Section 1

Human rights in mental health care: an introduction

Lakshmidhar Mishra

Introduction

The Right to Life is the most primordial of all rights as also the most pre-eminent. The very first couplet of the Ramayan by Maharishi Valmiki espouses lucidly and forcefully the essence behind protection of all lives – man or animal alike. To quote from the English translation:

> *"O hunter! Please do not kill this pair of beautiful hawks immersed in an act of pure love. What lasting fame would you attain if you wantonly kill them?"*

In the Bheesma Parva of Mahabharat, the grandsire of the Kuru dynasty utters words that reinforce the primacy and centrality of that philosophy of the sacrosanctity of human life. Bheesma had fallen on the tenth day of the battle of Kurukshetra and was lying stricken on a bed of arrows, writhing in physical and mental anguish. Yudhistira approached him along with his four brothers and asked him: 'O Pitamaha! Please enlighten us at this hour as to what is the ultimate truth of life'. Quick came the reply from the quivering lips of the grandsire:

> "*Let it be known by you and others, O Yudhistira, that human beings are the finest and best in creation. There is nothing greater than man*".

The Mahabharat of Vyasa is a product of his rich imagination and creativity. Yudhistira and all others are nothing but imaginary characters in the great epic. The central message underlying the beautiful lines of Bheesma Parva as quoted above is, however, important.

It is this:

> "*Protect, preserve and promote human life and its essence and do not destroy it (or its essence) for once destroyed it cannot be recreated*".

It also means the following:

Every human body and mind has an integrity which is inviolable. Every human being has certain irreducible barest minimum needs such as right to air, potable water, food, clothing, health, medical care and treatment, clean and hygienic conditions for living accommodation, environmental sanitation, personal hygiene and so on. Deprivation of any one of these amounts to violence to the person.

Definition of Human Rights

If human life is the finest and best in creation what exactly are human rights?

The simplest way of defining human rights is that they are about balancing the inalienable rights of all of us as human beings within the community regardless of differences in birth, social origin, gender, physical differences, faith and belief, ideology, nationality and so on. There can be no disagreement with the universally acclaimed truth that human dignity is the quintessence of human rights. Every human being is entitled to be treated with dignity, decency, equality and freedom regardless of the fact that we are born differently, grow differently, are different in our mental make up, thought proceses and life-style. Negation of this would mean negation of human rights.

A person with mental illness is entitled to treatment with the same dignity and decency as any other human being. A mentally ill person does not become a non person merely on account of certain disabilities. His human rights flow from the fundamental right to life as in Article 21 of the Constitution which includes:

- Right to living accommodation, food, potable water, education, health, medical treatment, decent livelihood, income, a clean and congenial existence
- Right to privacy, speedy trial (if involved in any criminal offence), information and means of communication.

International Treaties, Declarations and Guidelines

A series of international human rights treaties and other instruments have been in place since 1945. The UN provided an ideal forum for the evolution and adoption of these instruments. The international human rights law today comprises treaties, declarations, guidelines and principles – more than 100 in number.

The member States of the UN have reposed and reaffirmed their abiding faith in fundamental human rights, in the dignity, integrity and worth of every human being as a person and in the matter of equal rights of women and men as also in certain special rights for children.

Some of the international treaties, declarations, guidelines and principles which have affirmed and reaffirmed the human rights of every mentally ill person like any other human being are summarised in the accompanying table:

International Treaties, Declarations and Guidelines affirming/ reaffirming rights of persons with mental illness

	Year adopted
The Universal Declaration of Human Rights	1948
The International Convention on the Elimination of all forms of racial discrimination	1965
The International Covenant on Civil and Political Rights (ICCPR)	1966
The International Covenant on Economic, Social and Cultural Rights (ICESCR)	1966
The Declaration on the Rights of Mentally Retarded Persons	1971
The Declaration on the Rights of Disabled Persons	1975
The Convention on the Elimination of all forms of Discrimination	
Against Women (CEDAW)	1979

The Convention against torture and other cruel, inhuman or degrading treatment or punishment	1984
The Declaration on the Right to Development	1986
The Convention on the Rights of the Child	1989
International Conventions on the Protection of the Rights of all Migrant Workers and members of their families	1990
UN Principles for the protection of persons with mental illness and improvement of mental health care	1991
The Declaration of Caracas	1990
The Declaration of Madrid	1996
The WHO Technical Standards (Mental Health Care Law: Ten Basic Principles and Guidelines for the Promotion of Human Rights of Persons with Mental Disorders)	1996
The UN Convention on the Rights of Persons with Disabilities	2006

The UN principles for the protection of persons with mental illness and the improvement of mental health care (1991) recognise the enjoyment of the highest attainable standard of physical and mental health as the right of every human being.

In 1996, WHO developed the *Mental Health Care Law: Ten Basic Principles* as a further interpretation of the MI Principles and as a guide to assist countries in developing mental health laws. The WHO also developed *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders*, which is a tool to help understand and interpret the aforementioned UN principles 1991 (known as MI Principles) and evaluate human rights conditions in institutions.

Mental Health Care Law: Ten Basic Principles
1. Promotion of mental health and prevention of mental disorders
2. Access to basic mental health care
3. Mental health assessments in accordance with internationally accepted principles
4. Provision of least restrictive type of mental health care
5. Self-determination
6. Right to be assisted in the exercise of self-determination
7. Availability of review procedure
8. Automatic periodic review mechanism
9. Qualified decision-maker (acting in official capacity or surrogate)
10. Respect of the rule of law
WHO 1996

The principles with respect to the treatment of persons with mental illness can be summarised as follows:

- The aim of psychiatry is to treat mental illness and promote health to the best of his or her (*psychiatrist's*) ability, consistent with accepted scientific knowledge and ethical principles;
- Every psychiatrist should offer to the patient the best available therapy to his knowledge and if accepted must treat him or her with the solicitude and respect due to the dignity of all human beings;
- The psychiatrist aspires for a therapeutic relationship that is founded on mutual agreement. At its optimum it requires trust, confidentiality, cooperation and mutual responsibility;
- The psychiatrist should inform the patient of the nature of the condition, therapeutic procedure including possible alternatives and of the possible outcome;
- No procedure shall be performed nor treatment given against or independent of a patient's own will, unless because of mental illness, the patient cannot form a judgment as to what is in his or

her best interest and without which treatment serious impairment is likely to occur to the health of the patient or others;

- As soon as the conditions for compulsory treatment no longer apply, the psychiatrist should release the patient from the compulsory nature of the treatment and if further therapy is necessary should obtain voluntary consent;
- The value of positive mental health for every human being and the rights of all persons with mental disorders and with disabilities as full citizens of their countries should be recognised;
- All recipients of mental health services, regardless of age, gender, ethnic group or disorder must be treated in the same manner as other citizens in need of health care and their basic human rights and freedoms should be respected;
- The World Medical Association and its member associations have always sought to advance the cause of human rights for all people and have frequently taken actions endeavouring to alleviate violations of human rights;
- Members of the medical profession are often amongst the first to become aware of violations of human rights;
- Medical associations have an essential role to play in calling attention to such violations in their countries.

The UN Convention on the Rights of the Persons with Disabilities (2006) marks a "paradigm shift" in attitudes and approaches to persons with disabilities. It takes to a new height the movement from viewing persons with disabilities as "objects" of charity, medical treatment and social protection towards viewing persons with disabilities as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free, and informed consent as well as being active members of society. It has proposed a comprehensive definition of persons with disabilities as 'all those who have long-term physical, mental, intellectual and sensory impairments (Article 1). The Convention calls upon nations to take specific actions to protect the rights of people with mental disability.

Protecting the rights of the mentally ill

Availability, accessibility, acceptability and quality are the core obligations and elements of the right to health. A mentally ill person is in need of special care and attention both at home and in the hospital for the simple reason that he/she is unable to fend for himself/herself. The responsibility for special care and attention also lies with the care givers and includes the following:

At home:

- Treating the mentally ill person with dignity, decency, kindness and compassion;
- Not suppressing the information that someone at home has been affected by mental illness;
- Recognising that time is of the essence, and taking the ill person to a mental health facility for evaluation and admission, if considered necessary by the treating mental health professional ;
- Furnishing accurate postal address of the admitted individual to the hospital authorities at the time of admission;
- Not suppressing any information about relationship with the individual and about the nature of ailment;
- Volunteering to stay with the admitted relative in the family ward/ open ward, as the case may be;
- If it is not convenient to stay with the person for personal and family reasons, interacting with him/her at the hospital at frequent intervals as necessary;
- Ensuring that after the person has been effectively treated and fit for discharge, he/she is taken home, treated kindly and given the best care and attention, ensuring strict and timely compliance with the medicines prescribed;
- Taking the person to the hospital for follow-up as advised;
- Infusing hope, faith and confidence in the mind of the recovering person all the time that he/she can be effectively treated, cured and can resume a normal life like in any other illness;
- Extending cooperation to the psychiatric social worker during follow-up home visits.

In the treatment setting:

- No individual should be handcuffed or tied with ropes while being brought to the hospital or as an inpatient;
- There should be facilities for sedating disturbed individuals in the outpatient (OPD) setting;
- The OPD should comprise a large hall with sufficient number of chairs to seat persons seeking consultation and accompanying family members;
- The OPD hall should be well lit and ventilated with provision of potable water, toilet, newspaper stand and a television;
- A hospital canteen should be available nearby as waiting in the OPD may go up to 2 to 4 hrs depending on the average turnout of patients and the number of treating professionals available;
- At the OPD there should be sufficient number of registration counters to cater to the needs of people in different age groups (adults, adolescents, elderly and the children) as also women and men;
- The people at the registration counter should be given orientation and training to be civil, courteous, considerate to everyone seeking care, particularly the elderly;
- No mentally ill person or their caregivers should be subjected to any abuse or offensive treatment or treatment that borders on cruelty or torture; instead they should be treated with utmost civility, courtesy and consideration;
- No person seeking help for mental distress or illness should be refused examination at the OPD on any ground whatsoever;
- Similarly, no patient should be refused admission as an inpatient if the same is considered absolutely necessary by the physician examining him/her.

  Once a decision is taken that a patient requires inpatient care, certain other rights accrue to the admitted person such as:

- Right to wholesome, sumptuous and nutritive food according to certain prescribed scales;

- Right to potable water;
- Right to environmental sanitation including clean toilets;
- Right to personal hygiene;
- Right to books, journals, periodicals and newspapers in their language;
- Right to recreation (television in the room, dance, drama, music, other cultural activities, games and sports);

Right to food is further elaborated.

Right to Food

This includes:

- Preparation of food in the kitchen in a neat, orderly and tidy manner;
- Serving food courteously;
- Ensuring that the food is wholesome and nutritious;
- Making the hospital self-sufficient by developing a farm/kitchen garden to minimise dependence on market and ward off scarcity.

Preparation of food:

Food in hospital must be prepared in a modern kitchen which may be centralised or decentralised depending on the size of the hospital, number of beds and occupancy rate. The kitchen should have adequate space, ventilation, and lighting. This includes providing exhaust fans and chimneys. Glazed tiles should be fitted upto 1.5 metres height to ensure cleanliness in the kitchen with provision for regular cleaning of the tiles. There should be separate platforms for washing, cutting, cleaning and storing of vegetables meant for cooking. Adequate mechanisation must be encouraged, for example, providing electric kneader and chapatti-making machine. Care must be taken to check the food quality, and to ensure that it is neither undercooked or burnt. On no account should vegetables be cut on the floor or chapattis be made on the floor as is the practice in many hospitals. Cooked food should be properly stored and served as soon as possible.

Transportation and serving of food:

- Cooked food should be transported by a trolley and not manually as in the case in most of the hospitals. For this, proper paving of the roads inside the hospital should be done;
- Food should not be exposed or served in an open space. Dining facilities should be available, designed to ensure that there is no over crowding and that it is not too far from where the inpatients reside and that the service is smooth and prompt;
- The utensils should be made of stainless steel and not aluminium as the latter gathers dust and dirt and is no longer recommended;
- The timing for breakfast, lunch, evening tea and dinner should be such that the gap between two consecutive meals is not too long;
- The menu should be prepared for the whole week but should be altered daily to ensure variety. There should be separate menu for those not doing any physical activity and those engaged in physical activity in the occupational therapy units;
- The dining room and tables should be kept clean and free of flies and cockroaches;
- Soft music could be played at the time of serving food.

Ensuring that the food is wholesome and nutritious:

- Services of a dietician should be engaged to verify and attest that the food being served conforms to a minimum of 2500 kilo calories for women and 3000 kilo calories for men;
- The diet should be balanced and contain adequate nutrients as per established and recommended standards. The dietician must be sensitive to local preferences and food habits. The Indian Council of Medical Research (ICMR) has prescribed certain nutrient requirements and recommended dietary allowance (RDA) for able bodied adults (women and men).

Other Rights

In a similar fashion, the right to potable water requires ensuring that:

- There is sufficient water for drinking, washing, bathing, cooking and cleaning;

- Arrangements for distribution of water is made to all parts of the hospitals;
- Adequate state of the art technology is used to store and provide potable water;
- Regular checks to prevent contamination are carried out.

Right to personal hygiene includes providing adequate toilet facilities, adequate laundry facilities with mechanisation, clean and hygienic kitchens.

Right of access to information for the relatives includes ensuring arrangements for the relatives to visit their admitted relatives regularly, or make regular telephone calls. Such calls should be attended by trained and courteous attendants. There should be a computerised database for all outpatients and inpatients, to facilitate further treatment. A proper record system must be maintained with individual files for each individual seeking treatment. Strict confidentiality of such records must be maintained. While research scholars may have access to these records for academic purposes, procedures for such use must be clearly established.

Right to read and to recreation involves having access to reading material in the vernacular, opportunities to express one's creativity through fine arts, exploration and enhancement of inherent potentials in every individual.

Right to ventilate and redress grievances must include institutional mechanisms for such ventilation, time limit for redressal and communication of the decision regarding the grievance to the aggrieved.

Right to speedy trial of mentally ill undertrial persons

In Hussainara Khatoon (No.1) vs. Home Secretary, Bihar, it was held by the Apex Court that "*right to a speedy trial, a fundamental right, is implicit in the guarantee of life and personal liberty enshrined in Article 21 of the Constitution*". Speedy trial is the essence of criminal justice. These principles were reiterated in Abdul Rehman Antuley vs. R.S. Nayak in which detailed guidelines for speedy trial of an accused were laid down even though no time limit was fixed for trial of offences.

These notwithstanding, a number of cases have come to light where mentally ill persons who have been facing trial for an offence have been undergoing incarceration for long periods till their plight and predicament

surfaced through public interest litigations and much needed relief was provided by the Apex Court.

Supreme Court and human rights for persons with mental illness

In the case of Chandan Kumar Bhanik vs. State of West Bengal (1988) the apex Court observed: "*Management of an institution like the mental hospital requires flow of human love and affection, understanding and consideration for mentally ill persons; these aspects are far more important than a routinized, stereotyped and bureaucratic approach to mental health issues*".

In the case of Sheela Barse vs. Union of India and others the apex Court observed as under:

- Admission of non-criminal mentally ill persons in jails is illegal and unconstitutional;
- All mentally ill persons kept in various central, district and sub jails must be medically examined immediately after admission;
- Specialised psychiatric help must be made available to all inmates who have been lodged in various jails/sub jails;
- Each and every patient must receive review or revaluation of developing mental problems;
- A mental health team comprising clinical psychologists, psychiatric nurses and psychiatric social workers must be in place in every mental health hospital.'

In the judgment of the apex Court in Rakesh Ch. Narayan vs. State of Bihar certain cardinal principles were laid down by the apex Court. These are:

- Right of a mentally ill person to food, water, personal hygiene, sanitation and recreation is an extension of the right to life as in Article 21 of the Constitution;
- Quality norms and standards in mental health are non-negotiable;
- Treatment, teaching, training and research must be integrated to produce the desired results;

- Obligation of the State in providing undiluted care and attention to mentally ill persons is fundamental to the recognition of their human right and is irreversible.

Role and intervention of NHRC in mental health and human rights

In W.P. (Criminal) No. 1900/81 Dr. Upendra Buxi vs. State of U.P. and others the apex Court requested the NHRC to be involved in the supervision of mental health hospitals at Agra, Ranchi and Gwalior. The Commission on its part conceptualised and translated to action a Project on Quality Assurance in Mental Health Care in the country with Justice Shri V.S. Malimath, ex-Member, NHRC as Project Director and Dr. S.M. Channabasavanna, former Director and Vice Chancellor, National Institute of Mental Health and Neuro Sciences (NIMHANS) as the Principal Investigator along with a team of specialists as investigators. 'Quality Assurance in Mental Health' emerged as the end product of this marathon action research project with the following outputs:

- Existing status of mental health hospitals, failings and inadequacies;
- Comprehensive recommendations to achieve the object of ensuring quality mental health care in the country.

The NIMHANS team took enormous pains to visit and intensively review the functioning of 37 mental health hospitals all over the country. The review ended with a series of recommendations including steps to improve physical facilities, treatment and care of patients, occupational therapy as a tool of rehabilitation, training and research, and community outreach programmes.

The recommendations in a capsule form are:

- Immediate abolition of cell admissions;
- Gradual conversion of closed wards into open wards;
- Construction of new wards of shorter capacity (not more than 20) for use as open wards;
- Streamlining admission and discharge procedure in accordance with provisions of the Mental Health Act, 1987;

- Upgradation of investigation facilities;
- Inservice training of all staff members;
- Providing each patient a cot, mattress, pillow, bedsheet and adequate clothing for change;
- Improving supply of water and electricity;
- Ensuring supply of nutritive food of 3000 kilocalories per day to each patient;
- Developing occupational therapy facilities;
- Improving recreational facilities;
- Developing rehabilitation facilities including day care centres.

Since June 1999, when the 'Quality Assurance in Mental Health' report was released, the Chairperson, Core Member in charge of mental health and other members as also Special Rapporteurs have been regularly inspecting and reviewing the activities of all the 37 mental health hospitals including GMA, Gwalior, IMHH, Agra and RINPAS, Ranchi. A number of qualitative changes and improvements in the overall work environment, management and quality of treatment in these hospitals have taken place as a result of these visits, inspections and reviews. This runs into a long list and it will be difficult to recount all these changes and improvements.

The human rights dimension of mental health has occupied the pride of place in all these visits, reviews and inspections.

The NHRC can only play the role of a promoter, facilitator and catalytic agent as also a watch dog; it cannot, however, substitute the primary role or mandate of State Governments to ensure mental health as a matter of human right to every individual. Besides, it is not one department but a host of departments and agencies who are stakeholders in the process. NHRC has, however, adopted a totally open, transparent and participative style of monitoring the pace and progress of activities in the hospitals keeping the human rights dimension uppermost in view. It has hitherto used monitoring as a tool of correction and promotion of human rights of the mentally ill persons.

What is the ground level situation?

While cardiac arrest at present is the major health concern, according to

the WHO Projection, by 2020, depression will be the main cause for worry. The proportion of total global burden of disease attributable to mental, neurological disorders and substance abuse is projected to rise from 11.5% in 1998 to 15.5% by 2020. Increasing suicides/attempted suicides is yet another major cause for worry.

Why is this so?

There are multiple contributory factors responsible for increase in mental problems year after year. Unplanned urbanisation, unregulated migration, within and across States and borders, naked expropriation and exploitation at the worksite, and vulgar consumerism are major problems today. Breakdown of the joint family system, emergence of nuclear family structures, neglect of children in childhood, marital discord, breakdown of relationships, emergence of more and more distrust and suspicion among couples all lend to significant mental health problems. Collective social resistance to inter-caste and inter-religious marriages, intense discrimination between siblings by parents at home, emergence of adversarial relationship amongst castes, classes and sects gives rise to mindless violence, hatred and intolerance in a highly stratified society. Extreme fads, taboos, obscurantist ideas and practices, unrealistic parental expectations and pressures on school and college going children to prove themselves and rise to heights drives children to desperation. Neglect of the old by the young results in throwing the old by the wayside. A callous and insensitive society and State, footloose governance without any semblance of transparency and accountability are also factors which might be behind some of the mental problems.

All this constitutes a terrible source of uneasiness for any civilised human being or right thinking person. This is on account of the fact that mental illness affects health, freedom, security and well-being of individuals, families, entire communities and of the society and the nation. It inhibits the individual's ability to cope with stress. If the patient is a young and productive adult, it leads to a colossal waste of this most precious human resource.

Children, women and the elderly constitute the most vulnerable groups. Article 39(f) of the Constitution says that children should be given opportunities and facilities to develop in a healthy manner in conditions of freedom and dignity and that childhood and youth are protected against exploitation, against moral and material abandonment. In case of children

who are afflicted with mental problems, the petals of childhood wither away in wilderness before blossoming to flowers of youth and adulthood.

In case of adolescents and adults, mental illness substantially cripples the productive and reproductive phase of life. For women, good mental health is intrinsically important as they are the care givers and would not be able to play this role effectively when they are afflicted by mental illness. A woman is the most important resource for the family and mental illness robs her of the vitality and strength as well as the stability and strength for the family.

In case of the elderly, their plight and predicament on account of old age associated with seclusion, helplessness and abandonment by the young gets compounded by mental illness. Depression among the elderly often goes undiagnosed. It is associated with chronic physical illness; symptoms of depression are also a common side effect of prescriptive medications including anti-hypertensive drugs. Suicide rate is one measure of depression which is higher among people over 65.

With lower birth rate and high longevity, the number of elderly people in the world is increasing rapidly. In India (where there are 76 million elderly persons at present) the number is likely to go up to 100 million by 2013 and 200 million by 2030. The elderly need our special attention and care as they are in the twilight zone of their life.

Our public health system often ignores elderly people who are mentally ill and such negligence is a form of elder abuse. Elderly people in poor health are 3 to 4 times more likely to become victims of abuse than those who are in good health. Beds are not easily available to them at the time of hospitalisation, residential care is denied to them and community services are often wanting for this group. They turn out to be victims of the worst forms of neglect and violation of human rights.

Promoting human rights in mental health: what we have and what we do not

Internationally we have a series of treaties, customs, declarations, guidelines and principles some of which have been referred to earlier. Together they have set the international human rights standards. The primary responsibility for ensuring respect for the human rights of persons, however, rests with the Member States of the UN.

At the national level the old Lunacy Acts of 1912 and 1977 have been repealed and replaced by the Mental Health Act, 1987. The National Mental Health Programme was launched in 1982 which was reviewed and re-strategised in 2003. Successive judgements of the Supreme Court between 1986 and 1997, some of which have been referred to earlier, have clearly brought out the human rights dimension of mental health and need for a proactive approach to mental health and a humane approach to the patients. The meagre allocation of Rs 28 crore in the Ninth Plan was stepped up to Rs 190 crore in the Tenth Plan and has been further stepped up to Rs 1000 crore in the Eleventh Plan which has since been approved by the NDC in December, 2007. The emphasis in the revised NMHP is on:

- Integrated approach to treatment, training, teaching and research;
- Community outreach programmes;
- Destigmatization of mentally ill persons for acceptability and reintegration into the mainstream of society.

In terms of structures we have mental health advisory bodies at the Central and State levels. We have the District Mental Health Programme extended to 125 districts. We have Departments of Psychiatry in 271 of the 283 Medical Colleges (both government and private) in addition to 41 mental health hospitals. The Indian Psychiatry Society (IPS) has since its inception contributed significantly by way of action research. NIMHANS has been a trend and pace setter in both psychiatry and neurosciences and a number of institutions like 'Friends of NIMHANS' have come up under the umbrella of NIMHANS. A number of models of close collaboration between GOs and NGOs in providing rehabilitation and reintegration to mentally ill persons have also come up such as Medico Pastoral Association which set up the first half way home. The Institute of Human Behaviour and Allied Sciences (IHBAS) together with NIMHANS rendered yeoman service in providing psychological rehabilitation to those who were hit by natural calamities (earthquake, supercyclone, and tsunami).

The gap between the resources – human, material and financial needed on account of the growing demand for mental health services and the available resources is our major concern. According to established norms we need the following resources:-

- psychiatrists 1.0 per 1,00,000 population; one for every 10 inpatients;
- clinical psychologists 1.5 per 1,00,000 population; one for every 25 inpatients;
- psychiatric social workers 2.0 per 1,00,000 population; one for every 25 inpatients;
- psychiatric nurses 1.0 per 3 patients in a teaching hospital and one for every 5 in a non teaching hospital.

Going by the norms as above, we would need:

Psychiatrists:	9698
Clinical psychologists:	13,259
Psychiatric social workers:	19064

We have 61,521,790 major and minor mental disorders for which we have only 20,893 beds in government sector and 5096 beds in the private sector.

The gap is huge and unless timely action is taken to bridge the gap and the same is fully or substantially bridged, we will be no where in translating the human rights dimension to a concrete fulfilment; it will only remain an unrealised dream.

Simultaneously, a number of proactive steps will have to be taken in the following directions:

- All archaic structures must be dismantled giving rise to new modern, well lit, ventilated and aesthetically pleasing structures with a sylvan surrounding;
- Leaking roofs, eroded floors, overflowing toilets and broken doors must be made a thing of the past;
- All irrational practices (like lock up and dinner at 5.30 pm before lock up, treating patients not returning from leave and absconding patients as discharged, bringing patients to hospitals in ropes or fetters) must be completely abolished;
- Right to food, right to potable water, right to personal hygiene, right to sanitation, right to recreation and right to privacy must be fully respected; these are non-negotiable;

- All the walls of the hospital must be splashed with good quality information, education and communication materials which would breathe a new hope, faith and conviction among mentally ill persons and their relatives that nothing is lost and life can be started afresh;
- We must react to the observations contained in the WHO report, 2001 about status of mental health care institutions in India with sufficient sensitivity and concern.

Towards community care

Community care involves the care and treatment outside an institution of people who have or who are recovering from a mental illness. It is coterminus with de-institutionalisation (which does not necessarily mean total dehospitalisation) which means a policy of caring for the people with mental illness in the community instead of only (or mainly) in hospitals or psychiatric units. The rationale for community based mental health care has its origin from 3 sources, namely:

- Treatment of mentally ill persons in mental hospitals has its severe limitations;
- Institution-based psychiatric treatment through trained professionals (who are also limited) can be very expensive;
- Para professionals with short and simple orientation and training could deliver reasonably satisfactory mental health care.

Without the network of community based services and support systems it is difficult to integrate people from the hospital wards into the community.

The concept of community care includes:

- Arrangement for the care and support of families;
- Care and treatment for the significant proportion of people with mental illness who have never been admitted to a psychiatric facility and who may never need to be if they are provided with appropriate care, support and treatment in their own environment.

Community care also includes issues affecting people who may need occasional inpatient care as well as community care. They may manage well in their usual environment for a substantial period of time but may

periodically require hospital admission for treatment and stabilisation when an acute episode occurs.

The irony of the situation which we face in India is that substantial resources are allocated to institutional care, leaving very little to promote or sustain community care. This is what has resulted in conspicuous absence of comprehensive community services linked with mental health. Attempts have been made to launch a few community satellite clinics but there are formidable problems in its successful operationalisation. There is no campaign or movement for involvement of the entire community in mental health.

Conclusion

To sum up, human rights are not the exclusive preserve of any individual and group. They are neither owned by anyone nor can be doled out as a gift by one to another. They belong to all of us – individually and collectively. They are universal and indivisible. I conclude by quoting from the Vienna Declaration and Programme of Action adopted at the close of the World Conference on Human Rights:

> "*All human rights are universal, individual, inter dependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing and with the same emphasis. While the significance of national and regional peculiarities must be borne in mind it is the duty of the States regardless of their political, economic and cultural systems to promote and protect all human rights and fundamental freedoms*".

Select References

1. http://www.unhchr.ch/udhr/lang/eng/html
2. http://www.unhchr.ch/html
3. http://www.hrweb.org/legal/cpr.html
4. http://www.un-documents.net/a30r3447.htm
5. http://www.un.org/womenwatch/daw/cedaw

6. http://www.paho.org/English/HDP/HDD/LEG/BolisPaperMentalHealth-Amsterdam.pdf

7. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid

8. http://www.who.int/mental_health/media/en/75.pdf

9. http://www.un.org/disabilities/convention/conventionfull.shtml

10. AIR1979SC1369, 1979CriLJ1045, (1980)1SCC98, [1979]3SCR532

11. AIR 1992 SC 1630