

IN THE SUPREME COURT OF INDIA

**(CIVIL ORIGINAL JURISDICTION)
WRIT PETITION (CIVIL) No.334 OF 2001**

IN THE MATTER OF:

Re: Death of 25 chained inmates in

Asylum fire in Tamil Nadu ...Petitioner

Versus

Union of India & Ors ...Respondents

**WRITTEN SUBMISSIONS ON BEHALF OF ACMI
PURSUANT TO THE ORDER DATED 18-8-2004 OF
THIS HON'BLE COURT.**

1. The present written submissions are being placed before this Hon'ble Court by Action for Mental Illness ("ACMI") a registered trust under the Indian Trust Act 1860, pursuant to the liberty granted by this Hon'ble Court vide order 18-8-2004.

I. LOCUS STANDI OF ACMI.

2. ACMI is an advocacy organization for families that take care of family members who are under treatment for mental illness. ACMI wishes to place its views before this

Hon'ble Court in the Sarthak PIL because so far this Hon'ble Court has heard only from (a) governments that establish and run institutions to treat mentally ill out of public funds or (b) psychiatrists who man public institutions or have established private institutions for treatments of the mentally ill or association of psychiatrists or NGO's run by psychiatrists.

3. The viewpoints of the families of the mentally ill, who in fact are the most important care-givers of the mentally ill in India remain unrepresented even though they are the main care-givers of the mentally ill. Psychiatrists and NGO's run by them and governments are important parties but they cannot be the sole interlocutors in a public interest litigation that concerns the rights of the mentally ill. Particularly in the context of prescription of minimum standards for various types of psychiatric hospitals and homes, the views of families/family self-help groups must be taken into account. Given the paucity of public and private institutions/ hospital resources to treat the mentally ill, families are the main back-up resources for the mentally ill. Accordingly, it is respectfully submitted that it is vital that the interests of consumers of mental healthcare, i.e., the mentally ill and their families that are their primary support system, also must be represented.

II. BACKGROUND OF ACMI.

4. The founder-trustees of ACMI consist of two activists for the rights of the mentally ill, Smt. Nirmala Srinivasan and Smt. Laila Ollapally, both of whom have been involved in

the Karnataka High Court offshoot of the Sheela Barse PIL, which has heard and disposed of by this Hon'ble Court. They have also been actively involved with the activities of the Association for Mentally Disabled ("AMEND"), India's first autonomous self help group, and of ACMI. Based on their association with ACMI and AMEND, both the founder-trustees have also been actively involved in the efforts of Government of Karnataka and other institutions in Karnataka including NIMHANS to shape the regulatory framework for taking care of the mentally ill in Karnataka.

5. Smt. Nirmala Srinivasan, one of the founder-trustees of ACMI has had personal experience of mental illness in her own family and is also the founder of India's first autonomous self help group, the Association for Mentally Disabled ("AMEND"). Formerly a professor of I.I.M. (Lucknow) and later Guest Faculty at I.I.M. (Bangalore) and Professor I.I.P.M. (Bangalore), she is a lobbyist and advocate for the rights and concerns of the mentally ill in the rural and urban areas in the State of Karnataka, as well as other parts of the country. She is a recipient of the Ashoka fellowship, which was conferred on her in recognition of her work in the field of support for families and self help care of the mentally ill, besides advocacy on their behalf for the year 2003-2004. Ashoka fellowship in conferred by Ashoka innovators for the Public, Washington DC for social entrepreneurs across the world.

6. The other founder-trustee of ACMI, Mrs. Laila Ollapally, is an advocate who has been deeply involved in the field of mental health care for a long time. She has also dedicated herself to fighting for the rights of the mentally ill and restoring their dignity. As an advocate, Mrs. Ollapally has been herself actively assisting the court in the Karnataka High Court offshoot of the Sheela Barse PIL disposed off by this Hon'ble Court.
7. ACMI advocates an equal partnership between, on the one hand, family members who are care givers to the mentally ill and, on the other hand, psychiatrists and other professionals involved in the treatment of the mentally ill, working in tandem with governments, at the national and the state level.

III. CONCERNS OF ACMI.

1. **Short term emergency measures are necessary to address the current crisis in treatment of mental health problems.**
8. The biggest problem in the field of care for the mentally ill right now is the issue of how to address the immediate crisis that faces the country in the field of health care for the mentally ill. There are two crore (twenty million) persons suffering from serious mental illness in this country who require treatment for serious mental conditions and another 20 to 30 million who suffer from minor mental disorders, making for a 50 million Indians with major and minor mental disorders. However, it is already clear that the facilities/ infrastructure promised under the Mental health Act, 1987 (the "Mental Health Act") are a mirage. A copy of a presentation made by one

of the founder-trustees of ACMI on 13-2-2004 at RML Hospital, Delhi containing statements of parents of affected individuals is annexed and marked as Annexure-I

9. The pathetic state of affairs with respect to availability of psychiatrists and trained clinical psychologists in India is evident from the statistics. There are only 4 Psychiatrists per million population in India, taken as a whole, Statistics showing:

i) Statewise distribution of Clinical Psychologists per one million populations;

ii) Distribution of Psychiatric Beds per one million population above 10 million.

iii) Distribution of Psychiatrists per one million populations in states with total population above 10 million.

iv. Distribution of Psychiatrists per one million population in states with total population below 10 million;

v. Numerical supporting statistics;

Compiled by Dr.Srinivasa Murthy(currently working with the who under the STB-Mental Health and Rehabilitation Psychiatric services) and copy of the Article 'Recruitment of the consultant Psychiatrists are annexed herewith and marked as Annexure-II and III respectively.

10. It is clear that an immediate crisis management plan needs to worked out to overcome the huge deficit in availability of psychiatrists even while a medium term and long term solution is being worked out in terms of various policy documents and 10 year planning by the Government of

India and the State Governments. The National Mental Health programme 2002-2007, comments that:

“The available resources with regard to trained man power, infrastructure and physical inputs need to be augmented to cope with the immense burden of mental lillness”.

Even the scarce resources that are available are unevenly distributed only 27 out of the 593 districts in the country are covered by the District Mental Health Programme

11. In the Sheela Barse litigation itself, Dr.Srinivas Murthy had pointed out that early intervention is vital to avoid long term chronicity in mentally ill patients. In order to address the immediate crisis, he had proposed that at least one psychiatrist should be available in each District Hospital in every district throughout the country. This has still not been implemented to date as most states are nowhere near satisfying this requirement.
12. In the case before the Karnataka High Court which was an offshoot from the Sheela Barse public interest litigation, an intervenor Citizens for Action Group represented by Ms. Laila Ollapally, one of the founders of ACMI, asked for a plan of action to be submitted by the Government of Karnataka to address the mental healthcare needs of the State with appropriate budgetary allocations. On July 18,2002, the High Court ordered the Government of Karnataka to frame such a plan of action. On October 15,2003, the government filed its plan of action in the form of an “Action Taken Report”, which is hereinafter referred

to as the “Karnataka model”. The Government of Karnataka proposed that short-duration training should also be given to primary health center physicians so that they can take the burden of initial screening of patients to identify those with serious mental illness who need treatment by the psychiatrist at the district hospital Copy of the action taken report on the order dated 15-10-2003 of Hon’ble High Court of Karnataka alongwith other relevant document is annexed herewith and marked as Annexure-IV.

13. Lack of availability of basic medicines is the other huge problem in managing the immediate crisis. If medicines were made available, much of the load on the district psychiatrist could be relieved by asking families to take care of their mentally ill relatives at home in conjunction with family self-help groups and the primary health center physicians. In fact, the Karnataka model is certainly one that this Hon’ble Court could consider as an initial basis for tackling the immediate crisis.

14. ACMI endorses the need and requirement for one Mental Health Institute in every State as an apex body of super speciality mental health care besides state level research including manpower planning and projection; leadership and interpersonal communication skills for professionals, Self-development and advanced training and refresher courses for professionals on the lines recommended by the UGC for teachers. Besides this, the others can be general hospital facilities but with a special quota for Psychiatry admissions . Copy of the statement

filed by the intervenor, Citizens action Group in the WP No.,8741/91 before the High Court of Karnataka, Bangalore is annexed and marked as Annexure-V Colly. And copy of the order dated 16-3-2004 of the High Court of Karnataka in Writ Petition No.8741/91 is annexed and marked as Annexure-VI.

15. While ACMI agrees that this Hon'ble Court should reiterate its direction that both the Central Government and the State Government must immediately build the necessary psychiatric hospitals in each State, its apprehension is that the States do not have the resources right now to build one psychiatric hospital in each State. Moreover, it will take a long time for these hospitals to be built. Accordingly, it is suggested that for the present, the Central Government should be asked to make available to each State the financial resources for establishing at least one psychiatric hospital in each State on a time bound basis. This institution could serve as the nodal point for ensuring that absolutely vital services to tackle the immediate crisis reach the grass roots level by training primary health center physicians through video-conferencing etc, and deputing psychiatrists to each district hospital. The States could be asked to focus their resources on providing the necessary personnel including psychiatrists at each district hospital and in ensuring the training of primary health center physicians. Based on the Karnataka model, the States could also consider appointing District Mental Health Officers, who would be responsible for ensuring that family self-help groups are formed in each

district and for monitoring the facilities being provided by private psychiatric homes.

16. The non-availability of human resources clearly is preventing any possibility of intervention by Government at the Central or State level to resolve the enormous problems facing the mentally ill in India which is having a significant adverse impact on their right to a healthy existence under Article 21 of the Constitution . ACMI, therefore, respectfully submits that this Hon'ble Court should give suitable directions to the respondent Union of India to conceptualise, formulate and implement a policy that ensures immediate availability of at least one psychiatrist in every district in the Country.

17. The National Mental Health Programme, 2002-07, mentions that:

“The available resources with regard to trained manpower, infrastructure and physical inputs need to be augmented cope with the immense burden of mental illness.”

There is a crying need for 10-year manpower perspective planning to overcome the shortage of psychiatrists. There is an additional need for sufficient backup training to be given to doctors with M.B.B.S. degrees/general practitioners to deal with emergencies and situations involving the resignation or retirement of the sole psychiatrist in the district. The tentative budget allocation for treatment and research on mental illness under the 10th National Programme is approximately Rs.190 crores. This is not

remotely enough to deal with the problems of the mentally ill. However, even these resources are not being spent in a focused manner. Accordingly, in order to protect the Article 21 rights of the mentally ill, it is respectfully prayed that this Hon'ble court should give directions to the Respondent Union of India and the Respondent States to frame a comprehensive and concrete response to the immediate crisis facing the mentally ill.

2. Statutory and regulatory framework needs thorough revision.

18. ACMI is in full agreement with the recommendation of the amicus curiae that the Mental Health Act, 1987 requires a thorough revision. ACMI strongly urges, however, that any such revision should be based on integrating the family and the “community” model into the “institutional” approach to the treatment of the mentally ill.

i. Due representation to families in revising legislation.

19. It is submitted that while revising the Mental Health Act, the role of the family as the primary care giver should be given due consideration. Indian policymakers have not given adequate importance to the family as the primary care givers to the mentally ill either in framing policy or in the treatment process for the mentally ill. It is important to involve representatives of family self-help groups and advocacy organizations such as ACMI (other than NGOs) in the framing of policy by giving them adequate representation on the national and state mental Health authorities. At the same time, ACMI strongly recommends

that NGOs that run commercial facilities should not be involved in such policy making bodies.

ii. **Due weight to role of families in treatment.**

20. Given the lack of resources to address the problems faced by the mentally ill, it is necessary to involve families and communities in the treatment process as well. The devastating effect of illness such as schizophrenia, Bipolar disorder, OCD (Obsessive Compulsive Disorder), etc., leave families in chaos and thus there is a need for educating them and empowering them by giving them the skills to cope with the challenges that they face.

21. The dearth of professionals in relation to the demand for mental health care adversely affects services to the caregivers and consumers about mental illness education. Care givers are not involved as partners because the professionals do not have the time. As a result, caregivers are left out of the information and decision making loop. Most importantly, in a country like India where only 10% receive treatment and where there are only 4 psychiatrists for one million persons, the family has emerged as the main stay for support and care, adding dignity to the lives of the affected people. Most importantly, research shows that in addition to clinical interventions, family support is a significant input to cope with the responsibility of providing care for a person with chronic mental illness. Thus, in Dr. Srinivasa Murthy's Plan of Action report submitted to the Government of Karnataka, it was pointed out that:

“... Families are the primary care providers in the state. Families need support from the State and society in a number of ways including financial support. They also need an understanding of the illness in question and to know how to encourage medication compliance... They can be supported by visiting community nurses and other support staff, and encouraged to form networks of self help groups. State should facilitate these initiatives”

Karnataka State Medical Health Care Programme.

P.11.

22. As noted above, the only model that is viable and practical is the capacity building of family members, which ACMI is doing using the resources within AMEND. This model is proving to be the most cost effective under the present circumstances. One of the activities used as a tool by ACMI is sponsoring AMEND’S family co-counseling. This is perhaps the first program that uses the capacity of affected family members of AMEND to extend help, support and guidance to other affected family members. The entire training has been done by ACMI. Copy of the project report ‘ Kshema’ on family counselling is annexed herewith and marked as Annexure VII.

23. Moreover , the current statutory framework does not give any representation to families on various authorities established under the Act such as the National Mental Health Authority and the State Mental Health Authorities. Family care-givers, and grass root associations, need to be

given representation on the Board of Visitors referred to in Section 37 (1) of the Mental Health Act. The Mental Health Act Needs to be amended for this purpose.

24. In any case, it is clear that the views of family self-groups must be taken on board by any commission that is set up to review the need for amendments to the Act.

(iii) **Safeguard rights of mentally ill during periods of normalcy.**

25. It is impossible to place too much emphasis on the importance of distinguishing between the mentally ill and other types of disable people including mentally retarded people for purposes of deciding what rights are appropriately conferred on the mentally ill. The most important distinction between the mentally ill and the mentally retarded is that the mentally ill will frequently be completely functional in all respects, especially if they have adequate access to basic medicines. Keeping in mind the inalienable fundamental rights of all individuals including those suffering from mental illness as recognized by the international Covenant for Civil and Political Rights and the International Covenant for Economic and Social Rights, it is especially important to devise mechanisms to safeguard basic rights of the mentally ill and especially the following rights:

1. Right to vote
2. Right to marry
3. Right to have children and to maintain parental rights.

4. Right to own and to bequeath property
5. Right to work and employment
6. Right to education
7. Right to freedom of movement and choice of residence;
8. Right to health, which includes treatment, rehabilitation, and integration into society for those who are fit, etc.
9. Right to a fair trial including due process of law;
10. Right to sign cheques and engage in other financial transaction.
11. Right to privacy qualified only by rights of the caregiver;
12. Right to religious freedom and practice; and
13. Right not to be punished for attempts at suicide/ homicide during symptomatic phase.

During periods of normal functioning, it would be a great injustice to deprive those who are susceptible to mental illness or have suffered mental illness in the past of all their rights.

iii. **Wards to be open to guard against abuse.**

26. All closed wards including ones in NIMHANS must be thrown open to family members as attendants. The choice of attending to the needs of family members who suffer from mental illness must be made available to families who wish to do so. This is the best way to guard against abuse and ensure that the fundamental rights of the mentally ill are not violated. Since effective medications are available,

closed wards are not even warranted. Cases of abuse in closed wards and patients running away or not getting medicines these issues can be taken care of if family members or special attendants are allowed.

(v) Temporary certification and guardianship during mental illness.

27. The right of the mentally ill to exercise their right to live autonomously during periods when they are in a position to function normally must be safeguarded. The guardianship and property rights of the mentally ill are covered by the Mental Health Act, under which even family members do not have the right to nominate guardians. However, caregivers of persons with certain other types of disabilities have been given this right under the National Trust for Welfare of Persons with Autism, Cerebral palsy, Mental Retardation and Mental Disabilities Act, 1999(the “National Trust Act”). It is respectfully submitted that the National Trust Act must be amended to cater to the needs of the mentally ill as well. However, it must make provision for temporary certification and guardianship for the mentally ill only during the periods when they are unable to function normally and for resuming their right to take care of their own interest when they are able to function normally. This would enable the mentally ill to obtain the benefits of guardianship on a

temporary basis, only while they are suffering from mental illness that incapacitates them and prevents them from functioning normally. Accordingly, any amendments to the National Trust Act for the benefit of mentally ill patients should take into account the need for a certification procedure. Moreover, at least in cases where families are the source of funds and properties on which the mentally ill must rely for their sustenance, families must be given the right to nominate persons of their choice. A note on appointment of guardian for mentally ill person and relevant rules of the CCS pension rules are annexed herewith and marked as Annexure-VIII and IX respectively.

28. In any case, in framing a policy in this regard, the Union of India ought to remain receptive to the suggestions of representatives of groups that represent the interests of families as the primary care givers to the mentally ill.

(vi) Various types of infrastructural facilities necessary to support families in caring for mentally ill.

29. There are several patients languishing in the state mental health hospitals for want of any rehabilitation measures. The traditional model of rehabilitation relying completely on family support has completely disintegrated because of the modern phenomenon of all working -age members of families taking up full time jobs. In the circumstances, there is a need for various types of infrastructure to support families that need to take care of members suffering from mental illness including:

1. Quarterway homes;
 2. Convalescence homes;
 3. Day care centers
 4. Short stay Homes
 5. Half way homes;
 6. Vocational skills training centers;
 7. Suicide training centers;
 8. De-addiction centers;
 9. Shelter workshops; and
 10. Most importantly, long term care homes or shelters for homeless orphans or others suffering from mentally illness in cases where family care givers are not able to provide care on account of old age or cases where families of the mentally ill cannot afford private facilities.
11. Most of the facilities mentioned above pertain to rehabilitation phases of the treatment, which entail management of disabilities of mental illness. The Ministry of Health and the Ministry of Social Justice, Empowerment have overlapping responsibilities in this area. While mental healthcare falls within the charge of the Ministry of Health, mental illness is recognized as a disability under the persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 which falls within the purview of Ministry of Social Justice and Empowerment and not Ministry of Health. Therefore, it is essential that the ministry of Social Justice and Empowerment also must be involved in framing policy for mental healthcare and

rehabilitation in India. In order to smooth the functioning and co-ordination of the two Ministries, it is respectfully submitted that a task force to be headed by a responsible government official not lower than a Joint Secretary must be set up at least in the initial phase.

(vii) Enforcement of minimum standards for health care institutions.

29. Proper minimum standards for mental healthcare institutions are required to be framed and implemented. The Karnataka State Mental Health Authority has undertaken an exercise in this area alongwith the active participation of NGOs and family groups such as AMEND and advocacy organizations such as ACMI. ACMI has played a vital role in this as part of the Plan of Action sub-committee. These draft rules are pending final clearance by the concerned authorities. A copy of the original draft of the Karnataka Rules is annexed herewith and marked as Annexure-X.
29. The draft Karnataka rules certainly could serve as a model for the rest of the country. ACMI also prays for inspection and filing of reports on the conditions at the State run hospitals, and institutions, including those that come under the purview of the Central Government. ACMI respectfully prays further that this Hon'ble court may be pleased to give directions to the Central Government to consider framing similar rules on a nationwide basis.

**(viii) Guidelines for police to exercise powers under
Section 23 of the Mental Health Act.**

29. Section 23 of the Mental Health Act on role and duties of the police with respect to the mentally ill needs to be clarified. Institutions should be made liable to keep the mentally ill for the 24 hour period within which the police are required to obtain certificates from the Magistrate. The law is not clear on this and the authorities refuse admission until the Magistrate's certificate is given. Since the person taken into custody under section 23 is a mentally ill person, he/ she must not be incarcerated, nor kept in jail, but must be taken to a Government psychiatric facility. If the case is a false case, it can always be proved to be false by certificates from the psychiatrists.

ix. Rehabilitation Council of India must include mental illness as a handicap for purposes of the Handicapped Act.

29. There is an additional need for augmenting certification and clearance granted by the rehabilitation Council of India on the mechanisms and methods of rehabilitation as, it is clear from past experience that unsafe methods having adverse effect on the health and recovery of the person are frequently resorted to by untrained personnel.

x. Persons with Disabilities Act, 1995 must incorporate and safeguard rights of mentally ill.

29. Although the persons with Disabilities (Equal Opportunities, Protection of rights and Full Participation) Act 1995 (the "Disabilities Act") recognizes Mental illness

as a disability, it also discriminates against persons suffering from mental illness in various ways. An analysis of these lacunae as well as ACMI's recommendations in this regard is as follows:

1. **Emergency Services.** Lack of access to emergency ambulatory services that contravenes the right of Mentally ill to treatment;
2. **Free Education.** Presently ,Chapter V of the Disabilities Act permits free education only upto 18 years, which will not help the mentally ill, because their illness strikes around that age and the prognosis varies from case to case. On account of this lacuna, at least provision must be made that:
 - i. Open Universities and schools permit free education for the disabled on a life-long basis, eg., Indira Gandhi National Open University and National Open Schools;
 - ii. If a person wishes to continue or return to the original institution, after an episode of mental illness, the institution must renew admission and charge only 50%. This is true especially in case of the mentally ill who are in professional courses such as Engineering or medicine. The family has to support their treatment with medication and psychiatrist fees; rehabilitation expenses etc. Therefore, 50% concession must be made mandatory in all institutions.

(c) **Employment:** The measurement of mental illness is now made possible with IDEAS. So those fulfilling the below poverty line criteria must be given employment on par with others. The Act has reserved job quotas only for the Blind, Hearing impaired and Orthopedic Impairment. MI is today a measurable disability and hence it must be reconsidered.

IV SAARTHAKPIL:CONSTITUTIONALITY OF SECTION 81 (2).

36. Another area of grave concern for ACMI is Section 81(2) of the Mental Health Act, which permits research on mentally ill persons, Section 81(2) (i) permits research to be conducted on a mentally ill person if the same is of direct benefit to him without taking the consent of the mentally ill person or his/her guardian. Section 81(2)(ii)

permits research to be conducted on mentally ill persons if the mentally ill person consents to it or where the person is incompetent to give consent, his/ her guardian consents to the same. In this regard, it is important to note that drug trials are both formal and informal. For formal drug trials, there are ethics committees which ensure that the trials are conducted with due regard to the rights of the persons on whom the drugs are being tested. However, during informal drug trials, when new medicines are prescribed, most families do not get information about the side effects and

what support they can expect from the doctor. Therefore, the potential for abuse in Section 81(2) is tremendous and , therefore, unless and until sufficient safeguards are provided, the provision ought to be struck down.

37. It is respectfully submitted that Section 81(2) (i) violates the right of those suffering from mental illness under Articles 14, 19 and 21 of the Constitution for the following reasons:

1. To permit research to be undertaken on a mentally ill person, without the consent of either the person or his/her guardian on the basis that it is likely to be of direct benefit to such person under Section 82(1) (i), is clearly against the norms of a civilized society based on respect for the autonomy and dignity of the individual. The real question that the provision poses is who is to decide whether the research is of direct benefit to the mentally ill person. Assuming that the mentally ill person is incapacitated from giving consent, there must be good ground to disqualify the person's guardian from giving consent and, ultimately, in the absence of a guardian , some sort of committee must evaluate whether it is appropriate to grant consent.
2. The Constitutional rights enshrined in Articles 19 and 21 of the Constitution are all part of the larger right of an individual to lead his life with autonomy and dignity subject to reasonable restrictions guaranteed under our Constitution. Consent of the individual to any process or procedure that impinges on his/ her

physical or mental integrity is a prerequisite to human autonomy and dignity. Even if a person is mentally ill and, therefore, allegedly incapacitated from giving consent, there must be safeguards in place (such as the committee referred to in the previous paragraph as well as appropriate guidelines) to ensure that the research on the individual is actually in his interest. The mentally ill person cannot be left entirely at the mercy of the professional doctor/ psychiatrist. There is also no requirement in Section 82(1)(i) that, if there is an alternative tried and tested treatment which is beneficial(though not to the same degree or as speedy), then no experiment or research can be conducted on the mentally ill person.

37. It is respectfully submitted that Section 81(1)(ii) also suffers from the same vice as Section 82(1)(i) insofar as it does not incorporate any safeguards to ensure that the mentally ill person is actually competent at that time to give his/her consent, that the guardian, in fact, is acting in the best interest of the mentally ill person and that his/her consent is fully informed.

**V. WRIT PETITION BY RAHUL JANI(WP 118/2004):
APPLICABILITY OF U.N. GUIDELINES.**

37. ACMI supports the prayer of the writ petitioner in WP No.118/2004 that this Hon'ble Court should direct the respondent Union of India to frame necessary guidelines

on the basis of U.N.General Assembly Resolution 46/119 dated December

17,1991 known as the “Principles for the Protection of Persons with Mental Illness and the Improvement of Health Care” and the 10 basic Principles of Mental Health Care Law formulated by WHO in 1996. Copy of the above said principles formulated by the U.N.General Assembly is annexed herewith and marked as Annexure-XI.

37. The principles are essentially an adaptation of the fundamental rights of the individual to the specific situation of a mentally ill person and include the right to mental health care, to be treated with dignity, the right to protection against exploitation or abuse, right against discrimination, etc. To the extent that these principles do not conflict with statute, they can certainly be read into our domestic statutes. At the same time, to the extent that the U.N. principles can be read into Article 21 in relation to the mentally ill person, any statutory provision that conflicts with these principles could be struck down as violating Article 21 . Accordingly, it is legally permissible for this Hon’ble Court to give directions to the Central Government to implement the U.N. and W. H. O. principles.

37. At the same time, it is important to not that U.N. principles should not be extended to permit the mentally ill to refuse

treatment even when they are not in a condition to decide what is the appropriate treatment for them. This Hon'ble Court should make it clear that where the family caregivers and the professionals are agreed that a particular line of treatment is appropriate, a mentally ill person who is in the symptomatic phase of the illness cannot be permitted to refuse treatment against his/ her own best interest.

37. Subject to the above qualification, this Hon'ble Court in innumerable cases in the past like Vishaka Vs. State of Rajasthan(1997) 6 SCC 241, T.N. Godavarman Thirumalpad (2002) 10 SCC 606, Lakshmi Kant Pandey Vs. Union of India (1984) 2 SCC 244 and Gramophone Co.Ltd Vs. B.B.Pandey, (1984) 2 SCC 534, has passed directions implementing international conventions/ resolutions to which India is a party and which are not contrary to our municipal law. It is therefore submitted that until e Mental Health Act is revised, this Hon'ble Court ought to issue directions/guidelines to the Respondents herein, to implement the UN Resolution so as to protect the interest of the mentally ill.

VI. CONCLUSION:ACMI'S RECOMMENDATIONS.

37. In light of the foregoing submissions, ACMI respectfully seeks the leave of this Hon'ble Court make the following recommendations:
1. Central government should conceptualise, formulate and implement a policy that ensures that at least one Psychiatrist will be made

available in each district hospital in every district throughout India.

2. Basic medicines must be made available in order to help families take care of their mentally ill relatives at home in conjunction with family self-help groups and primary health center physicians.
3. One mental health institute must be established in every State as an apex body of super-speciality mental health care. Central government should make available the resources to establish at least one psychiatric hospital in each State on a time bound basis.
4. State level research including manpower planning and projection, leadership and interpersonal communication skills for professionals; self-development and advanced training and refresher Courses for professional on the lines recommended by the UGC for teachers should be implemented.
5. State Government to provide necessary personnel including psychiatrists at each district hospital and in ensuring the training of primary health center physicians.
6. State Governments should consider appointing District Mental Health Officers, who would be responsible for ensuring that family self-help groups are formed in each district and for

monitoring the facilities being provided by private psychiatric homes.

7. Revisions to the Mental Health Act should be based on integrating the “family” and the “community” model into the “institutional” approach to the treatment of the mentally ill.
8. Representatives of family self-help groups should be given adequate representation in the national and state mental health authorities and they should be involved in the framing of policies and revisions to the Mental Health Act.
9. Family care-givers, and grass root associations, need to be given representation on the Board of Visitors referred to in Section 37(1) of the Mental Health Act.
10. Mechanisms should be devised to safeguard the basic rights of the mentally ill such as right to vote; right to marry. Right to have children and to maintain parental rights; right to own and bequeath property; right to work and employment, right to education; right to freedom of movement and choice of residence; right to health, which includes treatment, rehabilitation, and integration into society for those who are fit etc; right to a fair trial including due process of law; right to sign cheques and engage in other financial transaction; right to privacy qualified only by rights of the caregiver; right to religious

freedom and practice; and right not to be punished for attempts at suicide/homicide during symptomatic phase.

11. Various types of infrastructure facilities such as quarter way homes, convalescence homes, day-care centers, half way homes, vocational training centers, suicide training centers, de-addiction centers, shelter workshops and long term care homes or shelters for homeless orphans or others suffering from mentally illness in cases where family care givers are not able to provide care on account of old age or cases where families of the mentally ill cannot afford private facilities should be established.
12. Proper minimum standards for mental health care institutions must be framed and implemented.
13. Section 23 of the Mental Health Act to be clarified so that institutions should be made liable to keep the mentally ill for the 24 hour period within which the police must be required to obtain certificates from the Magistrate.
14. Section 81(2) of the Mental Health Act should be read down by introducing guidelines and the requirement of approval by a committee before permitting research on the mentally ill.
15. Central Government should frame necessary guidelines on the basis of U.N. General Assembly Resolution 46/119 dated December

17,1991 known as the “Principles for the Protection of Persons with Mental illness and the improvement of Health care” and the 10 basic principles of Mental Health Care Law formulated by WHO in 1996.

Drawn by: Filed by;

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Mr.Prasad Vijayakumar Advocate for ACMI

Advocates.

Settled by:

Mr.Krishnan Venugopal

Advocate.

IN THE SUPREME COURT OF INDIA
(CIVIL ORIGINAL JURISDICTION)

WRIT PETITION (CIVIL) NO. 334 OF 2001

In the matter of :-

Re.Death of 25 Chained Inmates
In Asylum fire in Tamil Nadu. ..Petitioner

Vs.

Union of India & Ors. .Respondents

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Written Submissions on behalf of ACMI
Pursuant to the order dated 18-8-2004
Of this Hon' ble Court.

(Ms. T. ANAMIKA)
Advocate for the Applicant
on behalf of ACMI.

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