Summary

There are a number of health conditions in which patients face a double ordeal: the pain of bodily impairment and differential treatment by the society. Mental illness is one of them. Stigma and discrimination, the two facets of the same phenomenon, are common in the everyday life of persons with mental illness, and are experienced across the globe. Stigma comprises negative attitudinal components and discrimination is its behavioral manifestation. Experiences of stigma and discrimination are hierarchical. They occur at the individual level, interpersonal level and at the structural level. Of these, structural stigma and structural discrimination are emerging as the biggest challenges to the social inclusion of persons with mental illness. These phenomena are often detrimental to the society, because, being systemic in nature, they present barriers at a macro-level. They are the products of social deliberations, and are largely intentional. They have potential to curtail the freedom and opportunities of individuals in many spheres of life. Moreover, traditional approaches to end stigma and discrimination have seen limited success when efforts were focused at the individual and interpersonal levels. There is a growing consensus among researchers that future anti-stigma and anti-discrimination strategies should focus on barriers at the structural level. In accordance, the present research focused on understanding the legal and social barriers that prevent the inclusion of persons with mental illness in society.

Structural stigma and structural discrimination can be seen in societal frameworks such as laws, rules, policies and cultural standards. Unlike other social standards, discriminatory frameworks adhere to the ideologies that perpetuate stigmatized status of persons who have mental illness. Here, stigmatized status implies deeply discrediting, secondary and inferior treatment, and the denial of equal recognition before the law – that is a denial to recognize legal capacity of persons with mental illness and denial of agency to exercise it. Provisions of discriminatory structures are framed in such a way that it appears as if the best interests and safety of persons with mental illness are being protected. But in practice, such provisions protect the best interests of those who hold positions of power in society. With regard to persons with mental illness, these people include parents, guardians, custodians, clinicians, psychiatrists, nurses, other mental health care service providers and the state authorities.

Provisions of the structural framework, which fail to recognize the legal capacity of persons with mental illness and curtail their agency to exercise it, present barriers to the realization of the human rights of these individuals. These barriers are discriminatory in nature, and prevent participation in mainstream processes such as education, employment, banking, or marriage. As a result, inequality before the law appears to be a contributing factor to the vicious circle of disability, poverty and social exclusion. The problem of inequality before the law and the exclusion and marginalization of minority groups is of paramount significance for the United Nations Member States because the achievement of several Sustainable Development Goals is associated with it.

The principle of recognition of equality before the law has been central to the United Nations Convention on the Rights of Persons with Disabilities (CRPD); the realization of several other human rights enshrined in the Convention is contingent upon it. In the light of framework of CRPD, it was hypothesized that the
legal framework across the world would present structural barriers to employment, marriage, property and mental health care of persons with mental illness; these barriers would discriminate and lead to mass human rights violations. Structural discrimination would ultimately prevent inclusion of persons with mental illness in the society. Based on this hypothesis, the main research question was framed as follows:

*What are the legal and social barriers that lead to structural discrimination against persons with mental illness and prevent their inclusion in society?*

The main research question was answered with the help of seven research sub-questions. These sub-questions were based on a mixed method approach. The seven sub-questions were further divided into four parts based on the domain studied. Part I of this thesis explored legal and social barriers to employment of persons with mental illness. Part II, Part III and Part IV explored legal barriers to marriage, property and mental health care respectively.

**Part I - Employment**

1. *To what extent do domestic laws in the United Nations Member States pose structural barriers to the participation of persons with mental illness in formal employment?*

To answer this sub-question, legal barriers were explored in the context of right to work and employment as stated in Article 27 of the CRPD. We studied employment pertinent provisions in 193 United Nations Member States to find out whether the laws failed to prohibit discrimination against persons with mental illness; and whether laws failed to protect their right to equality – in terms of equal opportunities and equal access to workplace adjustments. In turn, this information revealed how far countries fulfilled their obligations to empower persons with mental illness.

Findings of the study revealed that persons with mental illness face series of legal barriers that prevent their rights-based participation in work and employment. Mental impairment is recognized as mental disability in only 62% of the countries worldwide. In 64% countries, discrimination on the basis of mental disability at the recruitment stage is prohibited. Laws in nearly two third of the countries fail to prohibit discontinuation of employment of an employee with a mental disability. Right to reasonable accommodation is recognized in 56% of the countries; where as in 59% countries employment of persons with mental illness is promoted through affirmative actions. The study shows that, even after 10 years of ratification, the paradigm shift brought by the CRPD has not particularly reached lives of persons with mental illness, especially in areas as crucial as employment. Compliance of domestic laws with the CRPD standards seemed to be a prerogative of the countries belonging to a higher economic stratum.

2. *What are the social barriers experienced by persons with mental illness in seeking paid employment, continuing employment, or returning to employment in the formal and informal sectors? What is the current level of support for persons with mental illness from employers and family members to overcome these barriers?*

To answer these questions, a qualitative study was conducted, where 33 male out-patients, aged 18-60 years, who had common or severe mental disorders, were interviewed. The interviews were conducted at a tertiary care mental health facility in Ahmedabad district of Gujarat in India. During these interviews, we explored the difficulties faced by these individuals at work after the onset of mental illness; how they and their families subsisted during the periods of unemployment; how patients managed to return to
work. Besides understanding the barriers, we tried to know whether employers and family members understood their situation and offered psychological and practical support. Findings revealed that, in addition to symptoms of mental illness and side effects from psychotropic medication, participants faced several challenges when it came to disclosing their mental illness. These included employers’ loss of trust related to productivity, reduced workload, reduced income, bullying, and frequent threats of terminating their employment. Self-employed individuals who worked with family members (e.g. in family businesses) faced fewer barriers to maintaining their livelihood. In few cases, individuals relied on external financial support or sustained on family’s savings during the course of unemployment. In addition, we found that well-identified gender roles of the family members fostered different types of employment support for men with mental illness. Based on this phenomenon, the study further demonstrated the significance of social capital in facilitating income generation for persons with mental illness, including family support as a strong determinant of sustained employment.

3. What is the rate, pattern and nature of employment among working-age men with mental illness in Gujarat, India? What are the clinical and social factors associated with employment? What is respondents’ awareness of the mental disability certification?

In this study, we aimed to identify the employment rate, nature and pattern of employment of persons with mental illness. We also investigated the factors (clinical or non-clinical/social) that were strongly associated with employed individuals, that distinguished employed individuals from the unemployed ones. For this, we conducted a survey on 295 working age out-patients who had common or severe mental illnesses. The survey was conducted at the same tertiary care mental health facility where qualitative interviews were conducted. During the course of this research, the disability legislation in India underwent reform. According to the new law, one percent of all government jobs are now reserved for persons with mental disabilities. To access these jobs, a certificate of mental disability is required. We therefore explored whether out-patients were aware of such a certification of mental disability, and whether they had obtained it. Our survey revealed that the employment rate among persons with mental illness was 50.8%. More than half of the employed respondents worked in the private sector, and largely (82%) in the informal sector. Only 4% of the respondents had government jobs. Forty per cent were self-employed. Nearly 90.6% of the respondents worked full-time. In 36.6% cases, respondents were the sole earners for the families of three to six members. Employed and unemployed respondents were similar in relation to demographics, type and duration of mental illness; but differed on marital status and prior work experience. Nearly 78.6% respondents were unaware that mental illness was recognized as a form of disability in India, and only 7.1% respondents had obtained mental disability certificates.

This study highlighted the role of social indicators that facilitate the employment of persons with a mental illness. In addition, it was found that, when these individuals are the family’s main breadwinner, they break the stereotype of being a burden on their family. Therefore, employment of persons with mental illness is an important strategy to reduce stigma. Persons with a mental illness in India are rarely aware of disability-related rights. There is a need to promote employment of people with mental illness using a multi-sectoral approach.

Part II – Marriage

4. To what extent do domestic laws in United Nations Member States pose structural barriers to the realization of ‘right to marry and remain married’ of persons with mental illness?
To answer this question, we explored legal barriers in the marriage laws of 193 United Nations Member States. We identified and assessed the provisions of laws that regulated the right to marry and remain married, i.e., protection from divorce on the ground of mental illness of the spouse. These provisions were evaluated against the framework of Article 23.1(a) of CRPD. We explored whether legal provisions deemed persons with mental illness unfit for marriage, or rendered their marriage as voidable or dissolvable. Because such provisions created barriers in the exercise of one’s right to marry, they were considered as discriminatory towards persons with mental illness. Findings of the study revealed that 37% of countries explicitly prohibit marriage of persons with mental illness. In 11% countries, presence of mental illness can render a marriage void or can be considered grounds for nullity of marriage. We did not observe an economic gradient among countries where marriage of persons with mental illness was not recognized by the law, however, lower middle-income countries were more likely to allow mental illness as a ground for divorce. The study revealed that the stereotype about persons with mental illness as lacking the capacity to take decisions and being unable to perform marital responsibilities, is deeply ingrained in the marriage laws of countries across the globe.

5. To what extent does the practice of matrimonial law in India discriminate against persons with mental illness? If so, how? What is the role of gender and medical evidence in matrimonial proceedings regarding persons with mental illness in India?

In this study, we aimed to identify discriminatory provisions in an Indian legislation that regulated the right to marry and remain married, when either spouse had a mental illness. We also aimed to understand the practice of law in relation to these provisions. Our review of relevant cases from the Family Court in Pune, all the High Courts in India and the Supreme Court of India revealed that discriminatory provisions of the Hindu Marriage Act, 1955 were largely (85%) used by the husbands to break nuptial ties with the wives who had mental illnesses. In 40% of the cases, annulment or divorce was granted without any medical evidence. The appellate courts in India (the High Court) had overturned judgment of the lower courts in 50% of such cases. Even in the cases where medical evidence was presented, strength of the medical evidence was poor. Analyses of the petitions showed that any challenge to the male authority, deviance from expected marital roles were likely to be construed as symptoms of mental illness, resulting in petitions of annulment or divorce on the ground of mental illness. The position of women with mental illness was thus jeopardized to a great extent. The study also showed that cultural expectations, lack of social support and poor economic standing of the women largely determined the outcomes of such cases.

Part III – Property

6. To what extent do domestic laws in United Nations Member States pose structural barriers to the realization of the ‘right to inherit property, right to contract and right to make a will’ of persons with mental illness?

In this study, we explored legal barriers in the realization of right to contract, right to succession/inheritance, and right to make a will of persons with mental illness. We studied pertinent laws in 193 United Nations Member States. We compared pertinent provisions of laws with the principle of Article 12 of CRPD to see if persons with mental illness could hold, enjoy and dispose of property at par with others. Findings reveal that only 21% countries across the globe recognize contractual capacity of persons with mental illness, whereas 38% countries do not recognize this capacity. Nearly 9% countries recognize capacity to enter into a contract only in the presence of a guardian or with the permission of a guardian. Another 70% of the countries allow persons with mental illness to succeed property, but the right to make a will is recognized in only 23% of the countries. This situation highlights a paradox that
Although many countries have an intention to protect best interests of persons with mental illness, their laws indeed exploit these individuals and deprive them of their property rights by denying legal capacity. The study also shows that protection and promotion of the right to property is upheld in countries belonging to higher economic stratum.

Part IV – Mental Health Care

7. To what extent does the mental health legislation in Commonwealth Member States structurally discriminate against persons with mental illness?

In this study, we explored structural barriers in the exercise of the right to affordable, accessible, available mental health care for persons with mental illness. Provisions of the mental health legislation in Commonwealth Member States were assessed using framework of CRPD. The study shows that mental health laws in 20% Commonwealth Member States belong to the pre-psychotropic medicine era (1960s), whereas in 90% Member States, mental health laws have been enacted in pre-CRPD era. Mental health is equated with physical health care in only 11% countries’ mental health legislation, and in 24% of the countries, community-based mental health care is promoted in mental health legislation. Laws in only 9% countries state that voluntary admission and voluntary treatment are the preferred ways of mental health care delivery. Protection from cruel, inhuman and degrading treatment is promised in the laws of 51% of the countries. Use of unmodified electro-convulsive therapy among minors is not banned in the mental health legislation of any of the Commonwealth Member States. In only 7% of the countries, it is unlawful to perform psychosurgery and give other irreversible treatments to involuntary patients. The study highlights that there is an urgent need to transition from plenary or limited guardianship provisions to supported decision-making models such as psychiatric advance directives. Countries also need to modify mental health laws that use archaic and stigmatizing terminology such as lunatic, imbecile, mentally defective for persons with mental illness.

Taken together, the studies on exploration of legal barriers to inclusion of persons with mental illness highlight that in order to give effect to the paradigm shift promised by the CRPD, countries must bring legislative reform, especially by protecting and promoting equal recognition of persons with mental illness before the law. Recognition and agency to exercise legal capacity forms the bedrock for eliminating structural discrimination against these individuals, and facilitating their rights-based inclusion within society.