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# MENTAL HEALTH ACT

AUTHORED BY - R. DIVYA

## Introduction

In India, from ancient times the description of mental illnesses and various types of mental disorders have been found in the Vedic texts. Traditional medical systems such as Siddha recognised various types of mental disorders that flourished in southern India. A vivid description of schizophrenia is also found in the Atharva Veda. Even in the great epics the Ramayana and the Mahabharata several references to disorders of mind are found.<sup>1</sup>The mind and the body influence each other<sup>2</sup>.

This concept has been documented in Indian history in the Ayurveda. The renowned Indian sage, Patanjali had emphasized on ‘Yoga’ as a way to healthy mind, strong body, and spirituality, which enables an individual to attain self-actualization.<sup>3</sup> According to Sushruta, the physician (—Chikitsak), the drug (—Dravya), the attendants or the nursing personnel (—Upasthata), and the patient (—Rogil) are the four pillars on which rests the success of the therapy.<sup>4</sup>While the historical roots of Indian psychiatry have been traced to periods as early as that of King Ashoka, spirituality has always been a pervading factor in understanding as well as treating psychiatric disorders in India.

Among the Arabs, for many centuries persons with mental illness were sheltered and taken care of. The growth of Muslim influence in India led to the establishment of separate enclosures for mentally sick.<sup>5</sup>

In the fifteenth century, during the period of Mohammad Khilji (1436-1469), there has been evidence of the presence of a mental hospital at Dhar near Mandu, Madhya Pradesh where the

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<sup>1</sup> M Weiss. History of Psychiatry in India. Samiksa 1986;11:31-45.

<sup>2</sup> N. Kumar. The Relationship between Physical & Mental Health: Co-occurring Mental & Physical Disorders. Indian J Med Res 120:434-436 (2004).

<sup>3</sup> C.R.Chandrashekar & S.B. Math, Psychosomatic Disorders in Developing Countries: Current Issues and Future Challenges. Current Opinion In Psychiatry 19:201-206 (2006).

<sup>4</sup> SH Nizamie & N Goyal. History of Psychiatry in India. Indian J Psychiatry 52(Supl):7-12 (2010).

<sup>5</sup> J.G.Howells (ed.), World History Of Psychiatry. New York, (1968).

physician was Maulana Fazulur Hakim. Though there was elaboration of symptoms and treatment in ancient medical practice in India, there were no specific well documented asylums. Mental health care was considered as a part of general health care. With the existence of large joint families and large support system, community care came into practice.

In England, it was a strong belief that mental illness was caused by devils, evil spirit, demons, curses, etc. Hence, the person with mental disorder was earlier taken care of by religious bodies such as churches and parishes where the priest and clergymen provided care. The humane treatment and moral therapy weakened the doctors' arguments against religious healers and authenticated the work of the clergy.

Later, mentally ill people were restricted to jails and asylums. Further developments were related to the initiation and consolidation of community psychiatry that led to the integration of mental health care in the community. Later, specific theories explaining the pathogenesis of psychiatric disorders created a more scientific approach to managing people with mental illnesses.

According to modern literature, the world's first institution to specialise in mental illnesses was Bethlem hospital in London, England. Established early in the 1300s, initially in-patient medical care was provided only to patients with physical illnesses. Later on in the century, it also started catering to victims of mental illness.

It was only in the 18th century the hospital facilities for the insane began to be provided in England, but it was on a relatively small scale. It stressed the significance of doctors and clergies for taking care of the mentally ill. Till 1812, there were no public asylums for the insane in England though there were several hospitals for the mentally afflicted founded by royal or private benevolence. There was no proper lunacy legislation till 1744. This led to the practice of doctors taking private patients into their homes. Thus, the trade in Private Mad Houses started.<sup>6</sup>

A bill for regulating 'Madhouses' was passed to regulate private asylums, where abuse was prevalent.<sup>7</sup>

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<sup>6</sup> Macalpine and R. Hunter, *George III And The Mad-Business*. London: Allen Lane, (1969).

<sup>7</sup> *A History of County Asylums*.

The purpose of this Act was the protection of society, as the asylums were considered to be too dangerous. There were mad houses operated by private people. No license was required to open such mad houses. There was exploitation and neglect of the inmates of the madhouses. The Act was repealed by the Madhouses Act of 1828. The new Commission in Lunacy licensed and supervised private madhouses in the metropolitan area, although the Act did not apply to county asylums. The Lunacy Acts of 1845 included county asylums.

There were no state run asylums. Majority of them were private, hence the "trade in lunacy" flourished during 17<sup>th</sup> and early 18<sup>th</sup> centuries. Initially mentally ill patients were taken care of by friends or by individual doctors. Later on, the rulers had to provide care for their army men and others who protected their interest in respective colonies<sup>8</sup>. During the 18<sup>th</sup> century, commercial activity in the care of lunacy was flourishing and was very competitive. The mentally ill patients were confined in psychiatric institutions, families pushed out the person with mental illness, whom the asylum pulled within its walls.<sup>9</sup>

With the expansion of trade, political influence and rule, the number of mentally ill cases increased enormously. Therefore more asylums had to be built for the care of such men in London, as it was costly and difficult to maintain asylums in their respective colonies.

The East India Company primarily came to India with the object of trade. In 1757 the Company established its rule in India which led to the development of civil and military services.<sup>10</sup>

The British tried to establish their power in India which resulted in frequent wars. Frequent wars and being far away from home led to psychological distress in the British army. Hence lunatic asylums in India was first started to shelter the English soldiers. The maintenance of asylums in India was a financial burden to the British, and then men were transferred back to Britain. For the temporary detention of the insane Englishmen, number of lunatic asylums were established in India. The first lunatic asylum in India was established in Bombay in the year 1745, followed by Calcutta in 1784 and Madras. These asylums in India were therefore destined to remain small-

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<sup>8</sup> V G Kiernan, *The Lords Of Human Kind: European Attitudes To The Outside World In The Imperial Age*, Harmondsworth, Penguin, p. 37(1972).

<sup>9</sup> A Suzuki., *Madness At Home: The Psychiatrist, The Patient, And The Family In England, 1820–1860*, pub University of California Press, California (2006).

<sup>10</sup> M.U.Mushtaq, *Public Health in British India: A Brief Account of the History of Medical Services and Disease. Prevention in Colonial India*. *Indian Journal of Community Medicine* 34(1): (2009).

scale establishments as it was a period of temporary confinement. Later, political, economic and social conditions in London and India led to a steady increase in the number of asylums. Because of the inhumane conditions within the asylums, the British were forced to enact legislations to control them.

The main reason for sudden proliferation of asylums was the introduction of Pitts India Bill (1784). According to this Bill, the activities of the Government of the East India Company came under the direction of a Board of Control and systematic reforms and welfare actions were taken to some extent.

### **The Bengal Enquiry (1818)**

The Bengal Enquiry of 1818 was one of the earliest descriptions of human right issues of the mentally ill in India. This followed a select committee revelation on the regulation of psychiatric care in England in 1816. The enquiry indicated that the mental health care settings were suboptimal the buildings are low and damp and not half-large enough for the number of patients, to which must be attributed the numerous deaths which occur. Inadequacies were<sup>11</sup>

observed in various domains like food supplies, staff handling of the mentally ill persons, issues related to restraining unmanageable patients and other similar aspects.

The recommendations suggested that the asylum had to ensure humane and caring behaviour of the staff towards the patients. Regarding restraints, it was emphasised that —unnecessary coercion should never be used, and heavy iron chains should not be applied except in extreme cases where light leg chains may be used<sup>12</sup>.

Some specific descriptions of various asylums followed:

- 1) The asylum at Murshidabad was regarded as wholly unfit, the building altogether a
- 2) wretched place even in its best state
- 3) The Rasapagla asylum in Calcutta was described in a worse situation

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<sup>11</sup> M.U.Mushtaq, Public Health in British India: A Brief Account of the History of Medical Services and Disease. Prevention in Colonial India. Indian Journal of Community Medicine 34(1): (2009).

<sup>12</sup> S. Sharma, L.P.Varma., History of Mental Hospitals in Indian Sub-Continent. Indian J Psychiatry 26(4):295-300 (1984).

- 4) The asylum at Patna was in a more pitiable than Murshidabad. It was erected on a low ground close to the breeding ground of miasmas and was provided with poor quality water. This probably resulted in a high death rate of 52%.
- 5) There was overcrowding in the Bareilly asylum, 105 patients were accommodated in 29 cells, with four persons often confined in a cell not bigger than 80 sq. feet
- 6) The Benares asylum was —on a scale so contracted and insufficient and in appearance
- 7) bore more resemblance to a prison than of an asylum for lunatics.

Diet supplies were also noted to be insufficient. Significant lacunae were observed in the handling of mentally ill persons in these asylums. Ernst summarised the 1818 inquiry as leading to —only moderate control of gross abuses, rectification of the institution's physical defects when ever practicable, and strongly expressed avowals to humane and moral treatment, proper gender segregation and classification of lunatics].

### **Native Lunatics**

In 1840, a second evaluation of mental health care issues was carried out. This investigation was on the state of native lunatics in Bengal. This was commissioned due to allegations of corrupt practices, and the highly variable rates of cure and death in different asylums. The summary of the findings emphasised the varying quality of conditions, influence of each superintendent 's individual style of functioning, management and their individual commitment to patient care. Based on this enquiry, the asylums in Benares, Delhi and Bareilly were condemned to be re-built. It also concluded that basic amenities like diet and other factors like occupation for atients; and the interest of the treating doctors were all vitally important. It was a paradoxical observation that the surgeon Paton in Delhi was practicing \_food restriction'as punishment. He considered this to be a very effective approach of enforcing discipline and productiveness among inmates. But the enquiry revealed that this was not a favourable cure; and on the contrary, it resulted in increased death rates.

### **Developments from 1850-1900**

During the second half of the 19<sup>th</sup> century, political unrest in British ruled India continued. The reins of power were taken over by the Crown from the East India Company on November 1, 1858. The year 1858 is also significant as the first Lunacy Act, known as the Act No. 36 was enacted. It gave guidelines for the establishment of mental asylums and procedure to admit mental

patients.<sup>13</sup>

## Developments during the early 1900s

In the early 1900s mental hospitals that were until then under the charge of the Inspector General of Police, came under the charge of civil surgeons. The posting of specialist psychiatrists as full time officers in these asylums became a requirement. The centralised supervision of all asylums was planned in 1906 and was implemented formally under the Indian Lunacy Act of 1912. Berkeley Hill, the then Superintendent of the Central European Hospital at Ranchi, made a significant contribution to an attitudinal change towards these institutions. He persuaded the government to change the names of the lunatic asylums to mental hospitals. Also, he highlighted the need to involve social scientists with the care of the psychiatric patients. Training of psychiatrists and psychiatric nursing personnel also began during this period. An Association of the Medical Superintendents of mental hospitals was also established and a manual for superintendents of mental hospitals was formulated in 1930. This manual described the procedures for care, administration and treatments, as well as the roles of different levels of staff.

## Mapother's Report of 1938

The Mapother's report is considered as a significant step in elucidating the needs of the mental hospitals in India. This report compared the state of psychiatric services in London and India. The contrasting perspectives of the mental health scenario were evident in this report. While the psychiatric bed ratio was 1:200 in London, the same was 1:30,000 in India. Five out of 8 beds for medical diseases were for the psychiatrically ill in London, in contrast to 1 out of 7 in India.

There was significant overcrowding noted in the mental hospitals. For example, Yerawada had 29% overcrowding and Madras had 93% overcrowding. Due to overcrowding, there was an annual death rate of 123/1000 in Agra mental hospital. Mapother cited that Indifference was stated commonly as a reason but this must be fought against. He was very critical of the medical services in India, —the Indians have been unable to exercise the authority to enforce change ... the only thing they knew is to lock up the worst patients<sup>14</sup>.

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<sup>13</sup> S. Sharma, L.P. Varma, History of Mental Hospitals in Indian Sub-Continent. Indian J Psychiatry 26(4):295-300 (1984).

<sup>14</sup> A Suzuki., Madness At Home: The Psychiatrist, The Patient, And The Family In England, 1820–1860, pub University of California Press, California (2006).

Mapother was extremely critical of the state of the mental health hospitals and compared them on a scale of —badness|. According to him, —most mental hospitals are desolate wastes, based on the conception that the insane are indifferent to ugliness and are destructivell. Mapother mentioned Madras as the \_best ‘of the \_typical ‘mental hospitals in India. He described the mental hospital in Pune as \_inspired by the public work department concept of lunatic ‘, with \_open air cages‘. He advocated a comprehensive programme for re-organizing mental health services in India.

The re-organisation programme suggested by Mapother comprised the following:

- 1) Admission Procedures:
- 2) Brief detention / observation exists but no short admission beds;
- 3) Voluntary admission exists but no beds in public wards.
- 4) India is not ready for non-volition order on account of corruption.
- 5) Every case should be seen by a magistrate before and after admission for detention.
- 6) Certification for detention should be limited to experts with recognized qualifications.
- 7) Visiting Committees needed to be set up.
- 8) Deputy to Public Health Commission with knowledge of psychiatry to be appointed
- 9) Institutional facilities to be included
- 10) Increase in beds irrespective of all pressures
- 11) Specialised services especially for the criminal, mentally retarded and involuntary patients
- 12) Classes of service to include – psychiatric clinic in Government hospitals and beds for mentally ill persons
- 13) Short treatments lasting for 1 month
- 14) Improvements of conditions for chronic patients
- 15) Increase in undergraduate education in mental health
- 16) Diplomas to be started
- 17) Teachers / researchers to have a stint of training abroad
- 18) Well-trained staff and mental health nurses required
- 19) Need to introduce social workers in mental hospitals
- 20) Organised occupation of patients and training of those whosupervise them is crucial
- 21) Survey and public propaganda as to the true incidence of mentalillness and whether certain illnesses could be prevented.

## Moore Taylor's Report

In 1946, Col. Moore Taylor, Superintendent of the European Mental Hospital at Ranchi and member of the Health Survey and Development Committee (Bhore Committee) was asked to survey mental hospitals and his report was based on the observations of 19 mental hospitals. His observations and recommendations were summarised as follows:

“the majority of mental hospitals in India are out of date, and are designed for detention and safe custody without regard to curative treatment<sup>15</sup>. The conditions of many hospitals in India today are disgraceful and have the makings of a major public scandal”. Many of Taylor's observations were similar to the observations made by Mapother.

- 1) Qualified and trained psychiatrists to head mental hospitals;
- 2) Requirement of adequate staffing;
- 3) Post-graduate training courses with emphasis on prophylaxis and prevention as per the
  - 1) principles of modern preventive medicine;
- 4) Undergraduate training in psychiatry is to be uniform;
- 5) Mental hospitals should be attached to medical colleges;
- 6) Requirement of mental health service, the medical staff with status, pay and conditions of
  - 2) service for purely professional work;
- 7) Urgent requirement for trained nurses;
- 8) The number and quality of ward personnel to be increased;
- 9) Both theoretical and practical instructions to be imparted to the nurses and ward
  - 3) personnel;
- 10) Work therapy and diversional therapy to be more systematic and planned;
- 11) Special homes for patients with physical problems (medical or nursing) under the
  - 4) supervision of the Medical Services<sup>16</sup> (it was observed by Moore Taylor that more than
  - 5) 50% of the patients in mental hospitals could be cared for in such homes);
- 12) Need for outdoor clinics in mental hospitals;
- 13) In schools mental health issues to be addressed, child guidance clinics, juvenile homes
  - 6) and remand homes services to be incorporated;

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<sup>15</sup> Agarwal SP (Ed). Mental Health – An Indian Perspective 1946-2003. Directorate General of Health Services. Ministry of Health and Family Welfare, New Delhi 2004.

<sup>16</sup> Agarwal SP (Ed). Mental Health – An Indian Perspective 1946-2003. Directorate General of Health Services. Ministry of Health and Family Welfare, New Delhi 2004.

- 14) Psychiatry should form links with other medical specialties.

Taylor cautioned that opening of psychiatric units in general hospitals would be suboptimal.

Once this was achieved the general hospital could share the treatment of mental illness treatment and prevention activities;

Need to create goodwill about mental hospitals by —letting the community know that the mental hospital has a real service to be given; convincing people that they need what it has to offer; making it easily obtainable; making people glad they can have what the institution has to offer. The onus of improvement of mental health services was placed on the government. Taylor mentioned that —this is a suitable time for Government to take stock, overhaul resources, and rechart the course for the next 30 years.

### **Bhore and Mudaliar Committees**

The description and the recommendations of the Bhore Committee have been summarised in the compilation – Mental Health – An Indian Perspective. The Bhore Committee divided mental ill-health conditions into two groups: mental disorder and mental deficiency.

- i) Mental disorder may be either inherited or acquired, and very often is both. No age is exempt from mental disorder although the types may be different at different age periods. A large proportion of them are amenable to modern methods of treatment.
- ii) Mental deficiency is ascribed, on the other hand, to a hereditary or congenital taint or to some accident or illness occurring just before or soon after birth.

The Bhore Committee stated that the position in India is extremely unsatisfactory. It mentions that chronic starvation or mal-nutrition, tropical fevers, anaemia and frequent childbirth in women who are unfit for motherhood<sup>17</sup> are responsible for the large numbers of mental break down in India. The report estimated the requirement of beds for mentally ill at that time was about 800,000. Only around 10,000 beds were then available for these patients. As per the efficiencies of mental health care in India, the Bhore Committee came out with the following proposals. The

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<sup>17</sup> Agarwal SP (Ed). Mental Health – An Indian Perspective 1946-2003. Directorate General of Health Services. Ministry of Health and Family Welfare, New Delhi 2004.

Bhore Committee recommendations (1940) for mental health, based on Moore Taylor's report, called for improvements in mental hospitals and the need for medical and mental health personnel. It was instrumental in the formation of the National Institute of Mental Health and Neurosciences (then known as the All-India Institute of Mental Health) in Bangalore.

The committee suggested the formulation of a mental health programme for the country after a preliminary investigation of the needs of individual provinces. Such a programme should aim at providing for the community, in successive stages, a modern mental health service embracing both its preventive and curative aspects. As a part of the implementation of such a programme two of the most urgent needs that should be met are

- (1) an improvement and augmentation of existing institutional facilities for the treatment of mental illhealth
- (2) provision for the training of different types of mental health workers, including doctors and ancillary personnell.

With these in mind, the following recommendations were made by the Bhore Committee for a short-term programme:

- a) Creation of mental health organization as part of the establishments under the Director General of Health Services at the Centre and of the Provincial Directors of Health Services;
- b) Improvement of the existing 17 mental hospitals in British India and the establishment of two new institutions during the first five years and of five more during the next five years;
- c) Provision of facilities for training in mental health for medical men in India and abroad and for ancillary personnel in India; and
- d) Establishment of a Department of Mental Health in the proposed All-India Medical Institute. Importantly, there had been a mention about the promotion of positive mental health, —the pursuit of which requires the harmonious development of man's physical, emotional and intellectual equipment.

The Bhore Committee suggested that apart from provision for the Mental Health Care and Human Rights prevention and cure of specific forms of ill-health, physical and mental, many of the

proposals by the Committee, for example, those dealing with health and physical education, the social aspects of programmes for mothers and children, for the school going population and for industrial workers, the removal of slums and the creation of parks and other facilities for promoting community life should also be encouraged to appraise the level of mental health in the community.

The Mudaliar Committee visualised the development of psychiatric units in all district hospitals in the next ten years. The Medical Council of India mandates the setting up of Departments of Psychiatry at all medical colleges.

## **Medical Superintendents' Workshops: Summary of the Proceedings**

Between 1960 and 1990 over a period of 30 years four workshops on the improvement of mental hospitals in the country were conducted.<sup>18</sup> In India, in November 1960 the first conference of Superintendents of Mental Hospitals was held at Agra, WHO workshop on —Mental Hospitals in India: Present Status, resources and future needs at Ranchi in February, 1986, Workshop on Mental Hospitals in India held as part of the NMHP implementation at NIMHANS, Bangalore in March 1988, and a WHO workshop on Future Role of Mental Hospitals in Mental HealthCare in India held at IHBAS, New Delhi in December 1990.

The following points were focussed at all these workshops:

- a) Living conditions to be improved;
- b) Hospital infrastructure and functions to be improved;
- c) Role of various personnel to be defined;
- d) Staff in mental hospital to be trained;
- e) Outpatient and emergency services to be provided;
- f) Daycare and rehabilitation services to be provided;
- g) Role of mental hospitals in teaching and training to be extended;
- h) Special services needed for (child, old age, drug and alcohol, criminal mentally ill);
- i) Need for development of GHPU's;

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<sup>18</sup> [https://www.rcpsych.ac.uk/pdf/PUBNS\\_IPv13n3\\_65.pdf](https://www.rcpsych.ac.uk/pdf/PUBNS_IPv13n3_65.pdf)

- j) Need for development of alternative services and linkage in the community for mental health care;
- k) Undergraduate and postgraduate training and refresher courses in psychiatry for other professionals;
- l) Provision to be laid for internal and external monitoring.

The workshops were well attended and the above recommendations were formulated by mental health professionals.

## **Indian Lunacy Act, 1912**

The Indian Lunacy Act was enacted in 1856 giving guidelines for establishment of mental asylums and procedure for admission and discharge of a mentally ill person. Lunatic means a person with unsound mind or idiot. The main aim for establishing these mental asylums was to segregate these persons who were considered to be troublesome and dangerous to the society and themselves. Thus these people were kept in mental asylums as they required custodial care. They were kept within high walls and the inmates were chained, beaten up severely and ill-treated.

The growing public concern about the pitiable condition of the mental asylums forced the government to have a direct inspection of these asylums. In the year 1906, the Government decided to inspect them from a central source. In 1912 the Indian Lunacy Act (ILA) replaced the Indian Lunatic Asylum Act of 1858. It provided guidelines for the treatment of insane persons. Separate hospitals were established for European and Indian patients. The names of all lunatic asylums were changed to mental hospitals and their administrative control was shifted from civil authorities to the district civil surgeons in 1920. The ILA, 1912 was in force for 80 years.

The ILA, 1912 provided guidelines for the treatment of insane persons. A person of unsound mind is a lunatic and is kept in an asylum for care and treatment. A criminal lunatic or a lunatic shall be received and detained in an asylum only on the receipt of application of a reception order. An application for a reception order shall be made by petition with the statement of particulars to the magistrate within whose local limits of jurisdiction the alleged lunatic resides. It should be supported by two medical certificates one of which shall be from a medical officer.

<sup>19</sup>A copy of the reception order is to be sent to the in-charge of the asylum. Only on the

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<sup>19</sup> B R Beotra (edited by R N Saxena), *The Mental Health Act, 1987*, Butterworths India, New Delhi, 2nd Edition, Page | 16

confirmation of the person being lunatic he/she can be admitted in the asylum and also it is to be made sure that the person in charge of an asylum is ready to admit the lunatic.

The cost of maintenance of the lunatic in an asylum shall be borne by the person himself or any person who is a party thereto or out of the estate of the lunatic as per the decision of the magistrate. If the magistrate is satisfied that a wandering person is produced by the police officer in charge of police station is lunatic, then the magistrate can make a reception order admission of such lunatic into an asylum. The asylum is to be licensed. If the magistrate feels that the lunatic is being ill-treated, then he can summon such relative and if the relative is legally bound to maintain the alleged lunatic then the magistrate can send such errant relative to imprisonment for a term which may extend upto one month. He can even order in writing and authorize the detention of the alleged lunatic in a suitable custody.

All the acts which the magistrate is authorised can be done in metropolitan towns by the commissioner of police. In case of districts where all the duties which officer in charge of a police station is authorised can be performed by an officer of police not below the rank of an inspector.

### **The Care and Treatment**

The state government shall appoint not less than three visitors, one of whom shall be a medical officer for every asylum. Inspection of every asylum is to be done monthly by the visitors and shall be maintained in the record with respect to the management and condition of the asylum and the inmates and also ascertain their state of mind.

The inspector-general shall visit the asylum at least once in six months. The order of discharge can be made by the visitors one of whom shall be a medical officer who can direct the discharge of the person detained in such asylum. This shall be communicated immediately to the authority who is taking care of the lunatic.<sup>20</sup>

The lunatic with special order from the state government can be removed from any government asylum to other asylum within the state or any other state in the country with the consent of the

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2000.

<sup>20</sup> Burns. J.K., *‘Mental Health and Inequity: A Human Rights Approach to Inequality, Discrimination, and Mental Disability. Health and Human Rights’*, 2009.

state government of that state.

## **Judicial Inquisition as to Lunacy**

The court may order inquisition as to the person alleged to be lunatic, insane or is of unsound mind and is incapable of managing himself and his affairs. Acquisition of such inquisition shall be made by any relative of the alleged lunatic person or by the advocate general. The court may take custody of lunatics so found by inquisition and the management of their estates. The court has the power to make an order on an application made by petition on concerning any matter related to the lunatic or his estate respecting the application. For the benefit of lunatic the court has the power to dispose the lunatic's property for certain reasons. E.g., To clear lunatic's debts, encumbrances, etc.

The Manager shall comply to execute the orders given by the court. The proceedings in the case of a lunatic shall be ceased or set aside if the court finds that the unsoundness of mind has ceased.

The state government may establish an asylum and license the establishment of asylum. It can also cancel the license if the provisions for treatment are insufficient. In case the lunatic is unable to bear the expenditure and there is no one on his behalf to bear the expenses the court may order the government to bear the same in the asylum.

The government has powers to regulate the management of asylums, care and custody of the inmates and their transfer from one asylum to another asylum. A penalty will be levied for improper detention or improper reception of lunatics. He shall be punishable with imprisonment which may extend for 2 years or with the fine or both. The State Government has powers to make rules regulating the procedure for reception and detention in asylums.

The ILA 1912 has no relevance today because our medical science has rapidly advanced. Mental illness is now not incurable and it can be cured with proper and timely diagnosis. The attitude of society has also changed and now it is realized that no stigma should be attached to such type of disease. The experience of working of the ILA 1912 has revealed that it has become outmoded with rapid advancement of mental science and the understanding of the nature of the melody. It has become necessary to have fresh legislation with provision for treatment of mentally ill persons in accordance with the new approach.

Within a period of 100 years there was unprecedented growth in the number of asylums, which included Bhowanipore in Calcutta, Patna, Dacca, Berhampur, Dulanda (in Calcutta), Tezpur, altair, Trichinopally, Madras, Colaba, Poona, Dharwar, Ahmedabad, Ratnagiri, Banaras, Agra, Bareilly, and Cuttack (Orissa). However, most of these asylums were set up primarily near cantonments, where the British army units were stationed<sup>21</sup>. With the establishment of mental hospitals, mental health legislation was implemented.

## Recent Changes in Medical Health Legislation and Policy

Of late, there has been a lot of focus and discussion in the society with regards to mental health, physical health and on the overall well-being of an individual in the society. It is always considered that mental health is as important and as equivalent to the physical health of an individual. It is proven that mental health plays a pivotal role in the development and progress of the human being in the society. With the progress of time the mental health is now considered as a primary object to be achieved.

The general meaning of mental health is a person's condition with regard to his/her psychological and emotional well-being

The World Health Organization (WHO), both in its Preamble and Article 1 of its Constitution emphasizes that:

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition

Among the overall well-being of an individual a clear distinction is made between the mind 'and the physical body'. In virtual reality there should not be any differentiation or line drawn between the mental health and physical health. It is always considered that poor physical health leads to poor mental health and this also leads to an increase in the risk of mental health problems. Similarly, poor mental health will impact on physical health or well-being of an individual. The physical well-being or physical health should be considered at par with the mental health and no distinction should be drawn.

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<sup>21</sup> Johari. J.C., *'The Constitution of India: A Politico-Legal Study'*. Pub: Sterling Publishers Pvt Ltd. New Delhi, 2007.

Hence, mental health and physical health are two vital strands of life that are closely interwoven and deeply interdependent. An individual's emotional health can considerably impact physical health which can lead to many problems both psychological and physical. Mental health is as important as physical health to the overall well-being of individuals, societies and countries. At the national level there has been a lot of influence on the mental health awareness and this is on the rise. The Government, with the influence of the society has taken drastic steps towards channelling the laws with special emphasis for the mentally challenged or the mentally ill individuals who play an integral and pivotal role in the well-being of the society together with its upliftment as a whole. The Government is taking steps to ensure that people suffering from mental illness should be given special care and attention so as to bring them at par with other members of the society and also to give special privileges to the needy who are or have been victims to the old myths, beliefs and practices of the society.

As there is more awareness and emphasis to the rights of the mentally ill persons wherein there has been a tremendous pressure on the government to repeal old and outdated laws and to bring in reformation so as to give meaning to the right of life and to live with dignity<sup>22</sup>. The right to life which includes the right to live with dignity is a fundamental right of every citizen which should not be denied to any individual including the persons who are mentally challenged.

The mental health legislations are concerned mainly with:

- i. rights of the mentally ill (right to care and human rights);
- ii. quality of care;
- iii. the use of administrative and budget control measures; and
- iv. consumer participation and involvement in the organization and management of mental health care services

The Mental Health Act, 1987 which was in force had many drawbacks. It was not successful in eradicating the social stigma attached to mental illness, there is no emphasis on the role of the family members in dealing with mentally ill patients, no emphasis on care after discharge and rehabilitation of patients and many more. The Mental Health Act, 1987 has not been updated. It is not on par with international treaties and laws made for the treatment and care of mentally ill patients. There has been strong pressure on government by the doctors, the society and the other

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<sup>22</sup> Seervai, H.M., 'Constitutional Law of India', N.M. Tripathi Private Ltd., Bombay, Volume 2, ed. 1993

members of the community to make a new and improved law for better health care of the mentally ill patients and the social stigma attached to the mentally ill patients. Hence the Government of India has drafted the new bill called the Mental Health Care Bill, 2013 which is in line with the International requirements needed for the treatment and care of mentally ill persons/patients.

## **Government Policy**

There have been significant advances with respect to mental health legislation in India. Some of the important legislations in India pertaining to mental health and well-being of the individuals include:

- 1) Narcotic Drugs & Psychotropic Substances Act, 1985 (NDPS 1985)
- 2) Mental Health Act, 1987(MHA 1987)
- 3) Rehabilitation Council of India Act, 1992 (RCI 1992)
- 4) Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (PWD 1995).
- 5) Juvenile Justice (Care and Protection of Children) Act, 2000 (JJA 2000)
- 6) National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 (NTA 2001)
- 7) Protection of Women from Domestic Violence Act, 2005 (DMV 2005)
- 8) The Mental Health Care Act, 2017

The common objective of the above legislations is to provide a dignified living, to protect human rights and to address, to promote, to prevent and to cure the mental health problems.

### **Narcotic Drugs & Psychotropic Substances Act, 1985**

The Narcotic Drugs and Psychotropic Substances Act, commonly referred to as the NDPS Act came into force on 14 November 1985. The Act extends to whole of India and applies to all Indian citizens outside India and to all persons on ships and aircraft registered in India.

According to the NDPS Act, it is illegal for a person to produce, manufacture, cultivate, possess, sell, purchase, transport, store, and/or consume any narcotic drug or psychotropic substance. The Act was amended in 1988 and 2001. By notification in the Official Gazette, the Central

Government may constitute an advisory committee<sup>23</sup> - "The Narcotic Drugs and Psychotropic Substances Consultative Committee" to advise the Central Government on matters relating to the administration of this Act referred to it by the Government from time to time.

## **The Passing of the Mental Health Act, 1987**

The first law in relation to mental illness in British India was the Lunatic Removal Act 1851, which ceased in 1891. This law was mainly enacted to regulate the transfer of British patients back to England. After the takeover of Indian administration by the British crown in 1858, many laws were introduced for the care of people with a mental illness.

These include:

- 1) the Lunacy (Supreme Courts) Act 1858
- 2) the Lunacy (District Courts) Act 1858
- 3) the Indian Lunatic Asylum Act 1858 (with amendments passed in 1886 and 1889)
- 4) the Military Lunatic Act 1877.

Under these Acts, patients were detained for an indefinite period in poor living conditions, with little chances of recovery or discharge. This led to the introduction of a bill in<sup>24</sup> 1911 that consolidated the existing legislation and led to the Indian Lunacy Act (ILA) 1912. The legislative history is a revolutionary process to re-examine the repealed enactments in a systematic chronological order. <sup>106</sup>

The Indian Lunacy Act, 1912 was amended by the following Acts:

- 1) The Indian Lunacy (Amendment) Act 12 of 1922
- 2) The Devolution Act, 38 of 1920
- 3) The Indian Lunacy (Amendment) Act, 6 of 1922
- 4) The Repealing and Amending Act 11 of 1923
- 5) The Indian lunacy (Amendment) Act, 32 of 1923
- 6) The Indian Army (Amendment) Act, 33 of 1923
- 7) The Indian lunacy (Amendment) Act, 5 of 1926

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<sup>23</sup> Szasz, Thomas. S, 'Law, Liberty & Psychiatry: An Inquiry into the Social uses of Mental Health Practices', New York, Macmillan Co. 1963, ILI, LIB, New Delhi.

<sup>24</sup> [https://www.rcpsych.ac.uk/pdf/PUBNS\\_IPv13n3\\_65.pdf](https://www.rcpsych.ac.uk/pdf/PUBNS_IPv13n3_65.pdf)

- 8) The Repealing and Amending Act 10 of 1927.
- 9) The Indian Air Force Act 14 of 1932.
- 10) The Amending act, 35 of 1934 The Part B states (Laws) Act, 3 of 1951.
- 11) The repealing and amending Act 36 of 1957.

It has been adapted by the Adaptation of Laws Order, 1937, the Adaptation of Laws Order 1948, the Adaptation of Laws Order 1950, the adaptation of laws Order (No. 2) of 1956. It was repealed in part and amended by the Devolution Act 38 of 1920 and repealed in part by the Second Repealing and Amending Act 17 of 1914, and the Repealing and Amending Act 18 of 1919.

The Indian Lunacy Act was extended to the new provinces and the merged states by the Merged States (Laws) Act 59 of 1949, and to the states of Manipur, Tripura and Vindya Pradesh by the Union Territories (Laws) Act, 30 of 1950.

It was extended to the Union Territory of Dadra and Nagar Haveli by the Dadra and Nagar Haveli (Laws) Regulation 6 of 1963, to the Union Territory of Pondicherry with effect from October 1, 1963 by the Pondicherry (Laws) Regulation 7 of 1963, to the Union Territory of Goa, Daman and Diu by the Goa, Daman and Diu (Laws) Regulation (No. 2) of 1963, and Laccadive, Minicoy and Aminidivi Islands from October 1, 1967 by the Regulation No.8 of 1965.

The Indian Lunacy Act was amended in its application to –

- 1) Bombay by Bombay Acts Nos. 15 of 1936, 15 of 1938, 8 of 1954 and 97 of 1958.
- 2) Gujarat by Gujarat Act, 49 of 1961.
- 3) Maharashtra by Maharashtra Act, 56 of 1956, and 54 of 1975.
- 4) Madhya Pradesh by Madhya Pradesh Act, 23 of 1952.
- 5) Tamil Nadu by Madras Acts, 14 of 1938, 15 of 1938, and 12 of 1943
- 6) Punjab by Punjab Act, 37 of 1956
- 7) Saurashtra by Saurashtra Act, 42 of 1953, and
- 8) Uttar Pradesh by U.P.Act, 24 of 1954.

The Act was extended to the states merged in the State of Bombay by Bombay Acts No.4 of 1950, to the State of Madhya Pradesh by Madhya Pradesh Act, 12 of 1950 and 23 of 1958, and to the States merged in the State of Punjab by Punjab Act, 5 of 1950, it was extended to Saurashtra and

Kutch areas of the State of Gujarat by the Gujarat Act, 49 of 1961 which also repealed the Saurashtra Amendment Act 42 of 1953. The Act was extended to the state of Madhya Bharat by Madhya Bharat Act, 25 of 1950.

The Indian Lunacy Act was declared to be in force in the Khondmals District by the Khondmals Laws Regulation, 1936(4 of 1936) and to the Angul District by the Angul District Laws Regulation, 1936 (5 of 1936). After the Second World War,<sup>25</sup> Universal Declaration of Human Rights was adopted by the UN General Assembly. Indian Psychiatric Society submitted a draft Mental Health Bill in 1950 to replace the outmoded ILA-1912.

The Mental Health Bill, 1981 served as a basis for the passing of The Mental Health Act, 1987 which received the assent of the President on May 22, 1987 and was published in the *Gazette of India, Extraordinary, Part II, Section 1, dated May 22, 1987*. The Mental Health Act, 1987 amends the laws relating to the treatment and care of mentally ill persons and thus makes better provisions for their welfare and matters connected therewith. The Act consolidates and amends the law relating to the treatment and care of the mentally ill persons to make better provisions with respect to their property and affairs and matters connected therewith or incidental thereto.

### **Mental Health Act, 1987**

The Mental Health Act, 1987 (MHA) repeals the Indian Lunacy Act, 1912 and the Jammu & Kashmir Lunacy act, 1977. The MHA 1987 came into effect in all the states and Union Territories in April 1993. The main aim of the Act is to consolidate and amend the law relating to the treatment and care of mentally ill persons, to make better provision with respect to their property and affairs and for matters connected therewith or incidental thereto. The Act is divided into ten chapters and consists of ninety eight sections.

According to the Act, the Central Government may, in any part of India or the State Government may, within the limits of its jurisdiction establish or maintain Psychiatric Hospital or Psychiatric Nursing Homes for admission, treatment and care of mentally ill persons at such places as it thinks fit; voluntary admissions and strict supervision of the existing Hospitals and Nursing Homes; Judicial inquisition; State liability to meet cost of maintenance of such detained persons;

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<sup>25</sup> Samuel. J. Brakel and Ronald.S. Rock, 'The Mentally Disabled and the Law' Revised Edition, Book No. – 0-226-07090-5, the University of Chicago Press Ltd, London.

protection of human rights and management of the property of mentally ill persons. The MHA, 1987 also provides for provisions for penalties and procedures under Chapter IX of this Act.<sup>26</sup>

## **Rehabilitation Council of India Act, 1992**

In 1986, the Rehabilitation Council of India (RCI) was set up as a registered society. On September, 1992 the RCI Act was enacted by Parliament and it became a Statutory Body on June 22, 1993. The Act was amended by Parliament in 2000. The objective of the Act is to regulate and monitor the rehabilitation of persons with disabilities including the training policies and programmes in the field of rehabilitation; to bring about standardization of training courses for professionals; to prescribe minimum standards of education and training of various categories of professionals/ personnel; to regulate these standards in all training institutions uniformly throughout the country and to recognize institutions/ organizations/ universities running master's degree/ bachelor's degree/ P.G. Diploma/ Diploma/ Certificate courses etc. The Act also prescribes punitive action against unqualified persons delivering services to persons with disability.

## **Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995**

This Act may be called the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995(PWD). It extends to whole of India except the State of Jammu and Kashmir. The Act received the assent of the President on the January 1, 1996. The main aim of the Act is to give effect to the Proclamation on the Full Participation and Equality of the People with Disabilities in the Asian and Pacific Region.

The Meeting was convened by the Economic and Social Commission for Asia and Pacific at Beijing on 1st to 5th December, 1992 to launch the Asian and Pacific Decade of Disabled Persons 1993-2002. The Act approved the declaration on the Full Participation and Equality of the People with Disabilities in the Asian and Pacific Region. India is a signatory to the said declaration. This Act was enacted to give effect to the said declaration signed by India in 1992. The Act emphasises on the socio-economic and civil rights of persons with disabilities in all the states of India except the state of Jammu & Kashmir. According to this Act \_Disability 'means - Blindness; Low vision;

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<sup>26</sup> The Mental Health Act, 1987 by B R Beotra, 2nd Edition (edited by R N Saxena), Butterworths India, New Delhi, 2000

Leprosy-cured; Hearing impairment; Loco motor disability; Mental retardation; Mental illness.

## **The Juvenile Justice (Care and Protection of Children) Act, 2000**

It is an Act to consolidate and amend the law relating to juveniles in conflict with law and children in need of care and protection, by providing for proper care, protection and treatment by catering to their development needs, and by adopting a child-friendly approach in the adjudication and disposition of matters in the best interest of children and for their ultimate rehabilitation through various institutions established under this enactment. The Indian Constitution has, in several provisions, including clause (3) of article 15, clauses (e) and (f) of article 39, articles 45 and 47, impose on the State a primary responsibility of ensuring that all the needs of children are met and that their basic human rights are fully protected; The General Assembly of the United Nations has adopted the Convention on the Rights of the Child on the 20th November, 1989; the Convention on the Rights of the Child has prescribed a set of standards to be adhered to by all State parties in securing the best interests of the child; the Convention on the Rights of the Child emphasises social reintegration of child victims, to the extent possible, without resorting to judicial proceedings; the Government of India has ratified the Convention on the 11th December, 1992 to re-enact the existing law relating to juveniles bearing in mind the standards prescribed in the Convention on the Rights of the Child, the United Nations Standard Minimum Rules for the Administration of Juvenile Justice, 1985 (the Beijing rules), the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (1990), and all other relevant international instruments.

## **National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999**

The Act received the assent of the President on December 30, 1999 and extends to whole of India. This Act provides for the constitution of a national body for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities. This national body shall be a trust. The objects are specified below:

- a) to facilitate and allow persons to live independently within the community to which they belong;
- b) facilitate to provide support to live within their families;

- c) to extend support to registered organization, to provide services in the event of crisis in the family;
- d) to deal with problems of such persons who do not have family support;
- e) to take measures for the care and protection of such persons in the event of death of their parent or guardian;
- f) to appoint guardians and trustees for persons who requires such protection;
- g) to facilitate equal opportunities, protection of rights and full participation of persons with disability; and
- h) to do any other act which is incidental to the aforesaid objects.

### **Protection of Women from Domestic Violence Act, 2005**

This Act provides for more effective protection of the rights of women guaranteed under the Constitution who are victims of violence of any kind occurring within the family and formatters connected therewith or incidental thereto. This Act was brought into force by the Indian government from October 26, 2006. The Act provides the definition of "domestic violence", which is broad based and includes not only physical violence, but also other forms of violence such as emotional, verbal, sexual, and economic abuse. It is a civil law meant primarily for protection orders and not meant to penalize criminally. The act does not extend to Jammu and Kashmir, which has its own laws, and which was enacted in 2010 the Jammu and Kashmir Protection of Women from Domestic Violence Act, 2010.

### **Mental Health Care Act, 2017**

The Act consists of one hundred and twenty six sections divided into sixteen chapters. According to the Act every individual suffering from mental illness shall have the right to specify the way he/she would like to be treated. The individual will also specify a nominated representative who will be responsible for taking decisions with regard to treatment, admission into a hospital, etc. The Act guarantees every person the right to access to mental health care and treatment from the government. A person with mental illness also has the right to equality of treatment and protection from inhuman and degrading treatment. The Act decriminalizes suicide and states that whoever attempts suicide will be presumed to be under severe stress and shall not be punished for it<sup>27</sup>.

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<sup>27</sup> <http://indianexpress.com/article/explained/new-mental-health-bill-provisions-rajya-sabha-2964545/>.

## Constitutional Provisions With Regard To Mental Health

The fundamental rights enshrined in Part III of Indian Constitution also known as the Magna Carta 'or the Human Rights 'for the citizens of India. These rights are enshrined in the constitution for the development and welfare of citizens of India. The fundamental rights are also justifiable rights; this means that the citizens can approach the court of law for their enforcement against unconstitutional or arbitrary encroachment. With the recent development of law, the meaning of Fundamental Rights has expanded its scope of horizon and that the fundamental rights are applicable to all citizens of India irrespective of caste, religion, colour, sex or origin. But when it comes to its application especially to the citizens with a mental disability the question arises whether these rights are easily available and justifiable? The answer to this question is the need of the hour as many of these rights though theoretically applicable, there are certain difficulties in their application. Under the Constitution the mentally disabled have been guaranteed the following fundamental rights:

The Constitution in its Preamble 'secures to all its citizens including the mentally disabled—Justice - social, economic and political;

**Liberty** - of thought, expression, belief, faith and worship;

**Equality** - of status and of opportunity; and to promote among them all.

**Fraternity** - assuring the dignity of the individuals.

This is the most promising preamble wherein the constitution ensures that all its citizens are treated equally under law including the assurance that the citizens are treated with dignity. Hence, a special reference can be given to the mentally disabled so as to recognise and give them their due social status, rights and privileges in the society.

The next most promising Article in the constitution is the Article 14 which imposes a liability on the state to treat all persons equally before law and provide equal protection and also ensure that there is no discrimination on the basis of religion, race, caste, sex or place of birth. Again, here a special reference can be made to the mentally disabled; wherein increasing the duty and responsibility of the State towards the mentally disabled ensuring that they are treated equally before the law and should not be subjected to any kind of discrimination which challenges their ability.

Article 15(2) states that no citizen shall, on grounds only of religion, race, caste, sex, place of birth or any of them, be subject to any disability, liability, restriction or condition with regard to its access to shops, public restaurants, hotels and places of public entertainment; or the use of wells, tanks, bathing ghats, roads and places of public resort maintained wholly or partly out of State funds or dedicated to the use of the general public. Here again, a special emphasis can be made with respect to mentally disabled where in the State shall not discriminate in matters of their access to shops, public restaurants, hotels and places of public entertainment or in the use of wells, tanks, bathing ghats, roads and places of public resort maintained wholly or partly out of government funds or dedicated to the use of the general public.

Article 21 of the Constitution guarantees —protection of life and personal liberty. It emphasises that no person shall be deprived of his life or personal liberty except according to procedure established by law.<sup>28</sup>

In the above provision it can be construed to include the rights of the mentally disabled by not only providing them their right and privileges to live in the society but also ensuring their right to protection from exploitation. With the advancement of time and improved legislations the scope of Article 21 had been broadened. On a number of occasions the higher courts have given significant judgements and have give more logical and meaningful concept to Article 21. With these momentous judgements the meaning of right to life can be deduced as something more than the rights available for mere survival of human existence. It includes within its ambit the right to live with human dignity, right to health, right to potable water, right to pollution free environment, right to privacy and right to education etc.

It is also laid down by the higher courts that the State shall strive to provide, improve and maintain public health. It can also be considered as one of the fundamental rights that can be claimed by, against the State which includes the Government and other Authorities established by the State. In other words, it can be said that it is an obligation that flows from Article 21 of the constitution. This means that mentally ill have fundamental/human right to receive mental health care and to humane living conditions in mental hospitals.

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<sup>28</sup> Seervai, H.M., '*Constitutional Law of India*', N.M. Tripathi Private Ltd., Bombay, Volume 2, ed. 1993.

In *Chandan Kumar Banik v. State of West Bengal*,<sup>29</sup> the Supreme Court has given the order to provide respite to mentally challenged inmates of a hospital in Hooghly district who were being kept chained by the hospital authority to control their unruly and violent behaviour. Article 32 - Right to constitutional remedies. According to this Article every disabled person can move to the Supreme Court of India to enforce his/her fundamental rights guaranteed in the constitution. The Indian judiciary has interpreted the right to health in many ways. Through public interest litigations there are substantial case laws in India, which shows a range of problems that are related to health.

In *Vincent v. Union of India*,<sup>30</sup> it was accepted by the apex court that —A healthy body is the very foundation for all human activities. In a welfare state, therefore it is the obligation of the state to ensure the creation and sustenance of conditions congenial to good health.

In *Consumer Education and Resource Centre v. Union of India*,<sup>31</sup> it was recognised that Right to Health is essential for human existence and is, therefore, an integral part of the Right to Life.

In *Francis Coralie Mullin v The Administrator, Union Territory of Delhi*<sup>32</sup> it was held that the right to life does not mean a mere animal like existence but a more meaningful life, a life of physical and mental integrity.

Further in, *State Of Punjab and Others v Mohinder Singh Randhawa And Others*,<sup>33</sup> it was also stated that right to health is integral to right to life.

Under Article 47, it is the duty of the State to raise the level of nutrition and the standard of living and to improve public health. The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.

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<sup>29</sup> *Chandan Kumar Banik v. State of West Bengal*, (1995) Supp(4) SCC 505.

<sup>30</sup> *Vincent v. Union of India*, AIR 990, 1987 SCR (2) 468.

<sup>31</sup> *Consumer Education and Resource Centre v. Union of India*, AIR 922, 1995 SCC (3) 42

<sup>32</sup> *Francis Coralie Mullin v The Administrator, Union Territory of Delhi* 1, AIR 746, 1981 SCR (2) 516

<sup>33</sup> *Punjab and Others v Mohinder Singh Randhawa And Others*, AIR 1992 SC 473, 1993 ,SCC 49

The primary duty of the State shall be, to raise the level of nutrition and the standard of living of its people. When it comes to the mentally disabled the Government is compelled and obligated to provide primary and basic health care facilities which are required for the well – being of the mentally disabled.

In *Mahendra Pratap Singh v. State of Orissa*,<sup>34</sup> the court held that in a country like ours, it may not be possible to have sophisticated hospitals but definitely villages within their limitations can aspire to have a Primary Health Centre. From the above discussion it is clear that the constitution of India incorporates provisions guaranteeing everyone's right to the highest attainable standard of physical and mental health.

Mental health legislation needs to address the following issues and provide a reasonable degree of right to health care. Reasonable degree of health care means and includes:

- a) easy access to health care – available at the community level, which is integrated within (a) primary health care.
- b) free supply of essential medications – a list of essential medicines needs to be declared (b) and made available free of cost continuously without any interruption.
- c) acceptability- service providers must respect medical ethics and the service provided (c) should be culturally appropriate.
- d) quality - health facilities and services must be scientifically appropriate and of good (d) quality.
- e) availability of emergency treatment at the primary health centre

## Conclusion

Legislation is an important mechanism to ensure appropriate, adequate, timely and humane health care delivery. The fundamental aim of these legislations is to protect, promote and improve the lives and mental well-being of its citizens. India has a comprehensive, but scattered, legislation related to health care. Some of these legislations for example the Mental Health Act, 1987, the Narcotic Drugs and Psychotropic Substances Act, 1985, the Rehabilitation Council of India Act, 1992, the Disability Act, 1995, the Juvenile Justice (Care and Protection of Children) Act, 2000,

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<sup>34</sup> *Mahendra Pratap Singh v. State of Orissa*, AIR 1997 Ori 37

and the Protection of Women from Domestic Violence Act, 2005 helped to clarify some of the health related legislation. These legislations, directly and indirectly, played an important role in protecting the rights of persons with mental illness. They ensured effective implementation of these laws by the state, other authorities and organisations.

