Structural Discrimination Against Persons with Mental Illness

Renuka Nardodkar
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“Any idiot can face a crisis – it’s day-to-day living that wears you out”.

-Anton Chekov
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STRUCTURAL DISCRIMINATION AGAINST PERSONS WITH MENTAL ILLNESS

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In dedication to those who kindly revealed their stories...

and to my parents for everything...
## Table of Contents

Account .......................................................................................................................... 1  
Chapter 1. Introduction ................................................................................................. 3  
  1.1 Stigma of a health condition .................................................................................. 4  
  1.2 How do stigma and discrimination affect lives of persons with mental illness? ........ 5  
  1.3 Model of stigma and discrimination ...................................................................... 8  
  1.4 Why do we need to explore structural discrimination? ........................................... 10  
  1.5 How can we study structural discrimination? ......................................................... 10  
  Bibliography ............................................................................................................... 14  
Chapter 2. Theoretical Framework ................................................................................ 22  
  2.1 International Framework of Human Rights ............................................................ 22  
  2.2. Theories of stigma and discrimination ................................................................. 31  
  Bibliography ............................................................................................................... 39  
Chapter 3. Research Framework .................................................................................... 47  
  3.1 Research Design .................................................................................................... 47  
  3.2 Research Methodology ......................................................................................... 50  
  3.3 Research Validity .................................................................................................. 54  
  3.4 Ethical considerations ............................................................................................ 55  
  3.5 Framework of research studies ............................................................................. 57  
  Bibliography ............................................................................................................... 58  
Part I – Employment ...................................................................................................... 59  
Chapter 4. Legal barriers ............................................................................................... 59  
  Legal protection of the right to work and employment for persons with mental health problems: a review of legislation across the world ...................................................... 59  
Chapter 5. Social barriers ............................................................................................. 79  
  Barriers to employment of persons with mental illness: a qualitative study from Gujarat, India ........................................................................................................................................... 79  
Chapter 6. Employment rate, nature and pattern of employment .................................... 98  
  Cross-sectional study of employment of persons with mental illness in Gujarat, India .......... 98  
Part II – Marriage .......................................................................................................... 108  
Chapter 7. Legal Barriers .............................................................................................. 108  
  Legislative provisions related to marriage and divorce of persons with mental health problems: a global review ........................................................................................................... 108  
Chapter 8. Legal Barriers ............................................................................................. 120  
  Gender, mental illness and the Hindu Marriage Act, 1955 ............................................. 120  
Part III - Property ......................................................................................................... 136  
Chapter 9. Legal Barriers ............................................................................................ 136
Account

Chapter 4 to 10 are based on co-authored articles that are published or submitted for publication in peer-reviewed journals.

Chapter 4


Chapter 5

Nardodkar R, Nair M, Stein M, Bunders J, & Pathare S. Barriers to employment of persons with mental illness: a qualitative study from Gujarat, India. (submitted)

Chapter 6

Nardodkar R, Nair M, Bunders J, Stein M, & Pathare S. Cross-sectional study of employment of persons with mental illness in Gujarat, India. (submitted)

Chapter 7


The author contributed to the data collection, substantially to the data analysis, drafted primary and later manuscript of the article, and answered queries of the reviewers.

Chapter 8


Chapter 9

The author contributed to the data collection, data analysis and preparation of the early manuscript of this paper. She answered queries of the reviewers.

Chapter 10


This article was a guest editorial based on a report - ‘Mental Health: a legislative framework to empower, protect and care - a review of mental health legislation in the Commonwealth member states’ (The Commonwealth Health Professionals Alliance, Commonwealth Foundation, 2013). For this review, the author had substantially contributed in the data collection and data analysis. She had contributed to preparation of the manuscript of the main report and this article.
Chapter 1. Introduction

It [the Bill] does not differentiate between mentally ill and mentally disabled person. But there is a difference between the two. If a person is mentally ill like schizophrenic, how can he be given a job? (The Quint, 2016)

In January 2016, a Union Council Minister of India made this statement at a panel meeting convened to examine the Rights of Persons with Disabilities Bill. The statement sparked controversy. It attracted immense criticism from the stakeholders of the mental health sector in India. The Minister further clarified:

For instance, there is no point putting leprosy with autism. Leprosy is a disease and autism at its extreme level is a disablement. If we put leprosy in the list carelessly then we leave the door open to cancer, liver/kidney failure, etc. and make the 3 per cent reservation a mockery. Regarding mental illness, I asked them to grade the different forms and see which can be employable and which needs a pension. The Ministry for Social Justice agreed to refine and reconsider the points I made. (Venkat, 2016)

Mental health activists in India took to social media to question the Minister, voicing their outrage over the statement. They discussed the ways in which it affected 50 million Indians who lived with mental illness. Activists from the metro cities triggered a movement (“Dear Mrs. Maneka Gandhi”, 2016), where hundreds of persons with mental illness strongly criticized the Minister for doubting their ability to work. The ‘we can work’ movement was only short-lived. Apart from the concerns raised by activists and patients, there were several other problematic aspects about his statement. It was made at the time when India’s disability legislation underwent reform after the ratification of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (UNGA, 2007). The statement clearly showed that the law-maker’s understanding of the term ‘disability’ was influenced by the medical model of disability.

According to the medical model, disability stems from a functional limitation or deficit that occurs as a result of physical, sensory and mental impairment of an individual. For example, mental illness, such as schizophrenia, may cause mental impairment, thereby making the person mentally disabled. The model has been criticized for its fixation on the illness and disempowering persons with disabilities (Mulvany, 2000). Its validity, assumptions, and adequacy have been widely questioned and rejected for the last 30 years (Oliver, 1996). In stark contrast, the social model of disability, which forms the basis of the CRPD, says that disability is a “loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers” (Barnes, 1991, p. 2). Oliver (1996) says that disability has nothing to do with the bodily impairment; rather it is social organization that fails to take into account differing needs of the persons with impairments. The CRPD requires that the State
Parties protect and promote rights of persons with mental disabilities on an equal basis with others. Hence, to realize that the Indian law-maker adhered to the medical model of disability in the post-CRPD era was a matter of great concern.

Furthermore, the law-maker had used derogatory language to express reservations about persons with mental illness, who are already subjected to stigma and discrimination across the world. The above incident was likely to support views of people who stigmatize persons with mental illness. The incident also gives a snapshot of the likely process of formation of discriminatory laws. It shows that stigma of mental illness is embedded in the mindsets of people who participate in the law-making process and it is likely to be reflected in legislative provisions. Such laws are likely to be discriminatory towards persons with mental illness.

This thesis aims to understand the structural discrimination against persons with mental illness in India and across the globe. It specifically reviews legal and social barriers that prevent the inclusion of persons with mental illness in the mainstream processes. The findings of this research give a broader picture of how often laws and social norms systematically restrict or prohibit the realization of human rights of a person with mental illness in employment, marriage, property transactions and in accessing health care on an equal basis with others. The findings show that legislation in nearly every country worldwide promotes the institutionalization of persons with mental illness and prevents their social inclusion. Moreover, the extent of structural discrimination appears to be significant in low- and middle-income countries.

1.1 Stigma of a health condition

There are a number of health conditions in which the patients face derogatory treatment by society at large. Some examples of such diseases are mental illness, physical or sensory disabilities, leprosy, certain skin disorders, sexually transmitted diseases, and human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) (Sartorius, 2007). People suffering these conditions face a double ordeal. Not only do they experience physical impairments because of the health condition, they also have to bear differential social treatment (Peters, 2015, p. 16). The differential treatment (discrimination) is a product of negative social attitudes, and can be more detrimental to the individual than just the impairment. This is because discrimination often curtails opportunities and movements of the patients in society. It negatively affects their education, employment, marital life, financial matters, health care, and social support, compared to those who have non-stigmatizing health conditions. Around the world, persons with mental illness have long been subjected to such discrimination. Their discrimination is a product of the stigma of the mental illness.
1.2 How do stigma and discrimination affect lives of persons with mental illness?

1.2.1 At work

Mental health, work and social integration are complementary. People’s self-esteem and social identity are associated with their ability to work and earn a living (Tiggemann & Winefield, 1984; 1990). Employment gives people wider opportunities for social interaction. It can improve people’s physical and financial security, enabling them to found a family, buy a house, educate their children, travel to different places, and pursue their creative, artistic and intellectual potential. They can contribute meaningfully to the society through their work. The diagnosis of mental illness, however, takes away most of these opportunities from an individual. It is now unequivocally accepted that stigma of mental illness negatively affects education, employment, treatment and recovery of the individual (Yeh, Jewell, & Thomas, 2016).

According to Thornicroft (2006, p.50), a review of the National Labour Force Survey in England showed that the adult population had an employment rate of 75% and those with physical health problems an employment rate of 65%. However, those with mental health problems had an employment rate as low as 20%. Moreover, only half of the persons with common mental illness had competitive employment (Meltzer et al., 2002, p. 68). A National Survey on Drug Use and Health in the United States shows that as severity of mental illness increases, the employment rate of persons with mental illness decreases, from 75.9% (no mental illness) to 54.5% (severe mental illness) (Luciano & Meara, 2014). A Canadian Survey on Disability indicates that unemployment rate among persons with mental illness in Ontario was as high as 22.6%, whereas persons with physical disabilities had a 9% unemployment rate and those without a disability had an unemployment rate of 7.7% (Ontario Human Rights Commission, 2015). These national surveys highlight that mental disability is a matter of concern because it affects an individual’s ability to obtain work and sustain it. Persons with mental illness are often denied jobs or are liable to being dismissed because of their mental illness. Read and Baker (1996) found that 34% of the workers in England either faced termination of their contract or were forced to resign because of mental illness. Nearly 39% respondents reported that their psychiatric history was a reason to deny them jobs in the first place. It was further worrying to note that 69% of the participants interviewed in this survey had put off applying for jobs because they anticipated unfair treatment. Furthermore, persons with mental illness face challenges when they want to return to work after an episode of illness (Andersen, Nielsen, & Brinkmann, 2012). Absence from work due to the waxing and waning nature of mental illness poses a risk of termination of employment (Nelson & Kim, 2011). In all of the above-listed studies, stigma of mental illness in interpersonal interactions, lack of legal protections against discrimination on the basis of mental illness, and lack of access to meaningful social roles have been highlighted as the toughest barriers to overcome. These barriers are likely to be systemic and social. Persons with mental illness want to work, but these barriers create
gaps between their aspirations and experiences in the job market (Thornicroft, 2006, pp. 51–52).

1.2.2 In marriage

Marriage provides a wider continuum for social interaction (Ross, 1995). It supports the couple’s emotional and physical well-being (Ross, Mirowsky, & Goldsteen, 1990; Simon, 2002). To marry and have children is a common and in many societies a primary cultural expectation. In a patriarchal society, women are assigned the central role of bearing and caring for children and the household, whereas men are assigned the role of earning an income and ensuring the family’s physical security. In this context, marriage improves a woman’s economic well-being (Lerman, 2002), giving her equal access to wider financial security benefits (Tebbe & Widiss, 2010).

However, when a spouse suffers mental illness, the position of that person is jeopardized. The pressure of marital responsibilities and illness becomes difficult to withstand. Mental illness increases the risk of separation or divorce, especially for women (Kessler, Walters, & Forthofer, 1998). A study on the personal impact of schizophrenia in five European countries shows that 65% of the patients were single, and only 17% were married (Thornicroft et al., 2004). Mental illness can be a cause and consequence of separation or divorce. According to Kposowa (2000), separation from the spouse negatively affects psychological well-being of the individuals; there is an increased risk of suicide among people who are divorced or separated. A British Household Panel Survey 1991–1998 shows that divorce can also delay recovery from mental illness, because there is a sudden loss of social support (Pevalin & Goldberg, 2003). In Southern India, Thara, Kamath, & Kumar (2003a) found that women with mental illness often fail to get justice in the process of marital separation. Due to the stigma of divorce and lack of economic resources, women are unable to be legally separated. Furthermore, they do not receive alimony. Even after years of separation, these women still harbour a hope that they might return to their marital house. Thara, Kamath, & Kumar (2003b) further found that the families of women who are separated or divorced because of their mental illness experience immense distress because they are worried about long-term future and security of these women and their children.

1.2.3 In property-related matters

Housing is a basic human need and right. But persons with mental illness are commonly discriminated against when they seek to buy property. In many instances, communities have resisted the de-institutionalization of persons with mental illness, especially when the latter were offered housing facilities in the community (Habermann, 2016; Pendall, 1999; Piat, 2000). Persons with mental illness commonly experience discrimination in the form of ‘Not in My Backyard’ (NIMBY) phenomenon, which symbolizes the tendency of people to avoid proximity with persons with mental illness. This is because such persons are perceived as dangerous and their presence is linked to a potential
devaluation of the residential property. A survey of service users with severe mental illness in the United States shows that 32% of the participants had experienced discrimination in housing matters, because they had psychiatric disabilities (Corrigan et al., 2003).

It is also important to note that the concept of property is not limited to buying a house or holding property in one’s name. The right becomes fully effective when the person is allowed to acquire the property, own it, enjoy it, and dispose of it as they see fit. That is, in order for persons with mental illness to realize the right to property, they need to be given equal rights to own property by succession, equal rights to enter into a contract to buy or sell property, and to dispose of the property by making a will. However, persons with mental illness often have to pass the scrutiny of being of sound mind to enter into a valid contract (Narayan & Shikha, 2013) when they buy or sell property. They also have to prove their testamentary capacity when they make a will (Shulman, Cohen, & Hull, 2005; Shulman, Cohen, Kirsh, Hull, & Champine, 2007). This is because their capacity to take decisions is constantly questioned. Unfortunately, little is known about how widespread the discrimination against persons with mental illness is in these areas.

1.2.4 In health care

Globally more than 650 million people are affected by mental illness (Vos et al., 2012). One in every four families is likely to have a member with mental illness of some kind (WHO, 2001, p. 19). But in high-income countries, such as in Europe and North America, the treatment gap for mental illness is as high as 74% (Alonso et al., 2004; Kessler et al., 2005; Wittchen & Jacobi, 2005). In low-income countries, the gap increases to 85% (Murthy, 2017; Wang et al., 2007). A review by Clement et al. (2015) shows that stigma of mental illness is one of the top five reasons that limit access of persons with mental illness to health services. Stigma at the individual level and public stigma of mental illness is commonly known to delay help seeking behaviour. In better-resourced countries such as the United States, there is a delay of one year between the manifestation of psychotic disorder and its assessment and treatment. For mood disorders, the waiting period is as long as eight years, and for anxiety disorders, up to nine years (Wang et al., 2005). In under-resourced settings, the waiting period is even longer (Thornicroft, 2006, p. 85). In addition, persons with mental illness face discrimination when they access health systems. Globally, over 70% of the young and adults with mental illness do not receive treatment from health staff (Thornicroft, 2008). Thornicroft explains that the mental health care gap exists because people are unaware of the symptoms of mental illness and that these can be treated. Health professionals, including psychiatrists, have negative attitudes towards persons with mental illness. And consequently, those who are diagnosed with mental illness avoid visiting mental health professionals because they anticipate fear and rejection. One survey of liaison psychiatry professionals found that the quality of care of persons with co-morbid mental illness at general hospitals is affected by number of factors (Noblett et al., 2017). These include diagnostic overshadowing (“a process by which physical symptoms are misattributed to mental illness” (Jones, Howard, & Thornicroft, 2008)), poor communication with patients, not respecting their dignity and delay in
investigation or treatment. Noblett et al. (2017) say that the stigmatizing attitudes of the hospital staff towards persons with co-morbid mental illness and complex diagnosis are the two most common contributing factors in the poor quality of care.

Taken together, it appears that the implications of stigma and discrimination are far-ranging. Even though stigma and discrimination co-exist, there are more complex factors that determine how stigma and discrimination due to mental illness will affect the lives of individuals. These factors include culture, gender roles, and the economic conditions of persons with mental illness and those around them. The presence of these factors makes the problem of stigma more complex. It intensifies the effect of discrimination. To cope with stigma and discrimination, it is first necessary to understand how widespread these are. Corrigan et al (2004) and Thornicroft (2006) say that one way to gauge the stigma of mental illness is to study discrimination. This is because discrimination is behavioural and can be measured. It can also be modified with the help of social standards and cultural norms. Thornicroft (2007, p.180-182) further says that models of stigma have been widely discussed in hundreds of research papers, but that most research has focused only on self-stigma and public stigma. This research has been descriptive in nature and has broadened our understanding of stigma. Yet, education based on models of self-stigma and public stigma has had limited success in bringing about a change in negative attitudes towards persons with mental illness and ending the discrimination against such persons. Moreover, Thornicroft says that theorists who discussed self-stigma and public stigma have rarely established relevance of these stigmatamodels with the disability policy, civil liberties and human rights issues. Hence, exploring self-stigma and public stigma have largely been ineffective in improving the living conditions of persons with mental illness. On the other hand, a number of authors have suggested that exploring structural stigma and structural discrimination can address these knowledge gaps (Corrigan et al., 2004; Pugh et al., 2015; Thornicroft, 2006, pp. 181–182). This is for two reasons. First, disability policies may directly benefit from the studies that explore structural discrimination against persons with mental illness. This is because structural discrimination in legislation is directly associated with the rights-based issues of persons with mental disabilities. Countries will be better equipped to include persons with mental illness if structural discrimination in the mainstream processes is eliminated. Second, discrimination is behavioural and can be controlled. Bilz & Nadler (2014, p. 1) assert that the main ambition of legislation is to modify the behaviour of human beings or institutions. Laws can increase or decrease occurrences of various activities through sanctions or rewards. Hence, the role of legislation becomes immensely important in promoting or curbing discrimination against persons with mental illness.

1.3 Model of stigma and discrimination

Stigma and discrimination can be seen as presenting two sides of the same coin. Stigma is a cognitive component which manifests as discriminatory behaviour. According to Goffman (1963, p.1) stigma is a discrediting attribute that reduces the status of the individual in society. Link & Phelan (2001) define stigma as “the co-occurrence of its components – labelling, stereotyping, separation, status loss, and discrimination”. This
definition considers the concept of stigma and discrimination as co-occurring. Although these definitions are significant, the one that is most influential to this research has been proposed by Corrigan et al. (Corrigan, Markowitz, & Watson, 2004; Corrigan & Watson, 2002). They identify three levels of stigma that people with mental illness experience – individual, intrapersonal and structural. Based on these levels, experiences of discrimination also vary.

At the individual or intrapersonal level, stigma of mental illness comprises negative stereotypes and prejudices towards oneself. Manifestation of self-stigma is seen in behaviour like avoidance and self-isolation (Corrigan & Watson, 2002). Here, the centre of the stigma and focus of discrimination is limited to the person.

At the interpersonal level, social or public stigma comprise negative stereotypes, prejudices and negative emotional reactions of society towards a group of persons with mental illness. Behavioural manifestations of social stigma occur during social interactions. It is seen in discriminatory behaviour towards the group of individuals based on their intrinsic and devaluing characteristics. For example, persons with schizophrenia are perceived as unpredictable and dangerous. Indiscriminate negative opinions against them lead to their social isolation (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Here, the centre of the stigma and focus of discrimination is limited to a group of persons with mental illness.

At a structural level, stigma can be observed in “the ways in which societal ideologies and institutions perpetuate or exacerbate a stigmatized status” (Corrigan & Lam (2007) cited in Bos, Pryor, Reeder, & Stutterheim, 2013). Social frameworks such as laws, policies, and cultural norms are some of the examples through which social ideologies are followed. These frameworks – “in both substance and process” – are a product of social deliberations and social cognition (Spellman & Schauer, 2013). Hence, social values, society’s stigmatic attitudes towards persons with mental illness, public understanding of contemporary models of disability (Dirth & Branscombe, 2017) and mental illness, are all reflected in these frameworks. Implementation of these frameworks is likely to result in structural discrimination against persons with mental illnesses in society. Structural discrimination refers to “the institutional practices and policies that work to the disadvantage of a stigmatized group even in the absence of individual discrimination” (Schomerus & Angermeyer, 2017). At this level, stigma is embedded in the structural frameworks such as laws, rules, and policies, but discrimination is faced by all persons with mental illness in the society. Due to its indirect focus, one may not always be able to locate who initiates structural stigma. This is because the sources of power (the stigmatizers) are distributed across wide range of groups in the society (Krupchanka & Thornicroft, 2017, p. 3). Structural discrimination occurs at the macro-social level. It is more systematic and planned than any other type of discrimination. It appears as if blanket protections have been used by the people to guard the best interests of individuals with mental illness. These protections often act as barriers to the exercise of freedom and rights of persons with mental illness. This thesis
is about structural discrimination against persons with mental illness. It explores how widespread the phenomenon is.

1.4 Why do we need to explore structural discrimination?

A socio-economic perspective illustrates why studies on structural stigma and structural discrimination are necessary.

Equality and inclusion go hand in hand. Equality in the laws and fairness in their implementation play a key role in the empowerment of minority groups. Policy measures such as affirmative action can facilitate the inclusion of minority groups into mainstream social processes. In such a scenario, if legislation restricts the access of minority groups such as persons with mental illness to development programmes, they are likely to be marginalized or even excluded from society. In the name of protecting the best interests of persons with mental illness, legal provisions may cause widespread human rights violations. Structural stigma and structural discrimination can, therefore, act as formidable macro-level barriers to the social inclusion of persons with mental illness. In addition, it is evident that mental illness, disability, poverty and social exclusion are interlinked (Funk, Drew, & Knapp, 2012; Lund et al., 2011; Patel & Kleinman, 2003; WHO & World Bank, 2011, p. 235). Annually, an economic output of more than US$16 trillion is lost because of poor mental health, unemployment and social exclusion, according to a report by the World Economic Forum (Thornicroft & Patel, 2014, p. 1). Hence, if structural discrimination against persons with mental illness is not urgently addressed, it is likely to delay the attainment of several of the Sustainable Development Goals (SDGs).

1.5 How can we study structural discrimination?

Research has under-explored approaches to understanding structural stigma and structural discrimination. Structural stigma is difficult to assess because of its indirect nature and vast attitudinal component, but structural discrimination is behavioural and is therefore measurable. Structural stigma and structural discrimination towards persons with mental illness have rarely been researched (Corrigan et al., 2005, 2004a; Pugh et al., 2015; Thornicroft, 2006, p. 181). A review of empirical studies on measuring stigma of mental illness shows that between 1995 and 2003, only two studies had empirically explored structural stigma (Link, Yang, Phelan, & Collins, 2004). This is probably because to assess structural stigma and structural discrimination, it is necessary to explore a wide array of socio-economic factors. Corrigan et al. (2004) and Pugh et al. (2015) say that one way to operationalize structural stigma of mental illness is by understanding and measuring structural discrimination in the laws and policies that regulate the lives of persons with mental illness. This is because structural stigma of mental illness is likely to be reflected in unequal and unjust legal provisions.
These provisions may arbitrarily restrict rights of individuals with mental illness, the only rationale for which could be the presumption of incapacity. Restriction of human rights on the grounds of mental illness/disability is discriminatory, and its occurrence in legislation can be objectively assessed.

Legal discrimination can be assessed in terms of “any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation” (UNGA, 2007, p. 4). Such occurrences are quantifiable. Hence, by analysing laws, we can also understand the magnitude of structural stigma and structural discrimination.

This thesis aims to quantify structural discrimination against persons with mental illness. It is divided into four parts. Each part deals with structural discrimination in one important domain of life. For every human being, these domains are necessary to lead a dignified life. Hence, structural discrimination in these areas may violate the human rights of persons with mental illness and delay their social inclusion. The four important domains studied in this thesis are as follows:

1. Employment of persons with mental illness
2. Marriage of persons with mental illness
3. Property of persons with mental illness
4. Health of persons with mental illness

In each of the four domains, the realization of one or more of the human rights is necessary. The human rights included in these domains are i) right to work and employment; ii) right to marry and remain married; iii) right to inherit property, right to enter into a contract to purchase or sell property, right to make a will; and iv) right to mental health care. In addition to these rights, the right to non-discrimination and the right to equality before the law are of prime significance for persons with mental illness.

Facilitating a realization of the above-listed human rights is the duty of the state’s legislative and policy framework. Domestic laws, rules, policies are required to protect and promote human rights of persons with mental illness if a country has obligations under international human rights law.

Of the four rights mentioned above, the right to work and employment has been widely debated in the context of the Americans with Disabilities Act, 1990 and the Disabilities Discrimination Act, 1995 of the United Kingdom. Several academics have highlighted
structural discrimination in these laws against persons with mental illness (Acemoglu & Angrist, 1998; ADA National Network, 2013; Bell & Heitmueller, 2009; Roulstone & Warren, 2006; Scheid, 2005; Stefan, 2000). The impact of the disability civil rights movements is evident in the work of disability rights activists and academics in these countries. However, the disability legislation, employment legislation, and human rights legislation in low- and middle-income countries have been rarely explored using the CPRD’s rights-based perspective. In the same way, structural discrimination in the matters of marriage and divorce, inheritance of property, right to contract, capacity to make a will has been little researched. Researchers have not used the rights-based approach of the CRPD to understand structural discrimination against persons with mental illness in the given areas. Rather, academics have debated issues of guardianship and assessment of capacity in these contexts (Hasson, 2009; Okai et al., 2007; Shulman et al., 2007). Structural discrimination in mental health legislation has been empirically explored in Commonwealth Member States (Fistein, Holland, Clare, & Gunn, 2009; Priebe et al., 2005). But these reviews have focused only on involuntary treatment and institutionalization of persons with mental illness. Other aspects of the right to mental health care, such as accessible, affordable care, have been rarely explored systematically. Moreover, the Commonwealth review assessed provisions of mental health legislation using the framework of the Universal Declaration of Human Rights (UDHR). It is to be noted here that CRPD offers the most comprehensive protection of human rights of persons with mental illness of all the international human rights treaties. Hence, any assessment of structural discrimination against persons with mental illness also needs to follow the CRPD rights-based approach. The present thesis aims to address this knowledge gap.

The purpose of this research is to assess structural discrimination in the matters of employment, marriage, property and mental health care using the CPRD framework. In addition, it focuses on exploring the implementation of marriage laws. The research also identifies social barriers to the employment of persons with mental illness. Its scope includes both national and international levels. That is, structural discrimination in employment, marriage, property has been explored in 193 United Nations Member States. Structural discrimination regarding the right to mental health care is explored in 45 Commonwealth Member States. Implementation of marriage laws is studied at the national level (India). The social barriers to employment of persons with mental illness are explored at the state (province) level of Gujarat (India).

Based on the significance of studying structural discrimination against persons with mental illness and review of literature, it was hypothesized that:

*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 violations of human rights. Structural discrimination would ultimately prevent the social inclusion of persons with mental illness.*
Based on this hypothesis, main research question of this thesis was formulated as:

*What are the legal and social barriers that lead to structural discrimination against persons with mental illness and prevent their inclusion in society?*
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Chapter 2. Theoretical Framework

This chapter presents concepts that illustrate structural stigma and structural discrimination. The chapter is divided into two parts. The first part discusses the international framework of human rights in the context of right to equality and non-discrimination, right to work and employment, right to marry, right to property and right to mental health care. In the second part, relevant theories of stigma and discrimination are discussed. These include theories that explain the processes of development of the stigma, components of stigma, types of stigma, levels of stigma, and manifestation of stigma – that is, discrimination. Along with each theory, its relevance to the international framework of human rights and structural discrimination is also discussed.

2.1 International Framework of Human Rights

2.1.1 The International Bill of Human Rights

The International Bill of Human Rights comprises the Universal Declaration of Human Rights (UDHR), the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights. The Bill has strongly upheld the realization of rights for every human being. Persons with mental illness are no an exception. In this section, we will briefly see how the International Bill of Human Rights addresses structural discrimination in relation to persons with mental illness.

The Universal Declaration of Human Rights (UDHR)

The United Nations General Assembly adopted the UDHR in 1948. It is the first of the three documents which make up the International Bill of Human Rights. The UDHR is a milestone in protecting and promoting the rights of every human being. Article 1 of the UDHR states that “All human beings are born free and equal in dignity and rights”. This Article recognizes that all persons including persons with mental illness have equal dignity and rights. The Article further elaborates that “They [all human beings] are endowed with reason and conscience and should act towards one another in a spirit of brotherhood”. Based on this framework, persons with mental illness also have “reason and conscience” to take decisions about their lives. This is primarily because they are human beings.
Article 2 of UDHR clarifies that everyone, including persons with mental illness, is an equal rights holder:

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (emphasis added). Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty. (UNGA, 1948, p. 6).

Based on this principle, people or nations cannot discriminate against persons with mental illness on the basis of their other status as ‘persons with disabilities’. Further, Article 6 of the Declaration iterates that everyone (including persons with mental illness) is equal before the law in every sphere of life.

Everyone has the right to recognition everywhere as a person before the law. (UNGA, 1948, p. 14)

The concept of ‘equal recognition before the law’ lies at the heart of prevention and elimination of structural discrimination against persons with mental illness. Structural discrimination occurs when domestic laws deny equal treatment to persons with mental illness; when the treatment is not at par with those who do not have mental illness. Historically, stigmatized groups have received inferior treatment in domestic laws (Mallory, Brown, Russell, & Sears, 2017, pp. 1–7; Marks, 2006). Inferior treatment in legislation diminishes the personhood of individuals. Essence of personhood lies in the autonomy of a human being. Decision-making power is central to the autonomy of a person. Article 6 of the UDHR rightly encapsulates the essence of the personhood of human beings – their autonomy. The Article recognizes the decision-making power of every individual, including persons with mental illness. Because of the right to equal recognition before law, others cannot make decisions about the lives of persons with mental illness.

The International Covenant on Economic, Social and Cultural Rights (ICESCR)

The United Nations General Assembly adopted the ICESCR in 1966. It is the second component of the International Bill of Human Rights. The Covenant recognizes the economic, social and cultural human rights of everyone in order to live a dignified life (UNGA, 1966). Article 1 of the Covenant says that everyone has a right to self-determination. By the virtue of this right, everyone, including a person with mental illness, has right to determine how they should earn money, or whether they should marry, buy or sell property.
All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development. (UNGA, 1966, p. 1)

Further, Article 2 of the Covenant requires the State Parties to guarantee that they will facilitate the exercise of economic, social and cultural rights without discriminating against individuals on the basis of their ‘other status’. The Covenant does not address rights of persons with mental illness/disabilities per se. However, General Comment No. 5 adopted by the Committee on Economic, Social and Cultural Rights (1994) states that persons with mental illness are equal rights holders (paragraphs 3 and 5). The Committee says that States Party to the Covenant are required “to legislate where necessary and to eliminate any existing discriminatory legislation” in order to uphold the rights of persons with mental illness (paragraph 13). To eliminate this discrimination and to refrain from discrimination against persons with mental illness in the future, comprehensive anti-discrimination laws are necessary in virtually all Member States (paragraph 16). With this obligation, the State Parties are required to prohibit legal discrimination against persons with mental illness. Thus, in line with the Article 6 of the UDHR, Article 2 of the ICESCR also gives a strong reason why structural discrimination against persons with mental illness must be eliminated.

*The International Covenant on Civil and Political Rights (ICCPR)*

The United Nations General Assembly also adopted the ICCPR in 1966. It is the third component of the International Bill of Human Rights. This Covenant recognizes the civil and political rights of everyone, including the right to self-determination (Article 1), right to equal recognition before the law (Article 16), and right to non-discrimination on the basis of “other status” such as “persons with disabilities” (Article 2).

2.1.2 UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles)

The General Assembly of United Nations adopted MI Principles by a resolution in 1991. The Principles aimed to protect persons with mental illness by improving their mental health care. They frame fundamental freedoms and basic rights of persons with mental illness. These include the right to best available mental health care, treatment with humanity, and respect and dignity of the person. The MI Principles also offered protection of civil, political, economic and cultural rights. They protected persons with mental illness from economic and other forms of exploitation. However, MI principles were criticized for following a medical model of disability (Rosenthal & Rubenstein, 1993). The MI Principles clearly denied legal capacity to persons with mental illness on account of their mental illness (Principle 1.6). They allowed substituted decision-making to protect the best interests of persons with mental illness (Principle 1.7).
2.1.3 The United Nations Convention on the Rights of Persons with Disabilities (CRPD)

The United Nations General Assembly adopted the CRPD in 2006 and it has been ratified by 174 countries (Division of Social Policy and Development - Disability, United Nations, 2017). In the pre-CRPD era, the International Bill of Human Rights protected the civil liberties of every human being. Within a decade, it was realized that persons with disabilities could not directly access the protections of this framework. This was because the ICESCR and ICCPR did not explicitly mention persons with disabilities as equal rights holders (Committee on Economic, Social and Cultural Rights, 1994). The General Assembly addressed this gap by adopting the most dedicated, most comprehensive human rights standard for persons with disabilities, that is the CRPD.

Principles of the CRPD are based on a social model of disability. The Convention does not define persons with mental disabilities but the term “persons with disabilities” includes persons with mental illness. It says:

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. (UNGA, 2007, p. 4)

By this definition, countries that have ratified the CRPD have an obligation to recognize persons with mental illness as persons with disabilities.

Further, in the context of structural discrimination, Article 4 of the CRPD is of immense significance. It is a guiding principle to curb structural discrimination in legal frameworks:

States Parties undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability. To this end, States Parties undertake:
(a) To adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention;
(b) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities;
(c) To take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes;
(d) To refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention;
(e) To take all appropriate measures to eliminate discrimination on the basis of disability by any person, organization or private enterprise; (UNGA, 2007, pp. 4–5)

This Article expressly frames the obligation to end legal discrimination against persons with mental illness. If the States Parties are implementing archaic laws to regulate lives of persons with mental illness, they must modify or abolish such laws. The Convention alerts public and private authorities to refrain from all discriminatory practices.

The Convention further upholds principles of equality before the law and non-discrimination in Article 5:

States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.

Article 12 reassures that persons with mental disabilities have the right to equal recognition before the law:

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

Equal recognition before the law goes hand in hand with the exercise of legal capacity. Article 12 confirms that persons with mental illness are equal before the law and have sovereign power to take decisions about their lives. This is true even if the symptoms of mental illness worsen. The Committee on the Rights of Persons with Disabilities issued a General Comment on Article 12 of the CRPD. In this comment, the Committee clarified that mental capacity and legal capacity are inherently different. Mental capacity refers to decision-making ability. It may vary from person to person. But legal capacity is inherent to adult human beings because of their personhood. Hence, alterations in mental capacity because of mental illness cannot affect legal capacity. The Convention condemns the use of substituted decision-making. Instead, it promotes use of autonomous or supported decision-making to exercise legal capacity. It says that the States Parties should avail measures to facilitate supported decision making, where wills and preferences of persons with mental illness are followed. Under this paradigm, countries can promote the use of supported decision-making models such personal
directives or psychiatric advance directives through legal frameworks. Recognition of the legal capacity of persons with mental illness is of paramount significance especially in the context of domestic laws worldwide. This is because, contrary to the case of other adult human beings, there is a presumption of legal incapacity in the laws in case of persons with mental illness and those with intellectual disabilities (Dhanda & Narayan, 2007). Such recognition highlights that persons with mental illness do not have the right to self-determination. Realization of their personal choices needs the approval of their carers, guardians or custodians. Denial of legal capacity is fundamentally discriminatory and violates the realization of human rights in multiple spheres of life. For example, if legal capacity is denied to a person with mental illness, that person concerned does not have choice to determine whether to receive treatment in a psychiatric institution or living in the community, what type of treatment should be received, whether to give consent to the treatment. The person cannot voluntarily make a decision about whether to marry, found a family, work, have bank account, buy or sell property. Whenever individuals are subject to formal and legal procedures or contracts, they must prove that they have the capacity to understand the information, appreciate its consequences, logically assess the options that are available and express their choices. Such examination and approval is not expected from the adult human beings who do not have mental or intellectual disabilities (Dhanda & Narayan, 2007; Ryan & Deci, 2000).

The Committee further raises a concern that derogatory labels such as “unsoundness of mind” are often used to restrict exercise of legal capacity of persons with mental illness (paragraph 12). Unsoundness of mind is not a medical term but is often used in laws and legal practices to denote mental illness. The Committee alerts the State Parties to refrain from using such labels to deny legal capacity to the persons with mental illness. Further, the Committee recommends that State Parties must “holistically examine all areas of law” to ensure that laws do not put unequal restrictions on the legal capacity of persons with mental illness (Committee on the Rights of Persons with Disabilities, 2014, p. 2). This recommendation reinforces the need to abolish structural discrimination that is embodied in laws.

However, user activists have criticized the Convention and the General Comment for not addressing common concerns that specifically relate to persons with mental illness. Bartlett (2012) says that Article 12 of the Convention does not demarcate mental capacity and legal capacity. The Article recognizes the interdependence of persons with disabilities (including those with mental disabilities) with the others (Dhanda, 2008), but does not provide guidance on implementation of the provision. In turn, laws of countries across the world remain “oppressive” (Bartlett, 2012). Activists say that there is internal inconsistency in the CRPD regarding which right prevails over the other. For example, whether the right to refuse involuntary treatment should be given preference over the right to be included in the community is unclear, and the Comment does not provide direction on this issue (Pozón, 2016). Further, the Convention and the Comment make it clear that the “will and preference” principle must prevail over the “best interest” principle in taking a decision. But, if it is not practicable to know the will and
preference (for example, when the person is in coma), the decision must be taken without consent by following “best interpretation of will and preference” principle (paragraph 18bis). Critics say that the Comment does not provide guidance on “what counts as an advantage or a disadvantage for the person” if a decision is to be taken by the people other than the closest ones (Pozón, 2016), or in situations where the individual has been long institutionalized and has no connection with others who can provide the support (Gooding, 2015). The General Comment further states that the States must provide safeguard against “undue influence” while exercising the legal capacity with the help of supported decision-making tools. Gooding says that in everyday life all adults are subject to influence, pressure and subtle coercion by those who are close to them. While using the tools for supported decision-making, it is therefore difficult to draw the line between “undue influence” and “manipulation” by the state or its representatives in the case of persons with mental illness. This is because what constitutes “undue influence” is adequately clarified in the Comment. Furthermore, the Comment rejects the functional approach to understanding the capacity, but its critics say that it is necessary to determine entitlement to additional support for exercising legal capacity (Dawson, 2015). Another common critique of the CRPD is that the definition of persons with disabilities set out in Article 1 includes persons with long-term mental impairments as persons with disabilities, and is likely to discriminate against persons who have short-term illnesses such as brief psychotic episodes (Pozón, 2016).

In low and middle-income countries and in a patriarchal society like India’s, the presumption of legal incapacity of persons with mental illness in domestic law poses a grave risk of human rights violations. For instance, these individuals could be denied the right to live in the community. Families could institutionalize women and elderly people with mental illness for years, by using the provisions of involuntary admissions. These individuals could be denied the right to voluntary discharge. Archaic mental health laws may not grant access to supported decision-making models such as advance directives, or ombudsman’s assistance in making decisions about their health care. Plenary guardianship provisions, such as the one in The Multiple Disabilities Act, 1999 of India, could be used to deny the involvement of persons with mental and intellectual disabilities in property-related matters (Brijesh Kumar Agrawal Vs. Rakesh Kumar And Others, 2012) and financial matters such as banking or accessing a pension (Reserve Bank of India, 2008, 2014). These individuals could be denied political rights, thereby denying them full citizenship (Bhugra et al., 2016). A woman who has mental illness (“a lunatic”) would need consent of the guardian to have an abortion (Rastogi & Yadav, 2010).

This section has presented various provisions of international human rights law that underpin a move towards ending structural discrimination against persons with mental illness. Hereafter, a framework of rights that are explored in this thesis is presented. Each right listed is discussed only in the context of the CRPD, which offers most comprehensive framework of rights of persons with disabilities compared to the ICESCR or different Conventions of the International Labour Organization (ILO).
1. Right to work and employment: This right is enshrined most comprehensively in Article 27 of the CRPD. To prevent structural discrimination in matters of employment, domestic laws need to include explicit provisions that uphold the principles of Article 27. These include prohibition of discrimination in recruitment advertisements, eligibility criteria and selection procedures. Laws need to clearly direct employers on framing policies of medical and psychiatric examinations before selection. Laws should mandate employers to give information about working conditions prior to accepting a job offer, as well as the allocation of positions and responsibilities. Laws should uphold provisions about assisting unemployed persons with mental illness to find employment. To promote continuance of employment, laws need to include job retention and return-to-work measures. The right to equal opportunities in career advancements, training and promotion should be framed in the law. Equal remuneration for equal value of work, just and favourable conditions of work, and a safe and healthy working environment should be explicitly promoted. Prohibiting suspension, dismissal or termination of the employment contract on the basis of mental disability, and protection from harassment and redress of grievances, have to be framed in law. Failure to provide reasonable accommodation at workplace for persons with disabilities leads to discrimination (UNGA, 2007, p. 4). Hence, laws need to mandate employers to adopt necessary and appropriate modifications and adjustments at the workplace. In addition, employment laws also need to ensure that persons with mental illness or disabilities have right to form and join trade unions, so that all workers’ interests are protected. As an obligation under Article 27 of the CRPD, countries need to promote employment of persons with disabilities by designing policies and measures that include affirmative action, and incentives for private employers in order to redress disparities in participation of persons with mental disabilities in a competitive labour market.

2. Right to marry and remain married: In order to avoid structural discrimination in marital issues concerning persons with mental illness, domestic laws of CPRD ratifying States should explicitly prohibit discrimination on the basis of mental illness. Discrimination in marital laws may occur in several ways. A report by Law Commission of India (1974) and Sharma, Pandit, Pathak, & Sharma (2013) show that laws do not allow persons with mental illness to marry. If they marry, laws may recognize such marriages as ‘void ab initio’. Laws may nullify the consent of an individual who has mental illness at the time of marriage, and allow the annulment of such marriages (Dhanda, 2000, p. 184). Such legal provisions violate the rights of persons with mental illness under Articles 4, 12 and 23 of the CRPD. Further, if one spouse has mental illness, and it is difficult for the other to stay with him/her because of this, laws may allow the dissolution of the marriage (Nambi, 2005). Such provisions are discriminatory towards persons with mental illness since the mental health condition is not being treated equally with other physical health conditions. Similarly, marital laws may structurally discriminate against persons with mental illness by limiting their marital rights. For example, laws may demand proof of capacity to be given by a Court. Legislation may mandate the permission of guardians or psychiatrists before marrying (Sharma, Pandit, Pathak, & Sharma, 2013b). Such provisions of marital laws violate the principles of Article 12 of the CRPD.
3. Right to inherit property, right to enter into a contract to purchase or sell property, right to make a will: For persons with mental disabilities, these rights are enshrined in the principles of Article 12 (5) of the CRPD:

Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property. (UNGA, 2007, p. 11)

Here, structural discrimination may occur if laws presume that persons with mental illness lack the capacity to enter into a contract or their capacity is limited. In the case of presumption of limited capacity, laws may mandate the appointment of a guardian or legal representative. Such provisions deny persons with mental illness an equal recognition before the law. They violate principles of Article 12 of the CRPD. Further, laws may also deny testamentary capacity to persons with mental illness, in which case they may invalidate the will. Laws may also restrict inheritance of property if one has mental illness. In all these cases, laws perpetuate structural discrimination against persons with mental illness.

4. Right to mental health care: To prohibit structural discrimination in the matters of right to mental health care, the mental health legislation needs to comply with several principles of the CRPD. Some examples of these provisions are as follows:

1. Article 12 (equal recognition before the law) – e.g. mental health legislation recognizes access to supported decision-making tools such as psychiatric advance directives, so that persons with mental illness can exercise their legal capacity;

2. Article 13 (Access to justice) – e.g. mental health legislation mandates that a person with mental illness, (who is a subject of guardianship) shall remain present and/or be represented at the hearing of guardianship order;

3. Article 14 (Liberty and security of a person) – e.g. mental health legislation specifies that persons with mental illness are not denied liberty during hospital admissions merely on the basis of their mental illness;

4. Article 15 (Freedom from torture or cruel, inhuman or degrading treatment or punishment) – e.g. mental health legislation explicitly prohibits torture, cruel, inhuman and degrading treatment; laws mandate treatment with dignity and respect, and that persons with mental illness be treated in humane way; laws mandate informed consent before all admissions, treatment and participation in research;

5. Article 16 (Freedom from exploitation, violence and abuse) – e.g. mental health legislation sets up a regulatory and oversight body to protect the rights of persons with mental illness within and outside mental health facilities;
6. Article 19 (Living independently and being included in the community) – e.g. mental health legislation mandates that mental health care be provided within the community settings, thereby promoting deinstitutionalization;

7. Article 22 (Respect for privacy) – e.g. mental health legislation respects the privacy of persons with mental illness; laws protect the confidentiality regarding persons with mental illness and their diagnosis; laws impose sanctions and penalties on those who breach the privacy and confidentiality of the persons with mental illness;

8. Article 25 (Health) – e.g. mental health legislation mandates that care should be provided at par with other physical illness, be affordable, accessible and available to persons with mental illness;

9. Article 26 (Habilitation and rehabilitation) - e.g. mental health legislation promotes rehabilitative psychosocial approaches.

Having considered the international framework of human rights, hereafter, theories of structural stigma and discrimination are presented. Along with each theoretical perspective, the relevance of the rights-based approach with the theory of stigma and discrimination is also discussed.

**2.2. Theories of stigma and discrimination**

**2.2.1 The social interaction theory**

Sociologist Erving Goffman pioneered the work on conceptualizing stigma, which he explained through social interactionist theory. In *Stigma – Notes on the Management of Spoiled Identity*, Goffman suggests that it was the Ancient Greeks who first conceptualized stigma. They used bodily signs such as cuts or burns to advertise a traitor, a criminal or a slave. The presence of these signs on the body symbolized something unusual, something bad about the person. Those who had such signs were considered as blemished, ritually polluted, and were to be avoided in public places (Goffman, 1963, p. 1).

According to Goffman, stigma is deeply discrediting. It arises when there is an undesirable gap between what is expected of a person (virtual social identity) and what the person actually is (actual social identity). The person who bears such attributes is perceived as less of a person. There is an “undesired differentness” from the “normal” (p.5). Goffman clarifies that “The normal and the stigmatized are not persons, but rather perspectives” (p.138). But, due to stigmatic attributes, the person’s desirability is reduced and their social identity is extremely tainted. The person becomes “quite thoroughly bad, or dangerous, or weak”, their presence disregarded. To avoid segregation, the individual may hide the stigmatizing condition – thus confirming the feeling of inferiority (p.2).
Goffman adds that “we believe the person with a stigma is not quite human. On this assumption, we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances” (p.3). Thereby, we develop a theory of stigma that explains inferiority and dangerousness. Without much cognizance, we start using stigmatizing labels as metaphors in our day to day life (p.3). A person’s defensive response about their condition such as disability is construed as an expression of the disability. Goffman further says that persons with stigmatizing condition may perceive themselves as normal. Yet these persons are correctly aware that others do not consider them as normal. Others do not accept these persons as they are, and are reluctant to establish contact with them on ‘equal grounds’. At this stage, individuals internalize shame by thinking they fall short of expectations (p.5). Goffman thinks that individuals with stigmatizing attributes and normal human beings try to avoid each other when they are in same social situation. The individuals may also show bravado or anticipatory cowering (p.17-19). There is anxiety on both sides, but there is a fear of disrespect from normal individuals. Avoidance of persons with a stigma is of concern, because it reduces individual social interactions. Stigma thus becomes a public mark, a product of public interactions.

Goffman’s social interaction theory has direct relevance to the rights-based perspectives upheld in international human rights law. Articles 2 and 6 of the UDHR, Article 1 of the ICESCR and ICCPR, and Article 12 of the CRPD have strongly upheld the right to equality. It is this right that has the inherent potential to address the stigma of mental illness that Goffman explains. When persons with mental illness are recognized equally before the law, their discrediting attributes become secondary. At a fundamental level, they gain the same rights and freedoms as any other citizen. Thus, negative social attributes can no longer be as effective as they were previously. Their impact (discrimination) is likely to be mitigated to some extent.

When a country ratifies a treaty like the CRPD, based on ethical, moral, legal principles, the state cannot deny freedom and rights to persons with mental illness. Even if the persons’ social identity is tainted because of mental illness, or if their desirability is reduced, laws cannot disrespect them on the basis of public opinion. The stigmatizing attributes then play only a limited role. A recent precedent in India explains this phenomenon in a simpler way. Like everywhere in the world, the transgender community faces high levels of stigma and discrimination in India. Before 2016, only 20% of transgender people could marry. Their marriages were informal and not legal. They engaged in ‘begging’ to earn a living because they would be denied employment opportunities. They had high prevalence of depressive spectrum disorders and alcoholism, but limited access to mental health care (Bharat, 2011; Garg & Singh, 2013; Kalra & Shah, 2013). In 2016, the Indian Constitution recognized their equality before the law. Now they have equal fundamental rights. Their right to vote and to work in mainstream employment is protected by law. Their marriage is now legally recognized. They can adopt children. Thus, even if public opinion towards transgender persons and persons with mental illness are currently different (comprising negative attitudes), laws have the potential to diminish the impact of negative attitudes in day-to-day life. The “undesired differentness” (Goffman, 1963, p. 5) of persons with mental illness need not
be a reason to deny them a life of dignity. Laws can achieve this by prohibiting discrimination.

Furthermore, equal recognition before the law implies that the persons have legal capacity and a right to exercise it. When a law recognizes persons with mental illness on an equal basis with others, their personhood is restored. They have equal opportunities to earn a living, to marry, and to be contributing members of the community.

2.2.2. The labelling theory

The labelling theory further expanded contemporary understanding of the stigma during the 1960s and 1970s. In *Outsider*, Howard Becker (1966) said that majorities tend to negatively label minorities who deviate from the cultural norms. The majorities are the social groups who have economic and political power. They work in coordinated associations. They act as guardians of the moral order. They define rules, and ‘outsiders’ (who do not have power) are required to follow these rules. Deviance occurs when minorities do not behave in a way that is expected of them. A behaviour is termed as ‘deviant’ when it does not fulfil the best interest of the majorities. Becker says that persons are not inherently ‘deviant’. Their deviance may be unintentional. But it is the tendency of majorities to give stigmatizing labels to minorities to regulate their behaviour. Becker further clarifies that there is fundamental difference between rule-breaking and ‘deviant’ behaviour. Deviance may not always result in an offence. Lemert (1973) added that labelling has a serious implication. There occurs change in self-concept; from being normal, the person becomes ‘deviant’. Others perceive the person as having stigmatic attributes.

Becker’s explanation of deviance gives us an insight into why laws discriminate against persons with mental illness. According to Becker, deviance is a product of mental illness (Becker, 2008, p. 5). It is a deviance from cultural expectations and from acceptable standards of behaviour. By this analogy, persons with mental illness are to be labelled “deviants – the outsiders”. Such labelling results in the loss of their self-esteem.

According to Becker, majorities define laws and rules to regulate the behaviour of ‘deviants’. In defining laws and rules, legal provisions are framed in a way that restricts the rights and freedoms of ‘deviants’ (persons with mental illness) and protects the interests of the majorities. In the case of persons with mental illness, the majorities comprise service providers (psychiatrists, clinicians, nursing staff), carers, guardians and state authorities. These individuals or parties hold social and political power in a day-to-day relationship with persons with mental illness, while the latter are at the receiving end of this power dynamic. Hence, according to Becker’s perspective, laws regulating the lives of persons with mental illness are framed in such a way that maintains the superiority of service providers, carers, and state authorities and protects their
interests. Persons with mental illness are indirectly forced to comply with the cultural, behavioural standards set by the majorities.

In addition, Becker says that majorities work in coordinated association. So, laws are also framed such that coordinated associations of majorities are built and protected. Using this analogy in the context of mental illness, it can be further said that service providers, carers, guardians and state authorities tend work in symbiotic relationships, by concentrating power on their side. These relationships are legally protected. To maintain coordinated association, laws are framed in such a way that multiple domains of lives of persons with mental illness are regulated simultaneously. Such restrictions are likely to result in discrimination against these individuals, and to initiate the process of institutionalization.

Examples of this phenomenon can be seen in laws regarding voting, mental health, guardianship, marriage and adoption, and property. In these domains, the rights of persons with mental illness are commonly restricted so that they do not violate the social standards, for example by marrying or parenting a child. By using guardianship provisions, service providers and carers can continue to institutionalize persons with mental illness.

Moving further, in relation to persons with mental illness, Thoman Scheff (1966) argues that deviations from social norms are considered as symptoms of mental illness. Once a label of mental illness is ascribed to individuals, society perceives them differently. The stereotyping imageries related to persons with mental illness (e.g. ‘nuts’, ‘crazy’) are commonly used in social interactions. Disturbing behaviour is associated with these terms. The person constantly receives negative social reactions, to the extent that they internalize these labels and accept the role of mentally ill. For Scheff, chronic mental illness is a social role assigned to the individual. Hospitalization of persons with mental illness further confirms these roles. These persons are forced to go through a process of social degradation and social exclusion. These processes are irreversible. In 1970, labelling theory was largely criticized for lack of empirical evidence. Gove (1982) emphasized that mental illness was a medical condition and that ‘deviant’ behaviours were symptoms of sickness which could be explained by medical models of psychopathology. He further added that a “vast majority of mental patients’ stigma appears to be transitory and does not appear to pose a severe problem” (p.282).

In 1989, Link and colleagues presented a modern labelling theory that suggests that even if labelling does not cause mental illness, it has negative outcomes for an individual. They explain the process of stigmatization as follows:

Our approach asserts that socialization leads individuals to develop a set of beliefs about how most people treat mental patients. When individuals
enter treatment, these beliefs take on new meaning. The more patients believe that they will be devalued and discriminated against, the more they feel threatened by interacting with others. They may keep their treatment a secret, try to educate others about their situation, or withdraw from social contacts that they perceive as potentially rejecting. Such strategies can lead to negative consequences for social support networks, jobs, and self-esteem. (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989)

Modern labelling theory also relates to the human-rights-based perspective of the CRPD. In the General Comment No. 5, the Committee on Human Rights of Persons with Disabilities said that countries should not use discriminatory labels such as unsoundness of mind to deny legal capacity to persons with mental illness. If such labels are used in laws, countries need to abolish or modify such legislation. This is because derogatory labels lead to negative outcomes in the lives of persons with mental illness. They are likely to perpetuate stigma of mental illness. Given this, if laws use such labels, the stigma of mental illness becomes widespread. To prevent this, laws should not use derogatory labels to denote persons with mental illness.

2.2.3 Social Model of Disability and Rights-based Approach

Although modern labelling theory presented a more comprehensive explanation of the process of stigmatization, in 1990 Mike Oliver argued that researchers over-emphasize cognitive processes of labelling, categorization and stereotyping. The overt consequence of such processes – ‘discrimination’ – has been largely underexplored. It has very prominent influence on the lives of minorities such as persons with disabilities. According to social theorists, including Mike Oliver, the loss of sensory, physical or mental functioning results in ‘impairment’. But discrimination in the form of denying appropriate accommodation to people who are disadvantaged results in disablement (Oliver (1990, 1996a) and Barnes (1991, 1999), cited in Anastasiou & Kauffman (2013)). According to Barnes (1991), disadvantaged people have limited opportunities to participate in the community on an equal basis with others. They often face physical and social barriers. This phenomenon sustains the marginalization of individuals with impairments. The social model of disability also brought to our understanding that individuals can avoid the negative impact of bodily impairments provided that society accommodates diversity. That is, if society adapts itself to include persons with impairments, the problem of their exclusion can be prevented. The social model of disability shaped the CRPD framework, which places the onus of creating an inclusive society on the State Authorities.

2.2.4 The “ism” of mental disability

In 1993, a US lawyer, Michael Perlin, proposed that ‘well-meaning’ citizens tend to disapprove of the incidence of racism, sexism, religious oppression (prevailing forms of
prejudices, “isms”) quickly and correctly. But they are often silent when persons with mental disabilities are the targets of the ism (Perlin, 1992). Perlin says that Sanism is a prejudice of “same quality and character” as that of racism, sexism and religious bigotry. It is as “insidious” as other forms of ism, but is more problematic because it is invisible and socially acceptable. Liberals, progressive and respectable individuals, who often decry other forms of ism, consciously or unconsciously practise sanism in public. According to Perlin, sanism is based on myths, superstitions, and stereotypes about a group of individuals with mental disabilities who deviate from the standards of majoritarians. Persons with mental illness may be perceived as “different”, “dangerous and frightening” and “presumptively incompetent to participate in ‘normal’ activities, to make autonomous decisions about their lives (especially in areas involving medical care), and to participate in the political arena” (p. 394). Sanism leads to dichotomous polarization (us versus them), where the group of persons with mental disabilities is perceived as morally weak, and the judicial system offers no remedy for their problems. In turn, the group faces discrimination in the laws and their application. Judges may ignore the voices of persons with mental disabilities and neglect their perspectives (p.387). Stefan (2000) has given a more detailed account of the discrimination against persons with mental illness in judicial processes. The author says that even courts seem to have held stereotypes against persons with psychiatric disabilities. In the ten years’ history of the Americans with Disabilities Act, 1991, courts have dismissed several cases, by finding that plaintiff’s mental illness does not meet the definition of disability; without giving due consideration to the plaintiff’s situation; by refusing plaintiffs with psychiatric disabilities to exercise their unqualified rights under the Federal Rules of Civil Procedures. This has resulted in insulating employers from judicial reviews for their stereotypical and illegitimate actions (p.276). Stefan says that primary reasons for discrimination against persons with psychiatric disabilities have been fear, shame and uneasiness and not their limitations in major life activities (p. 273).

2.2.5 Social-Cognitive Model

Patrick Corrigan was another theorist who presented a link between stigma and discrimination, presenting a social-cognitive model of stigma in 2000. According to this model, the symptoms of mental illness may give signals to the public. These signals activate stereotypes about persons with mental illness, and stereotypes lead to discrimination (Corrigan, 2000).
According to Corrigan & Watson (2002), stigma of mental illness functions at three levels. At the individual level (self-stigma), a person may perceive symptoms of mental illness as a weakness. Once an individual accepts this belief, their self-esteem changes. This ultimately translates into self-isolating behaviour. Similarly, at the public level, labels associated with mental illness are active in social cognition. Exposure of the public to symptoms of mental illness may confirm agreement with those labels. Thus, persons with mental illness are stereotyped. Stereotypes lead to discriminatory behaviour such as denying employment.

Figure 2: Similarities and differences between definitions of public stigma and self-stigma Source: Corrigan & Watson (2002)
Lately, along with other theorists, Corrigan has discussed stigma at the structural level (Corrigan et al., 2005; Corrigan, Markowitz, & Watson, 2004b). He says that social frameworks such as cultural norms, laws, rules and policies are influenced by stigma in the social cognition. Even if the stigma is indirect, it directs discriminatory behaviour towards the disadvantaged groups. Thus, stigma in the social cognition forms the basis of structural discrimination. To end or prevent this phenomenon, Article 4 of the CRPD says that countries must abolish or modify laws that discriminate against persons with mental illness.

2.2.6 Discrimination and hedonic costs of mental illness

Emens (2005) says that persons with mental illness face discrimination at the workplace because there are affective and emotional costs (hedonic costs) associated with them. That is, in interacting with persons with mental illness, people like co-workers are likely to experience either influx of negative emotions or the loss of positive emotions. The process of emotional contagion occurs at the unconscious level. The more co-workers interact with persons with mental illness, the more they are likely to absorb negative emotions, and so want to avoid them (Emens, 2004).

To conclude, the problem of stigma and discrimination is complex and multifaceted. A rights-based approach to end and prevent discrimination against persons with mental illness appears to have more potential and promise, but the burden to give fair treatment and deliver justice lies with legal practitioners. Of all the rights recognized in the CRPD, the right to equal recognition before the law, recognition of legal capacity and the right to exercise legal capacity are of paramount importance for the empowerment of persons with mental illness.
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Chapter 3. Research Framework

3.1 Research Design

Chapter 1 presented an account of the stigma and discrimination faced by persons with mental illness. We considered the need to shift the focus of remedial measures to addressing discrimination, rather than coping with the stigma. Although structural discrimination is likely to be the toughest barrier to participation, it has to date received little research attention in low- and middle-income countries. But it is likely to be a major barrier to their participation in all societies. Structural discrimination is also a matter of concern because it is systematic and intentional. In Chapter 2, we saw how social structures such as laws, rules, policies and cultural norms could be potential sources of discrimination. We also reflected on why countries must urgently address this problem (the principal reason being that non-discrimination is not subject to progressive realization or availability of resources). To devise measures to eliminate discrimination, the first step is to identify the sources of structural discrimination against persons with mental illness and to understand how widespread the phenomenon is. Having said that, the main research question of this thesis was framed as –

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

To answer this question, four important domains of life were selected for the research. We wanted to investigate whether laws regulating these domains systematically framed provisions that would curtail the rights and freedom of persons with mental illness. We also examined whether cultural norms encouraged discrimination against such persons, and if so, how.

Given this purpose, main objectives of the thesis were framed as follows:

1. To identify whether laws discriminate against persons with mental illness
2. To understand how laws discriminate against them
3. To explore how social barriers affect their social inclusion
4. To understand how implementation of laws affect lives of persons with mental illness

Accordingly, it was hypothesized that 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 violations of human rights. Structural discrimination would ultimately prevent the social inclusion of persons with mental illness.
The main research question of was divided into seven research sub-questions, further grouped into four parts, based on the domain under consideration.

Part I - Employment

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

To answer this sub-question, we aimed to study the legal provisions that dealt with the employment of persons with disabilities. As discussed in Chapter 2, human rights enshrined in the Article 27 of the CRPD were the guiding framework to evaluate legal provisions. We aimed to find out whether 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.

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?

The second research sub-question was framed to explore structural discrimination at the social level. We wanted to know how employers (being in positions of power) dealt with the ‘stigmatizing medical condition’ of their employees, whether they supported the employees or discriminated against them, and how employees managed to work during episodes of mental illness. We were also interested in knowing how families faced the crisis of mental illness of the principal breadwinner, how they subsisted during the periods of unemployment, and how patients managed return to work. In addition to understanding the barriers, we aimed to know whether employers and family members understood the situation of these individuals and offered psychological and practical support. We also sought to find out the nature of such support.

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 mental disability certification?

In addition to exploring the barriers and support in sub-question 2, we aimed to explore how many respondents were working at the time of the interviews, what jobs they were engaged in, and what was the nature of their work. We also wanted to explore the data to identify the factors (clinical and/or social) that were associated with employed individuals. During the course of this research, disability legislation in India underwent reform. The new law promotes employment of persons with mental illness through affirmative action (job quota). To access jobs reserved under the quota, a certificate of mental disability is required. We therefore explored whether study participants were
aware of such certification, and whether they had obtained a certificate. In turn, this enquiry also explored the level of awareness of the rights of persons with mental disabilities.

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?

The fourth research sub-question explored discrimination against persons with mental illness in marriage and divorce laws. We investigated whether these laws complied with the framework of Article 23.1(a) of the CRPD. We explored whether legal provisions deemed persons with mental illness as unfit for marriage or rendered their marriage as voidable or dissolvable. In turn, this enquiry also revealed information on whether persons with mental illness were recognized equally before the law.

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 chapter 1, we saw that factors such as being female, mental illness, marital responsibilities and low economic status intensify the impact of stigma and discrimination. If these factors co-exist, the social position of women with mental illness is severely jeopardized. Having said that, we were interested to know whether the application of the law discriminated against persons with mental illness, especially women; and if women accessed legal recourse to challenge discrimination against them.

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?

Structural discrimination in the matters of property was explored in the legal context. We studied whether domestic laws in United Nations Member States recognized the legal capacity of persons with mental illness, especially at the time of entering into a contract and making a will. We were keen to know if these individuals could lawfully inherit property, own it, enjoy it and dispose it of according to their wishes and preferences. In turn, this enquiry also highlighted how far countries treated persons with mental illness equally before the law.
Part IV - Mental Health Care

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

To answer this question, we explored mental health laws in the Commonwealth Member States. This enquiry was framed to know whether laws recognized rights-based access to mental health care. As discussed in chapter 2, rights-based access to mental health care has several dimensions. It includes the right to have access to mental health care on an equal basis with physical health care; the right to equal decision-making powers; the right to access to supported decision-making tools such as psychiatric advance directives; the right to access justice and have equal representation at court hearings. Rights-based access to mental health care also means that the law prohibits torture, inhuman, cruel treatment. On the contrary, laws will promote the treatment of persons with mental illness with dignity and respect; that they will have access to psychosocial rehabilitation approaches; and they will be able to live in the community.

Taken together, each of the seven sub-questions evaluates different dimensions of legal and social discrimination against persons with mental illness. Sub-questions 1 to 3 evaluate legal discrimination and social discrimination by employers. Sub-questions 4 and 5 assess legal discrimination in the marriage and divorce laws and their application. Sub-question 6 evaluates legal discrimination in buying or selling property. Sub-question 7 investigates legal discrimination in accessing the mental health care. Overall, these sub-questions give us an idea of the extent to which persons with mental illness face legal barriers which discriminate against them and prevent their full and effective participation in society.

3.2 Research Methodology

To answer the main research question and seven sub-questions of this thesis, a mixed-method approach was adopted. The following diagram illustrates how a qualitative and quantitative approach was deployed in the seven studies.
The overall purpose of this research was to gain a better understanding of structural discrimination facing persons with mental illness in everyday life. We explored the concept of structural discrimination in two ways – legal and social. Legal discrimination was assessed in terms of the presence of legal barriers. These barriers are quantifiable. Hence a quantitative approach was considered appropriate in identifying legal barriers in studies 1, 4, 6 and 7 (chapters 4, 7, 9 and 10). Further, in study 5 (chapter 8), the practice of law was also assessed in terms of the number of cases in which persons with mental illness faced discrimination. Here again, a quantitative approach was appropriate. In the third research sub-question, the aim was to estimate the rate of employment and explore clinical or social factors associated with the employment of persons with mental illness. Hence a quantitative approach was adopted. The second research sub-question used a qualitative approach to explore social barriers through open-ended interviews. Thus, of seven research sub-questions and seven studies, a quantitative approach was used in six and one used a qualitative approach.

The following section presents methodology of each study in brief.

Study 1
Legal protection of the right to work and employment for persons with mental health problems: a review of legislation across the world.
Copies of disability legislation, human rights legislation, labour law, and the Constitution of 193 United Nations Member States were obtained. Using key terms or a combination of key terms, we searched for five legal provisions that dealt with the following:

1. Inclusion of mental illness in the definition of disability or identifying persons with mental illness as persons with mental disabilities
2. Prohibiting discrimination in recruitment
3. Prohibiting dismissal on the grounds of mental illness
4. Access to reasonable accommodation
5. Promotion of employment through affirmative action

These provisions were systematically compared against principles enshrined in the Articles 1 and 27 of the CRPD. A score on compliance of each right in each country was computed. Thus, we obtained percentages of countries where laws complied with CRPD provisions. We further compared legislation based on countries’ income status and the status of ratification of the ICESCR and CRPD.

Study 2
Barriers to employment of persons with mental illness: a qualitative study in Gujarat, India

In this study, we conducted qualitative interviews of 33 male out-patients aged 18–60 years. These interviews were conducted at the Hospital for Mental Health in Ahmedabad (HMH-A) in January 2016. We followed a purposive sampling strategy to recruit the patients. During the interviews, we collected socio-demographic and illness-related information, details regarding disability certificates, and details of employment. Depending on their employment status, we used one of three pre-designed interview guides. Each interview lasted 30–35 minutes. Participants’ answers were recorded verbatim in Hindi and translated into English. An inductive approach was adopted to analyse the content of the qualitative data.

Study 3
Cross-sectional study of employment of persons with mental illness in Gujarat, India

In this study, we interviewed 295 males aged 18–60 years who had common or severe mental illness, and who attended the out-patient clinic of the Hospital for Mental Health in Ahmedabad (HMH-A). The interviews were conducted between January 2016 and November 2016. We used a structured questionnaire to collect information about the demographic profile and educational level of the patient, the principal breadwinner(s) of his family, the duration of his mental illness, physical illness (if any), certification of mental disability, current employment status, and job pattern and profile. Using descriptive statistics, we calculated the employment rate. With the help of inferential statistics, we compared employed and unemployed groups of respondents. These comparisons were based on respondents’ demographic profile, type of mental illness
and its duration, and employment-related characteristics. Through this analysis, we explored what clinical and/or social factors were associated with employed participants.

Study 4
Legislative provisions related to marriage and divorce of persons with mental health problems: a global review

Copies of the Family Codes, Civil Codes, marriage and divorce Laws of 193 UN Member States were obtained. Further we identified provisions of marriage, divorce, capacity, and mental health conditions, and other family relations in these laws. These provisions were compared with principles of Article 23(1)(a) of the CRPD. Using descriptive statistics, we calculated the compliance of the legislation with the CRPD. This compliance was systematically compared based on countries’ income status and ratification status of ICESCR and CRPD.

Study 5
Gender, Mental Illness and the Hindu Marriage Act, 1955

The Family Court in Pune maintains paper based records of all registered cases. These records were accessed to identify cases where the plaintiffs had pleaded for annulment or dissolution of marriage on the grounds of mental illness of the spouse. We manually extracted and anonymized information of all the relevant cases covered in a 17-year period (1996–2012). In a similar vein, we explored relevant cases from all the High Courts in India and the Supreme Court of India. These cases were collected from online sources. They covered a period of 32 years (1981–2013). Cases were explored to answer several issues, including who was the initial petitioner (husband or wife), what medical evidence was presented to the trial court, what was its strength, what was the outcome, whether the respondent appealed against the decision of the trial court in the appellate court, what was the reversal rate of decisions in the appellate court, in whose favour final verdicts were delivered, in how many cases persons with mental illness faced unjust treatment, and in how many cases they lacked appropriate representation. This information revealed how practice of laws was discriminatory towards persons with mental illness.

Study 6
Right to property, inheritance, and contract and persons with mental illness

Copies of law of contract, law of succession/inheritance, and law relating to testamentary capacity (wills) of all United Nations Member states (193 countries) were obtained. We explored these laws to know whether persons with mental illness could legally enter into a contract, and have succession rights. We also investigated whether
the testamentary capacity of persons with mental illness was recognized by the laws equally with others (based on principles of Article 12 of the CRPD). Scores of compliances of all legislation were computed. We followed descriptive statistics to analyse the data. Like previous studies, we systematically compared legislation based on countries’ income status and ratification status on ICCPR and CRPD.

Study 7
The need to reform mental health legislation in Commonwealth countries

We obtained copies of mental health legislation in Commonwealth Member States. Using a mental health legislation checklist compiled by the World Health Organization (WHO), we analysed provisions of the mental health laws. We wanted to know the extent to which mental health laws complied with various provisions of the CRPD. In addition to the issues covered in the checklist, we explored discrimination in the provisions of guardianship and whether laws promoted the use of supported decision-making models. If provisions of the mental health laws did not comply with pertinent CRPD criteria, they were considered as barriers that lead to structural discrimination against persons with mental illness.

3.3 Research Validity

Validity of the qualitative data

Internal validity

In qualitative research, data saturation ensures the content validity of the findings (Fusch & Ness, 2015). We adopted this method in study 2 (chapter 5). We collected qualitative data using a pre-designed interview guide. Using low-inference descriptors such as ‘direct quotations’ is a common strategy in qualitative research, and strengthens validity of the findings (Johnson, 1997). We used verbatim transcription to maintain objectivity in data collection. After each interview, the participant was debriefed on the information he had shared. Transcripts were then translated from Hindi to English. Accuracy of the translation was confirmed by back translation. We used constant comparative method to check the saturation. The researcher-triangulation technique was used to increase validity of the data analysis. Two researchers independently read the transcripts several times to develop complete understanding of the context and achieve a sense of the whole. They read the quotations word by word to derive the codes. Researchers made notes of their first impressions in analysing the codes, which were sorted to identify common themes. Researchers later discussed common themes that had emerged from the independent analysis. Once a consensus was reached, themes were categorized and a framework of findings was developed. In the case of
disagreement, the help of third researcher was sought. If new categories of the themes emerged, they re-analysed old transcripts to ensure presence of the new themes.

Validity of the quantitative data

There is an extensive interpretation of legal terms in study 1 (chapter 4) and studies 4–7 (chapters 7–10). To maintain consistency and accuracy in the interpretation of legal provisions, we deployed the researcher-triangulation technique. A fellow researcher confirmed the accuracy of the interpretation of legal provisions in the context of framework of the CRPD. When there was no consensus on the interpretation of the legal provision, we used external triangulation. That is, external literature sources such as books and government and academic reports were consulted in order to establish whether a legal provision in a particular country discriminated against persons with mental illness.

In study 5 (chapter 8), two researchers manually searched all the case records between 1993 and 2012 at the Family Court in Pune. They were trained in identifying a relevant case, reading, summarizing, and coding it systematically. One researcher in turn created case notes. The other researcher independently reviewed these case notes to reduce the bias in assessing the case and to confirm the accuracy and completeness of the information.

3.4 Ethical considerations

For analysing employment, marriage, property and mental health laws, no ethical permission was required. We obtained copies of the laws from open and official databases. These sources included World Health Organization’s MiNDBank (https://www.mindbank.info), International Disability Law Index (www.dredf.org), NATLEX of the International Labour Organization (http://www.ilo.org/dyn/natlex/country_profiles), World Intellectual Property Organization (http://www.wipo.int/portal/en/index.html), LandWise (http://landwise.resourceequity.org/), World Intellectual Property Organization (WIPO), EUR-Lex and the Constitution Project (https://www.constituteproject.org). When no pertinent legislation was found, we extended our search to official websites of the government in the particular country.

Study 2 (chapter 5) and study 3 (chapter 6) were approved by the Ethics Committees of the Indian Law Society (ILS) in Pune, Maharashtra (India) and HMH-A, Gujarat (India).

When recruitment commenced, we encountered an ethical issue. We had asked psychiatrists at HMH-A to refer patients for the studies if, based on a routine mental state examination, they assessed patients as being able to consent to participate in the interviews. In the absence of a psychiatrist, a medical officer (a medical professional
providing long-term mental health services) followed similar referral procedure. But soon we realized there was a power dynamic between referring-doctors and patients. It was evident that patients respected the doctor’s authority to direct them to the interviewer without further questioning. The psychiatrist’s agency was likely to influence a patient’s decision on whether to participate in the study. We attempted to protect against this bias during the consent process. We clearly explained to prospective participants that the interviewer was a psychologist pursuing academic interests, that there were no immediate tangible gains for the participants such as job offers, and by emphasizing that there was no obligation to participate. This clarification affected patients’ willingness to participate in the study, as evidenced by a refusal rate of 20% following our explanation. At this stage, if a patient expressed the wish to know more about the study, we continued the consent process. With patients’ verbal consent, we accessed medical records to note diagnosis of their mental illness. We gave information about the nature, purpose, and procedures of the study, and advised participants that the risks of participation were minimal. We informed patients that they had right to refuse to participate, decline to answer any question, and leave the study at any point. Each patient was offered an opportunity to ask questions so as to maximize their understanding of the study. Once informed consent was obtained, we asked participants if they were comfortable to be interviewed in the presence of their family members or they preferred a separate room. This was to ensure that participants could speak freely without being influenced by accompanying family members.

For study 5 (chapter 8), we obtained permission of the Family Court in Pune. We extracted anonymized data from paper based records in the Family Court.
3.5 Framework of research studies

Framework of research studies covered in this thesis is given in Table 1.

Table 1. Overview of studies covered in this thesis

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope and Location</th>
<th>Type of Study</th>
<th>Chapter</th>
<th>Part</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Legal protection of the right to work and employment for persons with mental health problems: a review of legislation across the world</td>
<td>Global (United Nations Member States)</td>
<td>Quantitative study (analytical review)</td>
<td>4</td>
<td>I</td>
</tr>
<tr>
<td>2. Barriers to employment of persons with mental illness: a qualitative study from Gujarat, India</td>
<td>Province level (Gujarat, India)</td>
<td>Qualitative Study</td>
<td>5</td>
<td>I</td>
</tr>
<tr>
<td>3. Cross-sectional study of employment of persons with mental illness in Gujarat, India</td>
<td>Province level (Gujarat, India)</td>
<td>Quantitative Study (cross-sectional study)</td>
<td>6</td>
<td>I</td>
</tr>
<tr>
<td>4. Legislative provisions related to marriage and divorce of persons with mental health problems: a global review</td>
<td>Global (United Nations Member States)</td>
<td>Quantitative study (analytical review)</td>
<td>7</td>
<td>II</td>
</tr>
<tr>
<td>5. Gender, Mental Illness and The Hindu Marriage Act, 1955</td>
<td>District level (Pune District) and Country level (India)</td>
<td>Quantitative study (analytical review)</td>
<td>8</td>
<td>II</td>
</tr>
<tr>
<td>6. Right to property, inheritance, and contract and persons with mental illness</td>
<td>Global (United Nations Member States)</td>
<td>Quantitative study (analytical review)</td>
<td>9</td>
<td>III</td>
</tr>
<tr>
<td>7. The need to reform mental health legislation in Commonwealth countries</td>
<td>Regional (Commonwealth Countries)</td>
<td>Quantitative study (analytical review)</td>
<td>10</td>
<td>IV</td>
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Bibliography


Legal protection of the right to work and employment for persons with mental health problems: a review of legislation across the world

Abstract

The right to work and employment is indispensable for social integration of persons with mental health problems. This study examined whether existing laws pose structural barriers in the realization of right to work and employment of persons with mental health problems across the world. It reviewed disability-specific, human rights legislation, and labour laws of all UN Member States in the context of Article 27 of the UN Convention on the Rights of Persons with Disabilities (CRPD). It was found that laws in 62% of countries explicitly mention mental disability/impairment/illness in the definition of disability. In 64% of countries, laws prohibit discrimination against persons with mental health during recruitment; in one-third of countries laws prohibit discontinuation of employment. More than half (56%) the countries have laws in place which offer access to reasonable accommodation in the workplace. In 59% of countries laws promote employment of persons with mental health problems through different affirmative actions. Nearly 50 years after the adoption of the International Covenant on Economic, Social, and Cultural Rights and 10 years after the adoption of CRPD by the UN General Assembly, legal discrimination against persons with mental health problems continues to exist globally. Countries and policy-makers need to implement legislative measures to ensure non-discrimination of persons with mental health problems during employment.

Keywords

Discrimination; legislation; mental disability; right to work and employment; social justice

Introduction

Mental health shares a two-way relationship with work and social integration. Self-esteem and social identity are closely tied with the ability to work and earn a livelihood (Tiggemann & Winefield, 1984; Winefield & Tiggemann, 1990). Work also provides an opportunity to integrate meaningfully with society. Yet, persons with mental disabilities face direct discrimination by employers and colleagues, and indirect discrimination through structural disadvantages such as lack of incentives to foster employment of
persons with mental disabilities, coupled with a generalized neglect by policy-makers (Stuart, 2006). Universally, participation of persons with mental disabilities in the labour market has been strikingly low. Their unemployment rate ranges from 70–90% (Baldwin & Marcus, 2006; Ettner, Frank, & Kessler, 1997; Jones, Latreille, & Sloane, 2006; Mitra & Sambamoorthi, 2005). Denial of job opportunities and removal from work are an everyday reality for many persons with mental health problems (Michalak, Yatham, Maxwell, Hale, & Lam, 2007; Nelson & Kim, 2011), and reduce their access to financial and material resources on an equal basis with others. It erodes their social roles and meaningful contribution to the society, and leads to marginalization and exclusion. Stigma of mental illness, whether internalized or not, has been known to pose the most prominent individual-level as well as structural barrier to the entry of persons with mental disabilities in the competitive labour market and earn wages on an equal basis with others (WHO, 2011). While stigma undoubtedly plays a role, discrimination is its behavioural manifestation. Hence, legislative and policy measures aimed at eliminating discrimination hold potential in empowerment of persons with mental illness (Bhugra, Ventriglio, & Pathare, 2016).

International law has adopted a human-rights based perspective for promoting participation of persons with mental disabilities in the labour market. In particular, Art. 23 of the Universal Declaration of Human Rights (UN General Assembly, 1948); Art. 6 and Art. 7 of the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1976), and Art. 27 of United Nations Convention on the Rights of Persons with Disabilities (CRPD) (UN General Assembly, 2007) protect the rights of persons with mental disabilities to work and employment. CRPD holds historical significance for bringing a paradigm shift in the perception of persons with mental disabilities from objects of charity to people with equal human rights. Art. 27 of the CRPD expressly proclaims that States Parties recognize that persons with mental disabilities have equal rights to work in open, inclusive, and accessible environment; and earn livelihood by the work of their free choice. It requires States Parties’ to ensure that persons with mental disabilities are protected from harassment and slavery in the labour market and promote realization of right to work through ‘legislation and other appropriate measures’ (paragraph 1 of Art.27). Moreover, equal access to employment opportunities for persons with mental disabilities also reinforces their equal recognition before the law and enjoyment of legal capacity as per Art. 12 of CRPD.

To realize this right to work for persons with mental health problems, laws need to address various aspects of employment including:

Recruitment: There is a need to prohibit direct or indirect discrimination in advertisements linked to recruitment, setting eligibility criteria and selection procedure including obligation of medical and psychiatric examination before selection, information of working conditions to be given before acceptance of job, allotment of positions and responsibility, and by providing assistance in finding the employment.
Continuance of employment: This includes facilitating job retention, return-to-work; granting equal opportunities in career advancements through trainings, promotions; providing equal remuneration for equal value of work, just and favourable conditions of work, safe and healthy working environment; prohibiting suspension, dismissal or termination of employment contract on the basis of mental disability at the initiative of employer, and offering protection from harassment and redress of grievances.

Provide access to reasonable accommodation: This can be achieved by eliminating physical, environmental, administrative barriers through ‘necessary and appropriate modification and adjustments’ (see Art. 2 of CRPD) so that persons with mental disabilities enjoy and exercise their rights at the workplace at par with others. Denial of reasonable accommodation at the workplace is discriminatory and should be addressed in domestic legislation.

Promotion of employment: Countries need to promote employment by devising policies and measures that include affirmative actions, and incentives for private employers in order to redress disparities in representation of persons with mental disabilities in a competitive labour market.

Although International Conventions and instruments protect these rights for persons with mental health problems, the realization of these rights remains a prerogative of domestic laws. Member States which ratify international conventions are legally bound to amend and/or abolish existing non-compliant legislation (see Art.4 (1) of CRPD). Unless domestic laws are made compliant to the CRPD and other International Conventions, the expressive power of these human rights treaties is under-valued. Prejudicial attitudes may prevail in domestic legislation (Stuart, 2006), and persons with mental disabilities may, thus, remain excluded from protections of international human rights law. For example, persons with mental disabilities face significant barriers when returning to work after an episode of mental illness (Andersen, Nielsen, & Brinkmann, 2012), and episodic absence from work due to exacerbation of mental illness is likely to culminate in discontinuation of employment (Nelson & Kim, 2011) if laws do not prohibit mental illness or disability as a ground for dismissal or termination of employment.

Murphy and Athanasou (1999), in a review of studies, highlighted that gaining employment improves mental health and loss impacts on mental health. In a 35-country study, Brouwers et al. (2016) found that, among their respondents with major depressive disorders, discrimination was related to both seeking employment and keeping it, which meant that nearly 60% had stopped themselves from seeking employment. Thus, external discrimination may lead to internalized stigma. What was surprising was that they had also stopped looking for education and training. So, discrimination can work simply beyond employment. A lack of training and education
can not only stop vulnerable individuals from seeking jobs, but can also isolate individuals.

Financial strain due to prolonged duration of unemployment can negatively impact mental health (Weich & Lewis, 1998). Loss of wages, increased health cost, and rapid social change further push persons with mental illness into the trap of vicious circle of poverty and mental ill health (Lund et al., 2011; Patel & Kleinman, 2003; Saraceno, Levav, & Kohn, 2005). Poor mental health, unemployment, and social exclusion together constitute loss of economic output of over 16 trillion dollars per year and impede sustainable development, according to a report by the World Economic Forum (as cited in Thornicroft & Patel, 2014, p. 1). Therefore, legal protections that foster participation of persons with mental disabilities in mainstream competitive employment can have a significant positive impact on mental health of individuals and their families.

**Aims**

We reviewed domestic legislation of United Nations Member States to identify their compliance with the provisions of Art. 27 of CRPD. We were keen to explore if domestic laws pose structural barriers to participation of persons with mental disabilities in competitive employment by failing to protect persons with mental disability from discrimination on the basis of their disability at the recruitment stage, by allowing discontinuation of employment on the basis of mental illness or disability, by failing to mandate access to reasonable accommodation at the workplace and by not framing provisions to promote employment of persons with mental disabilities through affirmative action. Country legislation from all UN member states was, therefore, examined for compliance on the above five issues.

**Objectives**

We prepared a set of five questions to examine compliance in UN member states with the ‘Right to Work and Employment’ of persons with mental disabilities, as enshrined in Article 27 of CRPD.

Q1: Does the definition of disability include those with mental health problems?

Q2: Does the law prohibit discrimination on the grounds of mental illness/mental health problems at the time of recruitment for employment?

Q3: Does the law prohibit dismissal/termination/suspension of employment on the basis of mental illness/ problems/disability?

Q4: Does the law provide access to reasonable accommodation to persons with mental illness/problems/disabilities at the workplace?

Q5: Does the law promote employment of persons with mental illness/problems/disabilities through affirmative actions?
Method

We obtained copies of disability legislation, human rights legislation, labour law, and the Constitution of United Nations Member States from various databases including WHO MiNDBANK (https://www.mindbank.info), International Disability Law Index (www.dredf.org), NATLEX of the International Labor Organization (http://www.ilo.org/dyn/natlex/country_profiles), and the Constitution Project (https://www.constituteproject.org). When pertinent legislation was not found, we extended our search to official government websites of the particular States. In cases of Federal Member States, we relied on federal legislation and, if this was absent, used legislation from the province with the largest population as representative of that Member State.

We identified relevant provisions of legislation using key terms or a combination of key terms listed below. For non-English versions of legislation, if an authoritative English translation was available, it was used for analysis. In other situations, we used Google Translate to translate key terms and pertinent provisions of legislation. Where we did not find bare acts, we relied on non-codified and secondary sources of information such as government reports and academic papers.

The key terms we searched for in legislation were: mental, unsound, mind, insane, infirm, psychological, emotional, psychiatric, imbecile, illness, disability, disorder, disease, health, fitness, sickness, diminished, loss, capacity, ability, recruit, hire, job, application, employ, discriminate, prohibit, distinction, exclude, suspension, dismiss, termination, eviction, extinction, expiry, breach, cancellation, discharge, duty, contract, access, reasonable, accommodation, adjustment, environment, condition, undue burden, hardship, affirmative, positive, action, mandatory, quota, reserve, tax, financial contribution, disability fund, right, labor, work, equal, promote, and protect.

To enable systematic comparison of legislation, we used World Bank Classification of countries by income levels and Member States’ ratification status of ICESCR and CRPD, as mentioned in the United Nations Treaty Collection.

Note: In the case of Q5, in countries which have adopted a disability specific quota system, a score of ‘yes’ was given if mental disability was recognized as one of the types of disabilities in the law, and the law stated the percentage of persons with disabilities to be employed. In such cases, we did not seek information beyond the scope of legislation to know whether the said percentage indeed covered persons with mental disabilities.
Results

The definition of ‘disability’ is crucial if persons with mental health problems are to benefit from protective legal provisions. We found that laws in 65% (n = 126) of the countries define disability to include those with mental health problems (see Table 1). However, 27% (52 Member States) of country laws do not explicitly define the term ‘disability’, and the term is left open to interpretation. Given the stigma related to mental health problems, there is a risk in these countries that persons with mental health problems will be either forgotten or actively excluded from protections given to persons with disability.

Table 1. Mental illness covered under the definition of disability

<table>
<thead>
<tr>
<th>Q1: Does definition of disability contain mental illness?</th>
<th>Frequencies (%) n= 194</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, mental illness/mental disorder/mental impairment/abnormality of psychological functions is explicitly stated in definition of disability/persons with disability</td>
<td>121 (62%)</td>
</tr>
<tr>
<td>It is implied from the general term ‘health’ or ‘illness’ that the law covers mental disability</td>
<td>5 (3%)</td>
</tr>
<tr>
<td>No, disability is not defined in the law, but law prohibits discrimination on the basis of physical disability or mental disability (there is explicit mention of mental disability/impairment)</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>Mental disability is not covered in the definition (when other forms of disabilities are listed)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>The concept of disability is not defined in the law</td>
<td>52 (27%)</td>
</tr>
<tr>
<td>The definition of disability does not consider health</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Unclear (when definition of disability implies mental illness, but further clarification excludes mental disability)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>No information—due to (a) act not found; (b) act cannot be translated</td>
<td>9 (5%)</td>
</tr>
</tbody>
</table>

Discrimination against persons with mental disabilities at the time of recruitment is an important structural barrier to their participation in competitive employment. Fourteen per cent (28 Member States) of countries do not have laws which explicitly prohibit discrimination on the grounds of mental disability at the time of recruitment, and another 13% (26 Member States) of countries have laws with conflicting provisions (see Table 2). Knowing that persons with mental disabilities are less likely to be preferred by the employers, absence of codified prohibition of discrimination leaves open the possibility of denial of employment to persons with mental health problems. It is also important to note here that, despite explicit mention of equal treatment and non-discrimination in 64% of country laws, in many of these countries persons with disabilities, including mental disabilities, were barred from specific areas of employment such as national security services, armed forces, or occupations that are deemed hazardous.
Table 2. Persons with mental disability and discrimination at the time of recruitment

<table>
<thead>
<tr>
<th>Q2: Does the law prohibit discrimination on the grounds of mental illness at the time of recruitment for employment?</th>
<th>Frequencies (%), n= 194</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes (examples of laws where discrimination on the basis of disability, including mental disability, is explicitly prohibited in relation to recruitment/hiring/job application/employment)</td>
<td>124 (64%)</td>
</tr>
<tr>
<td>Maybe (examples of laws where conflicting provisions exist)</td>
<td>26 (13%)</td>
</tr>
<tr>
<td>Maybe (secondary source)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>No (examples of laws where disability, including mental disability, is not explicitly considered as an unlawful ground for discrimination in relation to employment)</td>
<td>28 (14%)</td>
</tr>
<tr>
<td>No (secondary source)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Not covered (examples of laws where law is silent about prohibiting discrimination at the time of recruitment/hiring/job application/employment)</td>
<td>7 (4%)</td>
</tr>
<tr>
<td>No information (NI)</td>
<td>7 (4%)</td>
</tr>
</tbody>
</table>

Worryingly, in nearly half of the countries (51%, 98 Member States), there are no explicit protections in law against dismissal/termination/suspension of employment on grounds of health reasons including mental health problems (see Table 3). Variations in the criteria for suspension or termination of contract, such as duration of absence, process of determining loss of ability to work, classification and nature of disability are described below (see Table 5).

Table 3: Mental disability and discontinuation of employment

<table>
<thead>
<tr>
<th>Q. 3 Does the law prohibit dismissal/termination/suspension of employment on the basis of mental disability?</th>
<th>Frequencies (%), n= 194</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes (examples where prohibition of dismissal/termination/suspension of employment contract on the basis of disability, including mental disability, is explicitly stated)</td>
<td>68 (35%)</td>
</tr>
<tr>
<td>Maybe (examples where unclear / conflicting provisions of law exist)</td>
<td>20 (10%)</td>
</tr>
<tr>
<td>No (examples where discontinuation of employment due to absence from work or non-fulfillment of employment contract owing to health-related reasons is not explicitly prohibited) (see Table 5 below)</td>
<td>98 (51%)</td>
</tr>
<tr>
<td>No Information</td>
<td>8 (4%)</td>
</tr>
</tbody>
</table>

In 30% (58 Member States) of the countries, there are no explicit or implied provisions in the law for providing reasonable accommodation to persons with disabilities, including mental disabilities (see Table 4).
Table 4. Persons with mental disabilities and access to reasonable accommodation at the workplace

<table>
<thead>
<tr>
<th>Q4: Does the law provide access to reasonable accommodation to persons with mental disabilities at the workplace?</th>
<th>Frequencies (%) n= 194</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>109 (56%)</td>
</tr>
<tr>
<td>Maybe (examples where it is unclear whether access to reasonable accommodation is granted ‘at the workplace’ to ‘persons with disabilities’, including those with mental disabilities)</td>
<td>13 (7%)</td>
</tr>
<tr>
<td>Not covered</td>
<td>58 (30%)</td>
</tr>
<tr>
<td>No information</td>
<td>14 (7%)</td>
</tr>
</tbody>
</table>

Table 5. Countries where laws do not specifically prohibit dismissal/termination/suspension of employment due to health reasons

<table>
<thead>
<tr>
<th>Action</th>
<th>Common grounds</th>
<th>Frequency [n= 98+20=118] n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspension of employment contract</td>
<td>Absence due to disability; temporary disability; illness certified by a physician approved by the employer; Occupational disease; long-term illness; illness/ disease, physical or mental incapacity, ill health</td>
<td>12 (10%)</td>
</tr>
<tr>
<td>Suspension or termination</td>
<td>Suspension for temporary disability, termination for permanent disability; absence due to sickness for up to 6 months; termination for later absence</td>
<td>3 (3%)</td>
</tr>
<tr>
<td>Termination</td>
<td>(see below)(^a)</td>
<td>43 (36%)</td>
</tr>
<tr>
<td>Eviction/Exclusion/ Expiry of Contract/ Extinction of Contract/Breach of Employment Contract/ Cancellation of Contract/Discharge from Duty</td>
<td>Disablement; mental disability; long-term inability to work because of health; ill health; incapacity or illness; disability; temporary total disability</td>
<td>8 (7%)</td>
</tr>
<tr>
<td>Dismissal or Termination</td>
<td>Disability; Diminished capacity to work; loss of skills, aptitude, health or any other physical or mental quality; inability to hold employment by the reason of health, illness or disability</td>
<td>7 (6%)</td>
</tr>
<tr>
<td>Discontinuation neither prohibited nor action specified</td>
<td></td>
<td>45 (38%)</td>
</tr>
</tbody>
</table>

\(^a\) Disability; Physical or mental inability to work; Loss of functional capacity to work, recognition of status of disability; Permanent disability; Total disability; Physical and mental incapacity; inconsistencies in job due to health, preventing the continuation of
this work; disability/incapability to engage in gainful occupation by reason of some specific disease or bodily or mental disablement or deemed in accordance with regulations; common illness, occupational disease; Illness/disease; sickness leading to inability to work; disability resulting in loss of ability to work; Unfitness, Physical or mental disability that prevents the exercise of functions; Loss of long-term, his capability to perform current work due to his state of health; Incapacity of the worker arising due to any reason; Sickness; incapacity for work owing to illness; incapacity due to medical reasons; 75% inability to work due to illness; no longer capable of working due to a disease or disability certified by the medical authority; inability of the worker owing to sickness; Inability to work due to medical conclusion or a conclusion of the Disability and Working Capacity Assessment Office under the Ministry of Social Security and Labour; inability to resume work due to sickness; severe disability; Temporary disability, injury; Incapacity due to sickness; Inaptitude as a result of health condition; absolute disability when appropriate measures taken in accordance with the legislation are exhausted; Non-fulfillment of contract due to Sickness, Inability to fulfil written contract of service owing to sickness.

We also found that 26% of countries (53 Member States) do not have specific affirmative action provisions in law for employment of persons with mental health problems (see Table 6). In 59% of countries, affirmative actions included tax exemptions, incentives to facilitate employment of persons with disabilities, or disability-related quotas in public as well as private establishments. In case of employers’ inability to hire persons with disabilities, laws provided for sanctions such as mandatory contribution to disability welfare funds. It is important to note here that such sanctions may not necessarily improve participation of persons with mental health problems in mainstream employment for several reasons. First, due to stigma of mental illness, employers may choose to pay the fines rather than recruiting persons with mental illness. Second, even if such funds are spent on welfare of persons with disabilities, benefits may not indeed reach persons with mental health problems, considering their low participation in competitive employment. Third, in order to secure social welfare benefits through the employer, an employee will have to disclose information of his or her mental illness to the employer. Such disclosure may pose a direct risk of unlawful dismissal from the job, or derogatory treatment at the workplace.

Table 6. Promotion of employment of persons with mental disabilities through adoption of affirmative actions

<table>
<thead>
<tr>
<th>Q5: Does the law promote employment of persons with mental disabilities through affirmative actions?</th>
<th>Frequencies (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n= 194</td>
</tr>
<tr>
<td>Yes</td>
<td>115 (59%)</td>
</tr>
<tr>
<td>Yes, from secondary source</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Maybe (examples where it is unclear whether affirmative actions are to be framed or not)</td>
<td>10 (4%)</td>
</tr>
<tr>
<td>Not covered</td>
<td>53 (26%)</td>
</tr>
<tr>
<td>No information</td>
<td>14 (7%)</td>
</tr>
</tbody>
</table>
Protections by income-status of countries

Tables 7–10 show the different protections afforded by law to persons with mental health problems in countries, by income status of the country. In general, the protections in law are correlated with income status of the country, with high income countries providing more legal protections in employment to persons with mental health problems. Sixty-one per cent of countries in the low-income group prohibit discrimination on the basis of mental disability at the time of recruitment, as compared to 75% in the high-income group (see Table 7). Fifty-five per cent of countries in the low and lower middle-income group do not prohibit discontinuation of employment on the grounds of health conditions including mental health problems, whereas 45% of high income countries do so (see Table 8).

Table 7. Protection of right to work and income level of the country. Prohibition of discrimination and income level of the country

<table>
<thead>
<tr>
<th>Does the law prohibit discrimination on the grounds of mental illness at the time of recruitment?</th>
<th>Low income (n= 31)</th>
<th>Lower middle income (n= 49)</th>
<th>Higher middle income (n= 52)</th>
<th>High income (n= 61)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>19 (61%)</td>
<td>25 (51%)</td>
<td>35 (67%)</td>
<td>45 (75%)</td>
</tr>
<tr>
<td>Maybe</td>
<td>6 (19%)</td>
<td>11 (22%)</td>
<td>5 (10%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Maybe (secondary source)</td>
<td></td>
<td></td>
<td></td>
<td>1 (2%)</td>
</tr>
<tr>
<td>No</td>
<td>3 (10%)</td>
<td>7 (14%)</td>
<td>10 (19%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td>No (secondary source)</td>
<td>1 (3%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not covered</td>
<td>3 (6%)</td>
<td>1 (2%)</td>
<td>2 (3%)</td>
<td></td>
</tr>
<tr>
<td>No information</td>
<td>2 (6%)</td>
<td>3 (6%)</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

Note: The World Bank has not given classification of Nauru. Hence, the country is not included in the analysis.

Table 8. Protection of right to work and income level of the country. Discontinuation of employment and income level of the country

<table>
<thead>
<tr>
<th>Does the law prohibit discontinuation of employment on the basis of mental disability?</th>
<th>Low Income (n= 31)</th>
<th>Lower middle income (n= 49)</th>
<th>Higher middle income (n= 52)</th>
<th>High income (n= 61)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>10 (32%)</td>
<td>12 (24%)</td>
<td>17 (33%)</td>
<td>29 (48%)</td>
</tr>
<tr>
<td>Maybe</td>
<td>2 (6%)</td>
<td>5 (10%)</td>
<td>9 (17%)</td>
<td>4 (3%)</td>
</tr>
<tr>
<td>No</td>
<td>17 (55%)</td>
<td>27 (55%)</td>
<td>26 (50%)</td>
<td>27 (45%)</td>
</tr>
<tr>
<td>No information</td>
<td>2 (6%)</td>
<td>5 (10%)</td>
<td></td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

Note: The World Bank has not given classification of Nauru. Hence, the country is not included in the analysis.
Table 9. Protection of right to work and income level of the country. Reasonable accommodation and income level of the country

<table>
<thead>
<tr>
<th>Does the law provide access to reasonable accommodation to persons with mental disabilities at the workplace?</th>
<th>Low income (n= 31)</th>
<th>Lower middle income (n= 49)</th>
<th>Higher middle income (n= 52)</th>
<th>High income (n= 61)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>16 (51%)</td>
<td>18 (37%)</td>
<td>30 (58%)</td>
<td>45 (75%)</td>
</tr>
<tr>
<td>Maybe</td>
<td>3 (10%)</td>
<td>6 (12%)</td>
<td>2 (4%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Not covered</td>
<td>8 (26%)</td>
<td>20 (41%)</td>
<td>18 (35%)</td>
<td>11 (18%)</td>
</tr>
<tr>
<td>No information</td>
<td>4 (13%)</td>
<td>5 (10%)</td>
<td>2 (4%)</td>
<td>3 (5%)</td>
</tr>
</tbody>
</table>

Note: The World Bank has not given classification of Nauru. Hence, the country is not included in the analysis.

Table 10. Protection of right to work and income level of the country. Affirmative actions and income level of the country

<table>
<thead>
<tr>
<th>Does the law promote employment of persons with mental disabilities through affirmative actions?</th>
<th>Low income (n= 31)</th>
<th>Lower middle income (n= 49)</th>
<th>Higher middle income (n= 52)</th>
<th>High income (n= 61)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>16 (52%)</td>
<td>24 (49%)</td>
<td>35 (67%)</td>
<td>40 (67%)</td>
</tr>
<tr>
<td>Yes, from secondary source</td>
<td>1 (2%)</td>
<td></td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td>Maybe</td>
<td>2 (6%)</td>
<td>3 (6%)</td>
<td>5 (10%)</td>
<td></td>
</tr>
<tr>
<td>Not covered</td>
<td>9 (29%)</td>
<td>17 (35%)</td>
<td>9 (17%)</td>
<td>17 (28%)</td>
</tr>
<tr>
<td>No information</td>
<td>4 (13%)</td>
<td>5 (10%)</td>
<td>2 (4%)</td>
<td>3 (5%)</td>
</tr>
</tbody>
</table>

Note: The World Bank has not given classification of Nauru. Hence, the country is not included in the analysis.

More countries in the low income and lower middle-income group fail to offer access to reasonable accommodations (see Table 9) and promote employment through affirmative actions (see Table 10).

Legal protections for employment by ratification status of country on relevant international conventions

Tables 11–14 show legal protections provided by countries to persons with mental health problems during employment compared by the country's ratification status of ICESCR and CRPD. Of all, 10% and 13% of countries, respectively, which have ratified the ICESCR and CRPD, respectively, do not provide legal protection to prohibit discrimination on the grounds of mental health problems at the time of recruitment; 47% and 51%, respectively, do not provide protection from dismissal on grounds of mental health problems; 25% and 27%, respectively, do not have legal provisions for reasonable accommodation at work; 20% and 23% do not have legal provisions for affirmative action for employment for persons with mental health problems.
Table 11. Protection of right to work and ICESCR, CRPD ratification status of countries.  
Prohibition of discrimination and ratification status

<table>
<thead>
<tr>
<th>Does the law prohibit discrimination on the grounds of mental illness at the time of recruitment?</th>
<th>ICESCR ratified (n= 157)</th>
<th>CRPD ratified (n= 158)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>111 (71%)</td>
<td>108 (68%)</td>
</tr>
<tr>
<td>Maybe</td>
<td>21 (13%)</td>
<td>19 (12%)</td>
</tr>
<tr>
<td>Maybe (secondary source)</td>
<td>1 (1%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>No</td>
<td>16 (10%)</td>
<td>21 (13%)</td>
</tr>
<tr>
<td>No (secondary source)</td>
<td>1 (1%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Not covered</td>
<td>1 (1%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>No information</td>
<td>5 (3%)</td>
<td>4 (4%)</td>
</tr>
</tbody>
</table>

Note: United Nations Treaty Collection reveals that the CRPD ratification status of Belarus has been withdrawn. Hence, the analysis does not consider scores of Belarus on CRPD ratification.

Table 12. Protection of right to work and ICESCR, CRPD ratification status of countries.  
Discontinuation of employment and ratification status

<table>
<thead>
<tr>
<th>Does the law prohibit discontinuation of employment on the basis of mental disability?</th>
<th>ICESCR ratified (n= 157)</th>
<th>CRPD ratified (n= 158)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>63 (40%)</td>
<td>58 (37%)</td>
</tr>
<tr>
<td>Maybe</td>
<td>15 (10%)</td>
<td>14 (9%)</td>
</tr>
<tr>
<td>No</td>
<td>74 (47%)</td>
<td>81 (51%)</td>
</tr>
<tr>
<td>No information</td>
<td>5 (3%)</td>
<td>5 (3%)</td>
</tr>
</tbody>
</table>

Note: United Nations Treaty Collection reveals that the CRPD ratification status of Belarus has been withdrawn. Hence, the analysis does not consider scores of Belarus on CRPD ratification.

Table 13. Protection of right to work and ICESCR, CRPD ratification status of countries.  
Reasonable accommodation and ratification status

<table>
<thead>
<tr>
<th>Does the law provide access to reasonable accommodation to persons with mental disabilities at the workplace?</th>
<th>ICESCR ratified (n= 157)</th>
<th>CRPD ratified (n= 158)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>98 (62%)</td>
<td>96 (61%)</td>
</tr>
<tr>
<td>Maybe</td>
<td>10 (6%)</td>
<td>9 (6%)</td>
</tr>
<tr>
<td>Not covered</td>
<td>39 (25%)</td>
<td>42 (27%)</td>
</tr>
<tr>
<td>No information</td>
<td>10 (6%)</td>
<td>11 (7%)</td>
</tr>
</tbody>
</table>

Note: United Nations Treaty Collection reveals that the CRPD ratification status of Belarus has been withdrawn. Hence, the analysis does not consider scores of Belarus on CRPD ratification.
Table 14. Protection of right to work and ICESCR, CRPD ratification status of countries. Affirmative actions and ratification status

<table>
<thead>
<tr>
<th>Does the law promote employment of persons with mental disabilities through affirmative actions?</th>
<th>ICESCR ratified (n= 157)</th>
<th>CRPD ratified (n= 158)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>104 (66%)</td>
<td>100 (63%)</td>
</tr>
<tr>
<td>Yes, from secondary source</td>
<td>2 (1%)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Maybe</td>
<td>9 (6%)</td>
<td>8 (5%)</td>
</tr>
<tr>
<td>Not covered</td>
<td>32 (20%)</td>
<td>37 (23%)</td>
</tr>
<tr>
<td>No information</td>
<td>10 (6%)</td>
<td>11 (7%)</td>
</tr>
</tbody>
</table>

Note: United Nations Treaty Collection reveals that the CRPD ratification status of Belarus has been withdrawn. Hence, the analysis does not consider scores of Belarus on CRPD ratification.

Discussion

Employment, whether it is sheltered or independent, plays an important role in maintaining well-being of all individuals, especially those who experience mental ill-health. Employment also means different things to different people in different contexts.

Obligations of international treaties and states’ non-compliance

Article 2 of ICESCR and Article 4 (1) of CRPD oblige States Parties to bring domestic laws in line with these human rights instruments. However, States’ compliance of the international human rights treaties is often influenced by political will and varying priorities in distributing economic resources (Shelton, 2014, p. 221). Findings of our study highlight that, nearly 50 years after the adoption of ICESCR and 10 years after the adoption of CRPD by the UN General Assembly, legal discrimination against persons with mental health problems exists globally. Discrimination against persons with disabilities in workplaces, in disability legislation or labour law has been the subject of numerous regional studies (Beegle & Stock, 2003; Hvinden & Halvorsen, 2011; Kidd, Sloane, & Ferko, 2000; Shima, Zolyomi, & Zaidi, 2008). This study is the first of its kind to present a global perspective on legal discrimination against persons with mental health problems in employment matters across all UN Member States. It provides evidence that inadequate legal protections during employment and under-promotion of employment of persons with mental health problems are likely to pose a significant barrier for persons with mental health problems in securing employment, retaining work, and return to work after an episode of mental illness.

Impact of discrimination

Negative discrimination in the law leads to denial of equal opportunities to access economic resources. For instance, mention of ‘mental impairment’ in the interpretation of the term ‘disability’ in laws assures that persons with mental health problems have
equal access to disability associated rights protected by law in a particular state. Laws of nearly 56 countries which do not explicitly define disability or mention 'mental impairment/disability/illness' in the definition of disability leave scope for uncertain interpretation, thus leading to the likelihood of unequal access to rights and resources for persons with mental disabilities and mental illness. One third of countries deny equality to persons afflicted with mental illness by not prohibiting discrimination on the ground of mental disability during recruitment. Laws of another 61% of countries which do not explicitly prohibit discontinuation of employment on the basis of health grounds including mental disability pose barriers to retaining employment. Becker et al. (1998), Nelson and Kim (2011), and Michalak et al. (2007) recommend adoption of legislative measures because their studies show that employers’, colleagues’ stigma of mental illness often results in involuntary dismissal from work, denial for promotion and demotion, when legal protections are missing. Absence from work due to episodes of mental ill health is also linked to unsatisfactory, unlawful termination from work, as noted by Becker et al. (1998). Persons with mental health problems report difficulties in returning to work, for disclosure of the information about mental illness further increases risk of stigma and discrimination at the workplace (Brohan et al., 2012). Out of pocket expenditures, increased cost of living, and reduced wages increase financial strain on persons with mental health conditions (Mitra, Findley, & Sambamoorthi, 2009). Sustained conditions of unemployment and poverty negatively impact the mental health of individuals. Individuals and their family members are, thus, pushed into the vicious circle of ill health, disability, homelessness, reduced life expectancy, and poverty (Funk, Drew, & Knapp, 2012; Patel & Kleinman, 2003). Persons with mental illness are over-represented amongst those living in poverty across the world. Two thirds of the world’s burden of mental disorders comes from low and middle-income countries. We will not achieve sustainable development goals of poverty reduction, decent work, economic growth, and reduced inequality unless mental health and employment of persons with mental illness is adequately and effectively addressed in legislative and policy measures (Chan, 2010). Promotion and enforcement of non-discriminatory laws holds tremendous significance for inclusion of persons with mental illness in competitive employment.

It may be argued that restrictions on the nature of employment, workplace relationships with persons with mental illness are appropriate given the functional impairments associated with mental disability. There is evidence questioning the employability of persons with severe mental disorders (Bell & Bryson, 2001; McGurk & Meltzer, 2000). Besides, international diagnostic standards also recognize social and occupational dysfunction of persons presenting symptoms of mental illness. However, we, like Corrigan, Markowitz, and Watson (2004), believe that such arguments indicate stigma of mental illness and adherence to the medical model of disability. Traditionally, occupational rehabilitation of persons with mental illness has been limited to sheltered workshops. Two decades of research on the models of supported employment shows that individual placement and support services offer a promising approach to double the participation of persons with severe mental health conditions in competitive employment (Kinoshita et al., 2013; Modini et al., 2016), and should be included in evidence-based practice. Work is associated with improved health outcomes, including high self-esteem (Dongen, 1996); improved self-efficacy, sense of normality, belongingness, acceptance, and wellbeing (Leufstadius, Eklund, & Erlandsson, 2009).
Work reduces incapacity and fosters recovery from mental illness. Therefore, provisions of laws to give access to reasonable accommodations at workplace also play an important role in the rehabilitation process. Services required to deliver support for management of illness at the workplace, networking of mental health care professionals with employers can be adopted as part of reasonable accommodations at the workplace. It has been argued that affirmative action strategies such as a quota system, giving incentives to employers to recruit persons with mental health problems should be used to as strategies to eliminate stigma of mental illness, and can end discrimination towards persons afflicted with mental illness (Corrigan & Gelb, 2006).

As with other aspects of mental disability and its treatment (for example, human resources, see Saxena, Thornicroft, Knapp, and Whiteford, (2007)) our research reveals that laws in low and lower middle-income countries are less likely to protect against inequality, discrimination, and human rights violation at the workplace. Often, protection of human rights through legislative and policy measures requires government spending on mental health systems and parallel community and human resources. Policymakers frequently argue that ICESCR rights such as the right to work are subject to progressive realization (see General Comment No. 18, paragraph 19, CESC (2006)). However, 50 years after the ICESCR was adopted, countries have failed to amend or replace legislation which fail to halt discriminatory practices. Policymakers need to be reminded that, while ICESCR as a whole is subject to progressive realization, but the principle of non-discrimination is not subject to progressive realization or availability of resources. It is meant for immediate implementation (see paragraph 33) and countries are failing in their obligations under international human rights law when they fail to provide legal protection against discrimination in employment for persons with mental disability. It is also necessary to remind policymakers that affirmative action is an essential component of non-discrimination and legal protection must be provided against obvious as well as subtle discrimination (see paragraph 27).

Limitations of the study

There are several limitations of this study. We did not review subsidiary legislation such as rules and regulations, employers’ policies, or national programmes framed under the disability, non-discrimination, human rights legislation, or labour laws. Such subsidiary legislation or programmes may contain important provisions pertaining to reasonable accommodations or affirmative actions for persons with disabilities, including mental disabilities (see Table 4). We also did not look for or examine draft bills because provisions of final legislation arising out of these bills cannot be predicted at this stage. Further, when we could not translate provisions of legislation or could not find laws, or relevant information in secondary sources, we resorted to score of ‘No information’ in less than 7% of the countries. We believe that such a small portion of no information does not vitiate our findings.
We did not include gender, children, or disease-specific (e.g. HIV/AIDS) non-discrimination legislation or legislation regulating human rights commission, as this was outside the scope of our study.

It is important to note here that progressive provisions of the laws may not reflect actual practice on the ground. In this report, we have not examined customary practices or case law to determine actual practice of laws. Similarly, in this study, we did not review jurisdiction of law of contract (private law) that may regulate contractual employment. Thus, human rights violations occurring due to the exploitative nature of contractual terms remains beyond the scope of this study.

Conclusion

The present study highlights a pressing need of UN Member States to adhere to principles of international human rights treaties in the context of persons with mental health problems. While countries endeavor to achieve sustainable development goals, contribution of persons with mental health problems to the economy remains hindered due to structural barriers in domestic laws. Knowing that bringing legal reform is a complex and tardy process, it would be interesting if future research could demonstrate models for improving participation of persons with mental health problems in informal economies. We need explorations in quantifying such contributions, especially in low and middle-income countries.

Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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Barriers to employment of persons with mental illness: a qualitative study from Gujarat, India

Abstract
Social determinants of the employment of persons with mental illness (PWMI) are rarely explored in India. This qualitative study uncovers psychological and social barriers perceived or experienced by PWMI employed in the informal and formal sector in Gujarat, India. In January, 2016, we conducted semi-structured interviews of male outpatients, aged 18-60 years, diagnosed with a common or severe mental illness, at the Hospital for Mental Health in Ahmedabad. The participants had mixed experiences. In addition to symptoms of mental illness and side effects from psychotropic medication, they faced several challenges on disclosing their mental illness, including employers’ loss of trust related to productivity, reduced workload, reduced income, bullying, and frequent threats of terminating their employment. Self-employed PWMI who worked with family members (e.g. in family businesses) faced fewer barriers to maintaining their livelihood. In addition, 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 demonstrates the significance of social capital in facilitating income generation for PWMI, including family support as a strong determinant of sustained employment. Given the scarcity of evidence on alternatives to supported employment of PWMI in the informal sector in India, we highlight the need for feasibility and efficacy studies evaluating the use of social capital, such as informal networks and peer-support networks, in promoting employment and entrepreneurship by PWMI in the informal sector.

Introduction
Employment plays a pivotal role in recovery for persons with mental illness (PWMI). Paid work improves their sense of self-esteem and self-identity, holds personal meaning, and fosters financial security (Dunn, Wewiorski, & Sally, 2008; Leufstadius, Eklund, & Erlandsson, 2009). Employment likewise provides an opportunity to regain lost skills, maximize future job prospects, and pursue economic independence, thus enabling PWMI to combat the everyday phenomena of discrimination and social and economic exclusion.

In India, structural barriers such as lack of equal job opportunities and denial of capacity to enter into contracts prevent the formal employment of PWMI. Notably, ten years after India’s ratification of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), only 15% of the PWMI of working age are engaged in “main-work” that lasts for over six months, and 75% of that same population remains outside the
labor force (Ministry of Home Affairs, Government of India, 2011). The main types of work PWMI do are in agriculture, clerical jobs, shop-keeping, or physical labor, and they are invariably paid less than other employees (Prasad & Acharya, 2014). Individuals who change jobs after the onset of mental illness find it hard to return to work, and women with mental illness are more likely to remain unemployed due to cultural norms regarding male breadwinning roles (Jaleel, Nirmala, & Thirthalli, 2015). In addition, limited access to social security benefits and unsafe working conditions expose workers in the informal sector to psychological stress (Das, Das, & Mohanty, 2012).

Low rates of employment of PWMI call for urgent attention for several reasons. First, the presence of mental illness is both a cause and consequence of unemployment (Funk, Drew, & Knapp, 2012), and those in “blue-collar jobs” are more likely to be affected by this (Paul & Moser, 2009). Without intervention, manual laborers continue to oscillate between poor mental health and unemployment. Second, lost income opportunities and the high cost of living due to urbanization amplify the effects of mental illness and cultivate a vicious cycle of disability, poverty, and social isolation among PWMI in low- and middle-income countries (Patel & Kleinman, 2003). Finally, countries like India cannot achieve the Sustainable Development Goal (SDG) of reducing poverty if 150 million PWMI are excluded from development (Gururaj et al., 2016; Thornicroft and Patel, 2014).

Barriers to the participation of PWMI in paid employment

Globally, studies show that discrimination, stigma, negative stereotypes, and lower expectations of employers towards PWMI limit their participation in paid jobs (Shankar et al., 2014). The detrimental effects of mental illness on decision-making, memory and motivation further reduce employability, increase absenteeism, and contribute to frequent job changes or terminations (Singley, 2003). The dyad of self-stigma (internalized stigma) and felt-stigma (perceived stigma) of mental illness further devalues PWMI in society (Gray, 2002).

Although these barriers appear to be universal with respect to PWMI, individual and systemic factors that may influence their participation in paid work must be examined. It is essential to know, for instance, what impediments persons with moderate to severe mental illness encounter while working in the informal sector without legitimate work- or disability-related protections. We must also explore conditions that delay PWMI's return to work, the strategies used to overcome this delay, and how their families manage to subsist following the termination of employment. This is especially true for men as they are expected to be the primary breadwinners in a patriarchal society like India. While exploring such barriers, it is also important to look for cultural resources, such as attributes of social capital, that can advance support mechanisms for unemployed PWMI to earn an income. Such traits of community fabric are significant in culturally advanced yet economically developing countries (Peredo & Chrisman, 2006), where non-governmental organizations can contribute to overcoming enormous challenges of abject poverty or poor education.
**Aims**

This study explores (a) psychological and social barriers experienced by PWMI in seeking paid employment, continuing employment, or returning to employment in the formal and informal sectors; and (b) the current level of support PWMI have from employers and family members to overcome these barriers.

**Methodology**

This paper presents qualitative findings of a mixed-method study that explored PWMI and their barriers to employment (through qualitative enquiry), employment rate, patterns of employment, and job profiles (through structured interviews) in Gujarat, India.

**Settings**

Semi-structured qualitative interviews were conducted with male patients, aged 18-60 years, who visited the Out-Patient Department (OPD) of the Hospital for Mental Health, Ahmedabad (HMH-A) in January 2016. We did not interview female patients owing to the compounding influence of gender as a barrier to employment in patriarchal India. Before commencing the study, we obtained approval from the Ethics Committees of the HMH-A and Indian Law Society.

**Design**

A purposive sampling strategy was used in this exploratory study. We interviewed participants and analyzed the data until saturation, terminating the study at n=33 participants over a four-week period.

**Recruitment process**

We asked psychiatrists at HMH-A to refer patients for the study if, based on a routine mental state examination, psychiatrists assessed the patient as being able to provide consent to participate in the interviews. In the absence of a psychiatrist, a medical officer (a qualified medical professional providing mental health services on a long-term basis) followed similar procedures for referrals. Patients with acute symptoms of mental illnesses were excluded from the study. Once referred, with the patients’ verbal consent, we accessed medical records to note their diagnoses. The nature, purpose, and procedures of the study, as well as minimal risks of participation, were explained to the patients. We reiterated each individual’s right to refuse to participate, decline to answer any question, and leave the study at any point. We offered every patient an opportunity to ask questions regarding this study, so that they could understand the survey and its process; and could make an informed decision on whether to participate. Once informed consent was obtained, we asked participants if they were comfortable being interviewed in the presence of their family members or whether they preferred a
separate room. The aim was to ensure that participants could speak freely without being influenced by accompanying family members.

**Interviews**

We began interviews by collecting socio-demographic and illness-related information, details regarding disability certificates, and details of employment. Depending on their employment status, we used one of three pre-designed sets of interview-guides: those never employed, those currently employed, and those who were previously employed (but are currently unemployed). On average, each interview lasted 35 minutes.

**Data analysis**

Participants’ answers were recorded verbatim in Hindi and translated into English. Translation accuracy was confirmed through back-translation. We likewise adopted an inductive approach to analyze the content of the qualitative data. Open codes were adopted by word-by-word and line-by-line reading. Preliminary codes were determined while analyzing transcripts of early interviews. Transcripts of the later interviews were coded using pre-existing codes. When new data did not fit with the existing codes, new codes were added. Similar codes were then grouped into higher order, refined, broader but mutually exclusive categories.

**Ethical considerations of the study**

Because our referral process required a hospital doctor (either a psychiatrist or a medical officer), we recognized that a pre-existing power dynamic was at play between referring doctors and patients. It was evident that patients respected a doctor’s authority to direct them to the interviewer without further questioning, which may have influenced their agency in considering whether to participate in the study. We attempted to protect against this bias during the consent process by clearly explaining to prospective participants that the interviewer was a psychologist trying to pursue academic interests, that there were no immediate tangible gains such as job offers for the participants, and by emphasizing that they were under no obligation to participate. This clarification affected patients’ willingness to participate in the study, as evidenced by a refusal rate of 20%.

**Results**

Analyses of the 33 interviewees are presented in Table 1. Of these, two (6%) had never been employed; of the remaining 31 participants who were working or had worked in the past, 21 (67%) worked in the informal sector. The most common jobs in this sector were rickshaw drivers and construction workers.
Psychological and social barriers experienced by PWMI

During qualitative analysis of the transcripts, we delineated the psychological and social barriers experienced by PWMI. These barriers included:

(a) Symptoms of mental and physical illness and adverse reactions to medication;
(b) Discrimination and abuse at the workplace;
(c) Inadequate State support; and
(d) Lack of support and abuse by the family.

Each is discussed in turn.

Symptoms of mental illness and adverse reactions to medication

When asked if participants faced any difficulties due to their mental illness while working, 23 of the 31 (74%) reported that the symptoms of their mental illness affected their work periodically (emphasis added). These symptoms included lack of physical strength, lack of sleep, forgetfulness, tearfulness, fear, anger or irritation, lack of motivation to work, and low self-confidence – “Whenever I got tensed, I did not feel like working. Otherwise I never refrained from hard work”. Participants also mentioned that psychotropic medication interfered with their ability to work – “because of medicines, I get headaches. I think it will interfere with my work”; “I skip work sometimes, especially when I am restless because of medicines. (But) there are no complaints from the work place”. These symptoms created difficulties for participants when starting or continuing work, and led to numerous job changes – “I left jobs on the account of mental illness. I changed jobs 10-12 times for the same reason”.

Participants rarely had access to fixed paid or medical leave. They lost wages if they were absent from work during acute episodes of mental illness. Hence, at times participants worked despite feeling sick – “I have to go to work even if I don’t feel alright. I feel uneasy while making keys”; “If I do not go, then he cuts my monthly wages”; “He calls me for the work even if I am unwell…I wish that if I take leave when unwell, my employer would not deduct money from my salary”. Participants continued seeking new jobs, continued working, or returned to work because they were the sole breadwinners in the family, and felt no choice but to earn – “In spite of being ill, I have to go to work. If I don’t, I don’t get full payment”; “Even during my illness, I was the only earning member in the family. As such there weren’t any problems (due to my health while working in the mill)”.

A few participants, however, reported that they could work during episodes of mental illness, and symptoms of illness or effects of medication did not interfere with their work – “I did not have any problem (when I was ill). Customers never complained about my work”; “I did not experience anything like this (interference of mental illness / psychiatric medication while working). I was an expert in my work”.

83
Discrimination and abuse at the workplace

We asked participants if, after the onset of mental illness, they faced any new circumstances at the workplace that had a direct impact on their employment. Participants reported that discrimination and abuse at the workplace often resulted in reduced income, loss of opportunity, and discontinuation of employment. Incidents of discrimination are discussed below.

1. Reduced workload and income on disclosing a mental illness to the employer: Many participants stated that when they resumed work after a gap, their workload was reduced as employers questioned their capacity to work — “I was admitted for 3 to 4 months. When I returned to work, workload was reduced. No one seriously paid attention to anything I said...”. Presumptions of incapacity or loss of productivity after the onset of mental illness ultimately translated into reduced income and were not in the patient’s best interest.

Another unique case was assigned a separate code to report financial losses in the business: One self-employed person revealed that periodic depression cultivated mistrust among his business partners, as a result of which he suffered financial losses – “I have lost my confidence. Goodwill was hampered, people did not return my money. I suffered losses. Now I remain confused”.

2. Fear of telling one’s employer about mental illness: Seven out of 31 participants (23%) reported that they were afraid to disclose details about mental illness to their employer. They feared retribution in the form of dismissal from work or loss of trust – “I do not want to talk about my mental illness, otherwise it becomes difficult to get the job”; “I can share (information) with my supervisor, but it then spoils the relations”. In three cases, such fears had translated into reality and participants faced devaluation and discrimination resulting in the loss of job opportunities: “No one valued my work after learning about my illness”; “There was no one to understand me. They did not take what I said seriously. Production had lowered”. Participants working in the informal sector reported that beliefs about their diminishing credibility, disrespect, devaluation, and discrimination prevailed among employers or co-workers. One participant working in a government establishment revealed that he never used his medical leave while seeking treatment for depression because he feared being threatened with demotion if he revealed information regarding his mental illness in the fitness certificate to be presented to the employer on resuming work.

Furthermore, participants reported several incidences of physical or emotional abuse at the workplace. These included:

1. Bullying at the workplace: Most individuals worried about employers publicly disclosing information about their mental illness, and reported bullying by friends, co-workers, and employers, without effective forms of redress – “If I disclose information
Even if participants did not report physical abuse at the workplace, many received threats of physical violence from colleagues in positions of power – “He makes me do house-keeping work, but if I ask Rs. 200 for that extra-work, he threatens to slap me”. This finding is of great concern given that most instances of workplace abuse are not reported. Moreover, while many employees in the formal sector have access to some form of a grievance system, individuals who work in the informal economy or are self-employed lack accountability and access to redress mechanisms even when abused by co-workers.

2. Senior officers delegated all their work to me: An earlier theme noted that some participants experienced a reduced workload because of presumed incompetence due to mental illness. In other cases, however, participants reported that their supervisor delegated everything to them, which precipitated depression or other forms of mental illness – “One senior was delegating his own work to me. My work portfolio was already big”; “Seniors abuse. I tried to avoid that by doing all his work, was efficient and meticulous...difficulties faced outside a well-established government organization are obvious”. The last statement reflected a sentiment that government jobs offered more security, stability, and regulation than in the private sector or forms of self-employment.

3. Forced to do “down-line” (derogatory) work: One participant reported degrading treatment at the workplace – “Those people used to make me do house-keeping work as well. They used to ask me to do down-line work (derogatory work). That was not my job. They used to doubt me for taking commission from the auto-rickshaw drivers”.

4. Dismissal from work/forced to resign: By far the most commonly reported form of abuse was dismissal from work or being forced to resign because of mental illness - “People used to sack me from the work if I failed to remember something. Last time, the employer had given me an order to attach 300 zippers. I made some mistakes in that. Employer got upset with me because he had to bear the losses. So, he dismissed me from the work”. Participants had also been sacked for “saying unacceptable things,” “not going to work regularly,” “the allegation of drinking alcohol at the workplace,” and occasionally for simply disclosing that they had mental illness.

Other generic concerns that characterized the informal work environment included the following:

1. Complaints are not tolerated: The majority of participants reported that they had no grievance system in place - “I cannot complain to my employer frequently. If I cannot do
any work, then I have to ask my colleagues. Employer does not allow me to complain often. He says that if I want to work, then too many complaints won’t be tolerated”. This was also related to ‘loss of trust at the workplace’, wherein the concerns of PWMI were not acknowledged adequately.

2. No social security benefits: Some participants who worked in mills or as security guards noted that they could not take paid leave, or obtain benefits from insurance policies otherwise provided by employers. They did not have equal opportunity to work overtime, or receive adequate compensation for overtime work. No participant reported having access to hospital facilities near their workplace in the case of work-related injuries.

(c) Inadequate State support

Government support was perceived negatively for the most part. With respect to disability certificates and associated benefits, only seven (21%) knew that mental illness is recognized as a form of disability, and only one had a certificate of mental disability. There was no awareness of the process of obtaining a disability certificate and subsequently obtaining the associated benefits such as tax exemption, travel fare concessions, rights regarding access to micro-credit or capital to start new businesses, or vocational training programs.

Participants highlighted that they lacked government support in obtaining loans to start employment in a dignified and independent manner – “The only thing I want to do is to buy my own vehicle (an auto-rickshaw). It would save the money I pay as rent. To do so, I need to take loan from a bank. But I don’t have any property or anything like that which I can use to get the loan”.

There was poor awareness of government-run employability-enhancement programs: 67% of the participants with a history of employment in the informal sector had not taken advantage of any structured training programs for improving their job skills, in addition to their basic education (mean 8.8 years ± 4.4 SD). One participant indicated that he wanted to get a job, but “did not know what more to learn”. Another expressed a desire to work in the tablet-packaging department of a pharmaceutical company, and to get the necessary training, but knew of no such program that could be used to improve his employability.

(d) Lack of support and abuse by family members

In contrast to paid workers, self-employed PWMI reported a different set of barriers arising from their families. These included low trust, undermined autonomy, lack of financial support, and abuse. Each of these is discussed below.
1. Low trust: A few participants cited concerns regarding trust between family members. This ranged from breach of trust due to lack of integrity while running the participant’s business in his absence - “many times, brothers take a bigger share of the income”, to family members suspecting the participant as dangerous – “brother’s wife felt that I might harm her baby”. One participant opined, “since no one from my family can do this work, there is no option but to keep the shop closed”. He reported the loss of one month’s wages during his last episode of mental illness. Other participants noted a similar desire to have trusted family members help with family-driven businesses and income generation during their illness. One individual noted that he could not confide in his family members about his illness: “I cannot tell all my family members about my problems. Rest of the people including my parents, my wife does not know that I feel depressed, get fearful thoughts”.

2. Undermined autonomy: “I am 22 now; still, my parents decide what clothes I should wear, what kind of footwear I should have. I want to earn more, so that I would be able to make decisions for myself”; “My brother and father are very supportive...I don’t have any complaints about their support. But at times I feel they distance me at the time of making important decisions”. This participant was voicing an example of family support going too far and infringing on his independence and decision-making ability. Interestingly, there was no mention of wives infringing their independence, but rather parents and brothers.

3. Lack of financial support: In contrast to some participants whose family members lent them money or helped in income-generation efforts, most participants expressed disappointment about the lack of financial support from families – “But no one pays attention to me. We have mortgaged wife’s ornaments. My younger brother is inconsiderate towards his elder brother’s (my) problems”; “If I get monetary support from wife/brothers, I will feel better, less burdened”. In many instances, participants reported that siblings and parents had their own needs to earn a living, which led to unmet needs of participants – “he (brother) has his family to support. So, he cannot support me now”; “these days, my brother and his wife want to get rid of me...after my father’s death, brother and his wife admitted me to the hospital”.

4. Abuse: Participants reported incidents of emotional and physical abuse when they could not fulfil families’ expectations to earn money.

Family taunts me about not working: Some participants reported taunting by other family members as a form of verbal abuse: “people/family members/employers say - nothing enters in your mind...if it does, can you not use your mind?”
Family locked me up: In one case, verbal abuse escalated into family members actively isolating a person with mental illness from society. “Uncle used to lock me inside the room and used to get angry at me. At times, he took me to the doctor”.

Two participants reported that, in spite of earning adequately to support their families, they did not have a peaceful atmosphere at home owing to family disputes or drinking problems - “We (me and brother) fight often. Therefore, I want to start my own business”; “Wife also works in the same hospital. As such, we do not have any financial problems. My two brothers have drinking problems, but they stay with me in the same house. It bothers me a lot; because of these adverse conditions, my illness precipitated”.

Support provided by employers and families

Having learned about the barriers to work, we elicited information from participants on coping strategies, meaning how they nevertheless managed to work and earn a living to support their families. Participants cited positive examples of support from employers as well as families, thereby producing more nuanced and complex results. These are discussed below.

(a) Support from employers

Notably, a few employers were reported as having extended support to PWMI by encouraging them to seek medical help, treating them no differently after disclosure, or affirmatively adjusting their work schedules.

1. Employer understands my condition and is supportive: Four participants (19%) who were currently employed noted that their employer could empathize with them and encouraged them to see a doctor during the episodes of mental illness - “He is quite supportive...when I am unwell and do not go to work, he calls home, and asks me to stay at home for rest, but this is not very often”. One participant noted that his employer was “considerate” when he informed them about his diagnosis of depression. Other participants explicitly mentioned that employers listened to their complaints and were cooperative - “if I face any problem, I can inform my supervisor. He is very helpful”.

2. Employer did not treat me differently because of my mental illness: On nine instances, participants who were working or had worked previously mentioned that they felt comfortable disclosing information about their mental illness to employers because they were not treated differently – “I get medical leave. Manager does not treat me differently just because I have mental illness”. The majority of participants also reported that they thought they received equal wages for equal value of work.

3. Flexible working conditions: Only one participant reported that he got “weekly offs, compensatory leaves, 18 casual leaves for a year, and fixed medical leaves with 50% of the pay”.

88
(b) Support from families

Participants also indicated that the family support fostered the sustainability of their employment as well as commercial enterprises. Male family members supported PWMI in income-generating tasks whereas women provided support by taking on household chores. Although some dimensions of such support may not directly foster employment of PWMI, they assure participants’ general well-being, and aid in recovery-oriented efforts following episodes of mental illness. These dimensions include –

1. Family understands my condition and is supportive: Several participants reported that families or friends motivated them to seek help to treat mental illness and search for new jobs during or after episodes of mental illness. Their support also involved listening to concerns and offering help to meet other needs that otherwise went unmet – “Recently, I told my uncle (about my mental illness). He and one of my friends motivated me to come and see a doctor here”; “I have full support of my family members...they wish that my confidence should improve, that I should make progress in work”.

Participants often reported that family members are already “very supportive and happy with me”, and “whatever support is there is enough at present”.

2. Functional support when working: 24 participants (77%) reported they had adequate support from family members while they worked. These discussions centered mostly around the role of spouses or mothers in fulfilling all household responsibilities, reasserting the fact that men were the principal breadwinners (among 71% respondents) and enjoyed superior treatment at home. It was commonly reflected that when participants earned enough to cover the family’s needs, the family respected and valued them despite their status as ‘patients of mental illness.’

3. Financial support: Families of participants had extended financial support in different ways:

a) Family pays for treatment and meets financial needs: 12 participants (36%) revealed that due to their meager earnings, their family members, primarily parents or brothers, managed food, clothing, medication, and met other financial needs for them – “Father gives me whatever I want. They pay for my treatment”. But some participants also expressed discontent because they knew that full support of parents or brothers also implied their complete dependence on the family. They were aware of families being financially burdened in such situations – “My brothers are cooperative and caring. They take care of my medical expenses; but at times, even they express dissatisfaction because they find it difficult to manage subsistence”. In one case, a participant also highlighted how he was kept out of important decisions in the family because he was financially dependent on them – “My brother and father are very supportive. They pay for my treatment. But I do work as much as I can. I don’t have any complaints about their support. But at times, I feel they distance me at the time of making important
decisions”; “Uncle and wife motivated me to start this business. Uncle supported me financially. Later I paid him back”.

b) Family helps with income generation: 67% participants interviewed worked in the informal sector. One of their major concerns was complete loss of income during episodes of mental illness. In these instances, when asked how they managed sustenance during such times, self-employed participants reported that their family members looked after their business when they were unable to work. Family members who helped included brothers, fathers, mothers, wives, uncles, sons, and daughters. However, during such episodes, younger family members shared this burden at the cost of their studies or other duties. This was noted when one participant described how his “son and daughter left their Chartered Accountancy studies and started working”, while another mentioned that his wife “started working in a pharmacy” and his “college-going son started doing networking and computer and data-entry work” to support the household in his absence. In the same vein, another participant noted that in order “to support my earning, she (wife) has to work. She has to take care of the family; hence it is too much work for her”.

c) Family members helped in finding jobs/offered jobs: When asked what strategies participants used to find their jobs, it appeared that friends and family members, especially the brother and father, were an important reference while approaching employers. In several cases of self-employed individuals, participants had joined their family businesses.

Discussion

This study analyzed barriers experienced by PWMI while working in formal and informal settings. The findings broadly reveal that PWMI who encounter discrimination and abuse at the workplace and informal work settings are likely to have their mental illnesses exacerbated. By contrast, PWMI who work with family members (e.g. in family-driven businesses) face fewer barriers to maintaining their livelihood. This phenomenon highlights the potential impact of social support on business development among PWMI.

Hazards for PWMI at the workplace

The informal sector in India offers a plethora of job opportunities for unskilled labor. Unlike the formal sector, it does not pose structural barriers such as denial of job reservation or reasonable accommodation to employing PWMI (Nardodkar et al., 2016). All the same, we, note that vulnerability of PWMI is intensified in informal work settings, because in structurally unregulated, unprotected work environments their voices are likely to remain ignored owing to the negative prejudices about them (Santana, Loomis, Newman, & Harlow, 1997). That is, they are on the receiving end of a power dynamic in the workplace. While they have no choice but to work in order to
carry the burden of financial responsibility to their families in patriarchal societies like India, they become victims of discrimination and abuse at work due to the stigma associated with mental illness, for which they have no redress. This discrimination is reflected in employer-initiated actions, such as sudden loss of trust, reduction in workload once the employer is aware of the worker’s mental illness, job termination, and bullying. Incidents such as these often impede continuity of work for PWMI and result in frequent job changes that may last for days, weeks, or months.

Such instances also raise questions: why do perceptions of a worker’s capability change on disclosure of mental illness? Why are PWMI denied opportunities to compensate for unintentional losses incurred by them? Why do employers find terminating employment of PWMI as the only solution? As noted in a study by Shankar et al. (2014), presumption of complete loss of decision-making capacity due to mental illness illustrates why PWMI become victims of generalized distrust. Moreover, attribution biases towards PWMI are so dominant in social cognition that employers are likely to consolidate negative stereotypes, consider them as dangerous, uphold stigma regarding mental illness, and engage in direct discriminatory behavior towards them (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). At an unregulated workplace with few resources, PWMI are the first to bear the consequences of economic losses. Further testimonies of several participants of this study revealed that they face difficulties in finding a job after episodes of mental illness. This is because the label of being “mentally ill” or “having lost the mind,” once fixed, never leaves the person even after they have recovered. Such marginalization increases the likelihood of PWMI and their families living in conditions of perpetual economic deficit, thus prolonging a vicious cycle of mental disability, unemployment, and poverty (Patel & Kleinman, 2003).

*The promise and perils of family support as a form of social capital*

Most participants in this study reported the support of their family members as moderately to highly adequate. This was specifically true when PWMI were engaged in gainful employment and were committed to fulfilling their financial responsibilities to their families. On the other hand, as reported by the participants, family members/carers too expressed frustration in pulling together economic resources to subsist when an adult man in the family was not earning. In most of the cases of self-employment, participants reported fewer barriers when family members (father, brothers, sons) assisted them in their business, because they were not perceived as a burden on the family. Familiarity with the nature of the participant’s mental illness, and availability of human resources in emergency situations, helped family members in assisting the participant’s business during absence. In family-owned enterprises, this form of social capital inherently avoids barriers, such as threats of termination of employment contracts, bullying, or defamation at the workplace, which are otherwise common in the everyday life of PWMI in paid employment. With respect to self-employed individuals, reduced workload during the episodes of illness occurs by choice, and is not discriminatory or punitive in nature. Therefore, in business-oriented communities in some geographical regions in India (e.g. Gujarat, Maharashtra) (Tiwari, 2007, p.264), family-driven social entrepreneurship presents new avenues for PWMI.
However, the support of the family to males with mental illness also needs to be understood in the context of the patriarchal culture in India, where the birth of a boy is celebrated more than that of a girl. This is because men are considered as family’s principal breadwinners, women are not assigned this role because they move to husband’s home on marriage. As such, even those with mental illness will receive family support because, if not supported, their diminished livelihood will very likely threaten household survival (as well as personal dignity). Further, a family’s social standing and respectability are associated with male’s earning capacity and the nature and social recognition of his work. Under such circumstances, given the stigma of mental illness, if a male family member becomes mentally ill and does not earn a living, it brings dishonor and raises concerns about future family welfare. In this regard, elderly parents often wonder “who will take care of him after we die?” To avoid dishonor and cope with the worry, there is an inherent pressure for every family member to engage in jobs that promise higher remuneration. This push may appear in the form of support of the family members or friends to engage in paid work. Families and friends use informal networks based on relationships, language, religion, caste, geographical region, or type of entrepreneurship to offer employment to PWMI. Such networks are integral to local culture and inseparable from the economic transformations in society. For unskilled labor or for those with basic education, such networks provide a stronger source of information for job opportunities rather than job advertisements. Spreading knowledge of vacancies through informal networks can also be a faster, cost-effective and meaningful resource for individuals whose family members are unable to invest the financial resources to set up a business.

These circumstances highlight the need to study if peer-support-driven networks can constitute social capital to boost paid employment for PWMI. Peer-support-driven models of community-based entrepreneurship may help young entrepreneurs with mental illness deal with the stress of new responsibilities, find new opportunities, and develop social skills to use in the marketplace or with customers. Engaging peers from the same ethnic group may lead to symbiotic relationships between co-workers and also reduce the effects of stigma and discrimination in the workplace. Jobs obtained through such networks offer better opportunities for PWMI to integrate in their communities rather than being segregated. These networks serve to strengthen the social fabric of the community, and can share the burden of responsibility of economic empowerment of PWMI, especially when government support is inadequate.

Nonetheless, cultural prejudices towards PWMI are also common among family members. PWMI are often presumed to be incompetent to take financial decisions, so family members leave them out of decision-making process. As pointed out in the testimony of one participant, family members who assist PWMI in their entrepreneurial activities during an episode of illness may take over such ventures. Thus, family-driven social entrepreneurship may also pose a problem of substituted decision-making where PWMI work as helpers rather than owners of the business following episodes of mental illness. However, considering the limitations of evidence obtained in this study, there is
a need to further research the feasibility of this model for economic empowerment of PWMI in the informal economy.

**Accessing State support for income generation**

State support in fostering income generation among PWMI is underwhelming in India. Even the Rights of Persons with Disabilities Act, 2016, does not promise a fair share to PWMI in employment opportunities. S.34 of the Act reserves 4% of posts for persons with disabilities in government-owned enterprises. Of this 4%, the Act reserves 1% of posts each for persons with impaired vision, hearing and speech impairments, and locomotor disabilities. The remaining 1% of jobs reserved for persons with autism, intellectual disability and mental illness are also to be shared with persons with multiple forms of disabilities. Hence, given the stigma of mental illness, employers may identify posts for persons with some combination of other kinds of disability rather than reserving them exclusively for PWMI. Such unequal treatment in the law perpetuates stigma towards PWMI.

In addition, 25 (76%) participants interviewed in this study lacked awareness of mental illness being legally recognized as a form of disability, or did not know they were eligible to access disability-associated benefits. Such poor awareness could have occurred as a result of the under-promotion of benefits associated with mental disability by the local government due to the stigma of mental illness, since participants knew about benefits associated with physical and visual disability. Even when participants were aware of such benefits, they often expressed a concern that bureaucratic hurdles to obtaining mental disability certificates outweighed the value of benefits, for such certification did not promise any job opportunities unlike those with other forms of disability.

Overcoming the discriminatory practices against PWMI noted in this study requires a collective effort by all relevant stakeholders. To do so, we recommend:

1. Strong political will and greater allocation of resources to execute legislative reforms to eliminate discrimination against PWMI in labor laws. Considering the expressive power of the law, legislative reform holds special significance for reducing the stigma of mental illness.

2. Promotion of mental health and disability-awareness programs that facilitate integrated education, vocational training catering to the needs of PWMI, and improved access to mental health services, for these three aspects cannot be dealt with separately.

3. A larger body of robust evidence from different sources, such as national epidemiological surveys focusing on mental health, and the economic and professional profiling of PWMI. There is equally a need to improve the quality and accessibility of
national disability census data, to create reliable sources regarding the affected population and other pertinent information.

4. Knowing that models of supported employment like Individual Placement and Support are more suited to competitive jobs (Modini et al., 2016), additional research is required on finding appropriate alternatives to supported employment models in the informal sector. These alternatives may use the intrinsic characteristics of social capital to develop social-entrepreneurship programs. There is a need to improve the adequacy, availability, and accessibility of financial resources for PWMI.

5. Assistance of international communities to empower local civil society organizations to promote mental health and human rights advocacy.

Limitation of the study design

The experiences discussed in this study do not reflect the views of in-patients, people consulting private psychiatrists, workers from the organized public and private sectors, or even the perspectives of employers, colleagues, carers, and women with a mental illness. Factors such as an employee’s positive work history, focus on productivity, ability to consider mental illness as a legitimate medical condition, access to grievance systems at the workplace, prejudices towards PWMI, supporting the needs of employers and carers, and the availability of community resources to provide mental health care influence employment of PWMI, remain to be determined. In addition, there is a major need for a separate study of barriers that women face, given the interaction of gender disparities in employment, culture and mental illness.

Finally, data obtained in this study were prone to reaching saturation earlier than when conducted by more than one interviewer. The problem of early saturation is also true for a homogeneous sample in one setting. Hence, similar interviews conducted by multiple interviewers, with a larger sample size, and from multiple settings would be desirable.

Conclusion

The economic integration of PWMI is a major challenge in societies like India where government disability benefits are sparse. In this scenario, the informal economy offers far better opportunities for PWMI. However, stigma, discrimination and abuse constitute the biggest barriers to participation of PWMI in income-generation activities even in the informal economy. Pursuant to the Article 4 and Article 27 of CRPD, India needs to adopt legislative, culturally adaptable, scalable measures to end discrimination, make labor markets more inclusive of PWMI, and promote family-driven entrepreneurship in this segment of society.

Conflict of interest: None
References


Thornicroft, G., Patel, V., 2014. Including mental health among the new sustainable development goals. BMJ 349, g5189. doi:10.1136/bmj.g5189

Table 1: Demographics of the 33 participants interviewed in the study

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Frequency N=33 n (%)</th>
<th>Urban/Rural Mean Age</th>
<th>Number of participants/Type of Sector: Job Titles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently employed</td>
<td>21 (64%)</td>
<td>Urban 18 (86%); Rural 3 (14%)</td>
<td>35.9 years</td>
</tr>
<tr>
<td>Employment is discontinued</td>
<td>10 (30%)</td>
<td>Urban 7 (70%); Rural 3 (30%)</td>
<td>41.9 years</td>
</tr>
<tr>
<td>Never employed</td>
<td>2 (6%)</td>
<td>Urban 2 (100%)</td>
<td>24.5 years</td>
</tr>
</tbody>
</table>
Chapter 6. Employment rate, nature and pattern of employment

Cross-sectional study of employment of persons with mental illness in Gujarat, India

Abstract

Aim: To explore the rate, pattern and nature of employment among working age men with mental illness in Gujarat, India; to examine clinical and social factors associated with employment, and to identify awareness about mental disability certification among the respondents.

Methodology: We interviewed 295 out-patient clinic attendees at the Hospital for Mental Health, Ahmedabad using a structured questionnaire.

Results: We found that the employment rate was 50.8%. More than half of the employed respondents worked in the private sector, and largely (82%) in the informal sector. Only 4% respondents had government jobs. Forty percent of the respondents were self-employed. Almost 91% of the respondents worked full-time. In 36.6% cases, respondents were the sole earning members for the families of 3 to 6 members. Employed and unemployed respondents shared similarities on demographics, type and duration of mental illness, but differed on marital status and prior work experience. Nearly 79% respondents were unaware that mental illness was recognized as one of the forms of disabilities in India, and only 7.1% of the respondents had obtained mental disability certificates.

Conclusion: This study highlights the role of social indicators that facilitate employment of persons with mental illness. When these individuals become family’s principal breadwinners, they break a stereotype of being a burden on the families. Therefore, employment of persons with mental illness becomes an important strategy for stigma reduction. Persons with mental illness in India are rarely aware of the disability pertinent rights. There is a need to promote employment of persons with mental illness using a multi-sectoral approach.

Key words: Employment, mental illness, earning, informal sector.

Introduction

India’s recent Rights of Persons with Disabilities Act, 2016 aims to enforce the principles of United Nations Convention on the Rights of Persons with Disabilities. For the first time in India, law has promoted employment of persons with mental disabilities through affirmative action (1% job reservation in the public sector (government-owned
The law stipulates that the government has to identify posts for persons with mental illness who have 40% or more mental disability when assessed on Indian Disability Evaluation Scale (IDEAS) (Ministry of Social Justice and Empowerment, 2002). Accordingly, the government has to conduct the recruitment and review progress every three years.

The employment rate, patterns and nature of employment of persons with mental illness are underexplored in India. Available literature is limited to the National Sample Survey of 2002, report on the analysis of 2011 Census data, and a few regional research studies. Mitra & Sambamoorthi (2005) state that only 9.6% of the persons with mental illness were employed in India at the time of the National Sample Survey and that their employment rate was the lowest among persons with all types of disabilities across the country. The 2011 Census also shows that 75% of the persons with mental illness are out of the labor force. Only 15% of the persons with mental disabilities are engaged in non-seasonal work that lasts for more than 6 months every year (Ministry of Home Affairs, Government of India, 2011). These reports depict a dismal situation of employment of persons with mental illness. But regional studies in India show that persons with mental illness have higher employment rates. For instance, Srinivasan & Thara (1997) from Chennai showed that 53% of the study respondents with a first episode of schizophrenia (n=40) had ‘good occupational outcomes’ at the end of 10-year follow-up period. These occupational outcomes were measured in terms of duration of work, quality of work and level of income earned. However, this study excluded persons with schizophrenia who had less than 10 years of education and who could perform informal yet paid jobs. In a door to door survey in Chennai, Padmavathi, Rajkumar, & Srinivasan (1998) found that 69 out of 154 (45%) males with untreated schizophrenia were employed at the time of survey. Srinivasan & Tirupati (2005) observed that 67% of the respondents with schizophrenia from Chennai (n=88) were employed in mainstream employment. In a 4-year follow-up of a cohort study in Thirthahalli taluk of Karnataka, Suresh et al (2012) found that nearly two thirds of persons with schizophrenia surveyed (n=201) had “satisfactory work functioning” at the end of follow-up period; 37.3% of them worked as agriculturists, whereas 28.9% pursued household jobs. In another cross-sectional study in Manipal (Karnataka), Prasad & Acharya (2014) found that 42% of the study respondents with bipolar mood disorder and schizophrenia (n=152) were employed. Jaleel, Nirmala, & Thirthalli (2015) noted that 63% of the out-patient department visiting study respondents (persons with severe mental illness, n=216) at NIMHANS, Bangalore, (Karnataka) were employed at the time of study; 64% of these workers were engaged in unskilled or semiskilled work, 22.8% in skilled work, and 13.2% were semi-professionals or professionals.

Although employment rates among persons with mental illness presented in above studies seem considerably high, the available evidence has several limitations. These studies are conducted in India’s economically most progressive states. (Social Statistics Division, Ministry of Statistics and Programme Implementation, 2016). Therefore, data from these studies may not be representative of the employment rate of persons with mental illness in other agriculture-dominant states in India. These studies do not
separately analyze participation of persons with mental illness in public sector employment for which the affirmative action is framed in the new disability legislation. They identify job profiles based on levels of skills involved (i.e. skilled, semi-skilled, unskilled work), but do not specify what job profiles constituted these categories. It is thus unclear from the studies whether “working” or “employed” status of an individual was necessarily associated with a “paid employment”. This distinction is necessary because in India persons with mental illness are more likely to be financially and socially dependent on their family members (Social Statistics Division, Ministry of Statistics and Programme Implementation, 2016). They are more likely to engage in unpaid household work or unpaid work in family owned small businesses.

The present study targeted working age persons with common and severe mental illness who receive outpatient mental health services from a large tertiary care mental health facility. The study was conducted at the Hospital for Mental Health, Ahmedabad (HMH-A), Gujarat (India). The HMH-A is a district level mental hospital and patients living in Ahmedabad and nearby districts in Gujrat and Rajasthan use this hospital.

We studied the employment rate among men with mental illness after taking into consideration cultural expectation of men as primary breadwinners for their families. We aimed to understand the nature of their mental illness (severe mental illness and common mental illness), the patterns of their jobs (public sector and private sector), the nature of their work (formal vs informal, full-time vs part-time), and job profiles. A certificate of 40% or more mental disability is essential in order to access the affirmative action (job reservation) under mental disability quota in the government jobs. We explored if interviewees were aware that mental illness was recognized as one of the forms of disabilities in India. We also examined whether they had obtained such certificate. The study was approved by the Ethics Committees of Indian Law Society, Pune and HMH-A.

Methodology

We interviewed male patients, between 18-60 years, who attended the out-patient clinic of the HMH-A between January and November 2016 for the treatment of common and severe mental illness. We did not interview female patients because of the confounding influence of gender and mental illness on reduced participation in employment.

Recruitment

Psychiatrists at the out-patient clinic of HMH-A referred patients for this study if, based on a routine mental state examination, psychiatrists assessed the patients as being able to consent to participate in the study. Information about the nature and purpose of the study was given to each individual. He was also informed about his right to refuse participation in the study, to refuse answering any question, and to terminate the study
at any point. Once an individual consented to participate, we used a structured questionnaire to collect information about his demographics, education level, principal breadwinner(s) of his families, duration of his mental illness, physical illness (if any), current employment status, job pattern and profile. We assigned ‘employed’ status to a respondent if he had been engaged in paid work for a period of at least one month. With verbal consent, we noted diagnosis of the mental illness from their medical records.

**Ethical consideration**

At the recruitment stage, it was observed that referral by a treating psychiatrist influenced prospective respondents’ decision to participate in the study. We attempted to nullify the bias by reiterating that participation in research was neither obligatory nor it would result in any monetary or other benefits for the respondents. After this explanation, 73 out of 368 (19.8%) patients referred by the psychiatrists refused to participate this study.

**Data analysis**

We used the Chi Square test and the Independent-Samples T test to analyze the data. We compared the employed and unemployed groups of respondents based on their demographics, type of mental illness and its duration, and the employment pertinent characteristics. To classify their job as skilled, semi-skilled and unskilled labor, we used a schedule for classification of labor, provided by the Labor and Employment Department, Government of Gujarat (2014). Work in the government-owned enterprises (public sector) and the factories or mills (private sector) was considered as formal work. Self-employment was clustered under the category of the informal sector.

**Results**

Table 1 presents analyses of the information on demographics, physical and mental illness of the respondents. Table 2 summarizes employment related information of the respondents. We further discuss similarities and differences in the characteristics of employed and unemployed respondents.

Results of this study (Table 1) show that 50.8% of the respondents were working at the time of interviews. The employed and unemployed group of respondents did not differ significantly in terms of age, education, geographical location, and type of mental illness. Because it was a tertiary level mental health care facility, respondents with severe mental illness were over-represented in this study. Their distribution was non-normal on binomial test ($p=0.001$). Nearly 90% of respondents had severe mental illness like bipolar mood disorders, schizophrenia, schizoaffective disorders, and major depressive disorders. Approximately 10% of respondents had common mental disorders like obsessive compulsive disorder, anxiety disorder, depression, and panic attacks.
There was no significant difference in the duration of mental illness for the employed group \( (M=7.21, \ SD=6.538) \) and unemployed group \( (M=7.78, \ SD=6.612) \); \( t=-0.727(287), \ p=0.468 \). Nonetheless, when we compared the two groups based on respondents’ marital status, we found a statistically significant difference. There was a moderately strong association between ‘being married’ and ‘being employed’.

Table 1: Demographics of respondents \( (N=295) \)

<table>
<thead>
<tr>
<th>Measures</th>
<th>Employed ((n=150; 50.8%))</th>
<th>Unemployed ((n=145;49.2%))</th>
<th>( t(df)/\chi^2, p )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>37.9 ± 9.251</td>
<td>36.2 ± 10.651</td>
<td>( t=1.441(295), \ p=0.151 )</td>
</tr>
<tr>
<td>Education (years)</td>
<td>9.247 ± 3.849</td>
<td>9.345 ± 3.898</td>
<td>( t=-.218(295), \ p=0.828 )</td>
</tr>
<tr>
<td>Rural: Urban:</td>
<td>32 (21.3%); 118 (78.7%)</td>
<td>36 (24.8%); 109 (75.2%)</td>
<td>( \chi^2 = 0.508, \ p=0.476 )</td>
</tr>
<tr>
<td>Unmarried: Married: Separated:</td>
<td>42 (28%); 91 (60.7%); 2 (1.3%); 15 (10%)</td>
<td>71 (49%); 54 (37.2%); 7 (4.8%); 13 (9%)</td>
<td>( \chi^2 = 19.725, \ p=0.001, \ V=0.259 )</td>
</tr>
<tr>
<td>Common Mental Illness</td>
<td>15 (10%); 135 (90%)</td>
<td>14 (9.7%); 131 (90.3%)</td>
<td>( \chi^2 = 0.01, \ p=0.921 )</td>
</tr>
<tr>
<td>Severe Mental Illness:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Illness</td>
<td>15 (10%); 135 (90%)</td>
<td>16 (11%); 129 (89%)</td>
<td>( \chi^2 = 0.084, \ p=0.771 )</td>
</tr>
<tr>
<td>Yes:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of family members</td>
<td>5</td>
<td>5</td>
<td>( \chi^2 = 0.084, \ p=0.771 )</td>
</tr>
<tr>
<td>Median: Inter Quartile Range:</td>
<td>3 – 6</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Number of earning members</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Median: Inter Quartile Range:</td>
<td>1 – 2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

An analysis of the employment history of respondents (Table 2) shows that 6(4%) respondents worked in public sector and 84(56%) respondents worked in the private sector. Overall 33(22%) respondents worked in the formal sector (4% in public sector, 18% in private settings such as factories, mills). In 60(40%) cases respondents were self-employed. Of the employed respondents, 136 (90.7%) worked full time (8-10 hours per day), and 14 (9.3%) worked part-time (less than 5 hours per day).
Table 2. Employment Characteristics (N=295)

<table>
<thead>
<tr>
<th>Measures</th>
<th>Employed (n=150; 50.8%)</th>
<th>Unemployed (n=127; 43.1%)</th>
<th>Never Employed (n=18; 6.1%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Sector:</td>
<td>6 (4%)</td>
<td>6 (4.7%)</td>
<td>Nil</td>
</tr>
<tr>
<td>Private Sector:</td>
<td>84 (56%)</td>
<td>94 (74%)</td>
<td>Nil</td>
</tr>
<tr>
<td>Self-employed:</td>
<td>60 (40%)</td>
<td>27 (21.2%)</td>
<td>Nil</td>
</tr>
<tr>
<td>Level of employment skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled:</td>
<td>80 (53.3%)</td>
<td>76 (59.8%)</td>
<td>Nil</td>
</tr>
<tr>
<td>Semi-skilled:</td>
<td>23 (15.3%)</td>
<td>15 (11.8%)</td>
<td>Nil</td>
</tr>
<tr>
<td>Unskilled:</td>
<td>47 (31.3%)</td>
<td>36 (28.3%)</td>
<td>Nil</td>
</tr>
<tr>
<td>Respondent as principal breadwinner</td>
<td>107 (71.3%)</td>
<td>11 (8.6%)</td>
<td>Nil</td>
</tr>
</tbody>
</table>

Based on the classification of job profiles, it was found that 80 (53.3%) respondents worked as skilled labor and 47 (31.3%) as unskilled labor. The skilled workers had job profiles of an accountant, book seller, tours and travels agent, supervisor, lathe-machine operator, welder, jewelry maker, diamond cutting craftsman, carpenter, grocery or shoe shop owner. In contrast, unskilled laborers worked as agricultural laborers, helpers, loaders-unloaders, construction workers, liftmen, gardeners, and unarmed security guards. There was no significant difference in the level of skills of employed and unemployed respondents ($\chi^2=1.344$, $p=0.511$). However, when we compared the two groups based on years of work experience, they differed significantly (employed group: $M=15.3$, $SD=10.15$; unemployed group: $M=10.02$, $SD=10.36$; $t=4.17(264)$, $p=0.001$).

Furthermore, we found that out of 150 employed respondents, 107 (71.3%) respondents were the principal breadwinners of their families. In 55 (36.6%) of these cases, respondents were the sole earning members for families of 3 to 6 members. In rest of the cases (28.7%), respondents earned but other family members took a larger share of the financial responsibilities.

Among unemployed respondents, 10 (6.9%) respondents had borne the financial responsibility for their families when they were employed previously. In these cases, sons or brothers had taken over this responsibility at the time of interviews. In 5 (1.6%) cases, however, there were no earning member in the family. These families managed sustenance either through savings or financial help provided by extended family members. In 18(12.4%) cases, respondents were never employed and depended on their families for financial and social support.
We explored if unemployed respondents had willingness to work in the future and whether they were searching for new jobs. Twenty-five (17.2%) respondents informed that they did not want to work in the future due to their advanced age or recurring mental health problems. The remaining 120 (82.8%) respondents replied affirmatively to this question. In addition, out of these 120 cases, 108 (74.4%) respondents informed the researchers that they had previous work experience which could help them in returning to the work.

The disability legislation in India was undergoing reform at the time of interviews. Hence, we also enquired if respondents were aware that mental illness constituted one of the forms of disabilities in India. We found that only 63 (21.4%) respondents were aware of it, and only 21 (7.1%) respondents had obtained mental disability certificates.

Discussion

The present study shows that nearly half of the respondents were employed despite traditional barriers to employment such as low education, rural domicile, limited skills, and severity and chronicity of mental illness. One third of them were principal breadwinners for their families. Very few respondents had obtained the certificate of mental disability.

Social factors influencing employment and unemployment

The 50.8% employment rate observed in this study is similar to the employment rate noted in studies by Jaleel et al (2015) and Prasad & Acharya (2014). However, unlike previously discussed regional studies, present study highlights social (non-clinical) factors that are associated with employment of persons with mental illness.

In our study, the employed and unemployed groups of respondents differed only on work experience and marital status. Respondents with higher work experience were more likely to be employed and there was moderately strong association between employment and marriage of the respondents. We did not ascertain causality of these associations. Nonetheless, like Prasad and Acharya (2014), we too observed that unmarried respondents were more likely to be unemployed, and other family members supported them financially. It could also be true that due to unemployment, they did not marry or due to lack of spousal support, they could not continue their work. On the other hand, married men had a pressure to work and earn a living. This was either because of cultural expectations in the patriarchal society in India or due to the lack of unemployment benefits like those given in high income countries. Because respondents were only out-patient clinic attendees, it could also be true that their work-specific skills were unaffected because of the mental illness. So, their illnesses did not affect either their employment or marriage.
The present study also highlights a shift away from the medical model of disability towards the social model. Unlike clinical factors, two social factors appeared to have played an important role in influencing the employment of respondents. These factors were the predominant and accommodative informal sector in Gujarat (Hirway & Shah, 2015), and low cost social capital that respondents had leveraged to secure employment opportunities. Employment patterns and job profiles of the respondents reveal that 78% of them were working in the informal sector. Despite their low level of education, longer duration of mental illness (7 to 8 years), and limited skills, they were able to find paid work. During interviews, respondents often reported receiving help from family members and friends in finding new job opportunities. Thus, it can be observed that the use of social capital in the form of expanded informal networks, spousal support had facilitated recruitment, continuation of work of persons with mental illness in a cost-effective way.

This phenomenon underlines a unique opportunity for the mental health sector in India. Informal job opportunities are abundant in India (Hirway & Shah, 2015). These opportunities can be used for initiating income generation for persons with mental illness. Persons with prior work experience can be encouraged to return to work knowing that they are more likely to sustain their employment. Less educated, unskilled individuals can find paid work in the informal sector if informal social networks are used effectively to inform and secure job opportunities. Employment of persons with mental illness can not only mitigate the risk of being used as bonded labor in lieu of food, clothes and shelter; it can also aid to recover and improve self-esteem (Dunn, Wewiorski, & Sally, 2008). Using informal networks to secure job opportunities can reduce the cost of recruitment and strengthen cohesiveness of the communities. This is because improved contact with persons with mental illness is likely to reduce stigma of the illness and improve their acceptance within the community (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012). Similarly, if a family driven model of entrepreneurship is employed, the support of family members during the episodes of mental illness could be utilized to sustain income generation. However, persons with mental illness may face more human rights violations in the informal sector. They may not have access to redress mechanisms when employers or colleagues discriminate against them on the basis of their mental illness. Employers may sack persons with mental illness when symptoms of mental illness exacerbate. Persons with mental illness may be required to work at unsafe workplaces and at lower wages.

Primary role as breadwinners

The present study highlights that a significant number of persons with mental illness had successfully secured a job. They were fulfilling financial obligations towards their families despite pervasive stigma and discrimination. They functioned as the primary breadwinners in their respective families. Participants’ status as ‘principal breadwinner of the family’ challenges generalized perceptions that (a) persons with mental illness are unable or unwilling to work after the onset of illness, and (b) they do not earn and remain a burden on their families.
Poor awareness of and access to disability certificates

An important finding from the study was the poor level of awareness about mental disability certificate (21.4%) and access to mental disability certificates (7.1%). A disability certificate (indicating 40% or more disability on IDEAS) is required at the time of applying for government jobs under the mental disability quota in India. At this time, if patients do not know what their rights are and have not availed this certificate, they are unlikely to secure jobs under the disability quota. There is a need to promote awareness of disability associated protections and benefits amongst service users and their care-givers. Most marginalized and vulnerable patients who do not usually access such services are likely to remain excluded and be stigmatized further.

Conclusion

The present study sheds light on the role of social factors in shaping employment of persons with severe mental illness. It also provides insights into exploring a plethora of job opportunities in the informal labor market. It encourages use of cost-effective social capital such as informal networks to promote employment of persons with mental illness. The evidence documented in this study highlights the potential of employment as stigma reduction strategy.

Limitation of the study

This study observed employment rates among males who attended out-patient clinic only. To substantiate the evidence in Indian context, separate studies are warranted for females with mental illness or persons with mental illness who are admitted to the mental health facilities for short durations. Gender role expectations, duration of hospital stay, support of patients’ families may influence their participation in the employment.

Conflict of interest: None
Bibliography


Part II – Marriage

Chapter 7. Legal Barriers

Legislative provisions related to marriage and divorce of persons with mental health problems: a global review

Abstract

Realization of right to marry by a person is an exercise of personal liberty, even if concepts of marriage and expectations from such commitment vary across cultures and societies. Once married, if an individual develops mental illness the legal system often starts to discriminate against the individual. There is no doubt that every individual’s right to marry or remain married is regulated by their country’s family codes, civil codes, marriage laws, or divorce laws. Historically mental health condition of a spouse or intending spouse has been of interest to lawmakers in a number of ways from facilitating divorce to helping the individual with mental illness. There is no doubt that there are deeply ingrained stereotypes that persons with mental health problems lack capacity to consent and, therefore, cannot enter into a marital contract of their own free will. These assumptions lead to discrimination both in practice and in law. Furthermore, the probability of mental illness being genetically transmitted and passed on to offspring adds yet another dimension of discrimination. Thus, the system may also raise questions about the ability of persons with mental health problems to care, nurture, and support a family and children. Internationally, rights to marry, the right to remain married, and dissolution of marriage have been enshrined in several human rights instruments. Domestic laws were studied in 193 countries to explore whether laws affected the rights of people with mental illness with respect to marriage; it was found that 37% of countries explicitly prohibit marriage by persons with mental health problems. In 11% (21 countries) the presence of mental health problems can render a marriage void or can be considered grounds for nullity of marriage. Thus, in many countries basic human rights related to marriage are being flouted.

Keywords

Divorce; marriage; mental illness; mental deficiency

Introduction

Marriage is one of the oldest institutions and in many cultures, there is almost universal expectation that individuals will get married in order to procreate and bring the family up together as a unit. Depending upon whether the individuals are from ego-centric societies or socio-centric societies or from sex-positive or sex-negative societies their own expectations from marriage will differ from those of the society. Marriage of
people with mental illness or those developing mental illness once married has specific connotations. Another variable in the role of the marriage is related to gender. In many cultures women will be expected to marry according to gender roles and gender role expectations. Combined with mental illness this may create double jeopardy against women with mental illness and discriminate against them further.

Marriage provides a wider continuum for social attachment (Ross, 1995) and fosters emotional and physical well-being of the partners (Ross, Mirowsky, & Goldsteen, 1990; Simon, 2002). Marriage improves economic well-being of families, especially women (Lerman, 2002), and gives equal access to wider financial security benefits (Tebbe & Widiss, 2010). ‘Married’ status is associated with greater longevity, whereas unmarried, divorced, or widowed people, especially men, have higher mortality rates (Hu & Goldman, 1990). Divorced or separated persons have higher risk of suicide (Kposowa, 2000). Disruption in marital status of parents negatively affects overall psychological well-being and academic performance of children (Amato, 2001; Sun & Li, 2002).

Realization of the right to marry by a person is an exercise of personal liberty. Every individual’s right to marry or remain married is regulated by his or her country’s family codes, civil codes, marriage laws, or divorce laws. However, social expectations also play a role. For example, in some countries parents want to get their children with mental illness married off to ensure there is a care-giver after the parents are no more, and there is the assumption that marriage can cure mental illness. Historically, the mental health condition of a spouse or intending spouse has been of interest to lawmakers. Laws of many countries have considered conditions of unsound mind or insanity as lawful grounds for either not permitting marriage or annulling or dissolving nuptial ties (Ali, 2013; Hasson, 2009; McCurdy, 1943; Pathare, Nardodkar, Shields, Bunders, & Sagade, 2015; Reddy, 1995) In many countries, marriages of ‘idiots’ or ‘lunatics’ have been recognized as unlawful (Matloff, 2009; Nambi, 2005). This approach is based on stereotypes that persons with mental health problems lack the capacity to consent and, therefore, cannot enter into a marital contract of their own free will. Other possible reasons for prohibiting marriage of persons with mental health problems include concerns about inheritability of mental illness in the off-spring of such a marital union and questions about the ability of persons with mental health problems to care for, nurture, and support a family and children.

Internationally, rights to marry, right to remain married, and dissolution of marriage have been enshrined in several human rights instruments. These include Article 16 of the Universal Declaration of Human Rights (UN General Assembly, 1948) and Article 10 of the International Covenant on Economic, Social and Cultural Rights (UN General Assembly, 1966) (ICESCR). For persons with mental disabilities, provisions of Art. 23.1(a) of the United Nations Convention on the Rights of Persons with Disabilities (UN General Assembly, 2007) (CRPD) explicitly state that the State Parties (countries) shall ensure ‘The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is
recognized’. State Parties (countries) are also required to take ‘effective and appropriate measures to eliminate discrimination against persons with disabilities’ in relation to protection of right to marry and found a family. In the context of Art. 4 (b) of CRPD, these effective and appropriate measures include legislative measures ‘including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities’. Taken together, these obligations require Member States to bring their marriage regulating laws in line with the principles of CRPD, so that persons with mental health problems or disabilities can marry on the basis of free and full consent of the intending spouses.

We reviewed marriage and divorce laws of United Nations Member States to examine how national laws regulated marital issues for persons with mental health problems and to examine adherence of national laws with international human rights obligations.

Aims and Objectives

To marry, remain married, and protection against dissolution of marriage on the basis of mental health problems are integral in exercise of ‘right to marry’, as described in Article 23.1(a) of CRPD. The aim of this study was to find out whether national laws curtailed rights of persons with mental health problems to marry and remain married. The objectives of the study were to evaluate provisions of laws to examine if presence of mental health problems rendered persons being considered unfit for marriage, or rendered marriage as void or voidable, or rendered marriage as dissolvable.

Methodology

We obtained copies of Family Codes, Civil Codes, Marriage and Divorce Laws, of 193 UN Member States from various databases including LandWise (http://landwise.resourceequity.org/), NATLEX of International Labour Organization (http://www.ilo.org/dyn/natlex), and World Intellectual Property Organization (http://www.wipo.int/portal/en/index.html). For federal countries, we analysed laws of most populous state as a representative state of that country. When pertinent legislation was not found, we extended our search to non-codified sources like academic papers, books, university reports, and government’s reports. For non-English versions of laws, we used available authoritative translations. In other cases, we used Google Translate to translate key terms and pertinent provisions of the laws. We identified provisions of marriage, divorce, capacity, and mental health conditions, and other family relations using the following keywords: mental, unsound, mind, insane, sane, mad, cognitive, intelligence, infirm, imbecile, dementia, demented, full reason, deficient, derangement, disturbed, defect, capacity, incapable, ability, disability, disorder, disease, illness, disturbance, handicap, health, fitness, sickness, capacity, lunatic, family, impediments, requirements, curable, etc.
For marriage and annulment provisions, we searched key words or a combination of key words including: marry, at the time of marriage, void, voidable, divorce. For systematic comparisons of laws, we used World Bank Classification of income status of the countries, and Member States’ ratification status of ICESCR and CRPD as mentioned in the United Nations Treaty Collection.

Results

Our search revealed that the right to marry and remain in the marriage was codified in a diverse set of laws including civil marriage and divorce laws; civil codes, civil and commercial code; transitional civil codes, family code, code of persons and family, family and guardianship codes; birth, deaths and marriage registration laws; personal laws, laws regulating contraction and dissolution of marriage, personal status laws, domestic/family relations laws, ordinances, and in some countries, in a women’s charter of rights.

Section A: analysis of provisions of laws covering void and voidable marriages

We found that laws in only 30% (58 countries) do not impose any restrictions on the eligibility of persons with mental health problems to enter into marriage (See Table 1). In 37% (71 countries) laws explicitly prohibit marriage by persons with mental health problems. In 11% (21 countries) the presence of mental health problems can render a marriage void or can be considered grounds for nullity of marriage. In 6% (11 countries) persons with mental health problems are allowed to marry subject to approval from others. Of these 11 countries, four countries allow marriage with permission from the appropriate Court or Family Council, in four countries persons with mental health conditions may marry subject to consent from a parent, guardian, or custodian, and in two countries marriage is only permitted subject to approval from an expert or an institution (see Table 2).

<table>
<thead>
<tr>
<th>Overall frequencies</th>
<th>(n=193 countries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No restriction on marriage by persons with mental health problems</td>
<td>58 (30%)</td>
</tr>
<tr>
<td>Persons with mental health problems barred from getting married</td>
<td>71 (37%)</td>
</tr>
<tr>
<td>Persons with mental health problems allowed to get married on certain conditions</td>
<td>11 (6%)</td>
</tr>
<tr>
<td>Mental health problem rendering marriage void/being a ground for nullity (see Table 2)</td>
<td>21 (11%)</td>
</tr>
<tr>
<td>Marriages governed by Sharia</td>
<td>12 (6%)</td>
</tr>
<tr>
<td>Law not found</td>
<td>18 (9%)</td>
</tr>
<tr>
<td>Not clear</td>
<td>2 (1%)</td>
</tr>
</tbody>
</table>

Table 1 Overall Status of 193 countries on right to marry and persons with mental illness
Table 2. Conditions permitting marriage of mental health problems

<table>
<thead>
<tr>
<th>Overall frequencies</th>
<th>(n=11 countries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage allowed if the person has capacity to understand</td>
<td>1 (9%)</td>
</tr>
<tr>
<td>Marriage allowed subject to Courts/family council’s permission</td>
<td>4 (36%)</td>
</tr>
<tr>
<td>Marriage allowed subject to Parent’s/guardian’s/custodian’s consent</td>
<td>4 (36%)</td>
</tr>
<tr>
<td>Marriage allowed subject to Doctor’s/institution’s opinion</td>
<td>2 (18%)</td>
</tr>
</tbody>
</table>

Economic status of the countries and right to marry

There are no significant differences between countries based on their economic status. Our review revealed no restriction on right to marriage of persons with mental health problems in 10 countries (33%) from the lower income group and 18 countries (31%) from the high-income group. Similarly, laws of nearly 30% (n= 9) of countries from the low-income group, 42% (n= 22) from the higher-middle income group, and 36% (n = 21) from the high-income group prohibited persons with mental health problem from marriage (See Table 3).

Table 3. Income level of the countries (World Bank classification) and right to marry for persons with mental illness

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Low income (n= 30)</th>
<th>Lower middle income (n= 50)</th>
<th>Upper middle income (n= 53)</th>
<th>Higher income (n= 59)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No restriction on marriage by persons with mental health problems</td>
<td>10 (33%)</td>
<td>13 (26%)</td>
<td>16 (30%)</td>
<td>18 (31%)</td>
</tr>
<tr>
<td>Persons with mental health problems barred from marriage/marriage not recognized by law</td>
<td>9 (30%)</td>
<td>19 (38%)</td>
<td>22 (42%)</td>
<td>21 (36%)</td>
</tr>
<tr>
<td>Persons with mental health problems allowed to marry on certain conditions</td>
<td>1 (3%)</td>
<td>2 (4%)</td>
<td>3 (6%)</td>
<td>5 (8%)</td>
</tr>
<tr>
<td>Mental health problem rendering marriage void/being a ground for nullity</td>
<td>3 (10%)</td>
<td>7 (14%)</td>
<td>4 (8%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Marriages governed by Sharia</td>
<td>0 (0%)</td>
<td>5 (10%)</td>
<td>3 (6%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Law not found</td>
<td>7 (23%)</td>
<td>3 (6%)</td>
<td>4 (8%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Unclear</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

We also found that laws frequently use non-scientific, derogatory, and archaic terminology to describe persons with mental health problems. Such terms include: no sufficient use of reason, unable to reason, unsoundness of mind, dementia, demented, insanity, not being sane, mental illness/disorder/disease/disability/handicap, temporary
or permanent mental disorder, disturbance of mental activity, mentally disturbed, mental disturbance, mental defect, mentally unfit, incapable of judging, imbecility, deficient mental health, absence of sound mind, diminished in intelligence, demented, not gone mad, mad man, psychologically incapacitated, mental derangement, mentally deranged, and infirmity of mind.

Despite binding obligations under international treaties, 40% (n=63) of countries that have ratified the ICESCR and 41% (n=64) of countries that have ratified the CRPD prohibit marriage by persons with mental health problems (See Table 4).

Table 4. Ratification status by country and right to marry for persons with mental illness

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Ratified ICESCR (n=157)</th>
<th>Ratified CRPD (n=157)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No restriction on marriage by persons with mental health problems</td>
<td>45 (29%)</td>
<td>44 (28%)</td>
</tr>
<tr>
<td>Persons with mental health problems barred from marriage/marriage not recognized by law</td>
<td>63 (40%)</td>
<td>64 (41%)</td>
</tr>
<tr>
<td>Persons with mental health problems allowed to marry on certain conditions</td>
<td>10 (6%)</td>
<td>10 (6%)</td>
</tr>
<tr>
<td>Mental health problem rendering marriage void/being a ground for nullity</td>
<td>16 (10%)</td>
<td>19 (12%)</td>
</tr>
<tr>
<td>Marriages governed by Sharia</td>
<td>9 (6%)</td>
<td>12 (8%)</td>
</tr>
<tr>
<td>Law not found</td>
<td>12 (8%)</td>
<td>6 (4%)</td>
</tr>
<tr>
<td>Unclear</td>
<td>2 (1%)</td>
<td>2 (1%)</td>
</tr>
</tbody>
</table>

Section B: analysis of provisions of laws covering dissolution of marriages

We found in 63% (n=121) of countries that laws offer some protection to persons with mental health problems by not listing mental health problems as a lawful ground for divorce. Twelve per cent (n=23) of country laws allow mental illness (of any severity or duration) in a spouse as a ground for divorce, while, in 4% (n=8) of countries, long duration (3–5 years) and/or ‘incurability’ of mental illness was allowed as grounds for divorce (See Table 5).

Table 5. Overall status of 193 countries on mental illness as a ground for divorce

<table>
<thead>
<tr>
<th>Overall frequencies (n=193 countries)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental illness is a ground for divorce</td>
<td>23 (12%)</td>
</tr>
<tr>
<td>Mental illness not a ground for divorce</td>
<td>121 (63%)</td>
</tr>
<tr>
<td>Mental illness of 3–5 years of illness/incurability as a ground for divorce</td>
<td>8 (4%)</td>
</tr>
<tr>
<td>Marriages governed by Sharia</td>
<td>11 (6%)</td>
</tr>
<tr>
<td>Law not found</td>
<td>30 (16%)</td>
</tr>
</tbody>
</table>
Low middle-income countries were most likely to allow divorce on the grounds of mental illness (24% as compared to 6–10% in other income groups) (See Table 6). Eleven per cent (n= 17) and 12% (n= 19) of countries that have ratified the ICESCR and CRPD, respectively, allowed mental illness of a spouse as a valid ground for divorce. Another 4% of countries that have ratified the ICESCR and CRPD allowed divorce on the grounds of long duration of mental illness or incurability of mental illness (See Table 7).

Table 6. Income status: mental illness as a ground for divorce

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Low income (n= 30)</th>
<th>Lower middle income (n= 50)</th>
<th>Upper middle income (n= 53)</th>
<th>Higher income (n= 59)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental illness is a ground for divorce</td>
<td>2 (7%)</td>
<td>12 (24%)</td>
<td>3 (6%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Mental illness not a ground for divorce</td>
<td>19 (63%)</td>
<td>25 (50%)</td>
<td>34 (64%)</td>
<td>42 (71%)</td>
</tr>
<tr>
<td>Mental illness of 3–5 years of illness/incurability as a ground for divorce</td>
<td>0 (0%)</td>
<td>2 (4%)</td>
<td>5 (9%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Marriages governed by Sharia</td>
<td>1 (3%)</td>
<td>4 (8%)</td>
<td>2 (4%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Law not found</td>
<td>8 (27%)</td>
<td>7 (14%)</td>
<td>9 (17%)</td>
<td>6 (10%)</td>
</tr>
</tbody>
</table>

Table 7. Ratification status and mental illness as grounds for divorce

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Ratified ICESCR (n= 157)</th>
<th>Ratified CRPD (n= 157)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental illness is a ground for divorce</td>
<td>17 (11%)</td>
<td>19 (12%)</td>
</tr>
<tr>
<td>Mental illness not a ground for divorce</td>
<td>102 (65%)</td>
<td>102 (65%)</td>
</tr>
<tr>
<td>Mental illness of 3–5 years of illness/incurability as a ground for divorce</td>
<td>7 (4%)</td>
<td>7 (4%)</td>
</tr>
<tr>
<td>Marriages governed by Sharia</td>
<td>8 (5%)</td>
<td>11 (7%)</td>
</tr>
<tr>
<td>Law not found</td>
<td>23 (15%)</td>
<td>8 (5%)</td>
</tr>
</tbody>
</table>

Discussion

We believe this is the first study to present a comprehensive review of laws of all UN Member countries regulating marriage and divorce of persons with mental health problems. Findings of the study give a global perspective on provisions of marriage, annulment, and divorce of persons with mental health problems. Our findings highlight the important issue that discrimination against people with mental illness is rife in many countries. The likelihood of getting divorce on grounds of mental illness is another major problem. This may be used in domestic disputes to find an easy solution, thus isolating and discriminating further against individuals with mental illness.
Discriminatory marriage laws foster stigma of mental illness and prevent social integration

In many societies from Africa and Asia, married couples are treated with dignity and respect; whereas annulment or dissolution of marriage carries profound stigma (Arugu, 2014; Dommaraju & Jones, 2011). Society holds ‘disapproving and devaluing attitudes’ towards those who are divorced because of mental illness (Lauber & Rossler, 2007). Marriage laws further consolidate the stigma of divorce due to mental illness. In such cases, a Court order is a confirmation that concerned person’s mental illness is incurable and it is unreasonable to expect another person to stay with the person with mental health problems. Furthermore, such orders are likely to reduce future chances of remarriage of the person with mental health problems.

There is some evidence that women and their family members are more likely to be ridiculed by society if nuptial ties are broken due to the woman’s mental illness. In India, Thara, Kamath, and Kumar (2003a) found that women and family members experience extreme stigma and higher distress levels due to divorce because of mental illness than due to mental illness alone. These women and their children often lose access to financial and social securities that come along with the marriage (Thara, Kamath, & Kumar, 2003b). Family members who take care of these female patients find it burdening and exhausting. In such cases, if symptoms of mental illness are acute and there is little psychiatric help available, their families may even be forced to relocate. These families often express their burn-out saying ‘Her death will be our only relief’ (Thara et al., 2003a). One may argue that lack of social structures, including mental healthcare within the community, and dearth of academic and economic empowerment policies of women with mental illness also contribute to social exclusion as much as legal provisions of divorce on the basis of mental illness. Marriage laws, however, institutionalize the stigma of mental health problems and lead to downstream violation of multiple human rights, particularly for women with mental health problems.

Provisions of marriage laws differentially impact men and women

Although provisions in the law regulating annulment or divorce on the basis of mental health problems are gender-neutral in most countries, in practice these provisions have differential negative effects for women, as shown in studies from some countries. Pathare et al. (2015) have shown that over a 20 years’ period, in 85% of cases it was husbands who sought divorce on the grounds of mental illness. Surprisingly, in 14% of the cases, relief was granted ex-parte, meaning the woman was neither present nor represented in these cases in Court. The poor financial status of women, lack of emotional and practical support for women from their natal families and stigma associated with divorce means few, if any, women are likely to go to Court asking for a dissolution of marriage on grounds of their husbands’ mental health problems. In the case of uncodified personal laws, Mashhour (2005) argues that the patriarchal nature of many countries, and not religion, has led to ‘deterioration of women’s rights’. Divorce is one area where masculinity has dominated over the years (Shahidian, 2002, p. 56).
Patriarchal nature of the society and institutionalization of persons with mental health problems pose most common risks for misuse of annulment and divorce laws.

Presumptions of annulment or divorce provisions appear to be based on stereotypes rather than any concrete evidence of the inability to perform matrimonial duties. Use of non-standardized terms to describe mental health conditions typically denotes stereotypes associated with status approach. While decision-making capacity is task-specific, ill-defined terms such as ‘unable to reason’ and ‘unsound mind’ are likely to be equated with mental health condition. For example, the Supreme Court in India has interpreted ‘unsound mind’ to mean ‘mental illness’ (Hari Singh Gond vs State of MP, 2008), although there is no specific definition of ‘unsound mind’ in any Indian legislation. In this regard, the Committee on the Rights of Persons with Disabilities (2014) has expressly stated in General Comment No. 1 that ‘perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity’. Moreover, use of terms like ‘madman’, ‘demented’, or ‘deranged’ perpetuate stigma of mental illness. Thus, laws which invalidate consent of persons with mental health problems by provisions of void or voidable marriage need to be amended and brought in line with CRPD. Laws in some require an expert such as a psychiatrist to decide whether a person with mental health problems can perform and fulfil duties in a marriage. Lack of procedural protections is likely to lead to misuse of these provisions against women (Pathare et al., 2015).

It is evident from the results of this study that law makers and policy-makers in many countries urgently need to remove legal barriers to marriage of persons with mental health problems to ensure that non-discrimination as enshrined in ICESCR and CRPD is supported in national legislation.

Unobstructed right to marry and supported decision-making

An often-asked question is how legislation can provide procedural support to persons with mental health problems when they have to make major life decisions. The supported-decision-making model as promoted in the CRPD provides a way to ensure that assistance is provided to persons with mental health problems to enable them to realize their rights based on their will and preferences including the decision to enter into marriage.

Over the past decades, the world has gradually moved away from the notion of disallowing or invalidating marriage or allowing divorce on the grounds of a health problem of a particular spouse; for example, epilepsy, leprosy, and HIV/AIDS. It is time we adopt a similar principle for mental illness so that mental health problems by themselves cannot be considered as legitimate cause to either prevent marriage or enable divorce. Further research in this area may explore and address legal barriers in
accessing maintenance as a remedial measure in the cases involving mental illness as a ground for annulment or dissolution of marriage.

Limitations

We did not review subsidiary legislation such as rules and regulations, disability and women empowerment policies or national programmes, or case law framed under the family codes, and marriage laws in this study. Such subsidiary legislation, programme, or case law may contain important provisions pertaining to rights of persons with mental disabilities and may have been missed in this study. We also did not look for or examine draft bills because a final version of legislation that would be approved may differ from the current bill. We were unable to find laws pertaining to marriage in 10% of countries and legal provisions for divorce in 16% of countries. We do not, however, feel that this missing data significantly impacts our findings. Sharia law is uncodified and is interpreted variously in different countries. Hence, we were unable to analyse provisions of Sharia law. Variations in the definition of mental illness and equation with mental disability, mental disorder, and insanity, as well as various other terms may have a further emphasis on the legal aspects of marriage.

Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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References


Chapter 8. Legal Barriers

Gender, mental illness and the Hindu Marriage Act, 1955

Abstract

Introduction: Section 5(ii) of The Hindu Marriage Act, 1955 (HMA) states that under certain circumstances, mental illness is accepted as a ground for the annulment of marriage, while Section 13(1) (iii) states that mental illness is a ground for divorce. There is little data on how this provision is used and applied in matrimonial petitions. This paper assesses judicial practices in divorce cases, exploring the extent to which gender and the diagnosis of mental illness affect the decision to grant annulment or divorce.

Methods: The paper analyses judgments related to annulment and divorce at the Family Court in Pune and at the High Courts in India.

Results: In the Family Court at Pune, 85% of the cases were filed by husbands, who alleged that their spouse was mentally ill. Medical evidence of mental illness was presented in only 36% of the cases and in many cases, divorce/nullity was granted even in the absence of medical evidence. In 14% of the cases, nullity/divorce was granted even when both spouses were not present. Of the Family Court cases reaching the High Court, 95% were filed by male petitioners. The High Courts reversed the lower courts' judgments in 50% of the cases.

Discussion: Our analysis highlights the need for standardised guidelines for lower courts on what constitutes adequate medical proof of mental illness when hearing a petition related to nullity or divorce under HMA. It also provides a critical review of Section 5(ii) of HMA.

Introduction

Marital disputes and family matters in India: the legal scenario

Family-related legal procedures in India are governed by personal laws, which are steeped in religious beliefs and cultural values. Across all religions, cases pertaining to matrimonial issues, maintenance, alimony and the custody of children, whether during marital disputes or after divorce, are tried by the Family Courts or by District Courts. Before Family Courts were introduced, the Code of Civil Procedure was amended with the aim of establishing a special procedure for proceedings related to matrimonial disputes. In 1974, the report of the Status of Women Committee (1), together with the report of the 59th Law Commission (2), recommended that the Central Government establish a separate judicial forum to settle family disputes.
Family Courts were introduced in some parts of India through the Family Courts Act, 1984 (FCA), which was intended to be a part of the legal reforms related to the position of women in society. FCA enables the state government (in consultation with the High Court) to establish a Family Court in any area of the state which is a city, or in areas where the population exceeds one million. The idea behind the establishment of the Family Court and the separation of the functions of the Civil Courts was to expedite the settlement of family disputes (3). Although the central government issues the qualification criteria for the judges of Family Courts, the enforcement of FCA is governed largely by the High Courts, and thus, the Family courts are permitted to establish their own procedures.

A case filed at the Family Court goes up in appeal to the High Court and then to the Supreme Court. The High Court has jurisdiction over the entire state and has the legal power to transfer cases between Family Courts.

The role of Family Courts in Maharashtra

In Maharashtra, only 11 Family Courts (4,5) have been established since 1987. It is important to note that Family Courts in the state have marriage counsellors, who are expected to counsel couples and preserve the institution of marriage. Social welfare employees may also be employed in specific cases. Although the original idea behind having a marriage counsellor was to protect women, counsellors have been criticised for working against the interests of women as they see their role as being that of preserving the institution of marriage at all costs. Interestingly, the reports prepared by marriage counsellors are not binding on the judiciary and are not cross-checked (3).

Nullity or divorce on the ground of mental illness

According to HMA, a marriage may be solemnised on the fulfilment of certain conditions, specified in Section 5 of the Act. When HMA was enacted in 1955, Section 5(ii) specified the condition that “neither party to the marriage should be an idiot or lunatic.” The Marriage Laws (Amendment) Act, 1976 amended HMA and substituted this clause with another one (in the current Section (ii) of the HMA), which states that a marriage may be solemnised if “at the time of marriage, neither party is (a) incapable of giving a valid consent to it in consequence of unsoundness of mind, or (b) though capable of giving a valid consent, has been suffering from mental disorder of such a kind or to such an extent as to be unfit for marriage and the procreation of children, or (c) has been subject to recurrent attacks of insanity or epilepsy”. The term “or epilepsy” was deleted from this sub-section in 1999. None of the terms used here, such as “unsoundness of mind”, “mental disorder” or “insanity”, are adequately defined.

Under sub-section 1(b) of Section 12 of HMA, a marriage is “voidable” and “may be annulled by a decree of nullity...if... the marriage is in contravention of the condition specified in clause (ii) of Section 5.” Thus, mental illness may form the ground for
annulment of a marriage. Sub-section 1(c) of Section 12 allows for the annulment of a marriage if “the consent of the petitioner . . . was obtained by force, or by fraud as to the nature of the ceremony or as to any material fact or circumstance concerning the respondent.” Under this provision, petitioners may claim that the concealment of mental illness prior to marriage is a “material fact” and hence, seek annulment of the marriage on the ground of fraud.

Section 13 of HMA specifies grounds for divorce. In subsection (1)(iii) of Section 13, mental illness is accepted as a ground for divorce under certain circumstances. The subsection states that divorce is permissible if someone “has been incurably of unsound mind or has been suffering continuously or intermittently from mental disorder of such a kind and to such an extent that the petitioner cannot reasonably be expected to live with the respondent.” Section 13(1) has an “Explanation”, which states:“(a) the expression ‘mental disorder’ means mental illness, arrested or incomplete development of the mind, psychopathic disorder or any other disorder or disability of the mind and includes schizophrenia; (b) the expression ‘psychopathic disorder’ means a persistent disorder or disability of mind (whether or not including sub-normality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the other party, and whether or not it requires or is susceptible to medical treatment.”

These provisions of HMA are discriminatory against persons with mental illness as they make mental illness the only form of disability that can constitute a ground for the annulment of marriage or divorce. There is also a potential for the misuse of these provisions in a gender-biased manner. First, in a patriarchal society such as that of India, in which men are the sole decision-makers in the family, the equal enjoyment of rights and entitlements by women can be easily compromised. Second, the substantial stigma associated with mental illness reinforces the false notion that persons with mental illness are violent and dangerous to self or society and cannot be expected to continue in a marriage. Third, many people have the misconception that mental illness is associated with infertility and reduced childbearing capacity. This is reflected in Section 5(ii)(b) of HMA, cited earlier: “...though capable of giving a valid consent, has been suffering from mental disorder of such a kind or to such an extent as to be unfit for marriage and the procreation of children”. Finally, the misconceptions regarding the genetic inheritance of mental illness may have a negative impact on the use of such provisions. Women with a mental illness may face double discrimination in cases related to marriage laws (6,7).

The objective of this paper is to assess judicial practices to determine the role of gender and medical evidence in proceedings in matrimonial cases in at Family Court and High Courts.

To explore the issue, we conducted an analysis of judgments on annulment and divorce at the Family Court in Pune, focusing specifically on cases in which annulment or divorce
was being sought on grounds related to unsound mind and/or mental illness (Section 12 (1)(b) and (c) and Section 13(1) (iii) of HMA). We also analysed cases related to annulment or divorce on the ground of mental illness that had been decided by various High Courts in India.

Methods

We obtained permission from the Principal Judge at the Family Court in Pune to conduct this study. One faces major practical difficulties while searching for and retrieving cases in the Family Court. The data are not computerised, and all the physical data are stored in a record room and are not indexed. When a case is filed in the Family Court, the basic data (including the relevant Section of HMA under which annulment or divorce is being sought) are entered in writing in a register. These registers are maintained on a yearly basis. We first searched through the yearly registers and found details of cases in which the plaintiff had pleaded for annulment under Section 12(1)(b) or Section 12(1)(c) or divorce under Section 13(1)(iii). We then had to request the staff of the Family Court to dig out the relevant case papers. We were allowed to examine the case records and read through them. We were not permitted to take copies of the records or take them out of the records room. Although we had initially planned to search for cases spanning a 20-year period (1993–2012), it was logistically not possible for the staff to identify cases from earlier years. Therefore, this analysis covers only a 17-year period (1996–2012).

Further, it was only for 2011 and 2012 that we could collect the details of the total number of annulment or divorce cases filed. For all other years, it was possible to collect the details of annulment cases filed only under Section 12(1)(b) or Section 12(1)(c) or divorce cases under Section 13(1)(iii).

The data extracted from the case records were recorded manually and entered into an Excel spreadsheet. These data included information on: the date of marriage, date of separation, date of filing of the petition, date of the judgment, the person who had filed the petition (husband or wife), the type of relief sought, the type of medical evidence presented in the petition, and the final judgment of the court. No personal information that could be used for identification, such as the names, addresses and contact details, was recorded.

To look for cases at the High Court level, an electronic database search was conducted, using the Supreme Court Cases Database (SCC Online) and Indiankanoon.org and covering the period from 1976 (when HMA was amended) to 2013. The first relevant judgment yielded by the search was from the year 1981. Only those cases filed under the current HMA and those pleading for nullity or divorce on the ground of mental illness (Section 12 (1)(b) or 12(1)(c) or Section 13(1)(iii)) were included.
Descriptive statistics are presented as number and percentage. Where appropriate, statistical tests were performed using SPSS version 20 (IBM 2011). The chi-square test of independence was used for categorical variables, and the significance level for all analyses was set at $\alpha=0.05$.

Results

Cases at the Family Court in Pune

Our search revealed that in all the annulment and divorce cases filed under HMA in 2011, 61% of the petitioners were husbands (n=753) and 39% wives (n=480). Similarly, in 2012, 60% of the petitioners were husbands (n=877) and 40% wives (n=575).

Our search specifically identified 78 petitions filed on the ground of mental illness under HMA from 1996 to 2012. Of these, 67 were filed by husbands and 11 by wives. Of the 78 petitions, 21 sought nullity (18 husbands and 3 wives), 50 sought divorce (43 husbands and 7 wives), and 5 sought nullity and/or divorce (4 husbands and 1 wife). In 2 cases (both husbands), the kind of relief (nullity/divorce) being sought was unclear. Surprisingly, husbands filed 85% of the petitions, whereas wives accounted for only 15% of the petitions filed on the ground of mental illness.

We looked for medical (psychiatric) evidence in the case papers or recorded in the judgment. Medical evidence is defined as any medical information, data, medical records or expert witness testimony which substantiates that the opposite party has a mental illness. We were able to find medical evidence in only 36% (28 out of 78) of the cases. In the case of male petitioners, medical evidence of the mental illness of the wife was present in 39% (26 out of 67) of cases, while in the case of female petitioners, it was present in only 18% (2 out of 11) of cases.

In the 26 instances in which husbands provided medical evidence in the petition/court, prescription of psychotropic medicines was the only evidence in three cases, copies of medical notes were the only evidence in one case, and, invoices for the purchase of psychotropic medicines were the only evidence presented in one particular case. In the two instances in which wives provided medical evidence in the petition/court, multiple forms of evidence were presented (Table 1).
Table 1 Medical evidence presented at Family Court level

<table>
<thead>
<tr>
<th>Type of medical evidence</th>
<th>Witness-in-chief of psychiatrist</th>
<th>Certificate by psychiatrist</th>
<th>Prescription</th>
<th>Invoices for purchase of medicines</th>
<th>Copies of medical reports</th>
<th>Multiple evidence*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of petitions filed by husbands</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annulment (n=6)</td>
<td>1 (17%)</td>
<td></td>
<td></td>
<td></td>
<td>1 (17%)</td>
<td>4 (67%)</td>
</tr>
<tr>
<td>Divorce (n=19)</td>
<td>4 (21%)</td>
<td>1 (5%)</td>
<td>3 (16%)</td>
<td>1 (5%)</td>
<td>*Note: Multiple evidence was defined as two or more of the following pieces of evidence – witness-in-chief of psychiatrist, certificate by psychiatrist, prescription, discharge summary, psychometric reports, copies of medical reports, and bills for purchase of medicines.</td>
<td></td>
</tr>
<tr>
<td>Annulment and divorce (n=1)</td>
<td>1 (100%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Nearly a fourth (22%) of the petitions filed by husbands without medical evidence of mental illness were successful and nullity or divorce was granted on the ground of mental illness. When husbands did present medical evidence of mental illness, a greater proportion of the petitions were successful (35%) and annulment or divorce was granted. Interestingly, a large proportion of the petitions which were not accompanied by medical evidence (43%) were converted into pleas for divorce by mutual consent (Table 2). Even when medical evidence was presented, a significant number of these petitions (31%) too were converted into divorce by mutual consent (Table 2).

As for the nine petitions filed by wives who failed to provide medical evidence, divorce was granted on the ground of mental illness in two (22%) cases. A significant number of these petitions too (66%) were converted into divorce by mutual consent. Of the two cases in which the wives presented medical evidence of mental illness, one was successful and one was converted into divorce by mutual consent.

Of the six petitions filed by husbands for the annulment of marriage in which medical evidence was presented, three were allowed (Table 2). One of these was an *ex-parte* decision. Of the 12 petitions filed for the annulment of marriage by husbands who had not presented medical evidence, the Family Court allowed annulment in four cases. One of these was granted *ex-parte*. Of the divorces granted to husbands who had presented medical evidence, two judgments were delivered *ex-parte*. Interestingly, in 80% (4 of 5) of the divorces granted to husbands who had not submitted medical evidence, the judgments were delivered *ex-parte*. In the case of both women petitioners granted
divorce in the absence of medical evidence, the judgments were delivered *ex-parte*. One of the two women petitioners who did present medical evidence was granted divorce in her husband’s absence.

Table 2. Outcome of petitions filed by husbands, categorised by presence or absence of medical evidence

<table>
<thead>
<tr>
<th>Medical evidence provided</th>
<th>Type of relief sought</th>
<th>Nullity (n=6)</th>
<th>Divorce (n=19)</th>
<th>Nullity and divorce (n=1)</th>
<th>Total (n=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowed (n, %)</td>
<td>3 (50)</td>
<td>6 (32)</td>
<td></td>
<td>9 (35)</td>
<td></td>
</tr>
<tr>
<td>Dismissed (n, %)</td>
<td>1 (16)</td>
<td>5 (26)</td>
<td></td>
<td>6 (23)</td>
<td></td>
</tr>
<tr>
<td>Converted to mutual consent (n, %)</td>
<td>1 (17)</td>
<td>6 (32)</td>
<td>1 (100)</td>
<td>8 (31)</td>
<td></td>
</tr>
<tr>
<td>Withdrawn (n, %)</td>
<td>1 (17)</td>
<td>1 (5)</td>
<td></td>
<td>2 (8)</td>
<td></td>
</tr>
<tr>
<td>Other (n, %)</td>
<td>1 (5)</td>
<td></td>
<td></td>
<td>1 (3)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical evidence not provided</th>
<th>Type of relief sought</th>
<th>Nullity (n=12)</th>
<th>Divorce (n=24)</th>
<th>Nullity and divorce (n=3)</th>
<th>Total (n=41)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowed (n, %)</td>
<td>4 (33)</td>
<td>5 (21)</td>
<td></td>
<td>9 (22)</td>
<td></td>
</tr>
<tr>
<td>Dismissed (n, %)</td>
<td>2 (17)</td>
<td>3 (12)</td>
<td></td>
<td>6 (15)</td>
<td></td>
</tr>
<tr>
<td>Converted to mutual consent (n, %)</td>
<td>3 (25)</td>
<td>11 (46)</td>
<td>2 (67)</td>
<td>18 (43)*</td>
<td></td>
</tr>
<tr>
<td>Withdrawn (n, %)</td>
<td>1 (8)</td>
<td>5 (21)</td>
<td></td>
<td>6 (15)</td>
<td></td>
</tr>
<tr>
<td>Other (n, %)</td>
<td>2 (17)</td>
<td></td>
<td></td>
<td>2 (5)</td>
<td></td>
</tr>
</tbody>
</table>

*Note: There was no information available on the type of relief being sought in 2 of the 41 cases. In both cases, divorce by mutual consent was granted.

Cases in High Courts

Cases come up to the High Court when a party is not satisfied with the decision of the Family Court or the District Court (in areas where there are no Family Courts). We came across 97 High Court cases, starting from 1981 (the first relevant High Court case after the amendment of HMA was from 1981), in which nullity or divorce was sought on the ground of mental illness. The High Court judgments were first analysed according to whether or not the plaintiff had provided medical evidence. Medical evidence was taken to be present if it was mentioned in the High Court judgment and absent if not (Table 3).
Table 3 Outcome of petition by presence or absence of medical evidence

<table>
<thead>
<tr>
<th>Decision</th>
<th>Medical evidence presented (n=77)</th>
<th>No medical evidence presented (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nullity or divorce granted by lower court, confirmed by High Court</td>
<td>18 (23%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>Refusal of nullity or divorce by lower court, confirmed by High Court</td>
<td>22 (29%)</td>
<td>6 (30%)</td>
</tr>
<tr>
<td>Judgment of lower court overturned by High Court</td>
<td>37 (48%)</td>
<td>10 (50%)</td>
</tr>
</tbody>
</table>

Surprisingly, there was no statistically significant difference in the judgments of the lower courts and the High Courts with respect to either the presence or absence of medical evidence, $\chi^2=0.10$, $p=0.95$.

A chi-square test for significance reveals that the rejection of appeals by the High Courts was significantly higher for husbands than for wives ($\chi^2=7.70$, $p=0.00$), which perhaps indicates that women are more successful in having the family court’s judgment overturned (Table 4).

Table 4 Outcome of cases in High Courts

<table>
<thead>
<tr>
<th>Appellant at High Court</th>
<th>Appeal allowed or partly allowed</th>
<th>Appeal rejected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husbands (n=46)</td>
<td>16 (35%)</td>
<td>30 (65%)</td>
</tr>
<tr>
<td>Wives (n=49)</td>
<td>31 (63%)</td>
<td>18 (37%)</td>
</tr>
<tr>
<td>Both spouses (n=2)</td>
<td>2 (100%)</td>
<td>0</td>
</tr>
</tbody>
</table>

For all the High Court cases, we then explored who filed the original petitions at the Family Court/District Court and the outcome of the petitions at these courts. It is not practically possible to check the gender distribution of cases seeking nullity or divorce on the ground of mental illness in all Family Courts across the country, and we wanted to see whether the gender distribution of a sample of cases reaching the High Court from across the country would be similar to that found in the Family Court in Pune.

Table 5 Gender distribution and outcome of petition at lower court level

<table>
<thead>
<tr>
<th>Petitioner at Family Court/ District Court (N=97)</th>
<th>Petition allowed</th>
<th>Petition rejected</th>
<th>Judicial separation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husbands (n=92)</td>
<td>46 (50%)</td>
<td>43 (47%)</td>
<td>3 (3%)</td>
</tr>
<tr>
<td>Wives (n=1)</td>
<td>1 (100%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Both (n=4)</td>
<td>3 (75%)</td>
<td>1 (25%)</td>
<td>0</td>
</tr>
</tbody>
</table>
In 92 (95%) of the 97 cases, the husband filed the original petition. This is more than the 85% we found at the Pune Family Court, and shows that even in the case of petitions that had reached the High Court, it was the husbands who had filed most of them.

Table 6 Outcome at lower court of cases reaching High Court

<table>
<thead>
<tr>
<th>Decision</th>
<th>Medical evidence present (n=77)</th>
<th>Medical evidence absent (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nullity or divorce granted</td>
<td>42 (55%)</td>
<td>8 (40%)</td>
</tr>
<tr>
<td>Nullity or divorce refused</td>
<td>34 (44%)</td>
<td>10 (50%)</td>
</tr>
<tr>
<td>Judicial separation</td>
<td>1 (1%)</td>
<td>2 (10%)</td>
</tr>
</tbody>
</table>

Table 6 shows that 40% of the petitions were successful in the lower courts even in the absence of medical evidence; however, 50% of these judgments were subsequently overturned by the High Court (see Table 3).

Table 7 shows that while 13 of the 17 petitions filed by husbands were successful at the Family Court/District Court, the High Court reversed the lower courts’ decisions in more than 50% of cases.

Table 7 Reversal of lower courts’ judgments by the High Court

<table>
<thead>
<tr>
<th>Medical evidence present (n=77)</th>
<th>Petitioner</th>
<th>Success at Family Court/District Court</th>
<th>Appeal at High Court (HC)</th>
<th>Result</th>
<th>HC favoured</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 petitions for nullity</td>
<td>17 petitions filed by husbands</td>
<td>13 petitions successful</td>
<td>13</td>
<td>8 appeals allowed</td>
<td>Wives (n=7) and husband (n=1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 appeals dismissed</td>
<td>Husbands (n=5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 petitions dismissed</td>
<td>Wives(n=2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 appeals dismissed</td>
<td>Husbands (n= 2)</td>
</tr>
<tr>
<td>1 petition filed jointly by husband and wife</td>
<td>Petition allowed</td>
<td>1</td>
<td>Appeal allowed</td>
<td>Wife (n=1)</td>
<td></td>
</tr>
</tbody>
</table>

The High Court had overturned the lower courts’ judgment in the majority of cases in which medical evidence had been presented, in which the petitioner in the lower courts...
was male, and in which the ruling was in favour of the husband and divorce had been granted (Figure 1). On the other hand, the High Court had upheld the lower courts' judgment in a majority of the cases in which they had ruled against the husband and refused divorce (Figure 1). The High Courts had overturned the judgments of the lower courts when they had granted divorce in cases in which medical evidence was absent and the petitioner in the Family Court/District Court was the husband (e.g. 6 out of 7).

Figure 1: High Court ruling on judgment made at the Family Court level, when nullity or divorce was granted
<table>
<thead>
<tr>
<th>Table 8 Type of medical evidence (n=77)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Witness-in-chief of psychiatrist(s)</td>
</tr>
<tr>
<td>5 (28%)</td>
</tr>
<tr>
<td>10 (23%)</td>
</tr>
<tr>
<td>5 (31%)</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>Witness-in-chief of doctor(s)</td>
</tr>
<tr>
<td>2 (11%)</td>
</tr>
<tr>
<td>7 (16%)</td>
</tr>
<tr>
<td>1 (6%)</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>Examination report</td>
</tr>
<tr>
<td>2 (11%)</td>
</tr>
<tr>
<td>2 (5%)</td>
</tr>
<tr>
<td>3 (19%)</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>Examination report by medical board</td>
</tr>
<tr>
<td>1 (2%)</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>Prescription</td>
</tr>
<tr>
<td>1 (6%)</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>Referral letter/admission/discharge slip</td>
</tr>
<tr>
<td>1 (2%)</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>Multiple evidence</td>
</tr>
<tr>
<td>6 (33%)</td>
</tr>
<tr>
<td>19 (44%)</td>
</tr>
<tr>
<td>7 (44%)</td>
</tr>
<tr>
<td>32</td>
</tr>
<tr>
<td>Type of medical evidence not specified</td>
</tr>
<tr>
<td>2 (11%)</td>
</tr>
<tr>
<td>3 (7%)</td>
</tr>
<tr>
<td>5</td>
</tr>
</tbody>
</table>

With regard to the type of medical evidence presented to substantiate the allegation of mental illness, it is interesting to note that the only evidence submitted in 10 of the 77 cases was a general doctor’s evidence. In one case, a prescription was the only evidence, and in another, a referral letter/discharge slip (Table 8).

**Discussion**

This paper assessed the judicial proceedings and outcomes of divorce cases in Pune and explored the extent to which gender influences the decision to grant a divorce on the basis of mental illness. The analysis focused on annulment and divorce petitions and judgments at the Family Court in Pune and the High Courts nationwide.

We shall now discuss the three main findings of the analysis, as these merit further consideration. At the Family Court, 85% of the cases filed on the ground of mental illness were brought in by husbands. Further, of all petitioners who filed for divorce in general (i.e. not specifically on the ground of mental illness) in the Family Court, 61% were husbands. Similarly, of the cases that reached the High Court, 95% had originally been filed at the Family Court by male petitioners. If we take these findings in conjunction, it appears that more men than women file for divorce on the ground of mental illness, and perhaps use mental illness as a reason to seek divorce or nullity. This is possibly reflective of the difference in the standing of men and women with respect to marriage, and the intersection of disability with this factor. In this context, mention must be made of the socioeconomic anomalies between men and women, who, for example, are less likely than men to receive support for divorce from their natal families. In addition, they may not have the financial independence to feel confident
enough to file for a divorce. Second, cultural expectations regarding a woman’s role in a
marriage may influence the number of women who file for divorce. As Addlakha (8),
Ghai (9) and others (10) state, a woman with a disability is considered incapable of
fulfilling her duties as a wife, homemaker, mother, etc.

The second finding relates to whether or not medical evidence was presented in the
petition or in court. Our analysis revealed that in the Family Court, medical evidence
was presented in only a third of the cases, despite the fact that nullity or divorce can be
granted only if the plaintiff can establish that his/her spouse has a mental illness.
Divorce or nullity was granted in 22% of even those cases in which no medical evidence
was presented. The corresponding percentage for cases in which medical evidence of
mental illness was presented was only 35. Even when medical evidence was presented,
it was often of poor quality and not fit to be considered as robust proof of mental
illness. For example, in at least 20% of the 26 cases, simple prescriptions, copies of
medical records, and invoices for the purchase of medicine constituted the sole piece of
evidence and were accepted by the courts.

At the High Court level, too, no medical evidence was provided in nearly 20% of the
cases. This finding is disconcerting as the High Courts reversed the judgment of the
lower courts in only 50% of the cases in which no medical evidence was produced. It is
inconceivable that the courts should make such decisions in the absence of substantial
medical evidence. As in the case of the lower courts, the evidence presented before the
High Courts was of poor quality. Unless clear guidelines are formulated on what is
considered acceptable and sound medical evidence of mental illness, judicial practices
are unlikely to change.

Our analysis also revealed that 11(14%) of the 78 judgments at the Pune Family Court
were made under ex-parte conditions, despite the fact that the Madras High Court has
explicitly stated that ex-parte judgments should not be delivered and proper
representation is required (11)*. An unexpected finding of our study was that a
substantial number of the petitions for nullity or divorce on the ground of mental illness
were converted into petitions for nullity or divorce by mutual consent. Though the
underlying reasons for this are unclear and should be further explored, one could
speculate that given the stigma associated with mental illness in the Indian context, the
plaintiff may use the notion of “mutual consent” as a tool to pressurise his/her spouse
into agreeing to a divorce. This would reduce the stigma, as mental illness is not
documented in a judgment if the case involves mutual consent. This is not so if nullity or
divorce is granted on the ground of mental illness. The documentation of the presence
of mental illness in a judgment is problematic, since it could compromise any future
chances of remarriage. This is because of the tendency to shun marital alliances with
persons with disabilities (including mental illness), a tendency which is well documented
both in the Indian context as well as other contexts (8,10, 12–14).
Our analysis also found that the High Courts had overturned a large number of judgments of the lower courts, particularly in cases in which the petitioner was the husband and nullity or divorce had been granted. At the same time, the High Courts had confirmed the judgments of the lower courts in cases in which the latter had refused to grant divorce to a male petitioner. This means that the High Courts’ emphasis is on the preservation of marriage and/or supporting women, regardless of the presence or absence of a mental illness. This finding of our analysis has certain gender implications. Approximately 5%-6% of cases go up in appeal to the High Courts. Women, in particular, lack the resources to appeal to the High Court (15). The lack of financial resources is just one among many reasons that make women less likely to appeal to the higher courts. However, our data show that if women had the means to appeal, they would stand a good chance of having the judgment of the lower court reversed. High Courts appear to display greater gender sensitivity with respect to mental illness and marriage than do the Family and District Courts. Given that most cases do not go up to the High Courts, it is imperative to sensitise the lower courts to the social and gender aspects of the marriage laws with special reference to mental illness.

Broadly speaking, the language of HMA may also create conceptual confusion and be reflected in judgments. The phrase used in Section 13(1)(iii) is “incurably of unsound mind”. “Unsound mind” is a legal concept and does not have medical equivalence (16), while curability is a medical concept. It is difficult to understand what the drafters had in mind when referring to medical curability (or lack of it) with respect to a legal term (unsound mind). Further, the stigmatisation of mental illness is likely to increase if the concept of unsoundness of mind can nullify or dissolve a marriage (15). The definitions of “mental illness” and “psychopathic disorder” used in HMA do not necessarily correspond with the medical definitions and understanding of these terms. In HMA, the term “psychopathic disorder” encompasses intellectual disability. This term is hardly found in modern medical literature, which tends to use the term “personality disorder”. Besides, many concerns have been articulated in medical literature regarding the diagnosis of personality disorder, particularly the validity and reliability of the diagnosis (17–20). Personality disorders have long been described as deviance from social norms and values. In the context of India, where patriarchal norms prevail, any challenge to male authority can potentially be labelled as a personality disorder. This may partly explain why a disproportionate number of female spouses are labelled as having a mental illness in divorce cases.

Taken together, the findings presented in this paper have a number of implications for policy, practice and future research. First, there is a need for uniform guidelines for lower courts on what can be accepted as adequate medical proof of mental illness. Also, proof of mental illness must be required when a petition seeks nullity or divorce on this ground under HMA. Second, there is a need for greater awareness and more research on this topic so that a sizeable evidence base may be gathered to push for the amendment of HMA. Such evidence could be used to consider the deletion of Section 5(ii) and Section 13, as these appear to be used in a gender discriminatory manner. Their application is detrimental to the interests of women, and also does not fit with the
modern understanding of mental illness and its curability or otherwise, taking into account the recent Supreme Court judgment (21). Further, it clearly violates the UN Convention on Rights of Persons with Disabilities, to which India is a signatory and is thus bound to implement the Convention in its domestic legislation. Third, the judiciary must be made aware of the need to adopt a more gender-sensitive approach to mental illness and divorce. Sensitisation activities should focus on the complex social, legal, cultural and medical factors that play a role in the use of mental illness as a ground for divorce in the Indian context. Finally, it would be interesting if future research could determine whether such patterns of the use of mental illness as a ground for divorce exist in other Family Courts in India, and even in South Asia. Data could be accumulated and fed into potential theoretical frameworks on mental illness and marriage (and divorce), thus strengthening the evidence that could then be used to facilitate advocacy and prompt an amendment to HMA.

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* Corrections have been made in the placing of references, with the previously numbered Reference no. 21 now no.11, and all subsequent references re-numbered accordingly.
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8. Addlakha R. Gender, subjectivity, and sexual identity: how young people with disabilities conceptualise the body, sex, and marriage in urban India. New Delhi: Centre for Women’s Development Studies; 2007, 46 p.


Part III - Property

Chapter 9. Legal Barriers

Right to property, inheritance, and contract and persons with mental illness

Abstract
Discrimination against people with mental illness is rife across the globe. Among different types of discrimination is the policy in many countries where persons with mental illness are forbidden to inherit property, and they are not able to enter into a contract in a large number of countries. Using various databases, legislations dealing with law of contract, law of succession/inheritance, and law relating to testamentary capacity (wills) of all UN Member states (193 countries) were studied. With respect to federal countries, the laws of the most populous state as a representative state in the respective country were studied. Only 40 Member States (21%) recognize/allow persons with mental health problems to enter into contracts. Of these, however, only 16 Member States (9%) recognize the right of persons with mental health problems to enter into a contract without any restrictions. The remaining 24 Member States (12%) allow a contract entered into by a person with mental health problems to be invalidated under certain conditions. These countries also make the validity of the contract subject to the capacity to consent or based on the level of understanding of the person with mental health problems. They may allow persons with mental health problems to enter into contracts only for transactions of an insignificant nature or of personal rights. Only 9% of the countries allow people with mental illness to enter into contracts in an unrestricted way. Furthermore, there remain variations between high income and low-income states. In spite of international laws in many countries, laws remain discriminatory.

Keywords
Inheritance; mental illness; property; social discrimination

Introduction
The ownership of property is important to individuals for its economic benefits and its impact on the social status of the owner. Historically, in some countries only landowners enjoyed the right to vote. In many countries, women never had full ownership rights in respect of property. In patriarchal societies, male members of a family are placed as preferred heirs in the law of succession. The right to property is, therefore, an important right to enable individuals to participate fully in social and community life.
Attributes of the right to property

The concept of right to property is not limited to holding a property in one’s name. Right to property in its effective sense means the right to acquire, hold, enjoy, and dispose of the property based on one’s own wishes. Right to property also means the right to receive economic benefits out of it. A person can acquire/own property by making a contract to purchase the property or by succession. Similarly, the freedom to dispose of the property can be exercised by entering into a contract to sell, by gifting it or by making a will. Contractual and testamentary capacity are, therefore, equally important to exercise the right to property. Contractual and testamentary capacity are part of legal capacity and, thus, deprivation of contractual and testamentary capacity is the denial of legal capacity.

International and regional human rights conventions and the right to property

The right to property is recognized as a human right by the Universal Declaration of Human Rights (UN General Assembly, 1948) (UDHR). Article 17 of the UDHR states that ‘everyone has the right to own property alone as well as in association with others’ and ‘no one shall be arbitrarily deprived of their property’. Although the right to property has not been specifically protected in either the International Covenant on Economic, Social and Cultural Rights (UN General Assembly, 1966b) (ICESCR) or the International Covenant on Civil and Political Rights (UN General Assembly, 1966a) (ICCPR), other rights which impinge on the right to property are protected by these Conventions. For example, Article 16 of the ICCPR recognizes the legal capacity of ‘everyone’, which includes persons with disabilities. Later international human rights instruments more specifically protect the right to property. The right to own property as well as to inherit property is protected under Article 5 of the International Convention on Elimination of All Forms of Racial Discrimination (UN General Assembly, 1965). Article 15 of the Convention on Elimination of All Forms of Discrimination against Women (UN General Assembly, 1979) also recognizes women’s right to enter into contracts, and Article 16 of the same Convention recognizes women’s right to ownership, enjoyment, and disposal of property on an equal basis with others. The Convention on Rights of Persons with Disabilities (UN General Assembly, 2007) (CRPD) specifically calls upon countries to ‘take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs, and to have equal access to bank loans, mortgages, and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property’ (Article 12 (5) of the CRPD).

Regional human rights conventions do recognize the right to property. Article 1 of the European Convention on Human Rights (Council of Europe, 1950) recognizes a person’s ‘right to peaceful enjoyment of possessions’; Article 23 of the American Declaration on the Rights and Duties of Man (IACHR, 1948) states that ‘Every Person has the right to own such private property as meets the essential needs of decent living and helps to maintain the dignity of the individual and of the home’; Article 14 of the African Charter
on Human and Peoples’ Rights (OAU, 1981) explicitly states ‘The right to property shall be guaranteed’.

Aims and objectives

While recognizing that the right to property, in particular private property, has many aspects which are matters of intense debate, this paper is narrowly focused on the enjoyment of property rights by persons with mental health problems on an equal basis with others and, more particularly, on enabling the enjoyment of property rights protected under the CRPD.

This paper attempts to answer three specific questions:

1. Do country laws recognize persons with mental health problems right to enter into contracts?

2. Do country laws recognize persons with mental health problems right to succeed (inherit) to property?

3. Do country laws recognize their right to make a will?

Methodology

We reviewed legislation dealing with law of contract, law of succession/inheritance, and law relating to testamentary capacity (wills) of all UN Member states (193 countries). With respect to federal countries, we analysed the laws of the most populous state as a representative state in the respective country.

Copies of these legislations were obtained from the databases including WHO MiNDBANK, NATLEX of International Labor Organization, WIPO–World Intellectual Property Organization, EUR-Lex, etc.

We also searched for legislation of respective countries in their official language. For non-English versions of legislation, if an authoritative English translation was available, it was used for analysis. In other situations, we used Google Translate to translate key terms and pertinent provisions of legislation. Where we did not find bare acts, we relied on noncodified and secondary sources of information such as government report, court judgements, and academic papers.

We also collected uncodified information from official government websites of the particular country, US Government’s Country Reports of Human Rights Practices, and from university websites.
We identified relevant provisions of legislation using key terms and combination of key terms listed below:

i. For mental health problems: sane, psychic diseases, mental illness, weakness of mind, dementia, mental disturbance, mental disorder, sound mind, insanity, mental derangement or imbecility, Insane persons (loucos) of all kinds, severe mental impairment, madman, mental illness, demented, lunatic, permanent mental illness, usual idiocy, madness, infirm, mental retardation, psychic, mentally incompetent, mental trouble, idiots;

ii. For contract: ability, capacity, obligation;

iii. For succession: unworthy, heir, disqualified; and

iv. For wills: testament, testamentary capacity, will, capacity to make will.

To enable systematic comparison of legislation, we used World Bank Classification of countries by income levels and Member States’ ratification status of ICESCR and CRPD, as mentioned in the United Nations Treaty Collection.

Results

Thirty-eight per cent (74 Member States) do not recognize the right to contract of persons with mental health problems. Forty Member States (21%) recognize/allow persons with mental health problems to enter into contracts; of these, however, only 16 Member States (9%) recognize the right of persons with mental health problems to contract without any restrictions (Table 1). The remaining 24 Member States (12%) allow a contract entered into by a person with mental health problems to be invalidated under certain conditions or make the validity of the contract subject to capacity or level of understanding of the person with mental health problems or allow persons with mental health problems to enter into contracts only for transactions of insignificant nature or of personal rights (Table 2). Seventeen Member States (9%) laws specifically allow a contract to be entered into on behalf of a person with mental health problems through a representative or guardian appointed by a court for a limited purpose or allow persons with mental health problems to make a contract only with the permission of a guardian, or require that the contract is ratified by someone else (Table 3).
Table 1. Overall status of 193 countries on Right to Contract and persons with mental health problems

<table>
<thead>
<tr>
<th>Overall frequencies (n=193 countries)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to contract of persons with mental health problems is recognized by recognizing their contractual capacity/Right to Contract of persons with mental health problems is recognized by recognizing their contractual capacity in certain types of contracts (See Table 2)</td>
<td>40 (21%)</td>
</tr>
<tr>
<td>Right to contract of persons with mental health problems is not recognized, but law is provided for some facilitative mechanism to enter into a contract (See Table 3)</td>
<td>17 (9%)</td>
</tr>
<tr>
<td>Right to contract of persons with mental health problems is not recognized by denying their contractual capacity</td>
<td>74 (38%)</td>
</tr>
<tr>
<td>No information/insufficient information/translation not possible</td>
<td>51 (26%)</td>
</tr>
<tr>
<td>Not clear</td>
<td>11 (6%)</td>
</tr>
</tbody>
</table>

Table 2. Recognition to Right to Contract of persons with mental health problems (n=40, 21% of total countries)

<table>
<thead>
<tr>
<th>Recognition to right to contract of persons with mental health problems</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to Contract of persons with mental health problems is recognized by recognizing their contractual capacity</td>
<td>16 (9%)</td>
</tr>
<tr>
<td>Persons with mental health problems are given the option to set aside contract subject to certain conditions</td>
<td>10 (5%)</td>
</tr>
<tr>
<td>Recognition of Right to Contract is made dependent on certain degree/level of understanding capacity of person with mental health problems</td>
<td>8 (4%)</td>
</tr>
<tr>
<td>Right to Contract of persons with mental health problems is recognized by recognizing their contractual capacity to enter into transactions of insignificant nature/contract for gratuitous acquisition or strictly personal rights</td>
<td>6 (3%)</td>
</tr>
</tbody>
</table>

* This conclusion is derived by analysing legislations dealing with general principles of contract law. Special legislations (e.g. Sale of Goods Act) are not analysed here.

Table 3. Right to Contract of persons with mental health problems is not recognized but law provided for some facilitative mechanism to enter into a contract (n=17, 9% of total countries).

<table>
<thead>
<tr>
<th>Facilitative mechanism provided</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to Contract of persons with mental health problems is not recognized but law provided for some facilitative mechanism to enter into a contract. A contract can be entered into on behalf of persons with mental health problems through representative/ guardian/person appointed by court for limited purpose.</td>
<td>12 (6%)</td>
</tr>
<tr>
<td>Right to Contract of persons with mental health problems is recognized by granting capacity to make contract with the permission of guardian or contract made can be ratified by representative</td>
<td>5 (3%)</td>
</tr>
</tbody>
</table>
Member States in the low-income group are more likely to deny a person with mental health problems from entering into contracts as compared to high income Member States (Table 4). Forty-four per cent and 42% of Member States that have ratified the ICESCR and the CRPD, respectively, do not allow persons with mental health problems from entering into contracts (See Table 5). One hundred and thirty-four Member States (70%) recognize the right of persons with mental illness to succeed (inherit) to property (See Table 6). We were, however, unable to find information on nearly 28% of Member States regarding succession rights.

Table 4. Income level of the countries (World Bank classification) and Right to Contract of persons with mental health problems

<table>
<thead>
<tr>
<th>Overall frequencies (n=192 countries)</th>
<th>Low Income n= 31</th>
<th>Lower middle income n = 49</th>
<th>Upper middle income n = 52</th>
<th>Higher income n= 60</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to Contract of persons with mental health problems is recognized by recognizing their contractual capacity/Right to Contract of persons with mental health problems is recognized by recognizing their contractual capacity in certain types of contracts (n=40)</td>
<td>4 (13%)</td>
<td>10 (20%)</td>
<td>7 (13%)</td>
<td>19(32%)</td>
</tr>
<tr>
<td>Right to Contract of persons with mental health problems is not recognized but law provided for some facilitative mechanism to enter into a contract (n=17)</td>
<td>1(3%)</td>
<td>5 (10%)</td>
<td>5 (10%)</td>
<td>6(10%)</td>
</tr>
<tr>
<td>Right to Contract of persons with mental health problems is not recognized by denying their contractual capacity (n=74)</td>
<td>14 (45%)</td>
<td>17 (35%)</td>
<td>22 (42%)</td>
<td>21 (35%)</td>
</tr>
<tr>
<td>No information/ insufficient information/translation not possible (n=50) a</td>
<td>11 (36%)</td>
<td>15 (31%)</td>
<td>13(25%)</td>
<td>11 (18%)</td>
</tr>
<tr>
<td>Not clear (n=11)</td>
<td>1 (3%)</td>
<td>2(4%)</td>
<td>5(10%)</td>
<td>3(5%)</td>
</tr>
</tbody>
</table>

aThe World Bank has not mentioned income status of Nauru. Hence, the country is not included in the analysis.
Table 5. Ratification status by country and right to contract of persons with mental health problems

<table>
<thead>
<tr>
<th>Overall frequencies (n=193 countries)</th>
<th>Ratified ICESCR (n=157)</th>
<th>Ratified CRPD (n = 157)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to Contract of persons with mental health problems is recognized by recognizing their contractual capacity/ Right to Contract of persons with mental health problems is recognized by recognizing their contractual capacity in certain types of contracts (n=40)</td>
<td>32 (20%)</td>
<td>31 (20%)</td>
</tr>
<tr>
<td>Right to Contract of persons with mental health problems is not recognized but law provided for some facilitative mechanism to enter into a contract (n=17)</td>
<td>14 (9%)</td>
<td>14 (9%)</td>
</tr>
<tr>
<td>Right to Contract of persons with mental health problems is not recognized by denying their contractual capacity (n=74)</td>
<td>69 (44%)</td>
<td>66 (42%)</td>
</tr>
<tr>
<td>No information/ insufficient information/translation not possible (n=51)</td>
<td>33 (21%)</td>
<td>37 (23%)</td>
</tr>
<tr>
<td>Not clear (n=11)</td>
<td>9 (6%)</td>
<td>9 (6%)</td>
</tr>
</tbody>
</table>

Table 6. Overall status of 193 countries on right to succeed and persons with mental health problems

<table>
<thead>
<tr>
<th>Overall frequencies (n=193 countries)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons with mental health problems have right to succeed</td>
<td>134 (70%)</td>
</tr>
<tr>
<td>Persons with mental health problems have right to succeed with restrictions</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Persons with mental health problems do not have right to succeed</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>No information/ insufficient information/ translation not possible</td>
<td>55 (28%)</td>
</tr>
<tr>
<td>Not clear</td>
<td>2 (1%)</td>
</tr>
</tbody>
</table>

*For this study, provisions of law governed by principles of Sharia law are not reviewed.*

Similar to the right to contract, low income Member States are less likely as compared to high income Member States to allow persons with mental health problems to succeed to property (Table 7) and nearly all Member States who have ratified the ICESCR and the CRPD and where we were able to find information allow persons with mental health problems to succeed (inherit) property (Table 8). Eighty-Three Member States (43%) do not recognize the right of persons with mental health problems to make a will, another 16 Member States (8%) only recognize a limited capacity of persons with mental health problems to make a will, while only 45 Member States (23%) have an unrestricted recognition of the right to make a will (Tables 9–11).
Table 7. Income level of the countries (World Bank classification) and right to succeed of persons with mental health problems

<table>
<thead>
<tr>
<th>Overall frequencies (n=192 countries)</th>
<th>Low Income (n= 31)</th>
<th>Lower middle income (n= 49)</th>
<th>Upper middle income (n= 52)</th>
<th>Higher income (n= 60)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons with mental health problems have right to succeed (n=133)</td>
<td>17 (55%)</td>
<td>34 (69%)</td>
<td>36 (69%)</td>
<td>46 (77%)</td>
</tr>
<tr>
<td>Persons with mental health problems have right to succeed with restrictions (n= 2)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>2 (4%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Persons with mental health problems do not have right to succeed (n=0)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>No information/insufficient information/translation not possible (n= 55)</td>
<td>14 (45%)</td>
<td>15 (31%)</td>
<td>13 (25%)</td>
<td>13 (22%)</td>
</tr>
<tr>
<td>Not clear (n= 2)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>

The World Bank has not mentioned income status of Nauru. Hence, the country is not included in the analysis. 

Table 8: Ratification status by country and right to succeed of persons with mental health problems

<table>
<thead>
<tr>
<th>Overall frequencies (n=193 countries)</th>
<th>Ratified ICESCR (n=157)</th>
<th>Ratified CRPD (n = 157)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons with mental health problems have right to succeed (n=134)</td>
<td>116 (74%)</td>
<td>112 (71%)</td>
</tr>
<tr>
<td>Persons with mental health problems have right to succeed with restrictions (n= 2)</td>
<td>0(0%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Persons with mental health problems do not have right to succeed (n=0)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>No information/insufficient information/translation not possible (n= 55)</td>
<td>39 (25%)</td>
<td>42 (27%)</td>
</tr>
<tr>
<td>Not clear (n= 2)</td>
<td>2 (1%)</td>
<td>2 (1%)</td>
</tr>
</tbody>
</table>

For this study, provisions of law governed by principles of Sharia law are not reviewed.
Table 9. Overall status of 193 countries on Right to make a will and persons with mental health problems

<table>
<thead>
<tr>
<th>Overall frequencies (n=193 countries)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to make a will of persons with mental health problems is recognized by recognizing their capacity to make a will (see Table 10)</td>
<td>45 (23%)</td>
</tr>
<tr>
<td>Right to make a will of persons with mental health problems is limited by recognizing limited capacity to make a will (see Table 11)</td>
<td>16 (8%)</td>
</tr>
<tr>
<td>Right to make a will of persons with mental health problems is not recognized by denying their capacity to make a will</td>
<td>83 (43%)</td>
</tr>
<tr>
<td>No information/ insufficient information*/ translation not possible</td>
<td>43 (22%)</td>
</tr>
<tr>
<td>Not clear</td>
<td>6 (3%)</td>
</tr>
</tbody>
</table>

*For this study, provisions of law governed by principles of Sharia law are not reviewed.

Table 10. Persons with mental health problems have right to make a will (n=45, 23% of total countries)

<table>
<thead>
<tr>
<th>Persons with mental health problems have right to make a will</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to make a will of persons with mental health problems is recognized by recognizing their capacity to make a will</td>
<td>21 (11%)</td>
</tr>
<tr>
<td>Recognition of right to make a will is made dependent on certain degree/ level of understanding capacity of persons with mental health problems</td>
<td>4 (2%)</td>
</tr>
<tr>
<td>No provision to exclude persons with mental health problem from making a will</td>
<td>10 (5%)</td>
</tr>
<tr>
<td>Right to make a will of persons with mental health problem is inferred*</td>
<td>10 (5%)</td>
</tr>
</tbody>
</table>

*Inference is drawn by reading main provision along with ancillary provisions of relevant legislation

Table 11. Persons with mental health problems have limited right to make a will (n=16, 8% of total countries)

<table>
<thead>
<tr>
<th>Right to make a will of persons with mental health problems is limited by recognizing limited capacity to make a will</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>can make a will, only during lucid intervals / with condition that at the time of making the will the doctor certifies that person did not lack decision-making capacity at the time of making the will / unless there is no reason to believe that insane person’s mental state has had any effect on the contents of the provision</td>
<td>12 (6%)</td>
</tr>
<tr>
<td>Can make a valid will subject to approval/ permission of court/ king</td>
<td>4(2%)</td>
</tr>
</tbody>
</table>
Unlike other rights, similar proportions of low income and high-income Member States (45–47 %) do not recognize the right of persons with mental health problems to make a will (Table 12). Seventy Member States (45%) and 68 Member States (43%) that have ratified the ICESCR and the CRPD, respectively, do not recognize the right of persons with mental health problems to make a will (Table 13).

Table 12: Income level of the countries (World Bank classification) and right to make a will of persons with mental health problems

<table>
<thead>
<tr>
<th>Overall frequencies (n=192 countries)</th>
<th>Low Income (n= 31)</th>
<th>Lower middle income (n = 49)</th>
<th>Upper middle income (n = 52)</th>
<th>Higher income n= 60</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to make a will of persons with mental health problems is recognized by recognizing their capacity to make a will (n=44)</td>
<td>2 (7%)</td>
<td>9 (18%)</td>
<td>19 (37%)</td>
<td>14 (23%)</td>
</tr>
<tr>
<td>Right to make a will of persons with mental health problems is limited by recognizing limited capacity to make a will (n=16)</td>
<td>2 (6%)</td>
<td>4 (8%)</td>
<td>2 (4%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td>Right to make a will of persons with mental health problems is not recognized by denying their capacity to make a will (n= 83)</td>
<td>14 (45%)</td>
<td>22 (45%)</td>
<td>19 (36 %)</td>
<td>28 (47%)</td>
</tr>
<tr>
<td>No information/ insufficient information/Translation not possible (n=40)</td>
<td>13 (42%)</td>
<td>13 (27%)</td>
<td>9 (17%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td>Not clear (n=6)</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
<td>3 (6%)</td>
<td>2 (4%)</td>
</tr>
</tbody>
</table>

aNauru – monetary status is not mentioned.
Table 13: Ratification status by country and right to make a will of persons with mental health problems

<table>
<thead>
<tr>
<th>Overall frequencies (n=193 countries)</th>
<th>Ratified ICESCR (n=157)</th>
<th>Ratified CRPD (n=157)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to make a will of persons with mental health problems is recognized by recognizing their capacity to make a will (n=45)</td>
<td>35 (22%)</td>
<td>38 (24%)</td>
</tr>
<tr>
<td>Right to make a will of persons with mental health problems is limited by recognizing limited capacity to make a will (n=16)</td>
<td>14 (9%)</td>
<td>14 (9%)</td>
</tr>
<tr>
<td>Persons with mental health problems do not have capacity to make a will (n=83)</td>
<td>70 (45%)</td>
<td>68 (43%)</td>
</tr>
<tr>
<td>No information/ insufficient information\a/ translation not possible (n=40)</td>
<td>33 (21%)</td>
<td>31 (20%)</td>
</tr>
<tr>
<td>Not clear (n=6)</td>
<td>5 (3%)</td>
<td>6 (4%)</td>
</tr>
</tbody>
</table>

\aFor this study, provisions of law governed by principles of Sharia law are not reviewed.

Discussion

The picture that emerges from these findings is most Member States recognize the right of persons with mental health problems to succession (inheritance), but a significant number of Member States do not recognize the right of persons with mental health problems to enter into contracts (38%) or write their own will and testament (43%). The apparent non-discrimination in the right to succeed or inherit property is of little benefit to persons with mental health problems as they are unable to enter into contracts (to sell/dispose of the property) or give it away in a will or testament. Hence, effectively, they are unable to enjoy the inheritance in many Member States.

It is necessary to highlight here the derogatory and stigmatizing terminology used to refer to persons with mental health problems in the laws of many Member States, such as insanity, madman, mental derangement or imbecility, lunatic, usual idiocy (sic), madness, mentally incompetent, and idiots, to name a few. In most cases, these terms are not defined in the law and are left open to interpretation. The use of these pejorative terms in legislation also play an important part in increasing stigma against persons with mental health problems and, conversely, stigma associated with mental health problems is likely to mean that these terms are often interpreted in a manner which is detrimental to the interests of persons with mental health problems.

Laws dealing with contracts in many countries use the term ‘unsound mind’ or ‘sound mind’ to debar or allow, respectively, persons from entering into valid contracts. A plain
reading of the text does not necessarily equate the term ‘unsound mind’ with mental illness; however, Courts in countries have equated these two terms and treated them as interchangeable (Hari Singh Gond vs State of M.P., 2008) and, thus, led to denial of legal capacity for persons with mental health problems. In its General Comment 1 on Article 12 of the CRPD, the Committee on Rights of Persons with Disabilities has categorically stated that ‘The CRPD (Article 12) now makes it clear that “unsoundedness of mind” and other discriminatory labels are not legitimate reasons for the denial of legal capacity (legal standing and legal agency)’ and it further goes on to reiterate that ‘Under article 12 of the Convention, perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity’ (Committee on the Rights of Persons with Disabilities, 2014). Thus, Member States which have ratified the CRPD need to change their contract and other laws to be in compliance with Article 12 of the Convention.

Many of the laws governing contracts and wills in Member States are written with the intention of protecting the interests of persons with mental health problems and to protect them from being exploited and deprived of their property and finances. Paradoxically, the net effect of these protections has been to deprive persons with mental health problems of their rights by denying their legal capacity. There is a need to question what is being protected by these laws and whose interests and rights are being protected. In most instances, laws are focused on ensuring that property (and by property we mean material possessions) remains in the name of the person with mental health problems, but not necessarily on ensuring that the person with mental health problems is able to enjoy the rights of ownership. So, while laws recognize the legal status (capacity to hold rights) of persons with mental health problems, they do not recognize their legal agency (their capacity to act or to exercise the rights). Article 12 of the CRPD recognizes both the legal status and legal agency of persons with mental health problems (Committee on the Rights of Persons with Disabilities, 2014) and, therefore, laws relating to property in Member States that have ratified the CRPD need to be amended to protect both legal status as well as legal agency.

Policy-makers need to take into account that nondiscrimination is guaranteed under international law (e.g. ICESCR) and their countries have an obligation to ensure that laws do not discriminate against vulnerable populations such as those with mental health problems. Furthermore, principle of non-discrimination is not subject to progressive realization or availability of resources and is meant for immediate implementation (see General Comment No. 18 CESCR, paragraph 33, CESCR (2006)).

This raises the question of how persons with mental health problems may be enabled to enter into valid contracts and enabled to exercise their testamentary capacity. The CRPD suggests the use of a supported decision-making paradigm, instead of the prevalent substituted decision-making paradigm in country legislation (Committee on the Rights of Persons with Disabilities, 2014). Presently, in most Member States, a person with mental disability is judged as not competent to making decisions, and a
guardian is appointed to make decisions on her behalf. This substituted decision-making paradigm excludes the person herself from the decision-making process. On the other hand, a supported decision-making paradigm recognizes that persons with mental disabilities need support in making decisions and makes provisions for enabling persons with mental disabilities to access the necessary support. A supported decision-making paradigm ensures that persons with disabilities have control over all aspects of their lives, including finances and property. See Bach and Kerzner (2010) and Flynn and Arstein-Kerslake (2014) for a fuller discussion of supported decision-making paradigms and how they can be incorporated in legislation for the benefit of persons with mental health problems.

Limitations

As with other papers in these series, there are several limitations of this study. We did not review subsidiary legislation such as rules and regulations, employers’ policies, or national programmes framed under the disability, non-discrimination, human rights legislation or labour laws. Such subsidiary legislation or programmes may contain important provisions pertaining to reasonable accommodations or affirmative actions for persons with disabilities, including mental disabilities. We also did not look for or examine draft bills, because provisions of final legislation arising out of these bills cannot be predicted at this stage. Further, we were either unable to find legislation or adequately translate legislation from nearly 20% of the UN Member States and, hence, are unable to comment on the status in these countries.

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Funding

World Psychiatric Association (WPA) funded the global survey on discrimination against people with mental illness. This article is based on the findings of this survey.
References


Part IV – Mental Health Care

Chapter 10. Legal Barriers

The need to reform mental health legislation in Commonwealth countries

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) serves as a comprehensive and legally binding framework for the rights of persons with mental illness. The extent to which countries have adapted their mental health legislation to reflect the binding provisions outlined in the CRPD is unclear. This paper reviews the situation across the Commonwealth.

Shifting the discourse of mental health legislation

Historically, persons with mental illness (PWMI) were viewed as dangerous. This view later shifted to one of PWMI being vulnerable and requiring protection by sympathetic professionals and society. Internationally, this was reflected in the adoption of the Principles for the Protection of Persons with Mental Illness (commonly called the MI Principles) by the United Nations (UN) General Assembly in 1991. More recently, the UN Convention on the Rights of Persons with Disabilities (CRPD), adopted by the General Assembly in 2006, has shifted the discourse towards the entitlements and rights of PWMI – a more collaborative, empowering discourse. However, our review of Commonwealth mental health legislation (Pathare & Sagade, 2013) suggests that many countries have yet to incorporate this discourse into their mental health laws. The review examined the laws of 45 countries, 28 of which had, at that time, ratified the CRPD. By December 2013 (at the time of writing of this editorial), 38 Commonwealth countries had ratified the CRPD. Many of the laws are outdated – our review found 20% of the 45 Commonwealth countries had laws that had been enacted before 1960, when psychotropic medicines were introduced, 60% laws enacted prior to the introduction of the MI Principles and 90% laws enacted before the CRPD. At the time of the review, the oldest mental health law still in force in a Commonwealth country dated from 1902, while the most recent was from 2012. A law drafted prior to 1991 is unlikely to include provisions in line with MI principles and, similarly, laws drafted before 1960 are likely to reflect a perspective when there were few treatments for severe mental illness and incarceration was the norm. The outdated nature of many mental health laws is also illustrated through the terminology employed. Our review found the word ‘lunatic’ used in laws in 12 countries, ‘insane’ in 11, ‘idiot’ in ten, ‘imbecile’ in two and ‘mentally defective’ in two. Overall, 21 laws in Commonwealth countries (47%) use one of these terms, reinforcing the incapability of PWMI and thus reinforcing stigma.
Rights and services

Ensuring the right to health means mental healthcare is equated with physical healthcare, access to mental healthcare is specified in legislation and community-based care is mandated within law (in line with Article 19 of the CRPD). Our review found only 5 (11%) of the 45 Commonwealth mental health laws equated physical and mental health, and 11 (24%) had some provision for promoting community-based care. However, the broad thrust of these 11 laws was towards institutional treatment and regulation. Arguably, community-based care and deinstitutionalisation are matters of broader health policy and not legislation; however, mental health laws themselves may be a barrier to enacting and implementing such policies. Many PWMI receiving treatment are either unaware of their rights or not in a position to ask about their rights. Thus, a provision in legislation mandating health authorities to inform service users of their rights will help them to exercise those rights. Our review highlighted this deficiency, as the mental health laws of only 13 Commonwealth countries (29%) give patients the right to be informed of their rights while receiving care.

The transition from guardianship to supported decision-making

Under Article 12 of the CRPD, which is reaffirmed by Article 13, PWMI have the right to recognition as persons before the law and are entitled to equal benefit and protection of the law. Article 12 has been celebrated worldwide by disability activists as representing a ‘paradigm shift’ in our perception of PWMI. However, professionals and service providers have been less enthusiastic, primarily owing to concerns about the decision-making capacity of PWMI and the lack of practical models for implementation. Traditionally, concern about capacity led to the inclusion of guardianship provisions in mental health legislation – we found that 24 Commonwealth countries (53%) had guardianship provisions in their mental health legislation; of these, 7 (29%) allowed only limited guardianship (restricted to property matters), while 14 (58%) had provisions for both limited and plenary (full) guardianship. Plenary guardianship conflicts with obligations under the CRPD, as it does not allow PWMI to retain decision-making abilities, rendering them non-persons before the law, contrary to Article 12. Limited and partial guardianship are preferred over plenary guardianship, as PWMI then retain some decision-making abilities, although, ideally, provisions for supported decision-making would be in place in legislation, in line with Article 12. While the notion of supported decision-making is a relatively new concept and it would be premature to evaluate its implementation in legislation across Commonwealth countries, some (e.g. Australia, Canada, Scotland) have replaced guardianship provisions in mental health legislation with supported decision-making provisions, largely through separate capacity legislation. These countries could share lessons learned on transitioning to supported decision-making models with more resource-scarce Commonwealth states. Supported decision-making can be tailored to fit a country’s legislative framework and resources, and can even make use of existing community resources (e.g. peer support to become ‘supporters’). This more adaptive approach counters the argument that these rights for PWMI are particularly problematic in low- and middle-income countries, primarily due to fragmented public health systems and resource scarcity, based on a presumption that supported decision-making will be resource intensive. This is not necessarily true:
Kumar et al (2013) showed it was feasible in India for PWMI to write a psychiatric advance directive (PAD; one form of supported decision-making), despite active symptoms, and to engage carers in the PAD process with little in the way of additional resources. There are also major procedural problems with existing guardianship provisions in mental health legislation. Of the 24 countries with such provision, only 3 (13%) had legislation that gives the person who is the subject of the guardianship application the right to appear before a court at the guardianship hearing and to be represented there. In addition, 16 countries (67%) had no provisions for appealing to a higher court against a guardianship order; nor did 19 (79%) countries provide for regular time-bound review of guardianship orders, contrary to the requirements of Article 13(1) of the CRPD.

Involuntary admission and least restrictive care

The last few decades have seen a movement towards voluntary care. Our review found that 32 countries (71%) had provisions for voluntary admission; however, few had laws stating that voluntary admission and treatment are the preferred alternatives. The majority of laws specified that persons voluntarily admitted to a mental health facility can be treated only after informed consent is obtained. Currently, all Commonwealth laws allow involuntary admission and treatment for PWMI. We found laws in only 24 countries (53%) mandate that the mental disorder be of a specified severity to allow involuntary admission; in the remaining countries, there is no such requirement. Often, laws allow involuntary admission only if there is a serious risk of harm to self or others, or a likelihood of serious deterioration in the patient’s condition if treatment is not provided. This was the case in 31 Commonwealth countries (69%). Amendment of these provisions may be necessary to comply with the CRPD. In fact, the UN High Commissioner for Human Rights goes as far as to say that any form of involuntary admission or non-consensual treatment is considered non-compliant with the CRPD and provisions relating to involuntary admission and treatment should be removed from all mental health legislation (Mendez, 2013).

Moving forward

Although there is substantial encouragement from regional, national and international actors to reform mental health legislation, as well as the shifting discourse on rights, many mental health laws still espouse guardianship, institutionalization and protectionism as opposed to models of supported decision-making, community-based care and entitlement. The key goals of mental health legislation should be to facilitate better access to and the quality of mental healthcare, and to promote the rights to social inclusion of PWMI. A number of countries are currently reforming their legislation, the result of which may be more progressive mental health law. While legislation by itself cannot improve the situation in the absence of well designed and implemented policies and services, it is a necessary and important step. Future work in this area should look at subsidiary legislation, which may have important provisions for rights protection, and explore civil, political and economic laws, as well as social and
cultural rights for PWMI. The Commonwealth should provide technical and financial support, in particular for those countries with limited resources.

References


Chapter 11. Discussion and Conclusions

This chapter discusses findings and conclusion of the research which was guided by main question:

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

To answer this question, we studied rights-based access to four domains of life – employment, marriage, owning property, and health care. We chose these areas because they represent some of the most basic needs, aspirations and dreams of all human beings. These domains are interlinked and are essential for the full and effective social participation of persons with mental illness. Failure to attain any one of them can lead to negative outcomes in other areas of life. We studied the four domains through seven research sub-questions. In this chapter, the findings of each sub-question are summarized and its contribution to the main research question is considered. This is followed by the overall conclusions of the thesis. The issues which need to be pursued in future research are also discussed.

11.1 Barriers and structural discrimination

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

Persons with mental illness face social exclusion if the legal and social environment does not accommodate them. In study 1 (Chapter 4) we saw how laws present a series of barriers that impede the realization of the right to work and employment of persons with mental illness. The stages at which persons with mental illness face barriers are explained in Figure 1.
The interpretation of the term ‘disability’ is not consistent worldwide. Employment and disability laws in one in three countries do not explicitly include mental illness/impairment in the definition of disability. Persons with mental illness cannot make legitimate claims to access disability-related benefits unless they are legally recognized as persons with disabilities. The study highlights the need for mental illness to be included in the definition so that persons with mental illness are not excluded from the coverage of national disability-empowerment programmes.

Study 1 (chapter 4) further found that domestic laws in one in three countries do not prohibit discrimination against persons with mental illness in job recruitment. This protection is critical in order to give equal and fair opportunities to all candidates. Reasonable accommodation is essential at the workplace so that persons with mental illness can continue to work alongside with others. There is empirical evidence that persons with mental illness need accommodation such as flexible schedules, job modification or restructuring, communication facilitators, training for staff or supervisors, modifying supervision, policy changes, modifying the physical environment, providing special equipment, and changing work procedures. These accommodations are reasonable, 90% of them cost employers less than $100, and do not present undue hardship for them (Fabian, Waterworth, & Ripke, 1993; MacDonald-Wilson, Rogers, Massaro, Lyass, & Crean, 2002). Yet 30% of the countries do not guarantee these accommodations.

Promotion of employment of persons with disabilities is a responsibility of the State, according to Article 27(1)(h) of the CRPD, but one in three do not fulfil this criterion, and
in almost half, employers are allowed to terminate the employment contract on the
grounds of health, including mental illness.

Overall, it appears that employment laws in many countries still follow the medical
model of disability. The ‘diagnosis of mental illnesses’ becomes the individual’s identity.
The label of being mentally ill determines an individual’s eligibility status – whether
being called for interviews, and subsequently offered a job. It also determines the
individual’s social standing in the workplace. If an employee suffers from mental illness
during the work, it is far harder to retain the employment. Employers can deny
adjustments to persons with mental illness on the basis of undue burden or hardship.

In the case of 51% countries, laws allow employers to temporarily suspend or
permanently terminate the employment contract solely on the grounds of mental
illness. In some countries, an employment contract may not be terminated if an injury
or disability has occurred during the work or because of work. However, we did not
come across any examples of countries where laws explicitly stated that injuries or
disability also included mental distress or impairment. This issue is not only
discriminatory but complex to understand, because the aetiology of mental illness
cannot always be established. One may constantly be under mental distress due to work
pressure and/or an unhealthy work environment. In such circumstances, if one suffers
from mental illness, who is to be held responsible – the individual or employer or other
social circumstances? Mental illness carries, as such, an enigma that is hard to resolve.

To conclude, we found that rather than promoting employment opportunities for
persons with mental illness, laws tend to maximize opportunities to exclude them from
mainstream employment. Persons with mental illness face a series of legal barriers that
lead to discrimination against them. The discriminatory provisions, which use
derogatory labels such as ‘imbecile’ or ‘of unsound mind’, show the consolidated social
stigma of mental illness.

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 persons with mental illness from
employers and family members to overcome these barriers?

In study 2 (chapter 5) we saw that stigma, discrimination and abuse were the toughest
barriers to employment of persons with mental illness in the informal sector in Gujarat.
Employers’ stigma and prejudices towards persons with mental illness were evident in
the loss of trust related to their employees’ productivity. This, in turn, reduced both the
workload and income of several employees. Employees were either bullied or received
frequent threats of termination. For most participants, because of the informal nature
of work, employees did not have access to the grievance system or social security
benefits. Nonetheless, some did receive support from the employers during an
exacerbation of mental illness if they had been efficient before the onset of the illness.
On the other hand, self-employed individuals faced fewer barriers to employment, because their family members actively looked after the business in their absence.

In a patriarchal society like India’s, men are assigned the role of head of the family, and are the principal breadwinners. Due to cultural expectations, they are often compelled to work even when they are ill (Prasad & Acharya, 2014). If a man with mental illness is unemployed and is seeking a job, family members and friends help him informally to find one. This is particularly on the assumption that one day he will be able to live on his own, get married, and have a family to support him. Even if he does not marry, help is provided with an expectation that he will be able to subsist. He will live a life of dignity and not be a burden on his siblings after his parents’ death. When men with mental illness meet families’ financial needs, they are likely to receive the support, care and appreciation of family members. If family members believe that the person is unable to earn enough to support his family or to shoulder marital responsibilities because of mental illness, they do not allow him to marry. Family members think, if he does not fulfil his duties as a husband, he would bring dishonour to the family. This was evident in one participant’s testimony:

I like the support I receive, they manage my food, maintain my timings, I can share problems with family members. But they are not keen about my marriage. They think I should not marry because of my mental illness. If I do, my family will face defamation.

To conclude, this study showed that cultural expectations play an important role in promoting the employment of a man with mental illness. Employment and support of family members complement each other. If men with mental illness earn enough to support their families, they are less likely to face social stigma and discrimination.

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 the awareness of mental disability certification among respondents?

In study 3 (chapter 6), we found that one in two persons with mental illness was employed, the majority (84%) in the informal economy. This study highlighted the role of social factors (marriage and work experience) that promoted employment of persons with mental illness. This finding relates to study 2 (chapter 5), which also highlights that marriage and employment support each other.

In Mangalore (India), Kashyap, Thunga, Rao, & Balamurali (2012) found that lack of awareness was one of the biggest challenges to the uptake of disability benefits among persons with mental illness. In our study, we also observed that 79% of the respondents were unaware that mental illness is recognized as a form of disability in India. When we told these respondents about the certificate and benefits associated with it, many of them raised concerns. They questioned its usefulness. The theme of their concerns was similar to the following:
I am aware that people who have physical disability, blindness or hearing impairment also get such certificates. They use those certificates while applying for government jobs under disability quota. Do people like me also get this benefit? If no, then why should I bother to get one?

Some respondents explained:

Even if I get it after months of process, what do I do with it? I hardly travel out of the city. For local travel, I do not need travel concession. My income is not taxable, so I do not need tax deduction benefits. The disability pension is highly inadequate. It is not worth the time and effort spent on getting the certificate... I lose wages when I wait in the queues for hours!

These concerns highlight the dismal state of persons with mental illness in India. At the same time, they also show that awareness of the rights of persons with physical or sensory disabilities is higher, because the government has promoted their education and employment through affirmative action. However, there is little awareness and enthusiasm about the rights of persons with mental illness. This may be due to many reasons including the fact that since the implementation of the Persons with Disabilities Act of 1995, the employment of persons with mental illness was not promoted through affirmative action. In light of Article 8 of the CRPD, India has an obligation to raise awareness about the rights, capabilities and contributions of persons with mental illness, foster respect and dignity, combat stereotypes and prejudices against these individuals. It is important to note here that laws play an important role in shaping perceptions of a disadvantaged group. If laws are unequal and discriminatory towards persons with mental illness, they perpetuate the stigma of mental illness in the public at large. If laws promote the equality of a disadvantaged group, these are likely to modify public perceptions in a positive way. Thus, if laws guarantee a right to work and employment to a disadvantaged group like persons with mental illness, this is likely to lead to a positive change in the way people perceive them. Thus, ‘having a rights-based access to employment’ seems to be associated with shaping public perceptions of persons with mental illness and raising awareness of their rights.

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?

In study 4 (chapter 7), we found that in 37% of the countries examined, the marriage of persons with mental illness is not legally recognized, and in 11% countries marriage can be annulled on the ground of mental illness of the spouse. In 6% countries, persons with mental illness are allowed to marry only if the Court/Family Council gives permission or if the parent, custodian or guardian give consent. In some cases, the opinion of a psychiatrist or general doctor is to be sought. Mental illness is a ground for divorce in 12% of countries. In 4% countries laws use treatability and curability criteria to decide whether divorce should be granted; such laws require that the petitioner’s spouse must
be suffering from mental illness for three to five years, and that the illness is of an
curable nature. The petitioner has to prove that, because of these circumstances, it is
difficult to live with the spouse with mental illness.

These provisions not only violate right to marry as framed in Article 23(1)(a) of the
CRPD, they also deny equal recognition to persons with mental illness before the law.
They fail to acknowledge that persons with mental illness have the legal capacity to take
decisions about their marriage. Parents, guardians, custodians, and doctors are given
powers by law to decide whether a person with mental illness may marry. This is a
substituted decision-making, and the CRPD requires that such legal provisions should be
abolished. Such provisions also perpetuate the social stigma of mental illness. Further,
if a marriage is dissolved on the grounds of mental illness, the patient-spouse has to go
through a double ordeal: facing the stigma of being divorced and of being a mentally ill
person. Divorced persons, especially women, have reported that they are socially
devalued and are excluded from informal social networks (Gerstel, 1987). Because
social and financial support is withdrawn when someone is divorced, the person is
pushed towards a crisis (Kitson & Morgan, 1990), making it difficult to return to family
life.

Taken together, laws which allow the annulment of marriage or divorce on the ground
of mental illness perpetuate stigma of mental illness, and discriminate against persons
with mental illness at the social level.

5. To what extent does 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 the
matrimonial proceedings dealing with persons with mental illness in India?

Study 5 (chapter 8) examined how the discriminatory provisions of the Hindu Marriage
Act, 1955 were practised in relation to persons with mental illness in India. The study
showed that the provisions of annulment or divorce on the grounds of mental illness
were largely being used against women. That is, in 95% of cases, a husband had
approached the Family Court for annulment or divorce on the ground of mental illness
of his wife. In 50% of the cases, their pleas were accepted. Women could not always
have legal and financial resources to appeal to the higher court. But when they did, in
63% of the cases, their appeals were accepted.

In 22% of the cases, marriages were annulled or dissolved merely on the accusation
that other spouse had a mental illness. In these cases, medical evidence to substantiate
the claim was not presented. Furthermore, in 36% of the cases where medical evidence
was presented, the Court accepted a prescription of medication and an invoice of its
purchase as proof to support the plaintiff’s claim of being unable to live with the other
spouse who had mental illness.
This study highlights the discriminatory practice of the Hindu Marriage Act, 1955 in India. In addition, it shows that there are three issues that act as barriers to obtaining justice for a marginalized group. These issues include i) unequal distribution of power and financial resources; ii) stigma of divorce; and iii) stigma of mental illness. The marginalized groups include women as well as persons with mental illness. In a patriarchal society like India’s, women are likely to be discouraged from initiating divorce proceedings. This is either because of the stigma of divorce or due to lack of financial resources. Divorces are known to bring social rejection and embarrassment to the families, especially of women (Thara et al., 2003a, 2003b). Even if a woman experiences intense marital discord, divorce is not an option that is always available to her. If she initiates divorce proceedings, she may not receive alimony. Often the family members of the woman who wants a divorce fear that, once divorced she will lose the financial and physical security that comes with marriage. They also fear that, if she is not earning, after the divorce she (and her children) will return to her maiden home, will become a burden on her parents and brothers, and that the marital prospects of her siblings will be jeopardized. Women also bear the social pressure to sustain their marriage in order to protect the welfare of their children. Due to these concerns, women do not always receive support from family members to seek a divorce and they continue to go through troubled marriages. If they fail to fulfil assumed marital duties or the wishes of their husband and in-laws, their behaviour is construed as deviance – and as an indication of mental illness. During data collection, we often came across such cases where husbands had initiated divorce proceedings because, according to the husband and in-laws, his wife had failed to fulfil certain marital duties, and therefore the husband suspected his wife had some mental illness. That is, the wife’s denial to perform certain tasks was considered as deviation from her traditional role, and she was labelled as mentally ill.

In this study, we also came across cases where persons with mental illness or their family members had not revealed information about the mental illness before marriage. This was due to the stigma of mental illness, the fear of defamation, and social rejection. In these cases, parents of persons with mental illness were often concerned that if they revealed information about their child’s mental illness, she or he would never get married. Eventually, in these cases, persons with mental illness faced allegations of fraud, and their marriages were annulled.

In India, traditionally, parents or guardians arrange the marriage (Thara et al., 2003a), and the consent of the persons with mental illness, especially of woman, is usually not sought (Sharma, Tripathi, & Pathak, 2015). Here, family members may decide to hide information about the mental illness, so that the woman can at least get married (Nambi, 2005). A woman with mental illness is perceived as a burden that can be shifted to the husband after marriage (Loganathan & Murthy, 2011) In such cases, by hiding the information, family members connive in fraudulent behaviour (Sharma et al., 2015). But its consequences are borne by the woman when she moves to the in-laws’ house. Due to the sudden change in the circumstances, the increased burden of responsibilities, and discontinued medication, a woman may find it hard to withstand
the pressure of new marital roles (Nambi, 2005; Sharma et al., 2015; Thara et al., 2003a). In such circumstances, if the symptoms of mental illness are aggravated, the husband’s family members desert her (Loganathan & Murthy, 2011; Sharma et al., 2015; Thara et al., 2003b). She could either be sent to her parents’ home (Thara et al., 2003a) or admitted to a mental hospital. If she is hospitalized, her own family members may refuse to take her back if they think she is unable to earn a living (Loganathan & Murthy, 2011; Thara et al., 2003b).

Even if the information about mental illness of an individual is revealed prior to marriage, the other spouse can still apply for an annulment by claiming that the spouse was incapable of consenting to the marriage because of mental illness. Thus, practice of marriage law in India not only discriminates against women with mental illness, it ultimately leads to their social marginalization.

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?

Study 6 (chapter 9) showed that laws in 38% of the countries examined do not recognize the contractual capacity of persons with mental illness. Laws in 12% of these countries allow the invalidation of a contract by persons with mental illness, if their level of understanding (cognitive ability) is in question. By providing facilitating mechanisms, laws allow substituted decision-making in 9% of the countries.

In 70% of the countries, persons with mental illness can lawfully inherit property. A review of the existing evidence on inheritance, disability and poverty in low- and middle-income countries shows that, although inheritance is a significant way to transfer wealth from one generation to another, it is a social justice and practice issue. It has been largely unrecognized, and poorly understood as contributor to the poverty of persons with disabilities (Groce, London, & Stein, 2014). Moreover, these authors argue that persons with mental disabilities face ‘greater exclusion’ because it is presumed that they are not capable to take care of communal ancestral property. Families also express concerns that persons with mental illness cannot be given unregulated control to spend the inheritance. This could probably be one of the reasons that laws in only 23% of these countries allow persons with mental illness to make a will to dispose of the property.

The above findings indicate overall that persons with mental illness across the world cannot fully enjoy right to property. In most countries, laws allow the succession of property, but they do not allow persons with mental illness to dispose of the property based on their wishes and preferences. These laws assign power positions to the guardians to decide whether or not the choices made by persons with mental illness are appropriate. If there is a conflict of interest, guardians’ decisions are preferred. Thus, laws not only deny persons with mental illness equal recognition before the law, but laws place restrictions on their legal capacity.
7. To what extent does mental health legislation in Commonwealth Member States structurally discriminate against persons with mental illness?

The review of mental health legislation in the Commonwealth Member States (study 7, chapter 10) showed that the paradigm shift promised by the CRPD has yet to make a real difference to the lives of persons with mental illness. Mental health laws in many countries are outdated. They do not meet international human rights standards of mental health care. Laws in only 11% of these countries state that mental health care shall be provided on a par with physical health care. In 9% of the countries, mental health laws state that voluntary admission and voluntary treatment are the preferred alternatives for mental health care. In no country do mental health laws fully promote the de-institutionalization of persons with mental illness. Further, laws in 40% of the countries allow the state to recover the costs of treatment of involuntary admissions from the property or estate of the person with mental disorders or from their relatives, friends or carers. Laws in 47% of the countries do not recognize that persons with mental illness have the right to voluntary treatment and discharge. In 53% of these countries, mental health laws have provisions for guardianship. Tools that protect the autonomy of the patient (e.g. informed consent, supported decision-making) need to be embedded in the mental health laws of several low and middle-income countries.

Structural barriers have an economic gradient

In studies 1, 4, 6 and 7, we found a common thread. Structural barriers that lead to discrimination against persons with mental illness were largely embedded in the laws of low and middle-income countries. Protection of the rights of marginalized groups such as persons with mental illness seemed to be a prerogative of wealthier countries. We do not know the causality of this association. It could be because in developed countries, more financial resources are available for marginalized social groups, that societies are culturally more advanced, or that the law and policy-makers are more sensitized to empirical evidence. It could also be due to political will and timely measures that these countries have taken to cope with the problems of marginalized people. But it appears that social structures such as laws are influenced by national economic development. The more developed a country is, the more likely it is that the rights of persons with mental illness will be protected. In this regard, the General Comment no. 5 on the ICESCR specifies that countries’ economic constraints cannot justify discrimination against persons with mental illness (Committee on Economic, Social and Cultural Rights, 2000, para. 18). Hence, low and middle-income countries cannot justify the legal discrimination against persons with mental illness.

Impact of ratification of international human rights treaties

Interestingly in studies 1, 4, 6 and 7, we found that countries are quick to ratify international human rights treaties such as the ICESCR, ICCPR and CRPD, but they do not necessarily abolish archaic, non-compliant laws demanded by the ratification. In order to give effect to the principles of treaties like the CRPD, domestic laws must be made compliant. For this, countries must abolish or modify existing laws that discriminate against persons with mental illness.
Archaic terminology used for persons with mental illness perpetuates the stigma of mental illness

In studies 1, 4, 5, 6 and 7, we came across the derogatory legal terms for persons with mental illness. In India, 150 laws use the term ‘unsoundness of mind’ (Legal Review team of National Disability Network and Disabled Rights Group, 2012), but seldom it is clearly defined in the same laws. Section 12 of the Indian Contract Act, 1872 has illustrated what an unsound mind is. According to this interpretation, an unsound mind cannot be associated with mental illness, but in India, ‘unsound mind’ has been equated with mental illness (Hari Singh Gond v. State of M. P., 2008). Frequent use of this term not only perpetuates the social stigma of mental illness, but also leads to the exclusion of and discrimination against persons with mental illness.

Bhugra, Ventriglio, & Bhui (2016) argue that use of varying terminology to describe mental illness or people who have mental illness does disservice to the patients. These authors contend that replacing the term ‘mental illness’ with ‘mental health concerns’ or ‘mental health issues’ implies that the experiences of mental illness are “less severe, or less chronic, or less worthy, and maybe even positively valued states of suffering with no connection with illness, disease, or pathology” (p.1100). If such terms are used in laws, it could not only create confusion among people who practise law, policy-makers, scientists and the general public, it could also contribute to delaying the justice for persons who experience social disadvantage. In this regard, a mental health consumer’ and carers’ forum in Australia promotes using a term ‘psychosocial disabilities’ to describe ‘mental disabilities’. Proponents of this position argue that every person who has mental illness may or may not experience social disadvantage. Hence, those who experience such disadvantage, must be identified separately (National Mental Health Consumer and Carer Forum, 2014).

### 11.2 Theoretical Considerations

Framework of structural barriers

When we consider studies 1, 4, 5, 6 and 7, we see that structural barriers operate mainly by violating the right to equality. Even if domain-specific human rights of persons with mental illness are violated, at a fundamental level, violation of rights occurs in terms of a failure to get equal recognition before the law and denial of legal capacity. Denial of equal recognition before the law can be seen in those laws that fail to prohibit discrimination on the basis of mental illness, that fail to provide equal opportunities through affirmative action. Similarly, the denial of legal capacity can be seen in the provisions that negate individuals merely on the basis of the label of mental illness. It can also be seen in the provisions where consent of the individual can be nullified because of mental illness. This is illustrated more in Figure 2.
Furthermore, when we relate the findings of this research to the theories of stigma and discrimination (Chapter 2, part 2), we see that mental illness reduces a person’s desirability. It taints the social identity of a person to a great extent. Persons with mental illness are not assigned significant roles and responsibilities in social standards and cultural norms. This is because their capabilities are doubted on several accounts. It is presumed that they are incapable of taking care of themselves, incapable of making meaningful decisions, and they are unable to perform duties towards their employers, families, and the society. Employers can dismiss them from work. Those who do not have mental illness opt for annulment or divorce if the spouse becomes mentally ill. Their financial powers and rights are restricted. If anything, laws sanction such acts of exclusion. This is a matter of concern because, by allowing segregation on the grounds of mental illness, laws acknowledge that persons with mental illness can be abandoned, that they are incapable of living in a community, and their institutionalization is acceptable. Here, it appears that roles of parents, guardians, custodians, caregivers such as psychiatrists and health professionals are given more weight in the decision-making process. They are granted greater power through guardianship and custody. Laws are framed in such a way that best interests of these individuals are protected. Autonomy, well-being, wills and preferences of persons with mental illness are neglected. Laws use stigmatizing metaphors regarding mental illness to highlight deviations from cultural expectations. The use of non-operationalizable, non-scientific terms for mental illness is rampant in legislation. Using these terms, untrained people are given the responsibility to determine whether or not a person with mental illness is capable of decision-making. In this scenario, when countries are obliged to follow international human rights law and empower persons with mental illness/disabilities, the intentions of domestic laws become doubtful. There appears a gap between the two – between the intentions of
the international human rights law and the intentions of domestic law. Whether the gap exists only for persons with mental illness or it exists for persons with disabilities in general, we do not know. But looking at the magnitude of marginalization that is promoted in laws, it appears that structural stigma is one of the most formidable barriers to the social inclusion of persons with mental illness.

11.3 Conclusions

To summarize findings of this research and in conclusion:

1. Denial of equal recognition before the law and denial of legal capacity form the bedrock of structural discrimination against persons with mental illness.
2. Denying these rights leads to a violation of economic rights (right to work and employment), social and cultural rights (right to marry and remain married) and civil rights (right to contract, succession of property and to make a will). It also violates a fundamental right – the right to health.
3. Violation of these rights delays the social inclusion of persons with mental illness.
4. To protect and promote economic, social, cultural and civil rights, equal recognition of persons with mental illness before the law must be restored first. To do so, countries must promote the use of supported decision-making alternatives such as personal directives, psychiatric advance directives, ombudsman.
5. Use of archaic and derogatory labels in laws for persons with mental illness must be condemned and abolished. The state agencies cannot perpetuate stigma of mental illness.
6. Even if countries need time and resources to consider legal reform, the interpretation of domestic laws in the context of international human rights principles must be encouraged.
7. State Parties to the CRPD urgently need to provide equal employment opportunities to persons with mental illness. Employment of persons with mental illness can be used as a stigma-reduction strategy.

11.4 Validity of the findings

11.4.1 External validity

Reviews of laws on employment (study 1 – chapter 4), marriage (study 4 – chapter 7), and property (study 6 – chapter 9) are surveys where laws in 193 United Nations Member States are analysed. These reviews are the first of their kind to present an overview of structural discrimination against persons with mental illness across the globe. In these reviews, compliance of countries’ laws with domain-specific principles of
the CRPD is assessed. For instance, provisions of marriage and divorce were compared only with respect to right to marry and remain married. In such cases, we did not look for the right to equal access to justice. Similarly, in these reviews, subsidiary legislation such as rules and policies are not covered. In analysing legal provisions, we often faced difficulties in translating the laws because the scripts were illegible or we could not copy them electronically. This limitation resulted in reducing number of countries actually included in the surveys of marriage and property laws.

In studies 2 and 3, we interviewed out-patients at only one tertiary care mental hospital. Hence, the generalizability of these findings is limited to Ahmedabad and nearby districts in Gujarat. Experiences of men with mental illness and their employment rate may differ in other Indian states where societies are less industrialized or the informal economy offers different job opportunities. Similarly, the experiences of women with mental illness can also differ, because they face more challenges in exercising their right to work. These studies do not cover in-patients or private hospitals. Hence, the barriers faced by these individuals and employment rate of these individual may differ.

The findings of study 5 (chapter 8) are based on data from the Family Court in Pune. This is a district-level Court established under the Family Courts Act, 1984. So, one may say that generalizability of these findings is limited to Pune district. However, findings of this study are also based on the data from all the High Courts and the Supreme Court, which are the appellate courts in India. Every case that has reached these Courts has come from district-level lower Court(s) in the respective Indian states. Hence, it can be said that generalizability of the data of this study can be extended to the country level.

The findings of study 7 (chapter 10) are limited to the Commonwealth Member States. The Commonwealth is an intergovernmental organization of 52 Member States which were under British colonial rule. Hence the mental health legislation in the Commonwealth Member States is based on the principles of common laws, so the generalizability of this study is limited.

11.4.2 Internal validity

For studies 1, 4, 5, 6 and 7 (chapters 4,7,8,9 and 10 respectively) we relied on explicit interpretation of the laws. When there was no consensus on the interpretation of law, we sought the opinion of a third researcher with a legal background.

In study 2 (chapter 5), we used a redundancy criterion to decide when to end data collection. That is, we went on collecting information and simultaneously analysing the data until no new information was to be found. However, the author of this research was the only person who conducted in-depth qualitative interviews. Hence, we might have reached early saturation.
11.5 Future research

Understanding structural discrimination in the practice and implementation of laws

Studies 4 and 5 together can be considered as a model way to understand structural discrimination against persons with mental illness. These studies present structural discrimination in the legal framework as well as implementation of the laws. In the same line, research studies on implementation of employment, property-related, and mental health laws are warranted. It is essential to know if implementation of these laws promote the inclusion of persons with mental illness or their institutionalization. It is also essential to explore if justice is delivered in the same way to men and women.

Understanding barriers to implementation of international human rights law

The present research shows that countries are quick to ratify international human rights treaties like the CRPD. But they fail to bring legal reform to comply with Article 4 of the CRPD. It is therefore essential to explore the barriers to implementing principles of CRPD for persons with mental illness.

Further, in India, the newly enacted Rights of Persons with Disabilities Act, 2016 aims to promote employment of persons with mental illness. It is therefore essential to monitor how the law is being implemented, whether persons with mental illness still face discrimination in the availability of the employment opportunities, and the attitudes of employers to hire persons with mental illness in the light of the new law. Similarly, it is essential to study the implementation of the Mental Health Care Act, 2017 of India, to examine how the implementation of the supported decision-making model unfolds, and whether patients feel empowered by this access or whether it is merely perceived as a procedural issue.
Bibliography


Hari Singh Gond v. State of M. P., 16 Supreme Court Cases 109 (Supreme Court of India 2008).


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; whereas 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 outpatients, 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 for 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.
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