Comments on Accessibility Standards for Healthcare

Submitted by Centre for Mental Health Law & Policy, ILS, Pune, India

Executive Summary

These comments are being submitted in response to the public notice dated 02.06.2022, by the Ministry of Health and Family Welfare, requesting stakeholders to submit their feedback and suggestions on the draft 'Accessibility Standards for Healthcare'. The comments contained in this document have been submitted by the Centre for Mental Health Law & Policy (hereafter referred to as 'the Centre'), Indian Law Society, Pune, India.[1]

The mission of the Centre is to strengthen and transform the mental health of communities to be holistic and responsive in addressing individual and collective well-being. The Centre adopts a rights-based approach to mental health and works with governments to promote evidence-based policy reform for mental health and suicide prevention. The provided technical support to the Ministry of Health & Family Welfare, Government of India, for the drafting of India's Mental Healthcare Act, 2017 (hereafter 'MHCA').

While the objective of drafting the Accessibility Standards is to create a standardised set of guidelines for infrastructure developers, it is essential that provisions be included which acknowledge the diverse needs of different disabled groups including persons with mental illness.

The MHCA like the Rights of Persons with Disabilities Act, 2016 (hereafter 'RPDA') was enacted in compliance with India's international obligations as a signatory to the UN Convention on Rights of Disabilities (hereafter 'CRPD'). The RPDA contains provisions on the social, civic, political and economic rights of persons with disabilities, including persons with mental illness or psychosocial disabilities. Whereas the MHCA contains provisions to protect and promote the rights of persons with mental illness to access mental healthcare and treatment in India. Given the linkages and overlaps between the two legislations, we strongly recommend that provisions under the MHCA also be referred to before finalising the draft of the 'Accessibility Standards for Healthcare' (hereafter 'draft Accessibility Standards').

As recognized by the CRPD under **Article 17 - Protecting the Integrity of the person**, all persons with disabilities including persons with mental illness have the right to be treated with integrity on equal basis as everyone else. In this regard, the draft Accessibility Standards do not reflect a right-based approach.

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[1] [1] The Centre for Mental Health Law & Policy works towards strengthening and transforming the mental health care and services to be holistic and responsive in addressing individual and collective well-being. Using a rights-based approach and guided by the principles of the UN Convention of the Rights of Persons with Disabilities, the Centre works in collaboration with multiple stakeholders, including policymakers, mental health professionals, researchers, civil society organisations, persons with lived experience and the media. **More details:** https://cmhlp.org/about-us/

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Detailed Submission

In this section, we have provided specific and detailed comments for each section/ clause of the draft Accessibility Standards including the rationale for suggested inclusions or modifications.

2.1 Introduction

In defining access to healthcare service, the draft Accessibility Standards state that facilities must be made available to persons with disabilities and that they should be '*high quality, appropriate and safe services'.*

The MHCA under section 18(2) elaborates that all persons, irrespective of whether or not they have a mental illness have the right to access mental healthcare treatment and services that must be *'of affordable cost, of good quality, available in sufficient quantity, accessible geographically without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and care-givers'.* This provision aligns with Article 12 of the Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 14: The Right to the Highest Attainable Standard of Health which India has ratified. The Committee acknowledges accessibility of healthcare facilities, goods and services consists of four overlapping dimensions which are non-discrimination, physical accessibility, economic accessibility and information accessibility.

Thus, considering these varied and comprehensive aspects of accessibility, the definition of access in the Introduction of the Accessibility Standards must be **broadened to include the conditions stipulated under the MHCA, 2017 section 18 (2)** such as affordability, sufficient quantity, accessible geographically and without discrimination based on gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and **the dimensions of non-discrimination, physical, economic and informational accessibility highlighted by the CESCR.**

2.2. Legislative and Policy Context

Section 2.2 of the draft Accessibility Standards detail the international and national legislative and policy frameworks that form the basis of this draft of the Accessibility Standards. However, the MHCA has not been included. **The Mental Healthcare Act, 2017 must be included in this section.**

There is a just and appropriate focus on the right to aid and equipment, medical care and accessible physical spaces for persons with disabilities. However, it is critical that this section

also recognize the various rights violations persons with disabilities experience and the protections guaranteed by the law against such abuse and discrimination through provisions laid out under the RPDA and MHCA.

Section 20 of the MHCA, guarantees the right to protection from cruel, inhumane and degrading treatments to persons with mental illness and lays down the protections that must be adhered to within mental health establishments. Further, the right to equality and non-discrimination is assured under Section 21 of the MHCA. While enabling access to healthcare services, it is imperative that all instances of rights violations and discriminatory acts and behaviour perpetuated by healthcare professionals within such settings be eliminated while parallelly facilitating practices that promote equal and dignified access to healthcare.

Thus, **we strongly advise that in Part 2.2, both the right to protection from cruel, inhumane and degrading treatment in Section 20 and right to equality and non-discrimination in Section 21 of the MHCA should be incorporated in the Accessibility Standards.**

2.4. Disabilities

In the draft Accessibility Standards under Section 2.4 under Disabilities, **the definition of 'disabilities' should be as it is defined under the RPDA**, as per which

"person with disability" means a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others.

Similarly, **mental illness must also be included in the definitions and defined as under the MHCA**, as per which:

"mental illness" means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which isa condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence.

2.5 Barriers to Health Care

In listing out the barriers faced by persons with disabilities, the policy overlooks the role of structural determinants such as gender, caste, class, etc., which create barriers for persons with disabilities in accessing healthcare services. In addition, financial barriers must be listed separately as the cost of healthcare particularly for persons with disabilities is a major barrier to care in India.[2]

Factors that limit accessibility to healthcare must also include the insufficient quantity of physical infrastructure, facilities, staff and financial resources. Further, the draft Accessibility Standards must contain provisions to bridge the poor linkages between community and general healthcare services as well as intersectoral collaborations i.e., educational institutions,

[2] Understanding costs associated with mental health care in India: https://cmhlp.org/wp-content/uploads/2022/06/Issue-Brief-Cost-of-Care.pdf

workplaces, public facilities such transportation, leisure spaces and government services that can either facilitate or obstruct the access to healthcare for persons with disabilities.

2.8 Building Structure Guidelines

In this section, the minimum standards for mental health establishments as specified under the MHCA's Section 65 (4) under the regulations made by the Central Mental Health Authority or respective State Mental Health Authorities for different categories of mental health establishments must be included.

The Building Structure Guidelines must adapt a gender responsive and sensitive approach to designing and planning healthcare infrastructure and facilities considering the diverse gender needs and preferences specifically in areas such as privacy, security, space & layout, lighting and overall participation and inclusion of individuals with diverse gender identities in the planning and design process. Careful considerations should be made for Accessible Indoor Healthcare including provisions for gender neutral washrooms.

The draft Accessibility Standards must also include guidelines for creating spaces for persons belonging to different gender identities.

Moreover, age-specific considerations should be incorporated across Building Structure Guidelines to ensure that all physical spaces are easily accessible and can be safely navigated by children and elderly persons with disabilities.

4.5 Washrooms

Provision must be installed for locks in all toilet cubicles to ensure privacy and safety that can be used comfortably by persons with disabilities and guidelines for gender neutral toilets. Further, there should also be a system to dispose of waste properly and safely in washrooms.

5.2 Changing rooms

Multi-directional mirrors should be included in changing rooms that are at an accessible height and angle for persons with disabilities along with a locking facility (similar to those detailed in 4.5. Washrooms).

6.1 Ward

While persons with disabilities must be allotted a bed or room that has an easily accessible washroom, necessary steps should be taken to ensure that there is still sufficient privacy and distance so that they are not disturbed by people frequenting restrooms or are in discomfort due to their proximity to the washroom.

The MHCA in Section 21 states *"every person with mental illness shall be treated as equal to persons with physical illness in the provision of all healthcare which shall include the following, namely:– (a) there shall be no discrimination on any basis including gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class or disability; (b) emergency facilities and emergency services for mental illness shall be of the same quality and availability as those provided to persons with physical illness; (c) persons with mental illness shall be entitled to the use of ambulance services in the same manner, extent and quality as provided to persons with physical illness; (d) living conditions in health establishments shall be of the same manner, extent*

and quality as provided to persons with physical illness; and (e) any other health services provided to persons with physical illness shall be provided in same manner, extent and quality to persons with mental illness." Therefore, we strongly recommend the provision under 6.1 Wards **that persons with mental problems may be better managed in a single or isolated room be removed.**

7.3 Gynecological Examination Tables

In many instances, persons with disabilities are subjected to violations during health check-ups such as gynecological examinations.[3] Therefore, it is important that for all medical consultations, specifically invasive procedures, staff are trained to take informed consent from persons with disabilities and communication/ visual aids are made available for this purpose. The MHCA, under Section 2 (i) defines informed consent as *"consent given for a specific intervention, without any force, undue influence, fraud, threat, mistake or misrepresentation, and obtained after disclosing to a person adequate information including risks and benefits of, and alternatives to, the specific intervention in a language and manner understood by the person."* The draft Accessibilities must include provisions for seeking informed consent, defining it as it has been under the MHCA and also include for aids for communication and decision making.

8. Training Programmes

While improving delivery of services is essential, it is also important that all health professionals safeguard the right of persons with disabilities while providing treatment and care. Both the MHCA and RPDA have provisions which mandate that all health professionals including mental health professionals be trained on the implementation of the Acts which includes the range of rights guaranteed to persons with mental illness. In light of this, the objectives of trainings programmes must be revised to include the training of health professionals on the rights of persons with disabilities including persons with mental illness, as laid out under Section 43 & 55 of the MHCA and Section 39 of the RPDA.

In the second paragraph, when discussing modalities of communication, incorporate approaches for supported decision making, for persons with mental illness to make decisions regarding their mental healthcare and treatments. This would include provisions under Section 5 for making an Advanced Directive to self-determine how an individual wishes to receive treatment and care, in situations where they maybe be unable to exercise their legal capacity and Section 14 on the appointment of a Nominated Representative to take decision on behalf of a person with mental illness during such times where they do not have capacity to make decision regarding their treatment.

Health professionals must respect and consider a patient's right to decisional autonomy with regards to communicating, understanding, and making decision regarding their health care and treatment. The MHCA recognises the legal capacity of all persons. In Section 4 of the MHCA, the legislation makes provisions for how capacity to make mental healthcare and treatment

[3] Islam MM, Jahan N, Hossain MD. Violence against women and mental disorder: a qualitative study in Bangladesh. Trop Med Health. 2018 Mar 1;46:5. doi: 10.1186/s41182-018-0085-x. PMID: 29507506; PMCID: PMC5831218.

decisions maybe assessed refer to the Supported Decision-Making Manual for Service Providers as a training guide to facilitate supported decision making by persons with mental illness.

9.0. Accessible communication

Please revise the last sentence of the first paragraph as follows: The information should be provided in a manner that it is easy to understand so that they are able to make their choices and decisions according to their will and preferences.