Jiloha 2007) of psychiatric hospitals/nursing homes is helpful to keep a check on malpractices by such institutions, the strict process of licensing has also discouraged private psychiatric practitioners to offer psychiatric services to patients. This has also brought down the pace of developing mental health institutions in India. With an easier and generous licensing mechanism, mental health system would have developed effectively with increased private participation.

While Section 19 of the Act (The Mental Health Act 1987) establishes for the admission of patients under special circumstances without the involvement of judiciary, this provision has often been misused by relatives and guardians of patients who want to get rid of patients out of their personal interests. The Act also does not make necessary provisions for discharge of such patients. At times, custodians of such patients fail to show up when they get discharged from institutions adding to extra burden on institutional arrangements.

Section 23 of the Act empowers the Police to take custody and reception orders from a magistrate within 24 hours of a destitute mentally-ill person in need of treatment, self-harming individuals or individuals causing harm to others, abused or ill-treated mentally-ill persons (The Mental Health Act 1987). However, a large number of untreated and neglected persons with mental disabilities can be still found wandering in the public places.

The Act has not been properly understood by the Government bodies, due to absence of organized Mental Health Authority in many states (Jiloha 2007, 73). In some states, the Government stresses for obtaining license even for opening out-patient departments (Jiloha 2007, 73). While the Act encourages to open new psychiatric hospitals, it tends to ignore to make provisions to establish psychiatric in-patient and out-patient services within general hospitals and nursing home, a much cost-effective and budget friendly solution rather than establishing new hospitals for the same purpose.

Additionally, the Act completely ignores rehabilitatory and de-stigmatised prospects of treatment. While it focuses on legalistic framework, it tends to overlook humanistic therapeutic procedures, which includes rehabilitation, after-care assimilation of mentally ill within the community and de-stigmatised process of healing rather than institutionalized treatments which only adds to stigma.

The Act gravely fails to intrude within the private domains of families and communities where human rights violations, abuse and neglect of mentally-ill are rampant. The Act does not prescribe stringent provisions of penalties to such relatives or guardians who do not show up to receive patients after they get discharged. One of the psychiatrists at CIP, Ranchi mentioned that there are even relatives who want to pay huge sums of money in lieu of retaining patients and do not want to re accept them even after their complete cure. It was further added that in absence of due provisions of rehabilitation some cured persons often end up practising beggary on the streets. Also, the Act makes no provisions to monitor care of such patients within communities.

The Act fails to reprimand and penalise certain spiritual authorities where such patients are confined, exploited and left untreated. The Erwadi tragedy was one of such incidents to take lesson from. Furthermore, certain primitive societal practices which tend to in-dignify and unleash cruelty upon persons with mental illness are not being covered under the penal provisions of the Act. It could be concluded that while the Act aimed to legalise and enhance institutional mechanisms to ensure better treatment of persons with mental illness, it did little to ensure and protect their rights as well as support their integration to mainstream society through rehabilitation and community care remedies.

3.1. PERSONS WITH DISABILITIES (EQUAL OPPORTUNITIES, PROTECTION OF RIGHTS, FULL PARTICIPATION) ACT,1995:

This is the first Act which explicitly lists mental illness and mental retardation as conditions of disabilities. This entitles people with mental disabilities to have access to benefits meant for people with disabilities. The Act was meant to breach social gaps between people with disabilities and people with no disabilities through comprehensive development programmes, special benefits to people with disabilities and by preventing their exploitation and abuse. However, this Act holds little to advocate for people with mental disabilities in particular other than including them within the official category of people with disabilities.

3.2. NATIONAL TRUST ACT, 1999 (ACT NO. 44 OF 1999):

The National Trust Act was enacted in 1999 to provide for the “constitution of a body” (The National Trust Act 1999), as the definition says,” at the National Level for the welfare of persons with autism, cerebral palsy, mental retardation and multiple disabilities” (The National Trust Act 1999). This Act calls for the establishment of a National Trust for welfare of persons with Autism, Cerebral palsy, Mental retardation and Multiple disability etc. under the supervision of a Board to empower persons with disability to live independently, to ensure their full participation and exercise of opportunities, to help assign guardian or trustee for people with disabilities and extend family support to them who do not have a family.

3.3. UNITED NATIONS CONVENTION FOR RIGHTS OF PERSONS WITH DISABILITIES :

There are altogether fifty articles mentioned in the United Nations Convention on Rights of Persons with Disabilities (UNCRPD, hereafter).Some of the significant articles of the UNCRPD have been discussed here. This section attempts to evaluate the compatibility and relevance of provisions of the UNCRPD articles keeping in mind the existing Indian mental health scenario and national legislations on the mental health system in India.

ARTICLE 01: Article 01 of the Convention explains the purpose, which is, “ to promote, protect and ensure the full and equal enjoyment of all human rights and

fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity ” (Convention on the Rights of Persons with Disabilities and Optional Protocol). The statement also establishes that persons with disability include those who have “long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (Convention on the Rights of Persons with Disabilities and Optional Protocol).

The UNCRPD purpose(stated in Article 01), as already mentioned above, hence does not include all people with mental disabilities because many of such disabilities are not ‘long term’, however, those leave serious implications on the entire lives of affected persons(see chapter 01).

ARTICLE 03: The principles mentioned in this Article are as follows:

- To provide respect for dignity, autonomy and freedom of choice of individuals;
 - Non-discrimination;
 - Social inclusion and full participation;
 - Social acceptance of persons with disabilities acknowledging them as constituents of human diversity;
 - Equality of opportunity;
 - Accessibility;
 - Gender equality;
 - To protect rights, identities and respect capacities of children with disabilities.
- (05)

ARTICLE 04: This Article establishes general obligations for the States:

- To ensure and encourage full realization of fundamental and human rights for all persons with disabilities indiscriminately through
- Legislative and administrative measures towards implementation of rights;
- Amendments in legislations and practices that tend to discriminate against people with disabilities;

- Formulation of policies and programmes which ensure protection and promotion of human rights of persons with disabilities;
- Abiding by the guidelines prescribed in the Convention;
- Promoting research and providing goods, equipments, services and technology to meet availability of the needs of persons with disabilities and promoting universal development of standards and guidelines as well as promoting training of staffs and professionals to assist and serve persons with disabilities according to the guidelines of the Convention.
- Article 4(4) proposes that “nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of persons with disabilities and which may be contained in the law of a State Party or international law in force for that State. There shall be no restriction upon or derogation from any of the human rights and fundamental freedoms recognized or existing in any State Party to the present Convention pursuant to law, conventions, regulation or custom on the pretext that the present Convention does not recognize such rights or freedoms or that it recognizes them to a lesser extent”. (05,06)

ARTICLE 05: *Equality and Non-discrimination*

Article 05 establishes that States must ensure equality before law and equal benefits and protection of law for all persons with disabilities at par with others; prohibition of discrimination and legal protection against discrimination based on the grounds of disability; special measures to promote equality of persons with disabilities must not be considered discrimination (06).

ARTICLE 10: *The right to life*

The Right to Life acknowledges that persons with disabilities have equal entitlement to right to life as others and States must ensure total protection of this right of persons with disabilities (10).

In the context of India: This right is not specifically mentioned in the disability laws of India, except, Article 21 of the Indian Constitution- “Right to Life and Personal Liberty”. The *Human Rights Watch Report*(2014) shows that most hospitals refuse to

admit critical patients with mental illness considering their lives are not important to be saved (2014,10).

ARTICLE 12: This Article establishes that persons with disabilities must be entitled to exercise equal legal capacity, their rights, will and preferences. They must be ensured to exercise their right to own or inherit property, manage financial affairs and must not be withdrawn from their property (10,11).

However, this right in itself does not hold relevant for people with mental disabilities, as when they are declared ‘mentally incapable’, their right to legal transactions are suspended until they regain mental competency. During this phase, they can nominate a ‘guardian’ on their behalf to take care of their property and financial affairs. There are two ambiguities with this provision- firstly, the UNCRPD includes only those mental disorders which are ‘long term’, which implies that person may remain deprived of his/her right to legal transactions for a longer period; secondly, there arises a possibility that ‘caretaker/guardian’ may misuse or abuse his/ her authority of guardianship. However, the Article also proposes for “limited guardianship” in order to provide support to persons with disabilities in exercising their mental capacity, but this holds little for people with intellectual disabilities and severe mental impairments.

ARTICLE 13: This Article ensures access to justice for persons with disabilities and guides States to take measures such as provisions of accommodation to facilitate people with disabilities to have equal access to justice as others. The RPwD Act 2016 instructs the National and the State Legal Services Authority to make provisions for reasonable accommodation for people with disabilities (11).

ARTICLE 14: *Liberty and Security of Person*

This Article ensures that persons with disabilities have equal access to right to their liberty and security. However, if there is any deprivation of liberty, it must be in conformity with the law and should not be based on the grounds of their disabilities. States are to ensure that in case of deprivation of liberty, persons with disabilities must be treated according to human rights law in harmony with the objectives and principles of the Convention (11).

The provision of the Article appears ambiguous when it comes to the general treatment of people with mental disabilities. Institutionally confined treatment is one of the cases of ‘deprivation of liberty’ on the basis of disability. Even, detention within families is very rampant when it comes to people with mental disabilities. The Police conducts ‘round up’ operations which forcibly take such persons to the concerned institutions, is one such example (Parallel Report of India on the Rights of Persons with Disabilities 2017,19). The National Crime Records Bureau (NCRB) report that a total of 5203 inmates were reported as mentally ill out of a total of 419,623 inmates lodged in various jails in the country at the end of 2015, accounting for about 1.2 percent of the total number of inmates(19). Out of these, almost 50 percent are under- trials(19). There are even cases in which inmates suffering from mental ailments have remained in prison for nineteen to twenty-four years(19). As per law, a mentally challenged person can be tried by courts only when they are declared mentally- fit to stand trial by the law.

ARTICLE 15: Freedom from torture or cruel, inhuman or degrading treatment or punishment – Persons with disabilities must not be exposed to torture, punishment and inhuman treatment; to protect them, the States must ensure legislative, administrative, judicial or other safeguards to persons with disabilities (Convention on the Rights of Persons with Disabilities and Optional Protocol, 12).

ARTICLE 16: Freedom from exploitation, violence and abuse

The States must ensure freedom from all sorts of exploitation, violence and abuse based on disabilities, gender or age; they must ensure rehabilitation and reintegration of affected persons back to society by framing policies which encourages their welfare, self-respect, dignity and autonomy (12).

ARTICLE 17: The physical and mental integrity of all persons with disabilities must be respected (13).

All the three articles, namely, Article 15, 16 and 17, belong to the genre of core human rights. *The Human Rights Watch Report* reveals the narratives of cruelty and torture unleashed on mentally disabled people in institutions (Treated Worse than Animals- Abuses against Women and Girls with Psychosocial or Intellectual Disabilities in Institutions in India 2014) (also cited in Parallel Report of India on the

Rights of Persons with Disabilities 2017, 21). They are being denied their basic rights to dignity when they are being forced to share a bathroom with 73 others (India Treats its Mentally Disabled worse than Animals 2014) (also cited in Parallel Report of India on the Rights of Persons with Disabilities 2017, 21). *The Parallel Report on Convention on Rights of Persons with Disabilities, 2017* suggests that wherever there are community based organizations, the instances of abuse or exploitation have been fewer (Parallel Report of India on the Rights of Persons with Disabilities 2017, 21). But India lacks sufficient number of community based support systems which needs to be addressed urgently.

ARTICLE 19: *Living independently and being included in the community*- This Article empowers States to ensure and provide people with disabilities their choice of residence, in-home community support services, including personal assistance to support living and inclusion in the community, and to prevent isolation or segregation from the community (Convention on the Rights of Persons with Disabilities and Optional Protocol 13,14).

In the present scenario, support services for ‘living independently’ are almost negligible in India (Parallel Report of India on the Rights of Persons with Disabilities 2017, 22). The Report suggests that ”There are hardly any initiatives towards in-home and other community support services. There are now a few services (run by the private sector) that have been initiated for elderly people in certain cities but these do not cater to specific needs of people with disabilities. Moreover, the costs are exorbitant and beyond reach for many disabled people. There are a few non-governmental organizations (NGOs) which run *Community Based Rehabilitation* (CBR) programmes but their reach is very limited and approach is also sometimes medical based (barring some exceptions)” (Parallel Report of India on the Rights of Persons with Disabilities 2017,22).

The Report also reveals that under the National Trust Act, *Sahayogi*(care gives training programme) and *Gharaunda*(group home for adults),*Samarth*(Respite care residential service), *Nirmaya*(health insurance), *Sambhav*(aids and assistance), *Badhte Kadam*(Awareness and Community Interaction) (Annual Report 2014-15,2015-16, The National Trust Act 1999) are some schemes for people with developmental disabilities but their reach is very limited as per the data given in the Annual Report

(2014-15) of the National Trust. Under the former scheme, 2499 caregivers have been trained and only 1052 have been deployed, while the latter is present only at 8 places (Parallel Report of India on the Rights of Persons with Disabilities 2017, 23).

ARTICLE 26: *Habilitation and Rehabilitation*

This Article recommends that States must extend and strengthen habilitation and rehabilitation programmes in the significant areas like health, education, employment, social services etc. to ensure full autonomy, physical, mental, social well-being and full inclusion of persons with disabilities in various spheres of life. The States must ensure availability of knowledge and technological assistive devices for easy habilitation and rehabilitation (19).

In India, only 5 to 10 percent of persons with disabilities have access to basic rehabilitation services (Parallel Report of India on the Rights of Persons with Disabilities 2017,34). As per paragraph 199 of the *First Country Report, 2015*, the *District Disability Rehabilitation Centres(DDRC)* are present in 251 districts. It only covers 39 percent of a total of 640 districts in India as per 2011 census(712 districts as per 2018).Many of these do not meet requisite resources to provide adequate services. There are no nation-wide system/ infrastructure to provide rehabilitation services at rural level (Parallel Report of India on the Rights of Persons with Disabilities 2017,34g).A recent study conducted showed that most people with disabilities, particularly those with Multiple Sclerosis, Down's Syndrome, Cerebral Palsy had never received early intervention care. However, establishment of 92 District Early Intervention Centres(DEIC) by the Ministry of Health and Family Welfare in select Districts under *Rashtriya Bal Swasthya Karyakram* under National Health Mission is a welcome step in this direction.(35,see) There are hardly any programmes and schemes at the Government level for rehabilitation of people with psycho-social impairment.(35,see)

ARTICLE 28: *Adequate standard of living and social protection*

The Article suggests that States must ensure adequate standard of living like proper food, access to clean water, clothing, housing and decent living conditions to people with disabilities and their social protection, like freedom from poverty, public

housing, government retirement benefits and schemes without discrimination on the basis of disability.

ARTICLE 29: Participation in political and public life

The Article provides that people with disabilities can directly participate in elections or participate in choosing their representatives through voting and take active part in all forms of political and public events at par with others. The States must ensure them easy accessibility of voting procedures, materials, facilities and person-assistance as and when necessary, for the full exercise of their will. The States must also encourage their participation and representation in non-governmental organizations as well as various disability organizations at all levels.

In the Indian context, *The Rights of Persons with Disabilities Act, 2016* does not specifically mention the right of persons with disabilities to vote and to be elected but only accessibility to voting (report,p.41). Article 326 in the Indian Constitution and the Representation of People's Act 1951 prescribes "unsoundness of mind" as a disqualification to exercise *Adult Suffrage* and stand in elections. So, the Indian laws in particular are not concomitant to this provision of the UNCRPD.

3.4. MENTAL HEALTH CARE ACT, 2017 (ACT NO. 10 OF 2017):

After ratification of the UNCRPD on 01 October 2007, it became pertinent to revise existing disability and mental health laws in India to bring them in consonance with the former. A National Consultation on the Mental Health Programme and on the MHA'87 was held in January 2010 with the aim to review and revise the then existing *Mental Health Programme* on rights based framework. The *Centre for Mental Health Law and Policy*, ILS College, Pune presented the first draft of the proposed revised legislation to the *Ministry of Health and Family Welfare*, Govt. of India. After two revisions, the third draft was presented as the Mental Health Care Bill in 2010, which after certain revisions was enacted as the *Mental Health Care Act, 2017*(MHCA'17, hereafter) in 2017.

The Preamble to the MHCA'17 states that the MHCA is "an Act to provide for mental health care and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services and

for matters connected therewith or incidental thereto.”(The Mental Health Care Act, The Gazette of India, 2017, 01). It also states that this Act is enacted to harmonize existing mental health laws in concordance with *Convention on Rights of Persons with Disabilities*. Against this background, the MHCA’17 intends to transform persons with mental illness as ‘equal citizens with rights’ from a category of ‘subjects’ entitled for social welfare.

The Act holds sixteen Chapters and 137 Clauses. This section attempts to describe significant provisions exclusive to this Act and explore how far the Act satisfies its broader objective of situating mental health practices on the rights based framework, thereby, marking a deviation from institutional legal framework.

The definition of Mental Illness: The Act defines mental illness as a “substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgement, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub-normality of intelligence” (2017, 04). This is clearly evident that this definition shows an improvement in defining mental illness through inclusion of social factors and impacts. Hence, this definition establishes mental illness as a ‘disability’. The inclusion of psycho-social factors broadens the scope of putting different types of mental impairments within the purview of the Act. This definition makes a successful attempt to provide a comprehensive description of mental illness marking a shift from the MHA’87 which presents mental illness obscurely as a condition in dire need of treatment except the case of mental retardation.

However, to much disappointment the Act fails to accommodate people with intellectual disabilities (mental retardation, as mentioned in the Act) within its ambit. By depriving such persons of their rights to equal treatment, care and dignity, the Act retains their vague status within the mental health legislation in India. This seems to be one of the major flaws in the most progressive contemporary mental health legislation of India, which aims to ensure and safeguard equal rights and dignified living to people with mental disabilities. This is debatable particularly in the context

of human rights, whether or not their exclusion is an infringement to their capacity to exercise their right to life.

The determination of mental illness and capacity to make decisions regarding treatment: The Act makes a significant points of departure from the MHA'87 by assigning that the presence of mental illness is not the ground to declare a person to be of 'unsound mind' unless established by law. The determination of mental illness is to be based on criteria in accordance with national and international medical standards and not on social, political, racial, economic, religious and cultural affiliations of the person as already mentioned in the UNCRPD.

The MHCA'17 also recognizes that a person will be considered to have capacity to make decisions concerning their treatment provided they are able to measure the information related to their treatment and consequences of their decision as well as communicate the decision in whichever way they are capable of. The information is to be conveyed in the language or communication techniques which the person can relate to. Even if the person makes a decision considered improper or wrong by others, his/her mental capacity cannot be questioned.

The above guidelines for the determination of mental illness and exercise of mental capacity to make decisions seem to harmonise and provoke implementation of Article 12 of the UNCRPD, which calls for 'equal recognition of persons with disabilities before law'. The Article aims to ensure exercise of legal capacity among people with disabilities. The presence of mental illness as a non-ground for the determination of 'mental incapacity' enlarges the scope for people with mental disabilities to exercise their legal capacity. In a broader context, this provision compensates for the stigma associated with mental illness, thereby dismantling assumption that 'mental unsoundness' is inevitable consequence of mental illness.

Advance Directive: The Act empowers persons with mental illness to make an advance directive in writing, authorizing them to state how they should be cared and treated and how they would not want to be cared and treated for mental illness. Most importantly, this provision entitles them to be assigned an individual on their choice as their nominated representative. This must be made in writing to the Mental Health Review Board (MHRB) and is subject to amendment, cancellation or revocation by

the person who made the directive as well as by the MHRB if it is found to be contrary to the existing law, or written under coercion, or if the person is not mentally capable to make this directive. Advance directive, however, do not apply in the situations of emergency treatments. The medical officer in charge of a mental health institution and the psychiatrist offering treatment to the mentally ill must abide by the directive. However, they can make application to MHRB for review, modification or cancellation. Advance directives are to be reviewed periodically by the Central Authority, i.e. the Mental Health Review Commission, which is also authorized to make recommendations and examine whether it protects the rights of persons with mental illness. The Act also authorizes a 'legal guardian' to make advance directive on behalf of a minor with mental illness.

Nominated Representative: Chapter IV of the Act provides for the appointment of a nominated representative by persons with mental illness and the former must not be a minor, however, minors with mental illness are also entitled to appoint their nominated representative. The power to revoke, modify or alter nominated representative is vested with the MHRB. The Act also prescribes duties for the nominated representatives- to assist mentally ill persons to their best interests, in making treatment decisions, keep an information on diagnosis and treatment to support persons with mental illness, admission and discharge procedures, apply to the Board against violations of rights of the person with mental illness in a mental health institution, refuse or allow for research purposes.

Rights of persons with mental illness: Chapter V of the Act enshrines certain specific and significant rights to persons with mental illness. As already described earlier, the Act provides an extensive rights based approach towards the care of persons with mental illness, which is a revolutionary shift in the domain of mental health care in India. The rights mentioned in the Act have been described as below:

Rights to access mental health care: These rights qualify persons with mental illness to obtain access to quality, budgetary and affordable government funded mental health treatment and care indiscriminately. The Government is liable to offer necessary services like outpatient and inpatient services, supported sheltered accommodation, half-way homes, home based rehabilitation, community and hospital based rehabilitation services, child and elderly mental health services. The provision

also emphasizes on integration of mental health services to general health services and health programmes at all levels. Community based treatment is to be preferred over long-term institutionalized care; mental health services must be in easy accessibility within each district; a range of mental health services to be provided in all general government hospitals and basic as well as emergency services to be provided at all community health centres. Free and equal quality mental health treatment and services to be offered by the Government for poor, destitute or homeless patients. All medicines listed on “Essential Drug List” (p.10) to be provided free of cost to all patients with mental illness indiscriminately at Public Health Centres.

Right to community living: This provision entitles and empowers every person with mental illness to be part of society as a dignified human being and live within their respective communities. In the case of patients who are homeless or have been abandoned by their families, the Government supports them by sheltering them with legal aid. Every person is entitled to least restrictive treatment procedures preferably within communities over mental health institutions.

Right to protection from cruel, inhuman and degrading treatment: This right ensures protection from cruel, inhuman and degrading treatment in mental health establishments and to procure dignified living to persons with mental illness with their rights to safety and hygiene, privacy, choice of clothing to maintain dignity, exemption from compulsory tonsuring and protection from all forms of abuse be it physical, sexual, emotional or verbal.

Right to equality and non-discrimination: Every person with mental illness shall be treated at par with persons with physical illness in terms of quality of health care, treatment, emergency health services, living conditions and medical insurance. A female patient undergoing mental health treatment or rehabilitation can be allowed to keep her child below three years of age at a mental health establishment , provided that the attending psychiatrist does not examine her as prone to causing harm to child. In that case, she may be temporarily separated from her child but can have access to child under supervision. The decision is supervision is to be reviewed every fifteen days.

Right to information: The right to information entitles persons with mental illness and their nominated representatives to know complete provisions of the Act under which they have been admitted, proposed treatment plan for them, receive information in language known to them, have information regarding their application to the MHRB regarding admission review, full information to be given to the person when he/she is in a position to receive it or to his/ her nominated representatives.

Right to confidentiality: All health professionals are required to keep information concealed related to mental health care, treatment and physical health care of persons with mental illness except its release- to the nominated representative, other mental health and health professionals when needed for the care and treatment of person with mental illness, for protection from harm or threat to life, on an order by a Competent Authority, in the interests of public safety and security.

Restriction on release of information in respect of mental illness: Any information, be it electronic or digital related to person with mental illness undergoing treatment at a mental health institution cannot be displayed on the media without consent.

Right to access medical records: Persons with mental illness have the right to access their basic medical records while some records cannot be disclosed by the concerned mental health professional if it is mentally harmful to the person with mental illness or to others. However, the person may apply to the concerned Board for an order to release such information.

Right to personal contacts and communication: A person with mental illness has the right to accept or refuse visitors, electronic services according to the norms of the establishment. However, this does not apply to visits and calls from – Judge or Officer authorized by a Court, members of the MHRB or MHRC, MPs or MLAs, nominated representative, legal counsel of the person, medical practitioner in charge of the person, or other authorized person by the Government.

Right to legal aid: This provision entitles person with mental illness undergoing treatment under a mental health institution to procure free legal services under the Legal Services Authorities Act, 1987 to exercise his/her rights and this is to be informed by the medical officer in-charge of the person in mental health establishment.

Right to make complaints about deficiencies in provision of services: This provision empowers persons with mental illness or their nominated representatives in a mental health establishment to complain against irregularities in care, treatment and services to the medical officer in charge, concerned Board, the State Authority, without affecting their right to seek any judicial remedy for violation of their rights under such establishment.

The MHCA'17 successfully attempts to personalise human rights principles in resonance with the principles enshrined in the UNCRPD to provide a rights based outlook to the mental health practices in India. However, it seems ironical that Clause 104[1(a)] of the Act permits Electroconvulsive Treatment (ECT) on adults with the use of muscle relaxants and anaesthesia and Clause 103[3] abolishes the use of ECT as an emergency treatment therapy, while in the case of minors opposite is the case when ECT is allowed as a therapy during emergencies, and banned otherwise. The use of ECT is a very cruel form of treatment in itself and is a direct violation of the right to protection against cruel, degrading and inhuman treatment, as already explained above.(CLPR,2012,p.9) Under unavoidable circumstances, the use of ECT could have been permitted with the consent of person to be treated or on decision by the Board.

Duties of the Government: The Government is cordoned to plan, design, structure and implement programmes for prevention of mental illness, promotion of mental health and awareness programmes against mental illness, suicides, stigma, training of government officers.

Creation of new bodies: The Act calls for the establishment of the Mental Health Review Commission (MHRC) and district level Mental Health Review Boards (MHRB) to facilitate easy interaction and approach of persons with mental health care system as well as protection of their rights. The MHRBs are statutory bodies to review and protect violations of the Act. It is also a body which addresses complaints and grievances of persons with mental illness at interface level. In the MHA'87, this role was assigned to the Magistrate, who has little intervention in the present Act.

3.5. PRECURSORS TO THE UNCRPD:

In 1991, the UN *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (Principles for the Protection of Persons with

Mental Illness and the Improvement of Mental Health Care 1991) listed twenty- five comprehensive principles acknowledging that people with mental disorders have been subjected to historical oppression and it is high time, their rights to liberty be safeguarded. This statement of principles explicitly mentions right to life, right to treatment, protection of human rights and non-discrimination of persons with mental illness. The statement ensures dignified treatment to all persons with mental disabilities. Some of the important principles have been listed as follows:

- All persons have the right to mental health care and all persons with mental illness must be treated with respect and humanity; have the right to protection from any forms of exploitation and cruel treatment.
- There must be no discrimination on the grounds of mental illness. All must be equally entitled to enjoy rights as others. These rights include all civil, political, economic, social and cultural rights mentioned in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.
- All persons with mental illness have right to live and work in the community.
- The determination of a person to be suffering from mental illness must be based on internationally accepted medical standards and not based on social, political or economic affiliations or cultural, racial or religious affinities.
- Every person has the right to be treated according to his or her cultural background.
- All persons must be protected from threats like unjustified medication, abuse by others both physically and mentally.
- No person should be given forced treatment without their consent except in the case of involuntary admissions.
- Sterilization is prohibited to be carried out as a treatment of mental illness.

In 2005, the WHO Resource Book on Mental Health, Human Rights and Legislation developed a detailed guideline on mental health legislation covering almost all the aspects on mental health, formulation of mental health legislation based on human rights principles and most importantly, a Checklist on Mental Health Legislation. The document helps countries formulate their domestic legislation on mental health taking cue from the Checklist. However, this checklist is non-enforceable depending on the will of countries whether to comply with it or not. The document covers suggestions and framework for policies and legislations.

Though these international set of guidelines are not legally binding, however, the vulnerability and historical discrimination of people with mental disabilities urge for a dire need of efficient legislation in the field of mental health. As Brendan Kelly writes “ [...] while there were substantial advances in the articulation of human rights standards for the general population throughout the early twentieth century, the plight of the mentally ill remained bleak until much later in most jurisdictions, suggesting a need for specific and dedicated measures to protect their rights” (Kelly 2016, 170). This holds true in the Indian context, when existing mental health legislations focused on custodial aspects of mental health treatment rather than of rights of persons with mental disabilities.

To address this issue, India ratified United Nations Convention on Rights of Persons with Disabilities in May 2008. Countries which have signed and ratified the UNCRPD are supposed to bring their laws and policies in concordance with it. The two existing disability legislations in India- MHA’87 and PWD Act’95, too have underwent amendments to comply with the UNCRPD principles. The Convention marks a paradigm shift in the field of mental health legislation in India from a social welfare concern to one based on human rights. The new paradigm is based on the premises of equal legal capacity, dignity and equality (Kelly 2016, 170).

However, as already mentioned earlier in the chapter, Article 01 of the Convention identifies persons with disabilities as those having *long term*, physical, mental, intellectual or sensory impairments. Mental disability is a fluid category of different types of mental disorders. It could be chronic, short-termed, arrested or concealed. So, all types of mental impairments are not covered in the Convention definition of persons with disabilities. In other words, only persons with long term mental

disabilities fall under the definition and some do not. In addition to this, there are certain conceptual inconsistencies between the UNCRPD and the MHCA'17, discussed in the next section.

3.6. CONFLICT BETWEEN THE UNCRPD AND THE MHCA'17:

The Convention provisions and the MHCA'17's (the Act, hereafter) provisions contradict each other at two sites. Firstly, the *Article 14[1(b)]* of the UNCRPD states that every person with disability is granted equal access to liberty and security, even the justification for temporary deprivation of liberty must be based under the capacity of some law *rather than on the grounds of disability*. This is to say that the Article does not tolerate any deprivation or violation of liberty on the basis of *disability*.

However, legislative qualification for involuntary admission for treatment under mental health establishments mentioned as *supported admission* in the Act, holds that such arrested treatment is acceptable[Section 89{1(a) and(c)}] if it is confirmed by an independent medical examination that the person is severely mentally ill to the extent that he/she can cause self-harm and pose a threat to others, in addition to his/her inability to make independent decisions related to treatment and care, a ground enough for refusal to be treated as independent patient (The Mental Health Care Act 2017). The involuntary admission based on the grounds of mental disability, clearly violates the provisions of Article 14 of the UNCRPD.

Secondly, Article 12 of the UNCRPD establishes that all persons with disabilities have the right to be recognised as equal persons before the law and must be granted equal legal capacity like others. The Article comes into conflict with the above mentioned Section 89[1(c)] of the Act. The Indian civil, penal and property laws also suspend all legal transaction rights of a person when he/she is confirmed to be mentally incapable by the Court to the period he/she retains back mental capacity to carry out decisions.

3.7. SUPPORTED ADMISSION AND THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITES:

In 2009, the UN High Commissioner for Human Rights rejected to the contention of any relationship between 'involuntary admission' and threat to self or others out of mental disability:

“Legislation authorising the institutionalization of persons with disabilities on the grounds of their [disability] without their free and informed consent must be abolished. This must include the repeal of provisions authorizing institutionalization of persons with disabilities for their care and treatment without their free and informed consent, as well as provisions authorizing the preventive detention of persons with disabilities on grounds such as the [likelihood of them posing a danger to themselves] or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness” (United Nations High Commissioner for Human Rights 2009,paragraph 49, also quoted in Kelly 2016:171).

In 2011, the UN Committee on the Rights of Persons with Disabilities, reporting on Tunisia and Spain also unanimously consented on three decisions:

To review such National legislations which allow for the deprivation of liberty on the basis of disabilities including mental, psychosocial or intellectual disabilities;

To repeal provisions which legitimize treatment in detention due to disability;

To ensure that all health care treatments including the mental health care follow treatment and care procedures after the informed consent of persons with disabilities. (United Nations Committee on the Rights of Persons with Disabilities 2011, paragraphs 24,25,28 and paragraphs36,38 also cited in Kelly, 2016,171).

The Convention’s apparent denial of considering involuntary treatment on the grounds of disability is in consonance with the claims of United Nations’ advocacy for human rights, it stands in opposition to the mental health practices in most of the countries of the world where involuntary care has remained as an inevitable historical practice to treat persons with mental disabilities.

MENTAL CAPACITY AND THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES:

In 2014, the Committee on the Rights of Persons with Disabilities,appointed by the United Nations under the Convention, in a “general comment” on Article 12, clearly disagreed to consent on considering *mental capacity* as to be the determining factor for the right to exercise legal capacity. The Committee solely rejected to assess mental

capacity on one uniform and scientific basis, but, as a function of multiple manifestations and experiences of different behavioural, social, cultural, political and psychological contexts (Committee on the Rights of Persons with Disabilities 2014, paragraph 14, also cited in Kelly, 2016:172).

While taking a psycho-social viewpoint, the Committee completely tends to ignore clinical and biological realities of mental disability into heed. Moreover, the UNCRPD definition does not reveal as what types of mental impairments will be considered as disabilities and this being the case, not all types of involuntary admission and denial of legal capacity on the basis of mental insufficiency to make decisions falls under the purview of the UNCRPD.

The Mental Health legislations have a history of arbitrary regulative provisions in almost all the countries of the world. With the UNCRPD's ratification, an initiative towards change in such practices has proceeded. The enactment of the MHCA'17 has been one such step in this regard. Although imperfect in many aspects, it attempts to redress the issues and distress of persons with mental illness through relaxing stringent undemocratic way of practices, least restrictive and short term institutionalized treatment in the form of *supported admission*, decriminalization of suicides. I shall contend that though imperfect, the Act tries to comply with most of the provisions of the UNCRPD. It has been an year since the Act has been enacted and the mental health system in India is still undergoing legislative, administrative, structural and institutional changes to comply with the revised and new provisions of the Act.

PART II

3.8. POLICIES AND INSTITUTIONS:

National Mental Health Policy

The first National Mental Health Policy was enacted in 2011 by the Ministry of Health and Family Welfare and revised in 2014 to address both medical and non-medical issues on mental health. It acknowledges local practices on mental health and other socio-economic indicators of mental health. The policy is directed to adopt rights based approach and participatory inclusion of all to achieve mental health objectives. The National Mental Health Policy is in concordance with the Resolution WHA 65.4

adopted by the 65th World Health Assembly in 2013. The WHA 65.4 Resolution envisages mental disorder as global burden and calls for co-ordinated, synergistic effort through Community Health programmes to address this burden.

The Policy strives to prevent mental illness, promote mental health, provide quality and accessible health care to all along with safeguard of rights and promotion of social inclusion and de-stigmatization.

The principles of equality, justice, rights regulate objectives of the policy. The policy focuses on easy access to mental health care at primary level, community level participation and use of assistive technologies to facilitate well being of mental health service users. The policy provides ample scope to mental health care givers by encouraging them to participate in planning and evaluation of mental health services. Along with the Union and State government, the policy ensures participation of Civil Society, research institutions, care providers etc. in designing policy and delivery of better health-care facilities. The policy attempts to comply with UNCRPD guidelines by approaching health care issues based on Human Rights framework.

The main objectives of policy remain to provide universal access to mental health care, particularly to the deprived sections, address stigma through promotion of awareness regarding mental health issues and effective services. A significant inclusion in the policy is the recognition that mental illness and poverty are inter-linked. The policy tends to acknowledge that mental health patients mostly come from the lower socio-economic strata. The NMHP aims to address poverty and income inequality through preventive strategies. Under the NMHP, the National Mental Health Programme was launched in 1982 with the following objectives (The National Mental Health Programme 2015):

- Availability of minimal mental health treatment for everyone.
- Mental Health awareness in general healthcare systems and society.
- Promotion of community care and self-help groups.

District Mental Health Programme launched under NMHP in the year 1996 (in IX Five Year Plan). This was based on 'Bellary Model' and re-structured in X Five Year Plan 2003 (The National Mental Health Policy 2014):

- Early diagnosis and treatment of mental disorders.
- Training of Health professionals for diagnosis and treatment of mental illness.
- Promotion of Public Awareness
- Facilitated monitoring.

In X Five Year Plan, up-gradation of Psychiatry wings of Govt. Medical Colleges/ General Hospitals and Modernization of State Mental Hospitals were the new schemes/ components.

In XI Five Year Plan, the NMHP was re-structured for manpower development schemes- (MDS)- Centres of Excellence And setting up/ Strengthening PG Training Departments of Mental Health Specialities:

District Mental Health Programme (DMHP): The main objective of DMHP is to provide Community Mental Health Services and integration of mental health with General Health Services through decentralization of treatment from specialized Mental Hospital based care to primary health care services. It began with 4 districts and at present the DMHP is being implemented in 123 districts of the country. The DMHP envisages a community based approach to the problem, which includes: Training of mental health team at identified nodal institution, to increase awareness and reduce stigma related to Mental Health problem, to provide service for early detection and treatment of mental illness in the Community (OPD/ Indoor and followup), to provide valuable data and experience at the level of community at the State and the Centre for future planning and improvement in service and research.

New revised Consolidated DMHP included Components of Life Skills education and Counselling in schools, College Counselling services, Work place stress management and suicide prevention services should be provided.

- Modernization of State-run hospitals : Infrastructure and retained practice of Custodial Care pattern remains issues;
- Up-gradation of psychiatric wings in general hospitals and medical colleges;
- Manpower Development Scheme.

3.8.0. INSTITUTIONS:

Mental Health Care Act 2017 establishes Mental Health Authority at both central and state levels to regulate and guide mental health services in India. These Central and State Mental Health Authorities regulate psychiatric hospitals which are the immediate mental health care service providers to patients. This section looks at mental health institutions in India based on the study of National Human Rights Commission's Technical Committee's Report on Mental Health in India, 2016 and National Mental Health Survey of India, 2015-16, Ministry of Health and Family Welfare, Government of India.

Data based on the Technical Committee Review Report, NHRC, 2016:

There are 47 listed Government psychiatric institutions in India (see Appendix II, p.) with inpatient capacity of 18307.30 percent of these institutions (i.e.14) provide beds for children and 15 institutions offer specialized inpatient services for the elderly. 22 hospitals offer de-addiction services. Most of the hospitals offer direct emergency services but the record is listed only in IHBAS, Goa and PDH Jammu. The Report reveals that hospitals in Maharashtra, West Bengal, Uttar Pradesh (apart from Agra), Arunachal Pradesh, Bihar, Chattisgarh, Nagaland and Tripura have not kept pace with the other states in developing these facilities within the psychiatric institutions. It is important to mention here that inpatient de-addiction services still do not exist in 50% of these hospitals, inpatient children wards do not exist in 68%, beds for the elderly with mental illness do not exist in 67% and rehabilitation facilities do not exist in 39%. (Report of the Technical Committee on Mental Health 2016)

A report by the Human Rights Watch (Treated Worse than Animals- Abuses against Women and Girls with Psychosocial or Intellectual Disabilities in Institutions in India 2014) raises concerns of ongoing rights violations against women in some of these

hospitals like forced institutionalization, overcrowding, inadequate sanitation, compulsory head shaving, forced treatment, exploitation and lack of access to proper care, treatment and rehabilitation. Lack of some basic facilities like fans, water supply remains a rampant issue in most of these institutions. But the Special Rapporteur provides a different picture of the report as against the overcrowding issue. HMH Jamnagar and DIMHANS, Dharwad records under-utilization of beds. HMH, Jamnagar reports only 50% occupancy of beds while DIMHANS show utilized beds at 212 against the sanctioned bed strength of 375. Reason for the same is not listed. (Report of the Technical Committee on Mental Health 2016)

The provision of voluntary admission has induced short duration of stay of patients in the psychiatric hospitals, with a data showing about 65% of the patients having admission periods less than 3 months in duration. The rise of social acceptance and awareness could also be one of the reasons for early restoration to the family. (Report of the Technical Committee on Mental Health 2016)

22 out of 47 hospitals report visits by SHRC/NHRC. IHBAS, NIMHANS, HMH Vadodara and IMH, Hyderabad report receiving patient complaints regularly and responding to them. IHBAS has developed a document for Policy and Procedure for voicing of Complaints/ Grievances by the Users and their redressal- the IHBAS Quality Manual in 2012, with a policy regarding grievance redressal, the procedures for complaining and procedures for handling the complaints. Complaints resolved range from diet, mosquitos, apathy of attendants and management issues. 68% of the hospitals report displaying rights of the patients. (Report of the Technical Committee on Mental Health 2016)

77% of the hospitals report having laboratory facilities for basic investigations within the hospital. Hospitals in Nagaland, Jodhpur, Lumbini Park Hospital report not having in-house facilities. Hospitals in Arunachal Pradesh, Bihar and Haryana have not provided information. 70% of the institutions offer ECT services. Psychosocial counselling is available in most of the institutions. Availability of medicines is more or less regular except at MH, Kohima which reports poor availability of medicine. (Report of the Technical Committee on Mental Health 2016)

Most of the psychiatric hospitals provide recreational activities for patients, with the exceptions of Midpu MH in Arunachal, State MH in Sendari in Chattisgarh, MHI Cuttack . (Report of the Technical Committee on Mental Health 2016)

Across the 47 Mental Hospitals, 368 deaths have been reported annually by 2015. However, fewer deaths are recorded in most of the psychiatric hospitals. Regional Mental Hospital, Pune, Thane and Nagpur, MHI Cuttack, IMH Chennai, MH Berhampore, Calcutta Pavlov Hospital and GHME Kozhikode account record of such deaths. The hospitals of Maharashtra, Punjab, Tamil Nadu and Kerala record high patient deaths. Co-morbid physical illnesses and old age are prime reasons for such deaths, which is very close to the pattern of asylum deaths in the nineteenth century. (Report of the Technical Committee on Mental Health 2016)

In many hospitals, a significant number of long stay patients (more than one year) are destitute (in IHBAS, RINPAS, CIP, NIMHANS, GMA, MH Indore, RMH Thane and Nagpur, IMH Chennai and Calcutta Pavlov Hospital). The issue of long stay patients need to be addressed in order to encourage community-care. Within community patients receive least restrictive treatment and their quality of life improves. However, this must not encourage getting away from them to vacate hospital beds. Families of the patients must be trained to provide them necessary care to ease their burden, monitoring community-care programmes is also important. An important point to be noted is that the longer a person with mental illness is untreated and the longer a person remains in hospital without any attempt at rehabilitation and re-integration, the chances of independent living are likely to diminish. Thus, early intervention and early rehabilitation and appropriate medication whenever necessary are all very important factors in reducing chronicity and disability. (Report of the Technical Committee on Mental Health 2016)

Around 56.2% of hospitals are involved with some or the other aspect of *District Mental Health Programme*. A fifth of the hospitals report no collaboration with NGOs. Lack of human resource continue to be a problem in most institutions as well as in other settings. (Report of the Technical Committee on Mental Health 2016)

Medical Superintendent: In the past, it has been recommended that the medical superintendent should be a psychiatrist. However, in 13 of the 47 institutions which is

approx 28%, the medical superintendent is not a psychiatrist. These include HMH Shimla, GHPD, Srinagar, MHC Thiruvananthapuram and Thrissur, RMH Ratnagiri, MIMHANS Shillong, SMHI Dehradun, MH Varanasi and Lumbini Park MH, IMC Purulia, MH Berhampore and Calcutta Pavlov Hospital. In HMH Bhubaneswar, there is no director or medical superintendent, but the person in charge is a psychiatrist. In the SIMH Haryana, there is no post at all of Medical Superintendent. (Report of the Technical Committee on Mental Health 2016)

3.9.0. Non-Governmental Organizations:

At present, there are about 325 Non-Governmental Organizations (NGOs) in India working in the field of mental health and substance abuse across different states in India. (2016,163)

The distribution of these NGOs is not uniform throughout different states. There are certain states which show enthusiastic participation of NGOs in areas such as suicide prevention, education for children with special needs, Destitution and homelessness, rehabilitation, Stress management and mental health counselling, community mental health care, drug abuse etc. while some of the states show disappointing records of number of NGOs and there are even states which do not hold any NGO working in the area of mental health. However, number of NGOs are gradually increasing in number due to consistent focus on mental health awareness programmes throughout India.

3.10. EVALUATION AND CONCLUSION:

Based on the study of Human Rights Watch report (Treated Worse than Animals- Abuses against Women and Girls with Psychosocial or Intellectual Disabilities in Institutions in India 2014), The Census 2011, The Technical Committee Report on Mental Health, NHRC (Report of the Technical Committee on Mental Health 2016), this last section of the chapter will analyse the existing scenario on mental health condition in India as against the acts, programmes and policies enacted for mental health.

The Census 2011, records 2.68 cr. people with disabilities out of a total of 121 cr. population, which is 2.21 percent of it. Mental illness comprises 3 percent and mental retardation comprises 6 percent of total disabled population respectively. While

mental illness is considered under various acts and policies, nothing substantial has been done for persons with mental retardation (persons with intellectual disabilities, hereafter). Persons with intellectual disabilities comprise a larger proportion of beggars and vagrants at public places. Only 0.06 percent of total health budget has been allotted for the mental health in India. In addition to this, there are major lapses in correct data recording. The census till 2001 did not include data on disability, while there has been considerable increase in the percentage of disabled from 2.13 percent in 2001 to 2.21 percent in 2011.

The Human Rights Watch report, 2014 of 106 pages shows that almost all girls and women with psycho-social and intellectual disabilities have undergone forced institutionalization in government psychiatric establishments where abuse of rights, dignity and neglect of legal access is quite rampant. The report clearly shows violation of rights as against the rights claims of mental health legislations in India. The denial of general health services, sanitation, dignified living are very common in these establishments. Forced medication and abusive use of ECT are a routine in most of the establishments. The verbal, physical and sexual manhandling by the staffs are also reported. Unconsenting patients are abusively being subjected to ECT procedures in order to inculcate fear psychosis among them.

Among the 128 cases reported by the Human Rights Watch, in none of the cases any F.I.R. was filed. The police often picks up and institutionalize women found wandering on the streets. In this case of lack of judicial intervention, it becomes difficult for them to come out of such institutions.

At the policy formulation level, rights based framework is very well comprehended. But at the implementation level, this fails because of absence of an effective accountability and monitoring mechanism. In addition to this, no mental health legislation has so far advocated for de-institutionalized treatment procedures which should be stressed upon dismantling all supported and voluntary admission procedures.

CONCLUSION

Mental disability is mostly recognized by its exclusion rather than inclusion within the academic disability discourse. Within the policy paradigm, it adjusts within the category of disability based on scientific medical qualifications. The PWD Act, 1995 lists mental illness and mental retardation among the seven listed disabilities. Apart from listing, it merely water-dresses the issue of mental disability by reifying the already existing provisions of the Mental Health Act, 1987. Completely acknowledging that disability is a multiplicity of different experiences established in connection with social interactions. Mental disorders remain the most fluid sub-category among the various categories of disability primarily due to their obscurity in diagnosis, varied individual responses, social and physical environments, concealed prevalence etc. But, does this not qualify mental disability to be recognized by an explanation based on its own specific experiential terrains? The absence of value accretions to different spectrums of mental disability tend to suppress their human experiences of affected individuals to mere medicalized marginal identities, suppressed to internalize externally imposed experiences and inculcate a sub-human existence sugar-coated under various welfare schemes common to all disabled experiences.

This is to say, perceptions towards ‘mental disability’ in particular, and disability in general are based on different value judgements in different social and cultural contexts. For e.g. as already mentioned, there have been certain examples when a woman refusing to get married or raise voice against the established patriarchal norms have been compelled to disassociate from the mainstream society through forceful detention in mental hospitals. In certain contexts, the determination of disability status is based on racial and ethnic perceptions. When determination of disability status is assigned on the basis of varied perceptions, why can’t disability status be explained on the basis of individual disabled experiences? Also, how far is it relevant to measure all perceptions of disability equally based on the meanings imposed on them?

The social meanings attached to the identities of individuals guide biased social treatment towards them. Most of the disabled experiences are threaded by common experiences of stigma, oppression, discrimination, stereotyping etc. However, little has been focussed to address such perceptions and structures which generate such

treatments. Often, official bestowments to de-stigmatise and deconstruct disabled identities result in adding more stigma to the individuals. So, there arises need for the re-construction of disabled identities. This requires a re-definition of disability based on individual experiences, hence providing a scope for all inclusionary possibilities for a range of mental disabilities.

Coming over to the academic theorizations on mental disability, it would not be improper to put here that Social Science suffers a theoretical deficit on mental disability discourse.

This is partly, because even at experiential level, individuals with mental disability and individuals with other disability fail to relate to each other. Mental disability construes a condition of obscurity even within the public Acts and legislations. It become difficult to judge 'disability' based on particular cognitive conditions, so in order to establish a common theory on mental disability, social science must focus on building an experiential discourse on mental disability.

Historical discourses on mental disability do not disclose much on mental disability from the perspectives of the affected individuals. They depict mental disability as a category of unsuitable, threats and unproductive fit for segregation from the rest of society. The notions of common derogatory terms such as 'able-bodiedness', 'lunatics', 'mad', 'idiot' seem to dominate the theoretical discourse on mental disability. The Foucauldian analysis of 'power subjects' seem to find its place within the Indian historical discourses on mental disability. The discourse on mental disability in Colonial India has been drawn from the psychiatric lens rather than from the vantage-points of the affected. The contextual derivations of such discourse could be related to the Contemporary rise of capitalism and evolution of medical and scientific pathological as appendages to maintain societies based on productivity. Even, the narratives available reveal too less regarding the personal, demographic and social narratives of individuals with mental disabilities, let alone be exploration of their social identities apart from being politically subjugated subjects under the colonial power, defined by its perception of racial supremacy and 'Indianness,.

The public policy discourse on mental disability in India shows an apparent evolution of understanding mental disability as a transition from the legal custodial lens to

human rights framework. The changing social perceptions towards mental disability are best reflected in the state policies for persons with mental disabilities. The stress on rights based framework aims to breach inequalities and biases against persons with mental disabilities. The policies are framed to strike self-sufficiency and social inclusion of people with mental disabilities. However, at the execution level these policies remain far from attaining a satisfactory accomplishment. However, it has been only a year since the enactment of MHCA'17 and mental health institutions and authorities are still in the process to incline their practices according to the aforementioned Act.

The theoretical discourses on mental disability completely fail to represent unique mentally disabled experiences. While there are common conceptualizations discussed, experiential concerns are totally neglected. Completely agreeing to the fact that theories shape structural and institutional attitudes, it could be related that lack of proper understanding of concerns and issues of persons with mental disabilities would reflect inadequate policies and structures meant to address their problems.

The historical discourses on mental disability completely justify the statement of my proposition. Historically, mental disability has been defined by its exclusion through institutional practices and power structures.

The institutional structural arrangements and legislations remained central in shaping collective identities of people with mental disabilities.

The public policy discourse on mental disability focus on legal entitlements, stress on rights of people with mental disabilities, policy and rehabilitator aspects, while overlooking simultaneously that this adds to the burden of surveillance on people with mental disabilities. 'Mental Capacity' remains the prime deciding factor for any legal transaction; too much focus on legal entitlements demand their conscious effort to appear 'mentally intact', all the times. This conscious externally imposed obligation to compete for mental capacity tends to detach them from their very existence. The constant fears of losing rights tend to impose an internal surveillance on them to stand qualified for exercising their rights.

The mental health legislations, programmes and policies in India extensively and explicitly stress on rights to comply with the UNCRPD. Even after that, the existing

scenario is quite disappointing when abuse of rights are very frequent and blatant. The states have not shown required enthusiasm to promote mental health in India. The data on mental health services show that India lags much behind the required WHO criteria for developing countries in providing mental health services. While the policies are framed and implemented, proper monitoring is required.

I shall attribute this fallacy to failure in understanding the nature of mental disability. While the state framed policies stress on entitlement mechanisms, they fail to understand from the perspective of empowerment. The state conceives mental disability from a medical charity based vantage point. This is where it goes astray. While there is an urgent requirement to address issues related to mental disability, it is more urgent to re- theorize and re-structure conceptions regarding mental disability. This is to suggest dismantling of lens of able-bodied norms to re-construct a theory of mental disability based on agglomeration of individual experiences. At present an Indian theory on mental disability is lacking and policies framed are based on borrowed medical model, which is why the state has failed to address the problems of persons with mental disabilities. This study recommends that the Indian policies on mental health must reflect Indian experiential discourse on mental disability which, at present, is absent. Persons with mental disabilities though have presence as stigmatized social collective identity, they have not been recognized and represented as political interest groups so far within the current Indian political discourse apart from other marginalized identities. So, it would be futile to imagine that they are being represented.

APPENDICES:

APPENDIX 01: THE UNCRPD ARTICLES AND THEIR DESCRIPTION

	ARTICLE	DESCRIPTION
01	01	Purpose
02	02	Definitions
03	03	General Principles
04	04	General Obligations
05	05	Equality and Non-discrimination
06	06	Women with disabilities
07	07	Children with disabilities
08	08	Awareness raising
09	09	Accessibility
10	10	Right to Life
11	11	Situations of Risk and Humanitarian Emergencies
12	12	Equal Recognition before the Law
13	13	Access to Justice
14	14	Liberty and Security of Person
15	15	Freedom from Torture or Cruel, Inhuman or Degrading Treatment or Punishment
16	16	Freedom from exploitation, Violence and Abuse
17	17	Protecting the Integrity of the Person
18	18	Liberty of Movement and Nationality
19	19	Living Independently and Being Included in the Community
20	20	Personal Mobility
21	21	Freedom of Expression and Opinion, and Access to Information
22	22	Respect for privacy
23	23	Respect for Home and the Family
24	24	Education

25	25	Health
26	26	Habilitation and Rehabilitation
27	27	Work and Employment
28	28	Adequate Standard of Living and Social Protection
29	29	Participation in Political and Public Life
30	30	Participation in Cultural Life, Recreation, Leisure and Sport
31	31	Statistics and Data Collection
32	32	International Cooperation
33	33	National Implementation and Monitoring
34	34	Committee on the Rights of Persons with Disabilities
35	35	Reports by States Parties
36	36	Consideration of Reports
37	37	Cooperation between State Parties and the Committee
38	38	Relationship of the Committee with other bodies
39	39	Report of the Committee
40	40	Conference of State Parties
41	41	Depository
42	42	Signature
43	43	Consent to be bound
44	44	Regional Integration Organizations
45	45	Entry into Force
46	46	Reservations
47	47	Amendments
48	48	Denunciation
49	49	Accessible Format
50	50	Authentic Texts

APPENDIX 02: LIST OF PSYCHIATRIC HOSPITALS IN INDIA

	NAME OF THE INSTITUTION	NAME OF THE STATE
01	Midpu MH, Pampampure	Arunachal Pradesh
02	GMHC, Vishakapatnam	Andhra Pradesh
03	Lokopriya Gopinath Bordoloi Institute of Mental Health	Assam
04	Bihar State Institute of Mental Health, Bhojpur	Bihar
05	State MH, Sendari, Bilaspur	Chattisgarh
06	IHBAS	Delhi
07	IBHB, Panaji	Goa
08	HMH, Bhuj	Gujarat
09	HMH, Jamnagar	Gujarat
10	HMH, Ahmedabad	Gujarat
11	HMH, Baroda	Gujarat
12	RIMS	Harayana
13	HMH, Shimla	Himachal Pradesh
14	Psychiatric Disease Hospital, Jammu	Jammu and Kashmir
15	Govt Hospital for Psychiatric Diseases, Srinagar	Jammu and Kashmir
16	RINPAS, Ranchi	Jharkhand
17	CIP, Ranchi	Jharkhand
18	NIMHANS, Bengaluru	Karnataka
19	DIMHANS, Dharwad	Karnataka
20	MHC, Thiruvananthapuram	Kerala
21	GMHC, Kozhikode	Kerala
22	GMHC, Thrissur	Kerala
23	Gwalior Manshik Arogyashala, Gwalior	Madhya Pradesh

24	Mental Hospital, Indore	Madhya Pradesh
25	Regional Mental Hospital, Nagpur	Maharashtra
26	Regional Mental Hospital, Pune	Maharashtra
27	Regional Mental Hospital, Ratnagiri	Maharashtra
28	Regional Mental Hospital, Thane (W)	Maharashtra
29	Meghalaya Institute of Mental Health and Neurosciences, Shillong	Meghalaya
30	Mental Hospital, Kohima	Nagaland
31	Mental Health Institute, Cuttack	Odisha
32	Dr. Vijayasagar Punjab Medical Hospital, Amritsar	Punjab
33	Mental Hospital, Jaipur	Rajasthan
34	Mental Hospital, Jodhpur	Rajasthan
35	Institute of Mental Health, Chennai	Tamil Nadu
36	Institute of Mental Health, Hyderabad	Telangana
37	Modern Psychiatric Hospital, West Tripura	Tripura
38	Institute of Mental Health, Agra	Uttar Pradesh
39	Mental Hospital, Bareilly	Uttar Pradesh
40	Mental Hospital, Varanasi	Uttar Pradesh
41	State Mental Health Institute, Dehradun	Uttarakhand
42	Lumbini Park Mental Hospital, Kolkata	West Bengal
43	Institute of Mental Care, Purulia	West Bengal
44	Mental Hospital, Berhampore	West Bengal
45	Calcutta Pavlov Hospital, Kolkata	West Bengal
46	Institute of Psychiatry, Kolkata	West Bengal
47	MH, Munkundu	West Bengal

Source: Report of the Technical Committee on Mental Health, National Human Rights Commission, page 103-104.

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