

TOWARDS A NO-FORCE PARADIGM IN MENTAL HEALTH LAW

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Protection against the unlawful deprivation of life and liberty, assured to persons with disabilities in the United Nations Convention on the Rights of Persons with Disability, is a negative freedom, unrealisable unless the right-bearer has the ability to realise such a freedom. This is rooted in the proposition that we cannot be considered free to do that which we are unable to do. Law's recognition of ability to transact freely with the world is by way of the legal construct of capacity. Forced intervention and institution-alisation of persons with mental illness denies rational agency to persons with mental illnesses on an assessment of lack of capacity. The legal institution of 'guardians' and other substituted decision-makers further aggravate this denial of capacity of persons with mental illness by providing for a denial of agency. This paper argues that the universalist model of legal capacity requires law-makers to embrace a paradigm shift, from viewing ability as central to the human condition (and consequently to 'capacity') to viewing 'disability' as central to the human condition. This would entail the recognition of the fact that all human beings are in some sense disabled, thus widening the range of 'normal'. This paradigm would only allow function-specific capacity assessment to be undertaken so as not to render capacity a status by the tag 'mentally ill'. The paper also demonstrates the fallacy in the grounds employed to justify the use of force against persons with mental illness to further strengthen the case in favour of abolition of the use of forced medical intervention for persons with mental illness.

I. INTRODUCTION

Lay interaction with a person with mental disability reveals that persons suffering from mental illness despise the feeling of being treated as 'special' or different from 'normal' people. This constant negation of agency and the objectification that subliminally becomes the undertone in our behaviour and engagement with persons with mental disability have repercussions on the decisions made by persons with mental illnesses, sometimes even to the extent of suppression of their diagnosis from family and friends.

In disability law, human sensitivity is the normative argument for restructuring the disability-human rights paradigm to embody the universalist model of viewing *disability as central to the human condition*. Such a normative

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argument can be located in the United Nations Convention on the Rights of Persons with Disability ('UNCRPD'), in which the unstated demand for 'no-force' under Art. 14 should be read with Art. 12, which mandates universal capacity, Art. 17, which ensures the protection of bodily and mental integrity and Art. 25(d), which protects the right to give informed consent to treatment. This paper seeks to establish, with the aid of equality and non-discrimination theories of various authors, a sound framework for the abolition of forced treatment, intervention and institutionalisation of persons with mental illness in law.

Currently, the law prescribes forced medical intervention/institutionalisation on 'involuntary patients' if they are persons lacking capacity. The law seems to view willingness towards treatment/institutionalisation as the only rational decision that can possibly be made by a person with mental illness, after having understood the nature and quality of the treatment. I, therefore, argue that the law must not be used as an instrument to force medical intervention/institutionalisation, when a person with mental illness is discovered to be incapable of understanding the nature and consequences of medical intervention/institutionalisation.

I build a case for a no-force paradigm in mental health laws using the following structure- first, the paper describes the present state of mental health law in India, and then demonstrates that such law is steeped in several issues. The paper then puts forth the universalist approach which, it argues, should form the basis for recognising rational agency and consequently, capacity in persons with mental illnesses. Finally, the paper evaluates the justifications for the curtailment of liberty of persons with mental illness, supposedly done for their well-being, as well as the justifications for the use of force in law.

The scope of this paper is limited to raising arguments against *forced* intervention or institutionalisation, and not against intervention or institutionalisation itself. This limited scope is, however, without prejudice to the view taken in this paper that principally, intervention or institutionalisation itself is problematic and that the decisions and choices of persons with mental illness in relation to living arrangements and community support must be given primacy.

II. THE PROBLEM WITH MENTAL HEALTH LAW

According to the Mental Health Act, 1987 forced institutionalisation is prescribed if the Judicial Magistrate, upon application of the medical officer in charge of a psychiatric hospital, considers it necessary to institutionalise

a “mentally ill person” in “the interests of the health and personal safety of the mentally ill person or for the protection of others”.¹

While the Act defines “mentally ill person”,² the fact of mental illness in a person is evidenced by certification by a medical officer. Thus, §24(2) (a) of the Mental Health Act, 1987 stipulates that the Magistrate may order intervention or institutionalisation of the allegedly mentally ill person, if he/she is produced in Court:

- a. if the medical officer certifies such person to be a mentally ill person, and
- b. if the Magistrate is satisfied that the said person is a mentally ill person.

Similar is the procedure detailed under §22 that must be followed by the Magistrate while ordering intervention or institutionalisation on application by medical officers. Here too, the assessment of whether the allegedly mentally ill person is actually a person with mental illness, is undertaken by way of mandatory certification by the medical officers under §§20(6) and 21 of the Act. Thus, it is clear that the existence of mental illness is one that is assessed and certified by the medical officers and that these facts, in the scheme of *forced treatment and institutionalisation*, are seldom adjudicated upon by courts.

The element of force manifests itself in Indian statutory law by way of granting a wide array of substituted decision-makers the discretion to apply³ for “reception orders”.⁴ A particularly grave form of force is used when the law provides for forced institutionalisation when the mentally ill person “*does not, or is unable to express his willingness for admission as a voluntary patient*”,⁵ on the decision of a substituted decision-maker.

The problem with the law becomes evident from a quick reference to Art. 14 of the UNCRPD, which provides for protection against arbitrary and unlawful deprivation of liberty, mandating that the existence of a disability should not be construed as a justification for the denial of liberty. In addition,

¹ The Mental Health Act, 1987, §§22(1) and 24 read with §§20(2) and 21.

² The Mental Health Act, 1987, §2(1): “Mentally ill person” means a person who is in need of treatment by reason of any mental disorder other than mental retardation.

³ The Mental Health Act, 1987, §20(1): An application for a reception order may be made by: [...] by the husband, wife or any other relative of the mentally ill person.

⁴ The Mental Health Act, 1987, §2(s): “reception order” means an order made under the provision of this Act for the admission and detention of a mentally ill person in a psychiatric Hospital or psychiatric nursing home.

⁵ The Mental Health Act, 1987, §19(1): Any mentally ill person who does not, or is unable to, express his willingness for admission as a voluntary patient, may be admitted and kept as an inpatient in a psychiatric hospital or psychiatric nursing home on an application made in that behalf by a relative or a friend of the mentally ill person if the medical officer-in-charge is satisfied that in the interests of the mentally ill person it is necessary so to do.

the bill of rights in India as laid out in Part-III of the Constitution of India enshrines the right to liberty, along with the freedom of mobility, protection against arbitrary detention or confinement and equality rights. Such *legal* freedom, however, is a *negative* conception of freedom,⁶ that is confined by both natural and other contingencies.⁷ A meaningful right of freedom is one that is realisable, and is therefore linked inextricably to ability.⁸ As Hull succinctly puts it:

“...we cannot be said in any meaningful sense to be free to do that which we are unable to do.”⁹

Sen also takes this approach to equality by assessing individual advantage using the *freedom to achieve* or the *capability to function* as the determinant.¹⁰

Denial of capacity and the consequent denial of agency amount to a denial of this basic capability to function itself. Consequently, any assurance of liberty and freedom in the constitutionally protected fundamental rights is not an assurance of a realisable freedom.

Moreover, a model that validates force in law is one that denies rational agency to persons with mental illnesses and rests on several assumptions that this paper hopes to dismantle. The paper also endeavours to demonstrate that such a model discriminates between ‘involuntary patients’ and ‘voluntary patients’, objectifies persons with mental illnesses, validates fallacious grounds for use of force in law and prescribes a curtailment of liberty in pursuance of the best interests of the person with mental illness without exhausting less paternalistic courses of action.

III. CAPACITY IN MENTAL HEALTH LAW

Fundamentally, the problem with the concept of capacity in mental health law is its deep roots in the liberal notion of individualism, *i.e.*, the notion that individuals be valued for their individual merits. Fredman argues that the stress on individualism is problematic as the individual’s merit is sought to be quantified *de hors* social and natural context.¹¹ To draw an analogy similar

⁶ A negative freedom is one that is guaranteed through the assurance that no impediments shall be posed to the exercise of freedom (For instance, Art. 21 of the Constitution of India). A negative freedom must be understood in contrast with a positive freedom, which is a positive affirmation of a freedom by conferral of a special access to freedom.

⁷ Richard Hull, *Disability and Freedom* in ARGUING ABOUT DISABILITY: PHILOSOPHICAL PERSPECTIVES 97-102 (2009).

⁸ *Id.*

⁹ *Id.*, 99.

¹⁰ See AMARTYA SEN, INEQUALITY RE-EXAMINED 129 – 152 (1992).

¹¹ Sandra Fredman, *Disability Equality: A Challenge to the Existing Anti-Discrimination Paradigm?* in DISABILITY RIGHTS IN EUROPE: FROM THEORY TO PRACTICE 204 (A Lawson & C

to her argument, the assumption that *only persons without mental illness* can make rational, correct and good treatment decisions that are in their own best interest, is itself discriminatory (not to forget, completely untrue; if it were true, there would be no smokers, no addicts and no obese people). This assumption, unfortunately, forms the basis for legislating in substituted decision-making processes when a person with mental illness is evaluated to be lacking capacity.

Moreover, the assessment of capacity in mental health law ought to be specific to the decision required to be made at that point. In the Indian Mental Health Act, however, it is clear that the assessment of capacity undertaken by the Magistrate is *not function-specific* and thus results in the ascription of the “status” of mental incapacity to the person in question.¹² A good example of a function-specific assessment of capacity is:

“A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.”¹³

To the extent that this test of capacity is in the context of a particular function, as opposed to a general evaluation of capacity that is ascribed to the person as a status,¹⁴ the function-specific evaluation of capacity is comparatively progressive. The function test, however, is also critiqued as it ultimately operates in the same manner as a “status test” does in the hands of a judge or a forensic expert, who might inevitably employ the existence of the disability itself as evidence of incapacity.¹⁵

Moreover, I submit that it is problematic to advocate such a test as both the question of capacity and the “function test” are innately discriminatory towards patients who are classified as “involuntary patients”. To elaborate further, if a person with mental illness voluntarily approaches a psychiatric facility and asks to be admitted, no evaluation of capacity is carried out on

Gooding eds., 2005).

¹² The Mental Health Act, 1987, §24(1): If a person is produced before the Magistrate under subsection (3) of Sec.23, and if in his opinion, there are sufficient grounds for proceeding further, the Magistrate shall: [...] examine the person to assess his capacity to understand...; *See Ram Narain Gupta v. Rameshwari*, AIR 1988 SC 2260 (Courts have, however, shown sensitivity and caution against fixing a “label” of mental illness upon a person as it could potentially reduce the person to a “functional non-entity”).

¹³ Health Care Consent Act, 1996 (Canada), §4(1).

¹⁴ Amita Dhanda, *Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?*, 34 Syracuse J. Int'l L. & Com. 429, 431 (2007).

¹⁵ *Id.*, 432.

her;¹⁶ a “voluntary patient” is assumed to have the capacity to make a rational treatment decision!

Another legal trend that illustrates this innate bias against involuntary patients is the presumption of lack of capacity when a patient who understands the information on the nature and consequences of her treatment (and who thus has capacity, as per mental health laws), denies being ill.¹⁷ Clearly, *willingness* to being treated seems to be the underlying determinant of capacity. Unwillingness towards undergoing treatment/institutionalisation from someone who claims to understand the nature and consequences of the same is seen as irrationality, thus, calling “capacity” into question and substituted decision makers into action.

As a concluding thought on this segment, the freedom to make ‘bad’ decisions is something that inheres in all of us; we think and act irrationally because, as Gerard Quinn recognises, our ‘rationality’ is often shaped by our preferences and not vice versa.¹⁸ To quote Quinn, “...there is no necessary reason why rationality should be given such pride of place in describing personhood. The wholly irrational is no less a person.”¹⁹

IV. TOWARDS A UNIVERSALIST MODEL OF VIEWING PERSONS WITH MENTAL ILLNESSES

While the argument from Sen’s capability approach seems to be of instrumental value, capacity must be viewed as holding inherent value, and must thus be accepted universally. This approach also helps in sustaining the argument for universal capacity, should it be dismissed on the ground that there are few instrumental uses of capacity to a person with mental illness.

How the lay-person views a person with mental illness can be understood from envisioning a conversation with such person. An ideal conversation would be one in which both the person with mental illness and the relevant other proceed with the correct understanding of having *the same standing to partake in the conversation*. Difficulty in communication and the need for assistance in communicating, *inter alia*, could, however, impede the recognition of sameness in standing between the two parties.

The move towards recognising agency in persons with mental illnesses is a ‘transformative change’ (to borrow terminology from Fraser’s

¹⁶ See The Mental Health Act, 1987, §§15 and 17.

¹⁷ See *Kahn v. St. Thomas Psychiatric Hospital*, (1992), 87 DLR (4th) 289 (Ont CA); Steinbach v. Joffe, [1988] OJ No 1369 (QL) (Dist Ct).

¹⁸ Gerard Quinn, *Personhood & Legal Capacity – Perspectives on the Paradigm Shift of Article 12 CRPD* (Concept Paper at HPOD Conference, Harvard Law School, February 20, 2010).

¹⁹ *Id.*

analysis²⁰) that entails dismantling of the liberal notion of the autonomous and independent individual. For this, one may draw on the feminist critique of liberal equality.

Since liberal thought views the political space or the ‘public sphere’ as the only area of justifiable infringement of autonomy, the demand of liberal equality is only within the public sphere. The private sphere is seen as the sphere of complete freedom, with no interference in individual liberty and autonomy. Feminist critique of liberal thought has been this that in relegating the ‘social’ (as opposed to the ‘political’) to the private sphere, liberals make no demand for equality in a sphere that is rife with inequality.²¹ The private sphere, particularly in the familial space, where care-functions are carried out by mothers renders women automatically unequal to men. Consequently, liberal equality clearly makes no space for the values that women embody, namely those of dependence, care and a sense of community.²²

What liberal thought ignores entirely is that the autonomous individual in the public sphere is the way he/she is owing to the provision for and accommodation of his/her vulnerability and dependence within the private sphere. In truth, dependence, fragility and vulnerability are traits of *all* human beings and, as Siebers argues, are “central to the human condition”.²³ An understanding that every human being is in some manner frail and thus requires some kind of assistance and support in day-to-day dealings helps in developing a universalist approach towards viewing persons with mental illness. If frailty or ‘disability’ can be viewed as the least common denominator of all human beings, then we can widen the range of ‘normal’ by respecting difference.²⁴

Linda Alcoff, in refuting the argument that agency requires independence from others, supports this proposition by recognising that one can exercise agency only when one is capable of making a difference by one’s acts, when one’s opinions are heard and respected.²⁵

V. SUBSTITUTED DECISION-MAKING AND DENIAL OF AGENCY

Personal experience with persons with mental illness has taught me that objectification itself is a predominant cause of resistance to intervention. The fact of having been objectified as the ‘patient’ who could be treated

²⁰ NANCY FRASER, JUSTICE INTERRUPTUS – CRITICAL REFLECTIONS ON THE “POSTSOCIALIST” CONDITION 23-26 (1997).

²¹ FEMINISM AND EQUALITY 12-15 (Anne Phillips ed., 1987).

²² *Id.*, 17.

²³ T SIEBERS, DISABILITY THEORY 180 (2008).

²⁴ See generally Fredman, *supra* note 11, 206-207.

²⁵ L.M. ALCOFF, VISIBLE IDENTITIES: RACE, GENDER AND THE SELF 116-117 (2006).

only by heavy drug dosages without even attempting to engage in a dialogue to persuade the person of its benefits, has led to increased resistance towards the idea of medication and treatment itself. Often, discovery of a mental illness is accompanied by apprehension that one's decisions and choices will be undermined and undue concessions will be made in the name of mental illness by caretakers. Fear of having one's agency undermined itself is a reason to hide the diagnosis of a disorder, when, in reality, the knowledge of the disorder could lead to a more complete elimination of barriers that stand in the way of achieving one's capabilities.

One may argue that in providing for the substituted decision-makers' consent in the context of institutionalisation/treatment along with plenty of safeguards is itself a measure towards recognition of persons with mental illnesses. This, however, is merely *affirmative* recognition, in the sense that group differences are still perpetuated by way of capacity denial mechanisms.²⁶ Receiving respect from others itself contributes greatly towards one assuming full personhood as it creates scope for 'claims for co-authority'.²⁷ Also, a reading of Ikeheimo shows that ensuring inclusion in all possible ways, *viz.*, the technical (*i.e.*, provision of all material, technical facilities which enable participation in social life), the institutional (*i.e.*, inclusion by way of an attributed deontic status and even rights in the social order) and the interpersonal or social (*i.e.*, inclusion in interaction through attitudes of relevant others), still cannot ensure inclusion in the true sense.²⁸ This is so because often one may not be included as a *person*, when cognitive attitudes of relevant others do not accord *interpersonal standing* to the person in question.²⁹ In other words, such person is denied agency. In such a situation, inclusion as a non-person really amounts to social exclusion. This is exactly what capacity laws do to persons with mental illnesses.

VI. CURTAILMENT OF LIBERTY IN THE "PERSON'S BEST INTEREST"

Force in law conveys a systemic, institutional apathy and lack of respect towards the autonomy of the person. Should the choice of a person with mental illness seem worrisome to carers/doctors, the options of dialogue and persuasion, with support or assistance, are always open in order to encourage the person to consider treatment. When, however, a person with mental illness makes a choice to reject intervention/institutionalisation, and his/her autonomy in making that decision is undermined, medical institutions and carers of the

²⁶ Fraser, *supra* note 20.

²⁷ Heiki Ikaheimo, *Personhood and the Social Inclusion of People with Disabilities – A Recognition-Theoretical Approach* in ARGUING ABOUT DISABILITY: PHILOSOPHICAL PERSPECTIVES 82 (I. Kristiansen *et al.* eds., 2009).

²⁸ *Id.*, 85.

²⁹ *Id.*, 86.

person are essentially sending out the message that his/her life-choices are not worthy of support. Part of accepting disability as central to the human condition necessitates that support and assistance be provided for exercising and carrying out even *what the carers construe to be a "bad" life choice*.

In constitutional adjudication, the norm accepted in many jurisdictions (and of late, in India as well) for judicial review of discriminatory legislation is that of strict scrutiny; a legislation that claims to advance a *compelling state interest* must be *narrowly tailored*, through the *least rights restrictive means* available.³⁰ Thus a legislation that, for instance, curtails the right to employment of women beyond a certain time of the day in liquor stores in pursuance of ensuring safety of women, would fail to survive this level of scrutiny.³¹ This is so because, while ensuring that public safety is a compelling state interest, the means adopted are evidently not the least restrictive, given that such legislation operates as a gross curtailment of the liberty of women. So in such a case, a better way of pursuing public safety is by improving the security provided to women in the State by police patrolling unsafe areas after a certain time of the day.

In a similar vein, a mental health law that mandates forced treatment/institutionalisation in pursuance of the health and safety of others as well as of the person with mental illness, is clearly not adopting the least restrictive means to do so, as the autonomy and liberty of the person stands infringed. Instead, according dignity to even "bad" choices by providing medical care and community support would be the least restrictive means. A combined reading of Arts. 19 and 25(d) of the UNCRPD in fact mandates these means, *viz.* the right to choose where to live without being obligated to live in a particular living arrangement, access to in-home and community support services and assistance so as to enable a non-segregated inclusive living experience, and the right to free and informed consent, with support and assistance to facilitate such consent. To strengthen community support and assistance, public aid to disability must be considered as a community investment in ability and productivity, which is a community responsibility, as opposed to a personal or familial responsibility.³²

VII. FORCE

A. THE UNDERLYING ASSUMPTION

Susan Wendell exposes the underlying assumption of a law that provides for forced treatment in the best interest of the person with mental

³⁰ See C.R. DUCAT, CONSTITUTIONAL INTERPRETATION - RIGHTS OF THE INDIVIDUAL Vol. 2, 13 (2000).

³¹ See Anuj Garg v. Hotel Association of India, (2008) 3 SCC 1: AIR 2008 SC 663.

³² SUSAN WENDELL, THE REJECTED BODY: FEMINIST PHILOSOPHICAL REFLECTIONS ON DISABILITY 51-56, 81-85 (1996).

illness. She argues that the social deconstruction of disability cannot be achieved by viewing all disability as “curable”.³³ She finds that there is so much talk of *curing* disability that little recognition is accorded to “the potential and value of disabled people’s actual lives”.³⁴ The attempts to wipe out biological causes of disability, even if driven by the humanitarian instinct to ensure well-being, rest on the assumption that all disability is a *lack* and that all persons with disability *want* to be cured. This would, in practice, amount to not valuing difference through disability, thus making assumptions that are problematic, as the paper has argued above³⁵ (not to forget, untrue as per Wendell’s account).

B. FALLACIOUSNESS OF THE GROUNDS

The grounds used to justify forced institutionalisation are listed in §22(1) of the Mental Health Act, 1987:

- “22(1). Procedure upon application for reception order: On receipt of an application under sub-section (2) of Sec. 20, the Magistrate may make a reception order, if he is satisfied that -
- a. the mentally ill person is suffering from mental disorder of such a nature and degree that it is necessary to detain him in a psychiatric hospital or psychiatric nursing home for treatment; or
 - b. it is necessary in the interests of the mental and personal safety of the mentally ill person or for the protection of others that he should be so detained, and a temporary treatment order would not be adequate in the circumstances of the case and it is necessary to make a reception order.”

The first objection against these grounds is that they are not used to justify forced hospitalisation of persons *without* mental illness, when they choose not to voluntarily admit themselves in facility, *even if* their illnesses are capable of causing serious bodily harm to others or themselves.

Thus, it becomes clear that the ‘humanitarian concern’ for the patient’s well-being that is put forth as a justification for the paternalistic process of making decisions instead of the patient, is also a manner of avoiding the responsibility of providing sustained community assistance and support, should the patient choose not to be institutionalised or undergo treatment. This forced institutionalisation then has nothing to do with the person’s mental capacity to make a rational treatment decision; it is instead an exercise of our *ability* to objectify and dictate terms in the life of a person with mental illness.

³³ *Id.*

³⁴ *Id.*

³⁵ *See supra* Section III.

One may argue that persons without mental illnesses will be responsible for their treatment choices and any adverse consequences that may ensue from them, while persons with mental illnesses ought not to be subject to such consequences, which after all, are a result of a mental illness driven incapacity. Forced institutionalisation/treatment is, however, carried out on the mere *likelihood* that serious harm would result, and not a certainty. Moreover, the responsibility of a bad treatment decision (in terms of being against the patient's wishes) is as much the substituted decision maker's as it is the patient's, or possibly far worse.

Second, prescribing forced institutionalisation on the ground that a person with mental illness could cause harm to others owing to the nature of his illness, proceeds on the assumption that the approach of criminal law is preventive rather than reactive. Such an approach would demand that *all* preventable offences be proactively prevented by restraining "likely" offenders. Preventive detention laws across the world, however, prescribe such detention only for a narrow range of grave offences, such as terrorism, which pose a threat to the security of a nation. Riding on the probability that a person with mental illness might inflict serious bodily harm on another person as the basis for institutionalising him, presents a logic that would stand in complete opposition to bail laws!

The grounds in the Mental Health Act, 1987 that merit the use of force are far broader than those in other jurisdictions and thus present particularly grave problems. Grounds such as the non-expression or the inability to express willingness³⁶ for admission in a facility are over-inclusive. First, not expressing willingness could mean refusal, which can simply be overridden by a relative's or a friend's decision and the medical officer's opinion that admission is in the patient's interest. Second, the inability to express willingness is not even reflective of a person's capacity to understand the nature and consequences of admission, as the mental illness might not even be the reason for the said inability; it simply signals an inability to communicate, a difference that ought to be recognised in the law. Depending on the level and kind of mental illness, the assistance of new technology and research such as the 'brain computer interface' could be used to facilitate communication with the patient.

Finally, if intervention/treatment is absolutely necessary in the interest of the patient's well-being, means other than the use of force in law ought to be explored (such as assisted communication techniques) in order to engage in a persuasive discussion on the merits of the treatment.

³⁶ The Mental Health Act, 1987, §19(1).

C. SUPPORTIVE DECISION-MAKING

Art. 12(3) read with Art. 12(4) of the UNCRPD mandates that access to “support” in exercising legal capacity be provided to persons with disabilities, such supportive measures being respectful of the “rights, will and preferences of the person” and are “proportional and tailored to the person’s circumstances”. Supportive decision-making avenues that accommodate a person with mental illness as a rational agent can advance the cause of making the person concur with the carers on the notion of treatment in her “best interests”.

A supportive decision-making mechanism that ensures active involvement of the medical officer/doctor/expert, family or friend, and a survivor of a similar disability ought to be evolved to counter the possibility of undue influence on the part of either the doctor or the family. Yet, it is important to be mindful of the concern that such an environment of decision-making could render the person with mental illness vulnerable to pressures, thus reducing the chances of a truly autonomous decision.³⁷ For instance, relatives might want to avoid the effort of having to care for the person at home, doctors might portray the consequences of refusing treatment/institutionalisation as far more adverse than in actuality, for institutional advantage accrues from admitting patients to the facility.

VIII. CONCLUSION

This paper arrives at several conclusions. Capacity to consent to a treatment- decision places a misplaced reliance on the need for rationality; the assumption seems to be that a person with capacity would understand the nature and consequences of intervention/institutionalisation and would rationally be agreeable to the same. Thus, the law seems to make no space for the possibility of a decision that might be at odds with an objective rationality, having been guided by preferences and not by logic.

In adopting a universalist approach, the paper argues that we must recognise that *all* persons are dependent, vulnerable and in some sense, ‘disabled’; those viewed as independent and autonomous individuals merely have their dependence and vulnerability provided for in the social space. This approach helps in viewing disability as central to the human condition and not as an ‘abnormality’; we are thus able to widen the range of what we consider ‘normal’ while simultaneously ensuring that the disability disadvantage itself is not normalised. In doing so, we find a basis for according respect to the person with disability as a person with co-authority and agency.

³⁷ T. SHAKESPEARE, *DISABILITY RIGHTS AND WRONGS* 118 -32 (2006).

In undermining the choice of a person with mental illness to reject intervention, we essentially undervalue a life choice by dismissing it as unworthy of support and assistance. The universalist approach demands that even 'bad' decisions be respected and supported.

On examining the basis for use of force in law, it may be concluded that the reason medical officers/carers/relevant others see intervention/institutionalisation as a rational choice is their predisposition to viewing disability as a lack that needs to be *cured*. Further, it is concluded that the grounds of 'harm to oneself or others' are fallacious considering the same grounds do not find similar applicability in the case of persons without mental illnesses. It is submitted therefore that supportive decision-making could be a better alternative, but not without its own risks that one must caution against.

Finally, the paper explores the fulfilment of the 'strict scrutiny' norm of judicial review of laws, which requires that a law in furtherance of a compelling state interest must be narrowly tailored so as to ensure that the least restrictive means are adopted in achieving the said state interest. Mental health legislation must, in order to fulfil the test of narrow tailoring, not infringe the autonomy of persons with mental illnesses, by according dignity to even 'bad' treatment choices.

In the paper, I have, however, proceeded on the assumption that the person with mental illness is allowed no opportunity to raise objections to institutionalisation, as the law makes no space for dialogue with the said person, while prescribing forced institutionalisation. This is the scheme within which the arguments in this paper operate. If all forms of communication and persuasion with the person with mental illness have been tried and yet, consent to the idea of intervention/institutionalisation remains unascertained, I would argue that the "best interest" approach of substitutive decision-making be implemented, as the last resort.

