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SOCIAL DISCRIMINATION AND SOCIAL JUSTICE

Dr. Anurag Agarwal

(Assistant Professor)

Department of English

J.S. University, Shikohabad

All human beings are born free both in dignity and in rights, so why is it that individuals who go on to develop and experience mental illness are seen as a soft target for discrimination at a number of levels and in various domains in their daily lives? This discrimination is damaging, derogatory, and demeaning, thereby making individuals with mental illness second class citizens. By association, such discrimination also has an impact on people who look after individuals with mental illness (whether they are professional or lay carers).

World Psychiatric Association (WPA) in its 2014–2017 Action Plan, decided to look at public mental health agenda along with discrimination against people with mental illness. WPA represents over 250 000 psychiatrists from 117 countries around the globe, and is therefore interested and committed to challenging discrimination. It commissioned the Centre for Mental Health Law to conduct a survey of as many countries as possible, studying their laws for discrimination in areas of employment, voting rights, funding, and other potential aspects of individual functioning.

As has been shown in the case of racism (UNESCO, 1967), all human beings belong to the same species and descend from the same stock. Thus, no illness—be it mental or physical, acute or chronic—should lead to discrimination of any kind whatsoever. Social discrimination against people with mental illness is a global issue and it covers a range of spheres which influence daily living and daily functioning. Social discrimination appears to be lodged in the system and, therefore, can be pervasive and intrusive, and stop people from reaching their full potential and, more importantly, labelling them changes their identities. Micro-identities related to race, gender, age, religion, sexual orientation, and other components all get trumped by the label of being mentally ill.

Social discrimination is defined as sustained inequality between individuals on the basis of illness, disability, religion, sexual orientation, or any other measures of diversity.

Social justice is aimed at promoting a society which is just and equitable, valuing diversity, providing equal opportunities to all its members, irrespective of their disability, ethnicities, gender, age, sexual orientation or religion, and ensuring fair allocation of resources and support for their human rights.

Any number of diverse factors, including those mentioned above, but also education, social class, political affiliation, beliefs, or other characteristics can lead to discriminatory behaviours, especially by those who may have a degree of power in their hands.

Social justice means that all institutions—structures as well as processes should be freely and equally accessible and available to all individuals, irrespective of their characteristics. Laws and legal institutions must ensure that equal opportunity be provided for education, learning, earning, and living. Social justice is the basis of equal and equitable distribution of resources and opportunities in which outside factors that categorize people are irrelevant. Although traditionally the term targeted poverty elimination, it has come to take on a wider meaning wherein social institutions have to take on a wider role to ensure equity of resources. It can be argued that all governments have a moral and ethical responsibility to ensure that all its citizens have equal rights, opportunities, and resources. In most countries around the globe, for example, categories of gender are not used for discrimination on a legal basis, but sexual orientation, race, and religion are often employed to base discrimination on.

Social justice in relation to health in general (and mental health in particular) relies on the questions Daniels (2012) raised. The fundamental question is: what do we owe each other in the protection and promotion of health? He argues that there are three subsidiary questions: whether health should be seen as special; when are the health inequalities unjust; and how can we meet competing health needs in a fair and just way when the resources are finite? Healthcare ensures that individuals remain or become healthy in order to achieve their full potential and health, thus, ensures distinct (albeit limited) contribution to the protection of equality of opportunity. Unlike food or shelter, healthcare needs may be disproportionate, thereby creating an inherent inequality and discrimination. As noted elsewhere, social determinants influence mental health and it is appropriate that social inequalities are tackled. However, more significantly, in order to ensure greater justice to health outcomes, the focus should not be only on the traditional health sector, but also on joined up thinking across education, employment, and the criminal justice system.

Health of the nations (including mental health) depends upon factors other than wealth, although wealth may be important. Culture, cultural values, government policies, social capital, social organizations, and social cohesion all play a role in determining health status. In countries around the world, there has been inadequate access to mental healthcare, for a number of reasons, including discriminatory constraints consequent upon stigma, keeping costs down and seeing mental health as purely secondary to physical health (Ozar & Sabin, 2012). Using the US as an example, these authors note that recent changes, such as vigorous (and better) advocacy, better understanding of mental disorders, more effective treatments, and the means to contain costs, have changed funding patterns.

Mental health funding consistently lags behind that allocated to physical health. This is related to stigma and discrimination, part of which is to do with not really understanding what mental illness represents. The range of mental illness, its varieties across the lifespan, and varying presentations all mean that funders are not able to decide what it being funded. Furthermore, conditions such as depression have been seen as a sign of personal or moral weakness, thus negating the seriousness of the condition. Substance use disorders are seen as self-induced and as a sign of a lack of backbone, thereby not deserving to be taken seriously. Mental health needs should be seen as basic health needs, and not meeting these needs should be recognized as a failure of fundamental social justice (Ozar & Sabin, 2012). Consistent advocacy and better recognition of the symptoms of mental illness have contributed to a degree of change in attitudes and knowledge, resulting in improved funding.

Social institutions, whether these are schools, universities, courts, or others, must be strengthened in the context of social justice in order to ensure delivery of social justice. The healthcare system should also be seen as an institution which must deliver social justice, not only in terms of proper

accessible healthcare, but also preventive measures. Ruger (2010) offers ethical principles of human flourishing and these include: health capability, social choice on a dominance partial ordering of health capabilities, and relevant social decision-making; valuing central health capabilities, measuring inequalities, ethical commitment, and public moral norms; as well as to social determinants of health and joined up approach. What is worth bearing in mind is that at the core of social justice in health are also the ethical and moral frameworks. However, the key is also about getting the balance right between governmental responsibility and the individual's choice and responsibility for their own health and capabilities.

Social justice in the health context also means public education about mental illness, correcting false and harmful health norms. These have to be developed on a culturally relativist basis. There may be minimum criteria for some of the services, as described in this issue, but these have to be seen in and set in the norms context. This is where perhaps the capabilities approach may enable policy-makers to take individual needs and capabilities into account.

Social justice and social discrimination go hand in hand. Social discrimination can be measured in several spheres, from personal to political ones. There is widespread discrimination in not giving proper habilitation to individuals with mental illness and not to give them voting rights, which means that they cannot stand for elections and, therefore, are excluded from participating actively in the political democratic process. In this issue, some of these areas are covered. For each of these papers, well-known policy-makers and parliamentarians have been invited to write commentaries. These commentaries indicate that policy-makers do understand the issues and are keen and committed to support this endeavour.

One of the major issues in the social discrimination agenda is the huge degree of variation in definitions used. Some countries use mental illness, others use mental disorder or mental derangement, whereas some use medically certified insane or medically proven total mental incapacity. Mental incompetence, insanity, lost his mind, demented, seriously weakened mental state, mentally deficient, insane or imbecile, certified to be insane, and mental ineptitude were some of the other terms used. Interestingly and equally frustratingly, these terms are often not described, and the interpretation is left to the person using them. The procedure for how a person is judged to have a mental health problem is not laid down in law. This leads to *de jure* and *de facto* discrimination. In many countries, the primary language is not English, so translation of the laws has been carried out. This may have left some gaps, in spite of careful translation and interpretation.

Personal discrimination (in terms of a right to property) is highly prevalent across the globe. A right of contract of persons with mental illness is recognized by only 21% of countries. More than one-third of the countries completely deny the right to contract to persons with mental illness. Once again, there are clear differences between high income countries and low and middle income countries. In spite of the fact that many countries have ratified the Convention of Rights of Persons with Disability, there appears to be a significant gap in delivering on this. Interestingly, 70% of countries allow people to have succession rights, and these too vary according to income levels of the country. Forty-three per cent of countries do not allow people with mental illness the right even to make a will! Persons with mental illness are discriminated in a significant number of countries around the globe with respect to the right to property. To complicate matters further, the right to inherit property and make a will are not an effective right. The right to marry and options of divorce on the basis of mental illness are both limited across many countries. Once more, one of the major problems in this context is the varying, unclear definitions, which are prone to mis-interpretation.

Discrimination against individuals with mental illness, thus, is widespread and much more common in low income countries, which in materialistic terms may make sense. However, major steps need to be taken to move this agenda forward. These discriminatory laws may well reflect underlying stigma against individuals with mental illness at a number of levels. There is no doubt

that public attitudes to mental illness have varied from stigmatizing to accepting over a number of decades, especially varying among cultures. However, it must be remembered that positive attitudes do not lead to positive or more accepting behaviours. Teaching programmes certainly change knowledge about mental illness, but increased, improved, or better knowledge does not get rid of stigma against mental illness or individuals with mental illness. The challenge for policy-makers, clinicians, and individuals with mental illness is to attack discrimination using strategies similar to civil liberties, gender equality, sexual minority (LGBT) communities, which in many parts of the world have proven to be useful. It is important, therefore, that clinicians around the globe work with patients, their carers, and their families, as well as with relevant organizations representing these groups, to challenge discrimination, change laws, and ensure that these are applied equally. This equity must be enshrined in law for a number of measures, including funding for research, training, and healthcare delivery, as is the case for the physical health needs of the population. The challenges are, first, to ensure that laws change and, second, that accurate and regular reporting of these takes place and that these are monitored by impartial observers. There is simply no explanation for continuing discrimination against individuals with mental illness, their families, and those who care for them, whether they are professional or lay carers.