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Articles

State of the Reform of Legal Capacity in Chile

Not as Straight-Forward as that It's Just 'An Added Fuss' – Untangling How Indian Psychiatrists Construe Domestic Human Rights Legislation

Book Review

India's Mental Healthcare Act 2017: Building Laws, Protecting Human Rights, by Richard M Duffy and Brendan M Kelly (Springer, 2020)

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All submissions will be peer-reviewed by a double blind peer review process before being accepted for publication; naturally, there will be a process whereby an article may be accepted subject to minor or more major amendments being made. We will endeavour to provide feedback as to why any rejected submission has been rejected.

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Articles and pieces in this issue have been edited by:
Kris Gledhill, Kevin Stone, Penelope Weller and Darius Whelan

EDITORIAL

The Editorial Board is proud that the International Journal of Mental Health and Capacity Law is wholly open access, so that all our articles can be accessed without charge and we do not make any charges to authors, which is the model used by many commercial open access journals. But having open access at the time of submission and publication, and combining that with a robust peer review process, means that volunteer time and drive is what holds the Journal together. 2020 has been a challenging year, particularly for those who provide medical services: having to do so in the context of a pandemic has created significant problems. There have also been challenges, albeit of a lesser nature, for those of us who work in academia, including the need to learn more about how to teach online. I mention this simply to explain that this has impacted reviewing and editorial work, mainly by putting back the processing of some submissions.

Hence, this issue has only three pieces. However, they reflect our aim to be a place for international and comparative scholarship. We open with an interesting note on recent developments in Chile. How different jurisdictions give effect to standards founded in international documents is of interest, and accounts of similar reform proposals would be welcomed as submissions. The second article, which started life as a thesis but has been successfully translated for publication, reports the results of research into how psychiatrists in India operate a new statutory regime that was designed to implement a human rights model of mental health practice. This is complemented by the third piece, a review of a book written about the Indian legislation.

These all provide food for thought and avenues to explore. We are grateful to the authors, editors and peer reviewers, and the staff at Northumbria University Newcastle who take the final steps in the open access publishing process; and we that those of you who take the time to download and consider these pieces.

Kris Gledhill
(for the editorial team for this issue, Kris Gledhill, Kevin Stone, Penny Weller and Darius Whelan)

STATE OF THE REFORM OF LEGAL CAPACITY IN CHILE

PABLO MARSHALL[*]

I. INTRODUCTION

The Chilean legal regulation of disability has advanced towards an adequate legal framework for the progressive development of state practices respectful of the rights of people with disabilities. The ratification of the CRPD (2008) has been followed by an increasing amount of legislation directed to the inclusion of people with disabilities. The most important of this new disability regulation is the Law 20422 [on equal opportunities and social inclusion of people with disability].[1] Chile, in this way, can be regarded as a slow but persistent student of the teachings of the CRPD. Despite these positive developments, certain obligations under the CRPD are still pending, especially clear in the legal regulation affecting mental disability.[2] The controversies surrounding legal capacity and mental health law are probably the most important issues surrounding the hesitation to carry out a reform.

In recent years, an important group of reforms of legal capacity has been consolidated in Latin America. New laws in Argentina,[3] Peru,[4] Colombia[5], and Costa Rica[6] have anticipated and probably will inspire the reform that will be carried out by the countries of the region. Chile will most likely parallel the Colombian model, in which robust protection of autonomy following the support model of the CRPD is bound to a deficit in the public funding of support services and a weak regime of safeguards.[7] This statement is based on the fact that that two reform bills in Chile have unsuccessfully taken that direction. A third bill not released yet by the Government has been announced to drawn in the previous bills and presumably following the regional trend. In times of the political, health and economic emergency triggered by Covid-19, it is unlikely that the Chilean reform, or any other reform in the region, will include the

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[1] See also, art. 2 Law 20609 [establishing disability as a category protected by anti-discrimination legislation]; art. 61 Law 18700 [on assisted voting]; and Law 21015 [on standards for the inclusion of people with disabilities in employment].

[2] Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Chile, 2016, par. 23-7, 34, 42, 54, 62.

[3] See Chapter 2, New Civil and Commercial Code, 2015.

[4] See Legislative Decree 1384 [regulates legal capacity of people with disabilities in equal conditions], 2018.

[5] Law 1996 [establishing a regime for the exercise of the legal capacity of people with disabilities of legal age], 2019.

[6] Law 9379 [for the promotion of the personal autonomy of people with disabilities], 2016.

[7] The Colombian reform included strong protection of the autonomy of people with disabilities in the form of what has been called an 'universal model of legal capacity', closely following the Commentary nº 1 of the Committee CRPD. It may be unfair to criticize such a revolutionary legislation that is in the process of being implemented. However, it can be preliminarily observed in the text of the Law 1996 that the supervision mechanisms are limited and annual judicial review. No administrative service is committed to such task, and the work of monitors is not stated in the law.

necessary resources for a successful provision of publicly financed support services. Improving safeguards within the support paradigm is perhaps a feasible target for the legal capacity reforms in the region, learning from the experiences of previous reforms.

The purpose of this comment is to give a brief account of the state of the reform of legal capacity in Chile. For this aim, it briefly explains the conflict between the current Chilean legal capacity regime and the CRPD (II). Then, it describes the steps taken to remove said normative conflict (III). The paper examines the existing legislative bills on legal capacity that will inspire the new reform bill (IV) and ends with a brief reflection on the prospects for reform (V).

II. THE LEGAL CAPACITY REGIME IN CHILE BEFORE THE CRPD

I begin by sketching the conflictive relationship between the CRPD and the national legal capacity regime. Article 12 of the CRPD upholds the equal recognition of persons with disabilities before the law, the right to recognition of legal personality (par 1) and the obligation to implement a regime of legal capacity that places people with disabilities on equal terms with others in all aspects of life (par 2). Alongside, it indicates that the States Parties must incorporate the support measures required for the exercise of legal capacity (par 3) as well as safeguards to protect, among other things, the rights, will and preferences of people with disabilities (par 4). Support measures imply, on the one hand, the recognition of the freedom to decide of people with disabilities. On the other hand, they imply arrangements - which may include the participation of third parties but may also constitute, for example, the recognition of different and unconventional methods of communication - whose purpose is to facilitate the decision-making process and the exercise of legal capacity.[8] Finally, article 12 enshrines - and has been ratified by the Committee on the Rights of Persons with Disabilities (hereinafter the Committee) - the rejection of any form of regulation of legal capacity that discriminates against people with mental disability, demanding from the national legislation to eliminate those rules that have resulted in substituted decision-making.[9]

The current Chilean legal capacity regime is clearly incompatible with the provisions of the CRPD. Most worrying is that the legislation maintains a regime of substituted decision-making for certain people with disabilities, based on a declaration of incapacity through a judicial[10] or sometimes merely administrative[11] interdiction procedure according to which the person's medical or sometimes socio-medical diagnosis prevails over any other (social, functional) consideration. This feature corresponds to what has been called a model of administration of legal capacity *by status*, which assumes that the mental capacity of a person, medically diagnosed, correlates and therefore determines his/her legal capacity. This model rests on two

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[8] Committee on the Rights of Persons with Disabilities, General Comment 1, 2014, par. 17.

[9] Committee on the Rights of Persons with Disabilities, General Comment 1, 2014, par. 27-8.

[10] Arts. 456ff of Chilean Civil Code and 838ff Civil Procedure Code; art. 4 Law 18600 [on mentally handicapped]

[11] Art. 18bis Law 18600 [on mentally handicapped]

premises: first, it starts from a binary vision of mental capacity according to which one may or may not have such capacity; and, secondly, once a person is considered to be mentally able, he/she is given wide deference to take actions that may result in damage to his/her interests.[12] On the contrary, that deference is denied to those considered mentally incompetent, with respect to whom the state, society and families, but specially the law, acts with strong paternalism.[13] There is a broad consensus in the literature that sustains that the status model is incompatible with the provisions of article 12 of the CRPD and that, even if strong defences of substituted decision-making have been made in academia and by States Parties, defences have focused on the considerably more tailored functional models of legal capacity.[14]

Adapting the Chilean legal capacity regime to the CRPD implies reforming two longstanding institutions: 'insanity' as a source of legal incapacitation and 'curatorship' as the regime of substituted decision-making of the 'insane', both entrenched in arts. 338, 390, 456, 460, and 1445 to 1447 of the Chilean Civil Code and reinforced by Law 18600 [on mentally handicapped]. It also implies reviewing a series of dispersed legal institutions that implement 'insanity' and prevent the exercise of legal capacity by people with mental disability in various terrains. Examples of the latter are, among others, paragraph 8 of Law 20584 [on patient rights], which limits the autonomy to decide on irreversible medical treatments (such as sterilization) and authorizes forced hospitalization, and art. 16 of the Political Constitution that suspends the right to vote of those deemed 'insane'.[15]

III. THE REFORM PROCESS

Chilean society has spent a long period of time deliberating on the need to reform legal capacity. However, a concern about the non-compliance with the CRPD has been growing with the number of reports of national public institutions condemning the lack of action. The National Disability Service (2014),[16] the Chamber of Deputies [lower chamber of Parliament] (2013),[17] the Institute of Human Rights (2015),[18] and the

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[12] Gerard Quinn, "Personhood & Legal Capacity: Perspectives on the Paradigm Shift of Art. 12 CRPD," in *Conference on Disability and Legal Capacity under the CRPD, Harvard Law School, Boston).*

[13] Gerard Quinn and Anna Arstein-Kerslake, "Restoring the 'Human' in 'Human Rights': Personhood and Doctrinal Innovation in the UN Disability Convention," in *The Cambridge Companion to Human Rights Law,* ed. Conor Gearty and Costas Douzinas (Cambridge: Cambridge University Press, 2012), 41.

[14] John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 International Journal of Law and Psychiatry 70; Wayne Martin and others, 'Three Jurisdictions Report: Towards Compliance with CRPD Art. 12 in Capacity/Incapacity Legislation across the UK' (Essex Autonomy Project 2016).

[15] Other examples are the decisions on reproductive autonomy (Art 24 Law 20587 [on medical interventions]), property (Art 1682 Chilean Civil Code), family and emotional relationships (Art 5 Law 19947 [on civil marriage] and Art 12 Law 19620 [on adoption]), living independently (Art 9 Law 18600 [on mentally handicapped]), and working (Art 16 Law 18600 [on mentally handicapped]), among others.

[16] National Disability Service, Questionnaire to the States Parties of the Special Rapporteur on the Rights of Persons with Disabilities, 2014.

[17] Chamber of Deputies, Evaluation of Law 18600 [on mentally disabled], 2013.

[18] National Institute of Human Rights, 'Autonomy of people with mental disabilities', *Annual Report*, 2015.

Ministry of Social Development (2016)[19] have reported the pending matter. The same critical analysis has been made by NGOs working on the rights of people with disabilities.[20] The need of a reform became urgent for the government when a negative balance was issued by the Committee on the Rights of Persons with Disabilities in its Concluding Observations on the initial report of Chile. In the section relative to article 12, the Committee held:

> 23. The Committee is concerned about the continued applicability of the Civil Code of 1857, which denies persons with disabilities the right to legal capacity, and of Act No. 18,600 concerning the procedure for revoking legal capacity on the basis of a psychiatric report.
>
> 24. The Committee requests the State party to repeal all legal provisions that partially or completely limit the legal capacity of adults with disabilities, and to adopt specific measures to establish a supported decision-making model that respects the autonomy, will and preferences of persons with disabilities, in keeping with article 12 of the Convention and the Committee's general comment No. 1 (2014).
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> 25. The Committee is concerned that, under article 15 of Act No. 20,584, persons with disabilities, especially those whose legal capacity has been revoked and those who have been institutionalized on grounds of mental disability, are denied the right to informed consent in the context of medical treatment or surgery with irreversible effects.
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> 26. The Committee recommends that the State party amend and repeal provisions that restrict the free and informed consent of all persons with disabilities, including those whose legal capacity has been revoked and who are under guardianship and those living in institutions, and that it adopts the necessary regulations to ensure the full exercise of free and informed consent with respect to any medical or scientific procedure.[21]

As a response to the Committee concerns, the government of Michelle Bachelet drafted a bill during 2017 [on rules of equal opportunities and social inclusion of persons with disabilities to recognize the full legal capacity of people with disabilities and establish a system of support and safeguards for their exercise], hereinafter, the 'Bachelet Bill'. The draft was the conclusion of a broad process of consultation that included the opinion of experts, public institutions and NGOs working on the promotion and defence of human rights, as well as organizations of people with disabilities. The draft, however, was never introduced to parliament, likely due to the fact of 2017 being a general election year.

The discussion on legal capacity reform was restarted during 2019, this time in parliament, after Luciano Cruz-Coke, Congressional Representative, and father of a child with Down syndrome, introduced a new bill. This bill [on discrimination against people with intellectual, cognitive, and psychosocial disabilities, and on guaranteeing the right to autonomy], hereinafter the 'Cruz-Coke Bill', explicitly recognizes the effort made in the drafting of the Bachelet Bill and appeals to the current government to

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[19] Ministry of Social Development, Report Equal recognition of people before the law, 2016.

[20] See the alternative report of Chile before the Committee: <https://tbinternet.ohchr.org/Treaties/CRPD/Shared%20Documents/CHL/INT_CRPD_CSS_CHL_23091_S.pdf> acceded 19 May 2020.

[21] Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Chile, 2016.

support this new initiative. The government not only located the Cruz-Coke Bill among the legislative priorities during the first semester of 2019, but also provided administrative support to improve the drafting. During the first stages of the discussion, and due to a negative assessment by the Supreme Court regarding various of its aspects, the government soon realized the need to make profound modifications to the bill. Without going into technical details, the Supreme Court with reason affirmed that the bill was satisfactory in the aim of protecting autonomy, but too weak in safeguards against third party abuse.[22] Since then, the National Disability Service (*Senadis*) has been preparing a new legislative bill looking to consolidate the strengths and eliminate the weaknesses of the Bachelet and Cruz-Coke bills. To accomplish this, and give evidence and support to a new bill, it is developing a study to provide comparative evidence on the implementation of legal capacity reforms and to gather national evidence on support needs from the population with disabilities.

IV. OVERVIEW OF THE PROJECTS

The new bill has not been released (or perhaps not even drafted), and its content can only be predicted based on an analysis of the previous bills from which – as has been said by Senadis – it will draw inspiration. Through the revision of the central aspects of the Bachelet and the Cruz-Coke bills, we may grasp a sense of the directions of the forthcoming reform.

A. General aspects and principles

In general terms, both bills are explicitly based on the need to modify the legal capacity regime of persons with disabilities to adapt it to the international commitments on human rights law. Both texts propose to repeal the legal rules that entrench 'insanity' and the 'curatorship of the insane'. Both projects seek to transit from substitution to support decision-making for the exercise of legal capacity and to abandon the status model to embrace the universal model of legal capacity.[23] They do so through a set of reforms to various legal texts, but mainly through the modification of the Civil Code and the incorporation of a new title 'on support for the exercise of legal capacity' in Law 20422 [on equal opportunities and social inclusion of people with disabilities]. Notwithstanding these common features of the projects, the Bachelet Bill is more ambitiously transformative and involves a greater number of and more profound modifications in other areas of the exercise of legal capacity, beyond the mere aspects of private law.

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[22] Supreme Court Report <https://www.camara.cl/legislacion/ProyectosDeLey/tramitacion.aspx?prmID=12972&prmBOLETIN=12441-17> accessed 19 May 2020.

[23] eg Amita Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' (2007) 34; Eilionoir Flynn and Anna Arstein-Kerslake, 'Legislating Personhood: Realising the Right to Support in Exercising Legal Capacity' (2014) 10 International Journal of Law in Context 81, 85–8.

The two bills embrace, as a general principle, that people with disabilities have legal capacity on equal terms with others in all aspects of life.[24] Both projects add a series of principles, taken from the CRPD,[25] that should guide the application of the bills' rules, such as those on autonomy, independence, equality, non-discrimination, and dignity, among others.[26] The Bachelet Bill, however, considers additional principles: (a) capacity may not be limited because of a disability, respecting the support that may be required for its realization; (b) the right of persons with disabilities to use informal support they have and for this support to be recognized, respecting the right to request its formalization through the action of a courts; and (c) the duty of public services to guarantee universal accessibility in all areas in which people must exercise their legal capacity and the duty to provide reasonable accommodations to make that right effective.[27]

B. Principle of autonomy, independent living, equality, non-discrimination, full and effective inclusion in society, dignity of persons with disabilities, and freedom.

1. Support for the exercise of legal capacity

Both bills introduce a broad concept of support, which includes all kinds of relationships, practices and measures, of different degrees of formality and intensity,[28] despite the regulation focusing mainly on personal support. They state different objectives: the Bachelet Bill seeks to allow 'people with disabilities to make their own decisions and to communicate them to others with full respect for their will and preferences',[29] while the Cruz-Coke Bill aims to 'assist in communication, understanding of legal acts and their consequences, as well as in the manifestation and interpretation of the will, wishes and preferences of the person with disabilities'.[30] The person who provides support is called in both cases the 'facilitator for the exercise of legal capacity'.[31] The form of the appointment diverges but, in both cases, it is done by prioritizing the will and preference of the person with disabilities and the respect for his/her human rights.[32] The role of the judge in the appointment and oversight of facilitators is much more active in the case of the Bachelet Bill.

The Bachelet Bill contemplates four hypotheses for the constitution of the support relationship: (a) the person with disabilities can informally designate a third party of his/her trust to provide him/her with the necessary supports to exercise of his/her rights;[33] (b) he/she can also request the formalization of the support by the

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[24] Art. 83.1 Bachelet Bill; art. 83 Project Cruz-Coke

[25] From the art. 3 CRPD, the Cruz-Coke bill includes the principles of autonomy, independent living, equality, non-discrimination, full and effective inclusion in society, dignity of persons with disabilities, and freedom. The Bachellet bill includes additionally the principle of accessibly.

[26] Art. 84 Bachelet Bill; art. 83 Cruz-Coke Bill

[27] Art. 83 Bachelet Bill

[28] Art. 85 Bachelet Bill; art. 86 Cruz-Coke Bill

[29] Art. 85

[30] Art. 86

[31] Art. 89 Bachelet Bill; art. 87 Cruz-Coke Bill

[32] Art. 89 Bachelet Bill; art. 86 Cruz-Coke Bill

[33] Art. 89.1

appointment of a facilitator through a judicial order;[34] (c) he/she can dictate advanced directives for future support;[35] and (d) exceptionally, a third party with a legitimate interest may request a judge to appoint a facilitator, only if the circumstances of the person with disabilities prevent him/her from expressing his/her will and all possible means to obtain it has been exhausted.[36] The judicial appointment will be done by a family court, through an informal procedure in which a person of trust presented by the person with disabilities may be designated as facilitator. Exceptionally, when the person with disabilities does not have a trusted person, the court may designate a person from the Register of Facilitators, which is to be created by the Ministry of Justice and Human Rights.[37] When a third party requests the appointment, the court may designate the person who, according to the merit of the case, is most suitable to offer support, and not necessarily the applicant.[38] In any case, the court must respect the will and preferences of the person with disabilities, who must always be present throughout the procedure.[39] In turn, the Cruz-Coke Bill considers three hypothesis: (a) a support plan freely agreed upon between the person with disabilities and the facilitator and formalized in a public record,[40] following therefore the Canadian model;[41] (b) advanced directives for future support;[42] and (c) exceptionally, the judicial appointment of a facilitator requested by a third party when the person with disabilities cannot express their will in any way, after having exhausted all available means to obtain it.[43] The Cruz-Coke Bill fails to clarify before whom such designation will be requested or the procedure for the designation.

There are similarities in the regulations of the purposes and characteristics of the support, the obligations and the liability regime of the facilitators and grounds for termination of the support relationship.[44] Both projects require the facilitator be guided according to the will and preference of the person with disabilities, and must act diligently, honestly and in good faith, avoiding possible abuse, undue influence and conflicts of interest.[45] However, in case of not being able to obtain any manifestation of will or preferences, both bills indicate that the facilitator should attend to the life trajectory of the person with disabilities and must provide assistance in accordance with what the person with disabilities would presumably have preferred in attention to the values, beliefs and principles manifested in other stages of his/her life.[46] The Bachelet Bill adds that when such reconstruction is not possible, decisions will be made in the best interest of the person with disabilities, as defined by safeguarding his/her

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[34] Art. 89.1 and 101

[35] Art. 92

[36] Art. 89.2 and 101.b

[37] Art. 99ff

[38] Art. 104

[39] Art. 109

[40] Art. 90.1

[41] See Tim Stainton, 'Supported Decision-Making in Canada: Principles, Policy, and Practice' (2016) 3 Research and Practice in Intellectual and Developmental Disabilities 1.

[42] Art. 90.2

[43] Art. 87

[44] Art. 85 ff Bachelet Bill; art. 88ff Project Cruz-Coke

[45] Art. 85 and 88 Bachelet Bill; art. 85, 86 and 89 Cruz-Coke Bill

[46] Art. 96 Bachelet Bill; art. 89 and 92 Cruz-Coke Bill

rights.[47] This last idea is not present in the Cruz-Coke Bill, which informs us of the influence of the Committee's general comment No. 1 in the process of reform in Chile and in Latin America more broadly.

2. Safeguards

Regarding safeguards, the Bachelet Bill incorporates a permanent judicial supervision of the support relationship, in order to avoid informal substituted decision-making, undue influence or abuse. These safeguards will be carried out *ex officio* by the court, at the request of the person with disabilities or a third party with a legitimate interest, in cases in which the person with disabilities cannot access the court. The judge will order a hearing to audit the activity of the facilitator. If the judge comes to the conviction that the facilitator acted improperly, the support relationship will be terminated, and a new facilitator will be constituted. The acts carried out by the facilitator in an improper way will be considered legally void.[48] For its part, the Cruz-Coke Bill is very limited in safeguarding the support relationship, as noted by the Supreme Court report and it does not regulate jurisdictional supervision of facilitators.

3. Modifications to other legal bodies

The two bills introduce modifications in the field of private law, mainly the Civil Code and other special regulations such as civil marriage,[49] eliminating curatorship for 'insane' adults. In addition, both projects modify the Political Constitution[50] and Law 18700 [on Popular Voting] to permit the vote of people with disabilities who are currently under curatorship.[51] However, the Bachelet Bill incorporates deeper reforms in the Civil Code in areas such as parentage,[52] capacity to give a will and be a witness[53], and certain aspects of torts liability.[54] It also innovates in requiring the training of public officials and the Judiciary in matters of disability.[55] Finally, it proposes modifications in other areas of great relevance for the exercise of the legal capacity of persons with disabilities: it reforms the criminal liability that affects persons with mental disabilities who have committed a crime[56] and also reforms Law 20120 [on scientific research in humans, their genome, and human cloning][57] and Law 20584 [on the rights and duties of people in relation to actions related to their health care], changing the requirements and procedures to obtain free and informed consent from people with disabilities.[58]

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[47] Art. 96

[48] Art. 115ff

[49] Art. 5 and 13 of Law 19947 [on civil marriage]

[50] Art. 16

[51] Bachelet Bill modifies art. 28, 40, 54, 64 and 160; Cruz-Coke Bill modifies art. 40 and 61.

[52] Art. 109.1, 191.2, 226.1 and 267.1

[53] Art. 1005 and 1012

[54] Art. 2319

[55] Art. 16, Law 20422

[56] Art. 10.1 and 496.16

[57] Art. 12

[58] Art. 5, 10.2-3, 14.1, 15, 17.1 and 24

In general terms, the Bachelet Bill is a much more robust and comprehensive document, which more carefully balances the autonomy and protection of people with disabilities. This may be due, however, to the fact of being an executive bill; as such it has the advantage of being able to address financial issues that are vetoed for bills initiated by parliamentarians. Both, however, are aimed at the same objective under the same human rights standards and have aspects that are worth considering. A negative side of the bills is the lack of imagination when designing and giving guidelines about how the exercise of the support can be carried out in practice. This lack of specificity risks leaving reforms to legal capacity in a field far from the specific needs of people with disabilities. Furthermore, there is no mention of public provision of support services. This risks transforming the exercise of legal capacity into a luxury service that only some can pay or have the good luck of attaining, thereby putting in even greater vulnerability those who are not able to access said mechanisms.

V. FUTURE PERSPECTIVES

Chile has been affected by two acute crises in the last year. The health crisis caused by Covid-19 was preceded by a political and social crisis expressed in massive protests and human rights violations between October and December 2019.[59] Both crises have caused a total reorientation of the political and legislative agenda towards addressing the most urgent demands produced by these emergencies. While the social demands of the protests gave rise to the beginning of a constitutional process that includes a referendum, the election of a constituent assembly and a substantive debate about the model of society that citizens demand, the Covid-19 crisis has displaced the urgency of the constituent measures with emergency measures, both sanitary and economic.

In this scenario, projects that are not part of the government's critical priorities have been displaced. Among them, of course, is the reform of legal capacity. Although painful, this delay should not be seen as an indefinite postponement or a loss of opportunity for a reform necessary for Chile's compliance with the CRPD. There are two reasons for saying this: first, although the issue of legislative process may be lengthy, the commitment shown by the current administration to the drafting of a new bill promises a robust project; and second, there are few matters in which there is a substantive agreement among Chilean political parties as there is on disability issues. Disabilities produce, with very limited implications, a virtuous alliance. Regarding disabilities as a human rights issue allows right-wing politicians to be part of an area traditionally reserved for left-wing politicians since the return to democracy in 1990. On the other hand, left-wing politicians see policies that protect the rights of people with disabilities not only as a human rights issue but as a strengthening of the welfare state. The welfare dimension may be the critical point of the reform: the lack of public

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[59] Pablo Marshall and John Charney, "Crisis and Constitution Making in Neoliberal Chile", Social & Legal Studies (2021) online first; Domingo Lovera, "Protests, Riots, Inequality and a New Constitution for Chile", (OxHRH Blog, December 2019), <http://ohrh.law.ox.ac.uk/protests-riots-inequality-and-a-new-constitution-for-chile/> accessed 22 May 2020; Jorge Contesse, "Chile Constitutional Awakening", (Open Global Rights, April 2020), <https://www.openglobalrights.org/chiles-constitutional-awakening/> accessed 22 May 2020.

provision of support services (for those who cannot afford such services) may be a problem to the universalization of legal capacity access and may reproduce problems of substituted decision-making and abuse, even in a reformed legal capacity regime. The need to fund an existing public body or to create a new one to provide free support services for those who cannot afford to pay or do not have informal networks is therefore of the utmost importance.

The delay in the reform process can potentially open opportunities to learn from previous reforms. It is unlikely that Chile will adopt a functional model of mental capacity as a general regime. It is more likely that Chile will, instead, follow the efforts from the region, adopting a 'universal model of legal capacity' as the one in Colombia and Perú; or a regime that, as the one in Argentina, keeps exceptional hypothesis of guards for persons with disabilities who cannot communicate their will and preferences. Whatever the decision is in this much debated case, the Chilean reform will have the opportunity to learn from previous reforms in the region, avoiding mistakes and correcting the deficiencies identified in the design and implementation of the reforms in Argentina, Perú, Costa Rica and Colombia. Complementing the catalogue of principles, obligations and responsibilities that are meant to regulate the support relationship with a more robust process of supervision would be an important step towards the effective protection of the autonomy of people with disabilities. Specialization of judicial personnel in legal capacity matters, judicial procedures in which the voice of people with disabilities can be heard effectively by the Court, centralizing monitoring functions in an administrative agency capable of serving as a first and easy access step previous to the courts and the possibility of setting up private monitors could be some of the measures that would strengthen the universal model adopted in the region.

NOT AS STRAIGHT-FORWARD AS THAT IT'S JUST 'AN ADDED FUSS' - UNTANGLING HOW INDIAN PSYCHIATRISTS CONSTRUE DOMESTIC HUMAN RIGHTS LEGISLATION

ALENA KAHLE*

1. INTRODUCTION

After its ratification of the 2006 United Nations Convention on the Rights of People with Disabilities (UNCRPD), the Indian government proceeded to work through a list of laws from various fields – employment, housing, healthcare, personal status – that would need to be amended to guarantee the rights in the UNCRPD. Regarding the healthcare of persons with mental illness, the law-drafters deemed it insufficient to merely amend the existing law and proceeded to draft a new, innovative mental healthcare law. When the Mental Healthcare Act (MHA) was passed in 2017, responses were strongly polarised: On the one hand, it was lauded for staying true to the vision of the UNCRPD (Duffy & Kelly, 2019), while on the other hand, especially psychiatrists heavily criticised that they anticipated the law would adversely affect their ability to treat patients.

A. Aim and Argument of this Paper

As the MHA enters its fourth year, governmental and non-governmental policy experts begin to tentatively evaluate its impact and effect. Through this paper, I seek to untangle the criticism Indian psychiatrists[1] have expressed about the MHA and identify the main factors that inform how they construe the law. I identify 'internal' factors – the priorities and ideology of the psychiatric profession – and 'external' factors – the intentions of the law-drafters and how they are reflected in the law – as critical in shaping how psychiatrists construe the law. I find that psychiatrists criticise the MHA because they feel their priority to deliver health is subverted to priorities they perceive as less thought through and imminent. I also argue this is a direct consequence of the law-drafters wanting to prompt psychiatrists to critically reflect on their professional priorities.

I first summarise the main criticism expressed about the Act and then review existing literature on the regulation of organisations through law to demonstrate that Indian psychiatrists make sense of laws through the perspective of their field. I then highlight shortcomings in existing literature and justify the need to examine a law's specific innovations as a factor that shapes how a law is perceived. Based on my own conversations with psychiatrists, I then lay out the features of their professional culture with consequentialist priority-setting, its emphasis on treating and promoting

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[1] In this paper, I use the term "psychiatrists" to refer both to "Indian psychiatrists" and "the psychiatrists I talked to".

health. Next, I examine the most criticised innovations of the MHA – including advance directives and mental health review boards – and argue that these are considered problematic as they subvert medical and administrative decision-making to the procedures of bodies created by the legal system. I show that many psychiatrists feel unfairly singled out and seek a reason for their own considerations being subverted. I then consider the perspective of the law-drafters, and draw on the concept of communicative laws to argue that the law-drafters prioritised communicating in which situations human rights should be considered more, rather than designing the law to communicate human rights norms themselves. Finally, I discuss how laws are often used by legislators seeking social change in order to level the playing field within society prior to softer approaches. As many of the MHA's law-drafters themselves are psychiatrists, the feeling of provocation perceived by their colleagues is likely part of a larger strategy of human rights socialisation.

B. Background: Criticism of the MHA

The MHA contains prohibitions as well as positive obligations upon service providers. For instance, the MHA provides that electroconvulsive therapy – electro-shock treatment commonly used on cases of treatment-resistant depression – cannot be administered in the healthcare setting without anaesthesia, and that minors can only receive the treatment if permission is granted by a board (Sections 95(2)(a)-(b)). Other provisions of the MHA bestow persons with mental illness (PWMI) with the right to issue "advance directives" (AD), legally binding indications subject to certain exceptions of ways in which a person wishes to be – or not be – treated if they later lack capacity to make decisions (Sections 5-13). The MHA also stipulates that each state shall set up a Mental Health Review Board, to which psychiatrists must apply for permission should they want to administer any treatment that is excluded in the patient's AD, or should they generally want to admit a PWMI to a mental health facility against their will (Sections 11(1)-(2)).

Psychiatrists appear to still identify the same problems about the law after its entry into force as they did when it was first drafted. Several concerns circled in journals and newspapers around issues of feasibility and costs, such as the healthcare system in India not being equipped to implement the ambitious provisions of the MHA (Duffy and Kelly, 2019; Rao et al., 2016; Sachan, 2013; Kohli, 2018, Bada Math et al., 2019). As most such claims are backed by figures laying out concrete budgetary constraints, I do not scrutinise these further, but focus more on those claims regarding the creation of social and legal barriers to providing care. In a 2018 newspaper interview, Dr Nimesh Desai, director of Delhi's largest mental health facility, predicted that the MHA "will make it tough to treat patients", especially in the context of admitting people with mental illness into hospitals (Kohli, 2018; see also McSherry and Weller, 2010; Kala, 2013). An article published in the Indian Journal of Psychiatry describes advance directives and other features as elements of "alien Western law enforced on Indian cohesive family dynamics", without specifying what makes the family "cohesive" (Pavitra et al., 2019, p. 832). Several other articles condemn the MHA as being incompatible with "Indian culture", albeit without specifying what precisely is meant by this (see also Kumar Kar and Tiwari, 2014; Kala, 2013). Psychiatrists, thus, appear to have a clear view of the MHA that they frame as if self-evident: That it cannot be implemented in India.

C. The Regulation of Organisations and Professions

Laws are always received by and filtered through existing social institutions (Edelman and Suchman, 1997). To make human rights principles 'work', they must therefore be translated into terms that make sense to and resonate with different groups of actors (Merry and Levitt, 2017). I approach psychiatrists, as a group of actors, through the lens of "semi-autonomous social fields" (SAF) and professional organisations, each of which I define below.

The concept of a semi-autonomous social field (SAF) was devised by Sally Falk Moore (1973) to highlight that the social world is composed of several networks of actors, each with their own rules. Notably, these networks are not neatly distinct, but are layered and interact in complex manners, with each one being embedded in, overlapping with or containing others. As such, legal obligations may permeate, but never fully transform the rules of a smaller field that is embedded in the larger one dictating the rules. These SAFs are "semi-autonomous" in that they can never be fully regulated from the outside, but are always somewhat influenced by outside rules (Witteveen, 2014). Socio-legal scholar Wibren van der Burg (2009) compares the interactions between an SAF and the field it is embedded in as similar to a "medieval feudal relation between a powerful count and a distant emperor with little more than a nominal claim to sovereignty" (p. 156).

Organisations, such as companies or formal professions, are easily conceptualised as an SAF, as they clearly delimit members from non-members and enforce an (often written) code of conduct, but are nonetheless embedded in a nation state whose legal system they must abide by, and whose legal reforms inevitably impact them. In his analysis of professional organisations, van der Burg (2009, p. 147) introduces the term "centre-periphery perspective" – in which the profession is at the centre – to visualise why professionals primarily focus on their professional practice. Most fundamentally, individuals tend to consider things in relation to themselves. From this follows that a law's target group considers laws from a fundamentally different perspective than law-drafters. Van der Burg (2009) emphasises that "perspectives" are not merely passive; rather, one's perspective is an essential element in constructing and navigating reality, and the primary lens through which actions obtain meaning. When a law permeates into the SAF that is a formal organisation, this often "triggers a response in the affected subsystem which treats it like an external irritation, which leads to a mistranslation of the external message into the language and the ideology of the receiving subsystem" (Witteveen, 2014, p. 498).

SAFs therefore participate actively in socially constructing the meaning of law (Edelman and Suchman, 1997). Importantly, "certain ideas about law tend to become institutionalised within particular professions", such as the perceived reach, purpose and fairness of any legal regulation from outside (Edelman, 2005, p. 348). Several analyses found that professionals exaggerate the threat of the law, and for instance regard any legal regulation as "misguided, or even morally wrong, and as thwarting [their] actions" (van der Burg, 2009, p. 150). Such a collective legal consciousness – that is, the "ways they experience and understand the law and its relevance to their lives" (Merry, 2010 p. 42) – forms part of the so-called "professional culture" (Edelman, 2005, p. 342). Professional culture, in return, is crucial to the idea of SAFs, as it generates norms and rules around how members of the profession should act in general, and also how they should incorporate laws imposed by the SAF they are embedded in.

D. Regulating Psychiatric Professionals Through Human Rights Law

While the *Mental Healthcare Act 2017* (MHA) features some substantive provisions regarding explicit rights of people with mental illness, most provisions oblige psychiatrists to go through specific mandated steps before making any decision regarding the treatment of PWMI and their admission into hospitals. Above paragraphs sketched out the criticism psychiatrists have published about the MHA in journals, on websites, and in editorials; the nature of this criticism suggests that the Indian psychiatrists as a semi-autonomous social field react to the MHA in accordance with the existing literature: The SAF construes the meaning of the law by placing it within the frame of reference of the psychiatric profession.

This professional culture has been scrutinised in the field of medical sociology, although what is mapped out is the professional culture of doctors (not of psychiatrists specifically); a prominent author in this field is Eliot Freidson (1970a; 1970b; 1975), a sociologist who extensively researched the social role of doctors in 1970s' USA and whose findings remain confirmed today. Over the course of several works, he examined the implied entitlements society reserves for doctors as a consequence of their knowledge and prestige (more recent works that reiterate his arguments are Lidz, 2010, Parsons, 2013, Montgomery, 2006). An example of this is the observation that doctors are uniquely allowed to conduct intrusive operations on their patients for the sake of restoring their health (Lidz, 2010; Montgomery, 2006). Kapp and Lo (1986) expand on the sociology of medicine by contrasting the way doctors approach problems with that of lawyers, and discuss the origin of the strong stereotypes each often has of the other (see also Annas, 2008). Notably, this analysis is of *lawyers* and doctors, not law-drafters – while lawyers apply the law, the role of those who draft the law has not been scrutinised.

Additionally, van der Burg (2009) explains that doctors generally do not institutionalise new norms within their framework of reference but rather continuously consider regulatory law an external sanction. He argues that rather than institutionalising the *law*, doctors institutionalise a feeling of antagonism against laws and the legal professional in general. Notably, his and others' conclusions are limited to findings such as that 'doctors do not like being regulated', or that 'doctors do not find that law has a relevant place in medical practice' (Montgomery, 2006; Sivalingam, 2001; Willmott et al., 2016). Not only is the explicit content of 'the law' not specified in these analyses, but what specifically about a law is perceived as overly restrictive is skimmed over as well. This creates an impression that the content of the law is irrelevant – however, the law communicates between law-drafter and law-recipient, and the precise provisions may thus be crucial to understanding each unique case.

E. Research Design

The research question underlying the paper merits an examination of both the psychiatric profession as well as of the legal profession, and a closer look at the function of laws. My findings are based on an analysis of articles psychiatrists published on the MHA in scholarly journals, as well as primary data collected from personal conversations with psychiatrists in Northern India in January 2020, and with a psychiatrist involved in the law-drafting process.[2] Interlocutors were recruited through four main paths: contact details in academic articles, websites of major hospitals in the New Delhi area, LinkedIn, visits to hospitals in person. In total, ten interlocutors were interviewed, eight of which using a semi-structured interview method either in person, on call or via video chat, the other two ethnographically during a visit to IHBAS, the main psychiatric facility in Delhi. Oral consent was taken on the digital interviews; a consent form was provided to sign for the in-person interviews. All interlocutors were explained in detail the purpose of the interview as well as the way in which data are intended to be used. Interlocutors were asked if they preferred to remain anonymous; two requested for their identity to be anonymised. Each interview was concluded with the question whether any quote should be omitted from analysis, and both requests to do so by interlocutors were respected.

Emphasis was placed on interviews being conversations, in which arguments evolved fluidly as we progressed. While focus groups could have proven fruitful for the present research topic, as important new ideas could emerge due to collaborative thinking (Webley, 2010), such focus groups were unfeasible for the research because psychiatrists in India are highly busy, and assembling them in one place would have exceeded the scale of the research. To simulate the interaction sought in focus groups, interlocutors were asked to comment on quotes they and their colleagues had published in articles, and to react to the hypotheses of the researcher. Rather than extracting information from interlocutors, findings were intended as a collaborative effort, in which interlocutors were encouraged to analyse their own background and norms alongside the research. Understanding the perspective of a different discipline and what confinements, preferences and obligations exist within the minds of interlocutors was inherently an empathy exercise, and required stepping into their shoes, imagining what may prompt them to do what they do, and reflecting on how they interpreted the presence of the researcher. This reflects feminist notions of research in which the researcher "favor[s] the role of supplicant, seeking reciprocal relationships based on empathy and mutual respect, and [shares] knowledge with those they research" (England, 1994, p. 243).

Data analysis followed the steps of thematic analysis as best proposed by Braun and Clarke (2006). Their method proposes six steps: First, familiarisation with the data; second, the generating of initial codes; third, the searching for themes; fourth,

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[2] The research design received an official ethics sanction through the Ethics Review Board of Leiden University College on November 20, 2019, and its implementation was supervised by Prof. mr. dr. A.W. Bedner of Leiden University.

reviewing themes; fifth, defining and naming themes; and finally, the usage of the themes and data to construct a report. During the thematic analysis, theories were consulted of how laws are vernacularised and how organisations construe legal obligations. Theories served as "coat hangers" in that they helped connect together "particular pieces of data, which otherwise may seem unconnected or irrelevant" by "draw[ing] attention to particular events or phenomena" (Maxwell, 2005, p. 43).

II. FACTORS THAT SHAPE HOW PSYCHIATRISTS CONSTRUE THE MHA

A. The Professional Culture of India's Psychiatrists

As a semi-autonomous social field, the profession of psychiatry creates and enforces its own normativity while being embedded within the norms of the wider medical community and the legal system of India (Edelman and Suchman, 1997). Indian psychiatrists thus have an internal professional culture with its own professional perspective, through which these professionals navigate reality (Richardson and Asthana, 2006). Sketching out the general features of this professional culture is a fundamental steppingstone to untangle the criticism of the MHA and discover underlying issues. Importantly, the professional culture of Indian psychiatrists is neither static nor harmonious; while there are commonalities regarding norms and conceptualisations of reality, these are constantly renegotiated and refined (see Atkinson et al., 2004). Based on the existing literature on *doctors* and my own conversations with Indian *psychiatrists*, this section examines the professional culture of the latter and demonstrates that it is a major 'internal' factor in how they construe the law.

B. Notions of Harm and Good of the Professional Culture of India's Psychiatrists

In their training phase, Indian psychiatrists are socialised to act in conformity with Hippocratic traditions of medicine. The Hippocratic way of thinking is primarily concerned with a patient's *health*; beneficence is considered above all other considerations (Miola, 2007). The psychiatrists I talked with emphasised that their top priority was making their patient "well" again. A patient dying was described by one interlocutor, Dr Raheja, as the ultimate fear; psychiatrists are not among those who may accept someone's desire to die as legitimate, but rather view life as sanctimonious (confer McSherry and Weller, 2010). A majority of interlocutors brought forward that health can only be achieved by a medical professional, and that the best interest of a patient is thus to be treated. This line of reasoning prioritises any kind of treatment over no treatment, leading to the notion that action is preferable to inaction (Freidson, 1970a). Of course, action should be thought through and contribute to a legitimate purpose; in this regard, psychiatrists orient themselves along medical ethics, which, rather than dictating what behaviour is right and wrong, are "a normative framework that gives guidance on how to ethically come to treatment decisions" (Clouser, 1973, p. 787). In discussion with Dr Ukrani and Dr Sharan, it emerged respectively that neither medical ethics nor the Hippocratic Oath are actively summoned in a decision-making process; rather, both guide thinking subconsciously through prior internalisation and acculturalisation (see also Freidson, 1970b).

The notion that treatment is an absolute good pervades the professional culture and defines what behaviour a psychiatrist should *not* engage in. In all instances, the threshold to something being described as 'harmful' required *physical* harm to occur – a rather high threshold. Dr Kumar Kar, for instance, referred to chaining, beating, seclusion and restraint as harmful acts that patients have been exposed to but should not have been. Regarding the question what "human rights law" ought to cover, Dr Tripathi described his view that it violates a patient's human rights if, for instance, medication is prescribed without a diagnosis, or if a treatment plan is drafted solely based on second-hand reports of the patient's symptoms. When discussing the nature of human rights with the interlocutors, a general trend emerged in which only grave clinical mistakes – such as prescribing without a diagnosis – were considered condemnable, as these can lead to health deteriorating. From this follows that acts are measured by their consequence, and do not amount to condemnable harm if the ends justify the means. Dr Tripathi added that:

> If you allow the family members to take decisions for the patient, probably the chances of him getting cured becomes better. It might appear as an infringement of the human rights of a particular person, but, but, but if you see in totality that family members, if they are allowed to take decisions, the chances of the patient getting better […] are more than if they leave him on his own. […] I understand that this kind of goes against the basic understanding of human rights, that every person knows for him or herself. But if you allow the family to be part of it, to take decisions, the chances of human rights violations are there, but overall, there is more good than harm.

In this quote, Dr Tripathi attempts to expand on his definition of what constitutes harm, but he concludes by emphasising that he is primarily concerned with whether an act will contribute to overall health. Another interlocutor from Northern India described that:

> In some cases – and this is not a very legal thing – I do not tell [patients] about the side effects, because I notice that if they *do* know about the side effects, they do not take the treatment. Sometimes the side effects are as mild as some acidity, so I understand that the benefit is higher than the risk.

In this case, the psychiatrist forewent proper informed consent procedures, knowing that the chances of his patient's health improving were higher if he withheld certain information. Another interlocutor, Dr Sharan, opened up about a practice in which a procedure that promises health improvements is carried out without consent: "For certain anti-psychotics, there are many patients in India who are treated by liquid variants without their knowledge, and they're not in-patients." He described how the treating psychiatrist provides family members with the medication, who then at home "put it in a drink" and administer the medicine to the patient without their knowledge, "sometimes for years and years." Due to the consequentialist nature of their decision-making, neither Dr Tripathi, nor Dr Sharan, nor the third anonymous interlocutor found their acts to be condemnable, despite their awareness that they are not in accordance with law. These aspects of the professional culture form variables internal to the recipient, and are crucial in shaping how the profession receives the MHA.

C. Patient Autonomy in the Professional Culture

Merely upholding human rights for the sake of it does not feature in the line of thinking of any of the interlocutors. This section discusses how patient autonomy features in psychiatrists' professional culture, and thus presents an important factor in how psychiatrists construe the law.

While the idea of human rights was explicitly welcomed by several interlocutors, they never placed it above considerations of health; Dr Kala (2013) for instance stated in an editorial on the MHA that "advance directives have not worked as intended even in the West", and that while "the concept may have a certain kind of popular appeal, it has no scientific evidence to back it" (p. 217). His desire to find evidence of 'usefulness' links to a need to consider everything in relation to health; as he sees no evidence that advance directives lead to an improvement of health he dismisses them. Some interlocutors expanded on this notion by associating 'the human rights approach' itself with constituting harm: In conversation with Dr Sharan, I asked him about his approach to informed consent, and how much time he generally spends per patient to ensure that they understand the procedure. He pointed to the fact that he works at a well-visited government hospital, and that the vast amount of people waiting outside his practice allows him only a few minutes per patient. Notably, he did not consider this to be inherently harmful, and invoked that healthcare is a "social justice" issue:

> It fits the social justice principle: If there are so many people who need services and you are the only one available, then what do you do? Do you say to that: I'm treating 30 people and I'm not treating 370 [others]. […] From an equity perspective, it's a major, major problem.

By invoking the term "social justice", he appropriated the terminology generally associated with human rights activists, and highlighted how it would be absurd to require patients to fully understand the treatment and its risks if this could infringe upon another's right to access healthcare and treatment. Given the scarcity of psychiatrists in India – 43 psychiatric hospitals and approximately 4000 psychiatrists for 100 million PWMI in 2013 (Duffy and Kelly, 2019, p. 169) – psychiatrists balance the right to health of various people with each other, as I noticed through my interlocutors, who thought in terms of whether treating one person might mean not treating another. Dr Tripathi specifically highlighted that any consideration of how to treat one patient is done in light of an overburdened healthcare system:

> The patients taking voluntary admission were earlier just told to sign a paper and they will be admitted. They just signed the form. They didn't really know what exactly they are signing. This is changing now, but, you see, you cannot blame the doctor for it. The first response would be that the doctor is behaving unethically, right? No, he was being *practical*. He has to admit 40 patients a day, he is the only doctor, he has to explain everything and the patient doesn't even understand anything about all those stuff. So what option is he left with?

The priorities and norms of the professional culture are thus finetuned as psychiatrists are confronted with dilemmas in real life. In conversation, psychiatrists emphasised towards me that PWMI do in fact quite frequently try to refuse treatment. Dr Tripathi, for instance, mentioned common myths among the general population about psychiatric practice, such as that every psychiatrist chains their patient and puts them into a mental asylum, which leads to people not seeking help out of their own volition. Another psychiatrist indicated that many of the people who *did* take the leap of faith and came to see him believed that he would force them to take sedatives and felt worried about this. Dr Kumar Kar, who works at a large government hospital, expressed that he felt that he could not reconcile letting individuals with schizophrenia or other illnesses with persecutory delusions decide their treatment, as these often assert they do no need treatment and thus refuse to be admitted in almost all cases. Respecting their autonomy to make decisions, he argued, might lead to a harm to self as well as to society. Overall, interlocutors expressed that they feared allowing patients to make decisions about their own life, as these can be clouded by mental illness and stereotypes about psychiatry.

Given their experiences, psychiatrists have thus constructed an intricate system through which to most effectively uphold their professional norms in their individual context, such as in a hospital or a private clinic. Importantly, my interlocutors indicated that they tap into the individual cultural and social background of their patients to enhance treatment. Dr Tripathi, for instance, explained:

> Indian healthcare follows a paternalistic method of treatment. When I was in the US, I saw doctors doing this: They would sit with the patient and tell them that there are three options, option A is this, etc… And you choose. And I came back to India, and tried to do the same thing here, and the patients were puzzled – they were like, you are the doctor! You tell me, how would I know?

Regarding the same topic, Dr Kumar Kar described that many of his patients fundamentally respect any decision made by a superior given the hierarchical system of decision-making within many Indian families. He asserted that not asking some of his patients about their preferences and wishes is not a violation of their autonomy, but a variant of respecting their autonomy by understanding that they *want* another person to make a decision (see also Donnelly, 1984). Similarly, several psychiatrists indicated that they use family members as assets to help a person achieve health as fast as possible. As the proportion of patients living with their family is over 98 percent in India, psychiatrists can treat people *through* their family members (Singh, 2017, p. 101), as already indicated above. Another interlocutor stated that he makes use of a family's cohesiveness by asking a relative to stay with an admitted patient in the ward. That relative assists with feeding, personal hygiene, and supervision of the patient, and also makes decisions for them. Not tapping into this cultural arrangement would appear to psychiatrists to be a missed opportunity at enhancing the path to health. In order to directly resonate with psychiatrists, the MHA would therefore have to support these practices; otherwise, the professional culture is likely to construe the law as having 'odd' priorities.

D. How the Professional Culture Illuminates the Criticism

This paper seeks to understand not only what factors have shaped how psychiatrists construe the MHA, but also what can be learned from this about the criticism psychiatrists have expressed. Dr Raheja, Dr Pathare, and Dr Desai all asserted that the criticism their colleagues have uttered about the MHA are a pretext through which they express that they felt their power as psychiatrists is being undermined. Their impression is in line with findings by scholars researching compliance with medical law, who suggested that "[a]lthough the rhetoric is phrased in terms of benefiting the patient, an underlying issue may be loss of control and power by physician" (Kapp and Lo, 1986, p. 169). I argue that in the present case this is an oversimplification, given the intricate and complex professional culture of psychiatrists laid out above. The argument that the underlying issue is power, not patient wellbeing, suggests that these two are separate, when actually they go hand in hand – what gives the psychiatrist power is his bestowing the patient with health (confer Freidson, 1970a; 1970b; 1975). When describing the MHA, several interlocutors invoked terminology that accused law-drafters of overlooking how much effort psychiatrists have already put in to strike a balance between making sure people's health improves, and treating them with respect. Dr Tripathi specified:

> See, when you talk to Indian doctors, you might get the feeling that they are not too high on this human rights thing. […] There's a reason behind this, it's not that we are bad people. But, you know, it's all about trying to find what harms less to the population. Let's say there's a schizophrenic patient who has no family support. He himself does not understand stuff. The human right approach is to find out if his capacity to make decisions is there or not; if it is not there, to write a letter to the mental health review board, or to the magistrate, then take a decision… But we do not have resources for that. If you push a doctor to do all this – usually there is a single doctor in the emergency ward – he is short on time, he might simply refuse to admit this patient, rather than going through all the hassles. And the patient may end up being on the streets. […] The patient who could have gotten help is now devoid of this help.

Dr Tripathi understands from the MHA that it does not acknowledge that the Indian healthcare system is overburdened, and feels that it does not allow him to fulfil his sense of obligation towards ill people by treating them efficiently. As I demonstrate in the following, the MHA pushes 'health' as psychiatrists understand it into the background, and thereby increase the distance between psychiatrists and their goal of providing treatment.

E. The Devil in the Details of the MHA's Innovations

When I asked him what "the problem" with the MHA is, a young psychiatrist assessed that "with all of the experience that the older psychiatrists have, they do not want this *fuss* to happen!" As argued above, psychiatrists assert to have found the most efficient way of effectively treating patients given case-specific constraints. The introduction of any law thus requires psychiatrists to recalculate and find a new most efficient way within the new constraints. To understand what exactly constitutes the above-mentioned "fuss", this section demonstrates that psychiatrists I spoke with did not criticise that the MHA poses actual obstacles – rather, the issue seemed to be that the MHA impacts upon this recalculation through implicit messages.

Generally, psychiatrists will likely be able to continue treating as before in most cases. For example, while the MHA requires psychiatrists to explicitly assess the legal capacity of their patient to make healthcare decisions, the MHA only states than an Expert Committee will be appointed to provide guidelines to assist psychiatrists in this assessment. The same provision, Section 81(2), states that "every medical practitioner and mental health professional shall, while assessing capacity of a person to make mental healthcare or treatment decisions, comply with the guidance document" and thus makes compliance with external guidelines mandatory; however, it is unclear how a thought process could be policed, and therefore how this provision can be enforced.

Rather than creating actual obstacles and complications, the issue with this provision appears to be that psychiatrist's existing decision-making procedures, based on medical ethics and professional experience, are not trusted to do the job, wherefore additional guidelines are published. Van der Burg (2009) excellently maps out the thought process by explaining: "For the autonomous professional, this may seem preposterous. Who do these incompetent people in the capital think they are – looking for instruments to guide and control the behaviour of expert professionals?" (pp.156-157)

The criticism of psychiatrists can be traced back to their reading implicit messages from between the lines of individual innovations. For example, if a PWMI has issued an advance directive (AD), a document in which a PWMI can indicate ways in which they wish to be – or not be – treated if they later lack capacity to make decisions, the MHA mandates that a psychiatrist must align his treatment with it (Section 10). Dr Tripathi highlighted that the low level of education, as well as general misconceptions about mental health and psychiatric practices are already constraints that psychiatrists have to accommodate; the MHA, by allowing PWMI to issue ADs, increases the burden that these constraints already pose:

> [ADs are a] beautiful thing, surely, right? But the problem is that most of the people don't even consider mental illness a legitimate illness. […] When people don't even *understand* about mental illness, and a person then can write how they should be treated – this in theory is perfectly fine! The problem is that in India if someone were to write an AD, their preferences will be clouded by misconceptions about what mental illness is. […] In a country where people don't even know what kind of treatment is done for mental illness, how do you expect them to choose what is right and what is wrong for them?

If a psychiatrist finds that the nature of the patient's illness requires him to challenge the AD, or if a relative requests treatment to be done that is not permitted in it, an application must be made to a Mental Health Review Board (MHRB) for review (Sections 11(1)-(2)). ADs can be modified if the person did not intend the AD to apply to the current circumstances, especially if the current circumstances were unforeseeable, "unforeseeable" being a term left up to case-by-case consideration (Section 11(2)(b)). Each state is responsible for setting up its own MHRB and creating the rules of procedure of the respective MHRB. Given the flexibility, being granted permission to overrule an AD may not be a major hurdle. Additionally, ADs are not yet commonly used, and given that how much of a constraint an AD poses depends on the individual specifications, they do not appear to restrict professional practice much. However, the issue at hand seems to be that the choice of treatment is taken out of the hands of the psychiatrist and placed first into the hands of a PWMI whose judgment may be clouded by misconceptions and rumours, and second into the hands of a body set up by the government.

The above-mentioned innovations are major factors in how psychiatrists perceive the MHA, which emphasises the importance of studying the specifics of the law's provisions themselves. A final major innovation of the law are the steps required to carry out a supported admission – viewed from the perspective of the psychiatric profession, they can be taken as a major delay in or barrier to doing good. The first step keeps the centre of control within the profession itself: If a psychiatrist in a hospital wants to admit a patient without his consent, the MHA requires that two professionals – one psychiatrist and another medical professional – independently assess the PWMI and conclude that admission is necessary (Section 89(1)). A compulsory second step, however, is a vetting by a Mental Health Review Board. Importantly, the task of reporting to the MHRB is not that of the psychiatrist, but of the administration, and until the MHRB makes a decision, the psychiatrist can treat the patient as he would otherwise do (Section 89(11)). However, in this second step to a supported admission, the locus of decision-making is outside of the hospital, in a newly created body. Several interlocutors expressed that they did not understand the value of having someone outside of the hospital evaluate the patient's circumstances; Dr Ukrani added that because one member of a MHRB is necessarily a psychiatrist, asking a third psychiatrist to *yet again* determine whether admission is merited is redundant and a waste of time.

From the analysis above, it emerges that psychiatrists consider those parts of the MHA problematic that require them to follow new procedures, such as reporting to a MHRB after admitting a patient without consent. This continues a trend identified in 1997 by Edelman and Suchman, in which health practitioners construct the law as a major threat to healthcare and argue that they have the unique ability to perfect healthcare. However, I argue that this argument is only part of a larger picture in which psychiatrists infer a message from the procedural innovations of the MHA. As stated above, the procedures permit various outcomes – only few things, such as ECT without anaesthesia, are completely ruled out. The problem psychiatrists identify is that these procedures have to be done all the same. The crux of this section is that alongside the internal professional culture of psychiatrists, the specifics of the law – that is, what decision-making it governs and possibly prolongs – is a crucial variable in how psychiatrists view the law as a whole. The MHA is thus an "added fuss" in that decisions are always vetted through intricate review mechanisms, and this vetting cannot be circumvented regardless of any other considerations.

F. Tying it Together: The Message Psychiatrists Read from the Law

The MHA does not codify norms and asks psychiatrists to incorporate them in their practice themselves; rather, it specifies procedures in which psychiatrists have to interact with actors outside of their profession and abide by their standards, forms and terminology. The MHA is not placed within the medical field and left there to work its magic. Instead, psychiatrists are required to communicate with Mental Health Review Boards and actively involve them; they must thus first place the MHA within the reality of their own field and frame of reference, but then also refer back to the frame of reference as law-drafters designed it. This is more than just a cognitive effort – psychiatrists construe the law as a constant reminder that they cannot satisfy themselves with institutionalising the general human rights norms into their own procedures. As a MHRB is a state institution that has official sanction to veto a psychiatrist's decision – even if in practice it does not do so – the priorities of the psychiatrist are subverted, and all his considerations can be, in theory, dismissed as secondary. Notably, as the law was only introduced in 2017, MHRBs have yet to be set up in most states (Dr Kumar Kar, personal communication, January 3, 2020). The issue therefore does not seem to be whether treatment and admissions are *actually* overturned by a MHRB, or whether the procedures of requesting a review indeed take up much time – instead, the mere fact that it *can* do so appears to be problematic. Psychiatrists interpret this possibility itself as signifying that their perspective can be dismissed as wrong, and that the fundamental idea that health outweighs all other considerations is not universally valid.

G. Psychiatrists' Perceptions of Being Unfairly Targeted

How actors construe a law depends on whether they consider that the intentions of the lawmaker vis-à-vis themselves are good. Social psychologist Tom Tyler (2013) has thoroughly discussed the effects that trust plays in encouraging compliance. Fundamentally, he argues that if decision-makers show concern for the well-being of others, subjects will consider them more trustworthy and will be more inclined to cooperate with the decision. Even if the decision-makers make mistakes, what matters most is whether they act in good faith and what their intentions are (Tyler, 2013). Tyler (2013) elaborates:

> When a decision is being presented, authorities should emphasize that it accords with the ideas underlying the rules and procedures of the organization. In particular, they should explain the decision by reference to rules and organizational principles that show that the decision is not based upon personal prejudice or bias. (p. 47)

The MHA, as discussed above, does *not* conform to the perspective psychiatrists have of the world. In contexts such as these, Tyler (2013) advises: "When decisions go against the person, it is important to show that the decision was made by applying rules and using facts." (p. 47) In conversation with me, interlocutors expressed that not only was their perspective on being subverted, they also felt unfairly targeted. Rather than trusting that the MHA had been devised with concern for their interests, many felt that the law-drafter had singled them out.[3] One psychiatrist expressed this by referring to patients:

> So many laws are based on the idea that patients are vulnerable. I get that – but is it that only people with mental illness are vulnerable? People with other illnesses who are on their death bed are much more vulnerable!

Dr Ukrani directly referred to his own profession rather than to patients:

> Psychiatry is the only branch of medicine in India that is governed by [a special] law. They don't have a law for cardiologists, or dentists, or neurologists, that admissions have to be done in a certain way. They don't have to submit certain documents, they don't have to justify everything, there is no review board who then will give the permission. They can practice freely!

Dr Desai, director of IHBAS, the largest mental health facility in Delhi, reported that Dr Ukrani's view is common, as "some psychiatrists feel singled out because they think that it is unfair that only psychiatry is being regulated."[4] When I asked Dr Ukrani whether he felt unfairly treated by legislators, he paused, and nuanced that: "See, it's all about the stigma. Many times, psychiatrists *have* been misused by governments.

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[3] I discuss the actual intentions of the law-drafter that I identified in a subsequent paragraph.

[4] Note that immediately after, he admitted that he himself approved of the MHA; he believed that even if the MHA restricts psychiatry, it is needed to stop psychiatrists from thinking that they are "Gods".

There's a history behind that. […] To a certain extent a law is required." Finally, he exclaimed agitatedly: "But they should listen to what the psychiatrists are saying! We are not trying to harm someone intentionally!" In further conversation, Dr Ukrani explained that he felt the law-drafters of the MHA did not trust his intentions, but rather assumed that his intentions were to harm his patients. This, given the strong normative commitment to treatment and health within the semi-autonomous social field, makes Dr Ukrani feel offended. Another psychiatrist rounded off this argument: "The ways the laws are framed, it's always the doctor's fault if someone dies."

From the paragraphs above and the previous sections, it emerges that psychiatrists feel they are being placed under scrutiny and suspicion for acting in accordance with their professional goals – they attempt to promote what they feel is the patient's best interest (health) in the most efficient and effective way possible given the constraints of the overburdened healthcare system and the culture and preferences of the patient. As a logical consequence, psychiatrists wonder what the reason is for this: Why are the goals of the healthcare sector pushed into the background? In a previous section, this paper already discussed the ways in which the law's provisions themselves are relevant 'external' variables in shaping how psychiatrists view the law as a whole. The next section proceeds to the intentions of the law-drafters as main factors external to the psychiatric professional culture.

III. EXTERNAL FACTORS IN PSYCHIATRISTS' MEANING-MAKING: INTENTIONS OF THE LAW-DRAFTERS

This section examines the priorities of the law's drafters and argues that while the MHA may likely not be enforced, the MHA nonetheless seeks social change – not based on legal coercion, but on communication with a touch of provocation.

The Preamble of the *Mental Healthcare Act 2017* proclaims that its purpose is to "align and harmonise" Indian healthcare law with the United Nations Convention on the Rights of People with Disabilities (UNCRPD). India signed and ratified the UNCRPD in the year it was inscribed, and according to leading authors Duffy and Kelly (2019), the Indian MHA indeed succeeds in adhering to the UNCRPD. The explicit reference to satisfying international requirements in the preamble, however, may be taken as indicating that the law was not passed with the intention that the provisions would be enforced.[5] Whether or not, or to what extent, the MHA is implemented is not fundamental to untangling the criticism; rather, the content of the provisions themselves do not fit into the reality of psychiatrists, and are therefore perceived as subverting medical considerations, which are the essence and pride of psychiatrists. More important than the intentions of the government who decided a law is needed are therefore the intentions of the drafters – that is: those who were tasked with writing the law and decided the wording and content of the provisions in the first place.

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[5] Even if the intention of the legislator – as distinct from the law-drafters – may have been to enforce the law, a recent calculation by Bada Math et al. of the healthcare budget indicates that without serious changes in the overall budget that is available for mental healthcare, the costs for implementing the MHA, especially its MHRBs, are unlikely to be covered (see Bada Math et al., 2019; Ministry of Health and Family Welfare, 2017).

In 2010, three years after India ratified the UNCRPD, the Ministry of Health and Family approached the Indian Law Society and the Centre for Mental Health Law and Policy (CMHLP), both based in Pune, for support in amending a list of laws that were deemed as not conforming to the requirements of the UNCRPD (Kala, 2013). In conversation, Dr Pathare, Director of the CMHLP, stated that the existing Mental Health Act of 1987 fell short in so many aspects that merely amending it would not suffice; instead, a new law had to be drafted. Over the course of three years, the two civil society organisations conducted consultations with various stakeholders, among them PWMI themselves, their relatives, human rights activists, and mental healthcare practitioners ranging from psychologists over ayurvedic doctors to psychiatrists (Kala, 2013). In an otherwise highly critical editorial, psychiatrist Dr Kala (2013) commends that the drafting process of the MHA was overall "inclusive and transparent" (p. 218). In conversation, drafter Dr Pathare clarified that while "all" stakeholders were given space to voice their concerns, this did not at all mean that everyone's wishes would be incorporated. He clarified that the concept of Nominated Representatives (NR), for example, had been requested by several women with mental illness with abusive husbands, as they feared their husbands could control and exploit them if their mental health deteriorated to the extent that they lost their decision-making capacity. As can be seen in the final MHA, the law-drafters included these women's requests. The wishes of psychiatrists, however, were not fully accommodated; Dr Pathare emphasised that "worrying about the needs of the professionals is the last thing you should be doing." More specifically even, Dr Pathare spoke about actively wanting to not let psychiatrists have their way:

> This culture has such a high level of patriarchy. It does not benefit the individual person, but it benefits only the institution of collectivism. […] The law was made to disband privilege. The whole battle around it is about power dynamics!

The law-drafters likely drafted the MHA with these considerations guiding their every pen stroke. Dr Pathare specified:

> [Laws are] a way of saying that this is where society is supposed to be in a few years time. […] The law is a statement. In modern nation states, the law is a statement of intent of the state.

Importantly, he uses the words "intent" and "supposed to be", which indicate a plan to actually accomplish the things stated. Even though the provisions may never be enforced, the law-drafters express that the realisation of human rights can inch a step closer through the law nonetheless. This section argues that the message psychiatrists infer from the MHA's procedures is a direct consequence of the law-drafters' preferences – rather than using the law to communicate *human rights norms* themselves, the law-drafters communicate in what *places*, *decisions,* or *relations* human rights need to be considered, and where psychiatrists need to make space for alternatives.

Generally, when laws are described as "saying that this is where society is supposed to be", the law in question is communicative. In a piece celebrating the effectiveness of communicative laws, van Klink and Witteveen (1999) explain that rather than seeking to regulate behaviour through punishment and enforcement, communicative laws choose persuasion as their strategy. Generally, the process of drafting communicative laws is as follows: First, the drafter pinpoints specific values they consider essential, but which are not yet clearly actionable. Second, the drafter specifies legal norms based on these values that can guide the application of these values in specific cases. The provisions of communicative laws are thus purposely vague, so that the law can promote its norms in a cooperative manner (van Klink and Witteveen, 1999). Communicative laws are specifically useful when trying to get companies, professional organisations or other fields with their own codes of conduct to abide by new norms. As each organisation has its own reference points inherent to its perspective, communicating the priorities and essentials of the law can help organisations identify how to most efficiently comply and incorporate the law's norms into its own procedures.

Communicative laws thus have the potential to direct psychiatrists towards what Dr Pathare described as "where society is supposed to be". Interesting to note in this regard is that Dr Pathare was trained as a psychiatrist; before moving into the field of mental health policy, he worked as a consultant psychiatrist in a private hospital. He therefore himself inhabited the semi-autonomous social field that is Indian psychiatric practice, and undoubtedly has viewed phenomena through its social lens. It is therefore likely that he considered how his colleagues would construe a provision that communicated human rights themselves, and how they would construct compliance. Dr Pathare explicitly referred to this by saying:

> There is this notion that: I am a professional, and because I am a professional, my reality should trump everybody else's reality… I mean we are in 2020, that's just not a sustainable argument! If the law should remain *for* the people, then it should meet the requirements of multiple groups. Worrying about the needs of the professionals is the last thing you should be doing.

From revisiting the specific innovations of the MHA, it emerges that whenever the law presents human rights values, this is already done in association with things that the law-drafters had priorly singled out as problems. In light of the communicative law theory, it seems that psychiatrists are not communicated the *human rights* themselves, but the *place* in which the law-drafters think that human rights considerations should feature prominently: When a person is admitted, when their consent is taken, and when psychiatrists rank priorities in their overburdened daily practice. In fact, from the conversation with Dr Pathare, it emerged that he wanted to prompt psychiatrists to inquire into the essence of their role as a treating doctor:

> The medical community needs to do some reflection on the meaning of "treat". Are we treating the illness, are we treating the person? What are the intended outcomes of the treatment? You can couch it in the language of "duties" and "obligations", but fundamentally you need to examine if it is their self-interest they are actually considering most.

Rather than communicating human rights norms themselves, the MHA is therefore more of a preparatory document to human rights socialisation. From Dr Pathare's quote, its goal rather appears to communicate the foundation that is required *before* human rights can flourish in it. Given that Dr Pathare emphasised psychiatrists' reality cannot "trump" everybody else's reality, the MHA is thus rather a tool to signal to psychiatrists that they should reflect on their role in society.[6] From reviewing the intentions of the law-drafter, the provocation that psychiatrists perceive is arguably exactly what the law-drafters intended to convey.

IV. THE MHA AS PART OF A LARGER STRATEGY

Literature on the regulation of professions generally supports the idea that laws ought to prioritise persuasion and the communication of norms through vague laws if it aims to induce behaviour change from highly autonomous SAFs (see Edelman, 2005). The message conveyed through the MHA, however, is not received by the psychiatric profession as peaceful and collaborative. The crux of why a communicative law provokes antagonism in the present case appears to be, fundamentally, that the MHA is not simply any law. Rather than seeking to regulate the organisation for economic reasons or taxation purposes, it is a human rights document that, as explicitly indicated by Dr Pathare, aims to level the playing field of psychiatrists and PWMI. Given their medical background, Dr Pathare and his colleagues are arguably uniquely positioned to design the specific role of the MHA in the wider process of norm socialisation. In this regard, I asked Dr Pathare whether he thought using laws to initiate social change was the best strategy, to which he responded that the law is a supplementary tool to social movements and nudging. This suggests that the MHA was written as it was in order to contribute to a wider and long-term strategy.

A common model of the process of human rights socialisation is devised by Thomas Risse (1999), who found that actors employ three strategies in the process: First, forced imposition, second, institutionalisation and habitualisation, and third, moral consciousness raising and persuasion. Importantly, "each process is necessary to achieve the internalization of international norms into domestic practices […and…] the question then becomes which mode of action prevails at which stage" (Risse, 1999, p. 530). While Risse's model refers to states and processes at the international level, the three strategies are also applied at the domestic level to reach sub-communities, where "a balance between power and love, or confrontation and cooperation, must be sought rather than aggressively or exclusively pursuing one of the other" when advancing human rights (Parlevliet, 2015 p. 235). Which strategy change-makers pursue depends on the stage of vernacularisation, and the social position of those deemed 'human rights violators'. The greater the imbalance of power between those most at risk and those most likely to infringe upon their human rights, the more need there is to first introduce legal barriers, and to proceed to persuasion and cooperation only later on in the process (Parlevliet, 2015; Risse and Ropp, 1999).

Exactly this order seems to have been adopted in India: The MHA was drafted in 2010, and discussions about it began around the same time. As a sanction-based legal tool, it precedes 'softer' measures, such as initiatives to reduce mental health stigma through general and specific education initiatives. Psychiatrists who are open to changing their practice to promote human rights, among them some of my interlocutors, have started giving presentations at psychiatry conferences to

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[6] My data does not reveal what kind of role this is. While the conversations and a review of the literature suggest tentative themes, I refrain from analysing them here.

emphasise the importance of human rights, and thus work proactively to institutionalise human rights within psychiatry. Similarly, the Medical Council of India (2018) announced changes to the general medical curriculum in that students will forthwith study AETCOM (Attitude, Ethics and Communication) as a separate module.

V. CONCLUSION

This paper has sought to answer why psychiatrists construe the Mental Healthcare Act 2017 as an "added fuss", and to thereby untangle what exactly constitutes the "fuss". It identified that psychiatrists' criticism of the MHA is shaped by external and internal factors, external being the intentions of the law-drafters and how these are reflected in the law's provisions, and internal being the professional culture of psychiatrists. Notable about the MHA is that while it was passed primarily to align India's domestic law with the United Nations Convention on the Rights of People with Disabilities, the law-drafters went beyond this simple ambition and arguably aim to communicate to psychiatrists that practices they consider necessary for promoting health are not justified by default. Rather than aiming to institutionalise human rights within the field straightaway, from conversations with one of the drafters it emerged that they designed concrete procedures as well as innovative decision-making bodies in order to trigger a process of reflection. The psychiatrists I talked to view the MHA from the unique perspective of their professional culture – the internal variable – which emphasises providing effective healthcare over all other considerations. Psychiatrists' professional culture justifies certain paternalistic practices by referring to how they contribute to the realisation of the human right to health, whereas the MHA considers these practices *prima facie* untrustworthy and as always in need of justification. As such, at the core of the criticism that psychiatrists will lose power and that patients will suffer lies an awareness that the drafter does not agree with placing a patient's health as an indisputable top priority. Psychiatrists assert to have found the most efficient way to use local resources, such as cultural beliefs and family members, to treat their patients despite the constraints of an overburdened healthcare system. Whether the MHA will be fully enforced or not therefore matters little for the criticism. Fundamentally, the law appears to have been drafted to emphasise that the human right to health is not superior to other human rights, and psychiatrists have clearly received this message.

The findings of this research should be seen as indicative of a general trend within the sample studied. Limitations that ought to be considered are, for instance, that the only female input comes from an ethnographic interview with a post-graduate psychiatry student. Additionally, half of the interlocutors were active in the private set-up, and were not involved in admitting patients for in-patient treatment. They have therefore not been exposed themselves to many of the procedures mandated by the MHA.

This paper's argument could be read as implying that because of how psychiatrists construe the law – as intrusive, restrictive, and causing more harm than good – the process of implementing human rights is hampered. If the law stood alone, this may be a reasonable argument to make, but it is not what this paper means to imply. Dr Pathare confirmed that he anticipated psychiatrists would react the way they did, but deemed it necessary as part of a larger picture in which the MHA is only one of many approaches to making human rights reality. While the Mental Healthcare Act may appear catastrophic in psychiatrists' current reality – a new reality is on the horizon.

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BOOK REVIEW: INDIA'S MENTAL HEALTHCARE ACT, 2017: BUILDING LAWS, PROTECTING RIGHTS, BY RICHARD M. DUFFY AND BRENDAN M. KELLY (SPRINGER, 2020)

ALEX RUCK KEENE[*]

This book by two Irish psychiatrists examines what they assert – with some justification – to be "essentially the largest experiment ever undertaken in the field of rights-based mental health law" (page xix), India's Mental Healthcare Act 2017 ('the MHCA'), which received and was formally commenced on 29 May 2018. The legislation expressly seeks to align itself with the Convention on the Rights of Persons with Disabilities ('CRPD'), and also to create an express, justiciable, right to mental healthcare. Against this background, the book aims to provide a comprehensive context to the new Indian legislation, along with a detailed description of the 2017 Act itself and an analysis of it in the context of the CRPD and WHO standards for mental health law.

Given that the book is relatively short – just shy of 300 pages – it is perhaps unfortunate that it spends a little time getting going, with the first Part ('Mental Health Law and International Standards) essentially serving as a primer on these matters without any specific reference to India. Most readers would be likely to be coming to this book for what it has to say about the MHCA, so are therefore likely to move swiftly through the first 50 pages. However, things pick up considerably in Part 2, when the historical context of mental health legislation in India is addressed, including both colonial-era legislation and – as an important framing reference – the 2016 Rights of Persons with Disabilities Act ('RWPDA'), enacted to give effect to the CPRD.

The MHCA is then outlined in detail in Chapter 6, before, in Part 3, the Act is tested against international human rights standards. In an editorial decision which might raise some eyebrows, much of the testing is done against the 'Checklist on Mental Health Legislation' published in the World Health Organisation's 2005 Resource Book on Mental Health Legislation. Whilst this is a tool that the authors have used to test other legislation, the Resource Book has been withdrawn by the WHO because it was composed prior to the CPRD. The authors defend their decision to use the 2005 Resource Book because it "still has much in common with the CRPD and remains the most comprehensive human rights tool available for the analysis of mental health legislation in relation to human rights standards" (page 109).

The authors conclude that the:

> India's MHCA and Rights of Persons with Disabilities Act, 2016 have done much to bring India's legislation in line with the WHO RB. Owing in large part to these two ambitious pieces of legislation, Indian legislation currently meets

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> 68.0% (119/175) of the WHO RB's criteria. This far surpasses other countries whose legislation has been compared to the WHO RB, e.g. legislation in England and Wales meets 54.2% of the standards, while Irish legislation meets just 48.2% (Kelly 2011). Regarding the standards that remain unmet in India, eight relate to areas where direct comparison is essentially impossible and 10 are in areas of well-justified non-concordance, with the Indian legislation delivering nuanced positions that embrace the principles of human rights in a more insightful way than the WHO RB does. Many of the remaining unmet standards are not addressed directly in the legislation but provision exists for them to be addressed in policy. When areas of complex comparison are excluded from the analysis and areas of justified non-concordance are considered concordant, an impressive 77.2% (129/167) of the WHO RB standards are met in Indian legislation.

The authors then go on to assess the concordance of both the RWPDA and the MHCA with the CRPD, suggesting that they provide a "carefully considered example of what is possible" (page 203), They note that the most contentious article in the CRPD in the mental health context is Article 12, the right to equal recognition before the law, and dedicate a whole chapter to analysing the concordance of the Indian legislation with the Article. Their analysis encompasses the debates about the very meaning of Article 12, and the chapter is a helpful stress-testing of real world legislation against the different interpretations of the Article. They make the plausible suggestion (page 223) that "[a]reas of non-concordance are generally the product of efforts to balance competing CRPD rights with each other," noting that "this balancing act is often directly reflected in the text of the MHCA." It is, perhaps, a shame that the authors did not undertake the same exercise by reference to Article 14 CRPD, the right to liberty, about which the debates rage nearly as fiercely.

The authors then seek (in Chapter 10) to widen the lens back out again, exploring whether the divergences identified in the MHCA and RPWDA with the WHO Resource Book and the CRPD "represent necessary and appropriate flexibility to facilitate person-centred care, or, on the other hand, a failure by legislators to deliver CRPD-concordant provisions" (page 228). Whether or not the reader agrees with their conclusions, the chapter is helpfully thorough in pulling out the key underpinning ethical issues, and highlighting areas for further research, both in the Indian context (for instance the role of families in supporting decision-making) and more broadly.

The final chapter, an implementation update, is by Dr Soumitra Pathare, of the Centre for Mental Health Law and Policy at the Indian Law Society, Pune, India, and Arjun Kapoor. Dr Pathare had been a driving force behind the MHCA, and his chapter serves as much as anything else as a call to arms, opening with the critical reminder that:

> The promise of India's Mental Healthcare Act, 2017 (MHCA), as outlined in the previous chapters of this book, will remain just that—a promise—without effective implementation of the legislation. Readers who are not familiar with India will be more than a little surprised by the idea of a law existing on statute but not being implemented. However, India has a history of enacting

> progressive social sector legislation which remains unimplemented and 'customary practices' continue unhindered. For example, the previous Mental Health Act, 1987 was enacted by Parliament in 1987 but only brought into force six years later in 1993—a significant delay. As late as 2013, many state governments had not established a State Mental Health Authority as required under the 1987 Act. Glaringly, there continue to be anecdotal examples, frequently reported by popular media, of magistrates issuing Reception Orders under the Indian Lunacy Act, 1912, which was repealed by the 1987 Act!

As at the date of writing this review (June 2021), full implementation of the legislation remains some way off, and the call to action in the chapter just as relevant, not least given the impact of the COVID-19 upon mental, as well as physical, health in India.

Although not all of the editorial decisions taken by the authors of the book necessarily serve their purposes, overall, it is an extremely useful guide to legislation which seeks to take on the challenge of operationalising the CRPD in the mental health context in a way that few other jurisdictions have sought to do. It therefore serves, or should serve, as a useful provocation for law reformers in other jurisdictions as they grapple with the question of how to reshape mental health legislation for the 21st century.