NOTES AND COMMENTS

A BRIEF HISTORY OF MIND: THE DEVELOPMENT OF MENTAL HEALTH LAWS IN INDIA

'*Sometimes the worst place you can be at is alone and in your own head*

Abstract

This paper, running into three parts, focuses on the development of mental health laws in India. It begins with the striking characteristics of mental illness and the stigma attached to it. First part pertains to development of mental health laws in India starting from 1858 till the recent amendment enacted in 2017. Various judgments of the Supreme Court of India and the principles prescribed by the United Nations and the World Health Organization for mental health have been noted. In second part, important changes introduced by the Mental Health Act, 2017 are highlighted, *viz.*, a wider definition of 'mental illness' and adherence with internationally accepted standards. Third part concludes the article by making suggestions for an effective implementation of the 2017 Act, *viz.*, a magistrate to mandatorily inquire into the ability of family/friends to take home a mentally ill person.

I Introduction

'MENTAL ILLNESS' the very mention of the term causes instant prejudice in the mind of an average person, a prejudice that is absent even when terms such as 'cancer', 'tuberculosis' or even 'AIDS' are mentioned. They are all diseases, they are all beyond the control of the patient and they are all capable of treatment, however, there is a stigma and prejudice attached to 'mental illness',[1] which is not the case for other diseases. A large reason[2] for this is the comparatively limited understanding, both of experts and laymen, on the cause for 'mental illness', its symptoms and its treatment.

This lack of understanding is caused not due to a lack of interest or a shortage of study of the human brain, but simply due to the fact that the human brain is an extremely complex structure, consisting of over 100 billion neurons that gather and transmit signals which govern our thoughts, perception and movement. Be that as it may, the focus of this article is to briefly trace the development of mental health law in India and not on the complexities and mysteries of the human brain, howsoever interesting they may be.

The pain and suffering felt by patients of mental illness is unique in the sense that it is all in their head, without any outward manifestation of there being something wrong,

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1 Byrne, P., "Stigma of mental illness and ways of diminishing it" 6(1) *Advances in Psychiatric Treatment* 65-72 (2000).

as is the case with all non-mental illness, such as cancer, tuberculosis, jaundice etc. All the organs continue to perform normally, all tests are routine; however, the mind of the patient is anything but.

This has two equally unfortunate consequences,[3] a) the patient feels isolated, alone and unable to relate or reach out to others; and b) the patient's actions are seldom understood by others and are viewed as being caused as a result of some personality trait or other weakness in the patient as opposed to a mental illness, that is beyond the control of the patient. These two factors only deepen the stigma and prejudice attached to mental illness. As a result, many times mental illness end up undiagnosed and continue to adversely affect the life of the patient. Another common feature with mental illness is the reluctance of a patient to admit that she is suffering from a mental illness, due to her own perceptions or society's perceptions about mental illness. In fact, in many parts of India, cases of mental illness continued to be treated by '*jaadutona*'[4] and involve advise not from psychologists/ psychiatrists but from '*tantriks*', who, true to their depiction in cinema, use a broom to quiet literally, sweep away the '*evil spirit*'[5] inhabiting the patient.

These aspects of mental illness, i.e. its tendency to isolate, the lack of understanding about its causes, symptom and treatment and the social stigma attached to it, feed into each other and create a vicious cycle of sorts, whereby, the ultimate sufferer are the persons with mental illness.

However, over the last 25-30 years, there has been a marked shift in how mental illness is viewed, internationally and also in India. A big reason for this has been the active role played by the United Nations in spreading awareness about mental illness and its symptoms and treatment. This is also reflected in India in the passing of the Mental Health Act, 2017 (Act of 2017), which is a welcome amendment to the Mental Health Act, 1987.[6]

Before proceeding further, it is crucial to note that the basic principle underlying the Mental Healthcare Act, 1987 and also the Act of 2017[7] is to ensure that persons

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2 Mental Health Foundation, *Stigma and Discrimination, available at:* https://www.mentalhealth.org.uk/a-to-z/s/stigma-and-discrimination. (Last visited on May 30, 2019)

3 Phelan, J., & Link, B., "Fear of People with Mental Illnesses: The Role of Personal and Impersonal Contact and Exposure to Threat or Harm" 45(1) *Journal of Health and Social Behavior* 68-80 (2004).

4 Laungani, P., "Cultural Influences on Mental Illness" 24(43) *Economic and Political Weekly* 2427-2430 (1989).

5 Rubinstein, J., "Spirit Possession as a cause of illness among English spiritualists" 9(1) *Cambridge Anthropology* 12-3 (1984). See also, Gächter, O., "Evil and Suffering in Hinduism" 93(4/6) *Anthropos* 393-403 (1998).

6 The Mental Health Act, 1987.

7 The Mental Health Act, 2017.

suffering from mental illness are able to fully exercise the rights guaranteed to them under part–III of the Constitution, including the right against discrimination, right to freedom of speech and expression and the right to life and dignity and its many manifestations as have been enumerated by the Supreme Court in a catena of judgments.[8] Therefore, the aforesaid Acts have to be looked at in terms of how effectively they enable persons with mental illness to exercise these basic rights and how they enable them to live a full, free and dignified life. The value of living with dignity has been recognized as a core feature of their right to life guaranteed under article 21, most recently by a nine judge bench of the Supreme Court, in the matter titled *KS Puttaswamy* v. *UOI*.[9]

The first part of this article will focus on the development of the law in India, starting from the Indian Lunatic Asylums Act, 1858 and ending with the Act of 2017. The second part will highlight some of the important changes introduced by the Act of 2017 and the third part will conclude by highlighting certain suggestions by the present author for a more effective implementation of the Act of 2017.

II Development of mental health law

A research paper titled "*History of Psychiatry in India*"[10] by provides an interesting insight into the history of practice of psychiatry[11] and how the State and the law perceived it. According to the said paper, the earliest form of a mental hospital was a Greek[12] sanctuary at Epidaurus. Later, mentally ill patients came to be treated in refugee camps by Christian and Muslim missionaries. The first so-called modern mental hospital was the Bethlehem Hospital located in London in the 13thcentury. Till the early 18th century, mentally ill patients were ill-treated and often neglected. The emphasis was on '*containing*' rather than on their care or treatment. Thus, there was rampant use of chains and other restraint devices. It was only in the 18th and 19th century that treatment of mentally ill patients was revolutionized. The credit for this is given to Philippe Pinel, a French physician who propagated the adoption of a humane approach. Modern psychiatry is thus modeled on the principles of Pinel and other later scholars.

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8 *AK Gopalan* v. *State of Madras*, AIR 1950 SC 27; *Maneka Gandhi* v. *Union of India*, AIR 1978 SC 597 (personal liberty); *Olga Tellis* v. *Bombay Municipal Corpn.*, AIR 1986 SC 180 (Livelihood); *Shantistar Builders* v. *Narayan Khimalal Totame,* AIR 1990 SC 630 (Shelter); Parmananda Katara v. Union of India, (1995) 3 SCC 248 (Medical Care), etc.

9 (2017) 10 SCC 1.

10 Authored by Haque Nizamue and Nishant Goyal and reported in *Indian Journal of Psychiatry*, Jan 2010 – 52 (Suppl. 1).

11 Psychiatry refers to the study and treatment of mental illness, emotional disturbance, and abnormal behaviour.

12 Blue, A., "Greek Psychiatry's Transition from the Hospital to the Community" 7(3) *Medical Anthropology Quarterly,* 301-318 (1993).

In India, the oldest record pertaining to mental illness is the Atharva Veda. The Vedic text describes conditions similar to schizophrenia and bipolar disorder. According to the Vedas, diagnosis and treatment of mental illness was based on the five senses and supplemented by inquisition. There is record of mental illness even in the Unani system of medicine, wherein seven major types of mental disorders are described. Though it is not clear as to how mentally ill patients were treated but from several sources, the root cause of mental illness was believed to be sin and witchcraft. Sadly, even today, our society associates mental illness with witchcraft and sorcery, as typified by the '*tantrik*' and his '*jhadoo*'.[13]

According to the recorded history of the pre-colonial era, there were several centers/ hospitals established by the king/sultan to look after the mentally ill. When the British arrived, they brought with them the western concept of psychiatry, which was in the process of shifting from being persecutory to being humane.[14] Though initially the emphasis of the British was to serve only Europeans and the soldiers of the British army, yet this led to the overall development of the science of psychiatry. Several institutions were set up in different parts of British India.

The British era saw the enactment of the first codified law on the subject in India *viz.* the Indian Lunatic Asylums Act, 1858. A perusal of the said Act however, makes it clear that it deals only with lunacy proceedings and provides for the consequences thereof. It does not provide for reception or admission of mentally ill or for their care or treatment. The sole object of the 1858 Act was to give powers to a court (and not a medical officer/doctor) to determine if a person was lunatic or not and if he was found to be lunatic, the Act provided the consequences as regards pending legal proceedings, his estate and other liabilities.

The 1858 Act was repealed by the Indian Lunacy Act, 1912 (Act of 1912). While the 1912 Act introduced the concept of care and treatment of mentally ill persons, however stigma attached to mental illness continued. While it was softer in its approach than the earlier legislations, yet the Act of 1912 was also archaic, especially if judged on the basis of contemporary standards. The Act of 1912 introduced the concept of a reception order, and mandated that no mentally ill person shall be received or detained in an asylum without a reception order being passed to that effect. Much emphasis was laid on the medical certificate to be prepared by a medical practitioner. Such medical certificate was treated as the only evidence of lunacy upon which a court could issue a reception order. Apart from lunacy proceedings, the 1912 Act provided for the care

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13 Nizamie, S. H., and Goyal, N., "History of psychiatry in India" 52(Suppl 1) *Indian journal of psychiatry* 7–12 (2010).

14 Rajpal, S., "Colonial Psychiatry in Mid-nineteenth Century India: The James Clark Enquiry1" 35(1) *South Asia Research* 61–80 (2005).

and treatment of those mentally ill persons, who were either found wandering or were found to be not under proper care and custody.

Though the 1912 Act was reformatory in its approach, yet it was premised on the basis that mentally ill persons were dangerous and thus, their confinement was the only option. Persons suffering from mental illness are described in the Act of 1912 as 'lunatics' or 'criminal lunatics' (both being defined terms in the Act)[15] thereby implying such persons as distinct and inferior to persons not suffering from a mental illness. With time, the society's perception of mental illness changed and there was development in treatment and care for mentally ill and it became accessible, however, the law on the subject continued to stagnate.

With an increase in understanding of mental illness, the Parliament of India enacted the Mental Health Act, 1987 (Act of 1987) *w.e.f* April 1, 1993, to reflect the fact that the attitude of society towards persons suffering from mental illness has changed considerably and it is now realized that no stigma should be attached to such illness as it is curable particularly when diagnosed at an early stage; that mentally ill persons are to be treated like any other sick persons and the environment around them should be made as normal as possible. With the rapid advance of medical science and the understanding of the nature of malady, it has become necessary to have fresh legislation with provisions for treatment of mentally ill persons in accordance with the new approach.[16]

The Act of 1987 was passed in pursuance of powers conferred by the Concurrent List of the Constitution of India, under Entry 16 of List III which reads as follows '*Lunacy and mental deficiency, including places for the reception or treatment of lunatics and mental deficient.*' The Act of 1987 did away with the use of the terms 'lunatic' or 'criminal lunatic' and instead used the terms 'mentally ill person' or 'mentally ill prisoner'. The Act of 1987 also envisaged the creation of mental health authorities and of psychiatric hospital and psychiatric nursing homes. Psychiatric hospital and psychiatric nursing homes were mandated to have a license, which was to be issued by the authority specified by the concerned state government and renewed after a period of five years. The said Act also provided for the procedure for admission in psychiatric hospital or psychiatric nursing homes for mentally ill persons and for their detention by a police officer or by a magistrate. The Act also contains provisions with respect to management of the property of a person who may be suffering from a mental illness as also the persons who will be responsible for paying for the admission of mentally ill persons in psychiatric hospitals or nursing homes. Section 81 of the said Act specifically provides that a mentally ill person shall be treated with dignity and without any physical or mental cruelty.

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15 The Indian Lunacy Act, 1912, ss. 3(4), 3(5).

16 Statement of Objects and Reasons.

That there have been a few important judgments relating to the Act of 1987, which are being discussed herein below: The said judgments throw light on the prevailing situation at the ground level and the practical problems being faced in the implementation of the Act of 1987.

Sheela Barse v. *UOI* [17] the issue before the court, raised by the petitioner through a writ petition, was that in Calcutta, many children and adults were being committed to jail for the reason that they were determined to be lunatics when, in fact, they were not suffering from any mental illness. Upon being committed to jail, they were categorized as non-criminal lunatics and were deprived of their liberty on the pretext that their commission to jail was for their own treatment. Thereafter, when these persons were produced before the judicial or the executive magistrate for assessing their mental health, they were routinely again committed to jail without the Magistrate specifying the duration of commission to jail or fixing any next date in the matter.

The Supreme Court had appointed a court commissioner to submit a report on the concerns raised in the writ petition and after going through the report, the court was pleased to pass certain important directions, including a declaration that admission of non-criminal mentally ill person to a jail is illegal and unconstitutional; the subsequent assessment of mental health of persons who are mentally ill persons, will be carried out only by a judicial magistrate and not an executive magistrate; a judicial magistrate will cause such a person to be examined by mental health professional and if so advised, send the mentally ill person to the nearest place of treatment and care; and that further the Judicial Magistrate will send quarterly reports to the high court, setting out the number of cases of persons brought before him and the action taken in such cases. Given the important of the mater, even though the grievance in writ petition was only limited to the State of West Bengal, a copy of the order passed by the Supreme Court was directed to be sent to chief secretaries of every State to ensure its implementation across India.

In *Nathalie Vandenbyvanghe* v. *State of Tamil Nadu*:[18] The writ petition was initially filed by a foreign national for release of her father, who had come to India as a tourist, lost his passport, could not speak English, was not mentally ill yet he was rounded up along with more than 100 persons with respect to all of whom reception orders were issued under The Mental Health Act, 1987.

The high court was constrained to note that strictly speaking upon return of the petitioner's father, no further orders are necessary, however, given the quality of treatment of mentally ill persons by the police and doctors, further orders had become necessary. Of a particular anguish to the court of the fact that the reception orders

17 (1993)4 SCC 204.

18 MANU/TN/2091/2008.

passed for about 115 persons by the magistrate, appear to have been passed as a matter of routine and without any real inquiry having been conducted. The court was constrained to note that the mentally ill persons are not criminals and are entitled to the right to live with dignity and all other fundamental rights that have been guaranteed under part-III of the Constitution of India. It was reiterated by the court that the inquiries as mandated in sections 23 and 24 of the Act of 1987, have to be strictly followed by the police and medical authorities and persons cannot be categorized as mentally ill in a mechanical and routine manner.

Death of 25 chained inmates in asylum fire in T.N. v. *Union of India*[19] the matter was initiated on the basis of a note submitted by the Registrar (Judicial) with respect to a news item about a gruesome tragedy in which more than 25 mentally challenged patients housed in a mental asylum were burned to death. The Court passed detailed directions to each state and union territory to undertake a district wise survey of all registered/ unregistered bodies purporting to offer psychiatric/mental health care and to reject/ grant licenses depending upon whether the minimum prescribed standards are being fulfilled. The court also directed the Central Government and the state government/ union territory to ensure that there is at least one government run mental hospital in each state and union territory. The Central and State Governments were also directed to undertake the awareness campaign with focus on rural areas with respect to the rights of mentally challenged persons.[20]

Reena Banerjee v. *Govt. of NCT of Delhi*[21] the proceedings were with respect to the poor conditions prevalent in hospitals/shelters available under, inter alia, the Mental Healthcare Act, 1987. The court directed the central and state authorities for mental health service to file a detailed affidavit inspecting and evaluating the conditions of the psychiatric hospital and psychiatric nursing homes and other mental health service agencies under the control of the Central Government and the state government.

That there were several important developments, both internationally and also nationally after passing of the said Act of 1987.

a) On December 12, 1991 the United Nations General Assembly adopted '*The Principles For Protection Of Persons With Mental Illness And Improvement Of Mental Healthcare*' . An underlying principle of these principles was that the least restrictive measure should be used for treating a person suffering from mental illness and all efforts should be made to ensure that the mentally ill person is

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19 (2002) 3 SCC 31.

20 The said matter continued to be listed from time to time up till Aug 21, 2017, on which date, in light of the coming into force of the Mental Healthcare Act, 2017, the said Writ Petition was disposed of with liberty to the learned amicus curiae to, if so advised, challenge the validity of the Mental Healthcare Act, 2017.

21 (2017) 2 SCC 94.

able to lead a normal life without being admitted in any institution. Even in case where mentally ill persons are admitted, there should be a regular review of their treatment so that they are released at the earliest possible opportunity.

b) In 1996, the World Health Organization formulated the '*Ten Basic Principles Of The Mental Healthcare Law*'. The said principles emphasize the importance of consent of either of the patient or a nominated representative in the treatment of a mentally ill person.

c) The Protection of Human Rights Act, 1993 was enacted by the Parliament of India *w.e.f.* September 28, 1993. It envisages the setting up of a National Human rights Commission, to, *inter alia*, inquire into the violation of human rights. Section 2(d)[22] defines 'human rights'[23] to mean 'the rights relating to life, liberty, equality and dignity of the individual guaranteed by the Constitution or embodied in the International Covenants and enforceable by courts in India.'[24] Section 2(f) defines 'International Covenants' to mean 'the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights adopted by the General Assembly of the United Nations on the December 16, 1966 and such other Covenant or Convention adopted by the General Assembly of the United Nations as the Central Government may, by notification, specify'.[25]

d) On October 10, 2007, The Convention on the Rights of People with Disabilities, 2006 (CRPD) was ratified by India. The CRPD has been notified under Section 2(f) and is therefore applicable and binding in the territory of India unless there is any Indian Law that is contrary thereto. The CRPD provided a great impetus in promoting the rights of Persons with Disabilities (including persons suffering from mental illness) not only in India but all around the world. The CRPD[26] reaffirms the importance of consent and dignity of a person suffering from mental illness and enjoins the state to ensure that persons suffering with disabilities are not unlawfully deprived of their liberties. The CRPD also led to the passing of the Rights of Persons with Disabilities Act, 2016 by the Indian Parliament.

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22 Protection of Human Rights Act, 1993, S. 2(d).

23 Assembly, U. G. (1948). Universal declaration of human rights. *UN General Assembly*.

24 Duffy, R. M., and Kelly, B. D., "Concordance of the Indian Mental Healthcare Act 2017 with the World Health Organization's Checklist on Mental Health Legislation"11 *International journal of mental health systems* 48 (2017).

25 Chaturvedi, S., Basavarajappa, C. and Ahamed, A., "Mental Health Care Bill, 2013 and United Nations Convention on the rights of persons with disability: Do they go hand in hand?" 31(2) *Indian Journal of Social Psychiatry* 107 (2015).

26 Márton, S. M., Polk, G., & Fiala, D. R. C. (2013). Convention on the Rights of Persons with Disabilities.

III The Mental Healthcare Act, 2017

The statement of objects and reasons of the Mental Healthcare Act, 2017, makes it obvious that it has been enacted to meet India's commitment under the CRPD. The Act of 2017 came into force w.e.f July 7, 2017. Some of the important changes made by the Act of 2017 are as follows:

a) *Definition of Mental Illness (Chapter I and II)*: 'Mental illness' has been defined to mean 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 is a condition of arrested or incomplete development of mind of a person, specially characterized by sub-normality of intelligence'. This is a welcome change from the Act of 1987 that defined 'mentally ill person' as 'mentally ill person" means 'a person who is in need of treatment by reason of any mental disorder other than mental retardation'.

Further, section 3 of the Act of 2017 makes it clear that mental illness shall be determined as per internationally accepted standards[27] (including the classification of diseases issued by the world health organization)[28] and not on the basis of moral, social, religious or cultural constructs. Section 4 greatly increases the involvement of the patient in the decision-making process by creating a deeming fiction of the situation(s) where a patient will have the capacity to make decisions regarding her healthcare, which include the ability to communicate a decision w.r.t her treatment by means of speech, expression, gesture or other means.

The definition inserted by the Act of 2017, which lays down a significantly more objective criteria than the Act of 1987, should help in reducing the arbitrary admission of individuals into mental health establishments, as was noticed by the courts in the judgments cited above.

b) *Advance Directives (Chapter III and IV)*: A new regime that has been introduced by the Act of 2017 is that of an advance directive,[29] *i.e.,* a document made by a person specifying the manner in which she wishes to be cared and treated for mental illness and the persons that she wants to be appointed as her nominated representative, to take care of her while she is suffering from a mental illness.[30]

See also, Kayess, R., and French, P., "Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities" 8(1) *Human rights law review* 1-34 (2008).

27 Magnusson, R. (2017). Advancing the right to health: the vital role of law.

28 World Health Organization. (1992). The ICD-10 classification of mental and behavioural disorders : clinical descriptions and diagnostic guidelines. World Health Organization.

29 Legislation & Regulations, 30(1) *Mental and Physical Disability Law Reporter* 155-155(2006).

30 Parsons A., "Consent to treatment and mental health 96(6) *Journal of the Royal Society of Medicine* 315–316 (2003).

c) *Rights of Persons suffering from a mental illness (Chapter V)*: Chapter V of the Act of 2017 mandates that a person suffering from mental illness shall have a right[31] to: (i) be a part of the society and not be segregated there from solely because he or she is suffering from mental illness; (ii) be protected against cruel inhumane or degrading treatment and to live in a safe and hygienic environment where certain basic necessities such as privacy, sanitary conditions, religious practices, food, clothing *etc.* are provided; (iii) not be discriminated against in the matter of healthcare services solely because of their mental illness; (iv) confidentiality with respect to their mental treatment; and (v) free legal aid to exercise any right given by the Act of 2017.Further, in case a person suffering from a mental illness has been admitted to an institution, she a right to be regularly informed of the provision of law under which she has been admitted and a right to make an application for a review of her admission and her proposed treatment plan.

   It is clear that a statutory recognition of these basic rights has been done to emphasize on the importance of consent and dignity of a mentally ill person. It is implicit in these rights that mentally ill persons should not be discriminated against solely on the basis of their mental illness and should be given equal chance of assimilating into society and leading a happy life. In this regard, the only rights guaranteed under the Act of 1987, was under section 81.[32]

d) *Central Mental State Mental Health Authority (Chapter VII-IX)*: The said authorities are set up in substitution of the extant authorities under the Act of 1987. The Act of 2017 provides for transfer of assets and liabilities of the old authority to the authorities set up under the Act of 2017. The said authorities consist of various senior bureaucrats (up to secretary level) and stakeholders (i.e. doctors, persons suffering from a mental illness and caregivers of persons suffering from a mental illness). The main function is to register mental health establishments; monitor their functioning; maintain a register of clinical psychologists, mental health nurses and psychiatric social workers and impart training and awareness in the filed of mental health at the central/state level.

e) *Mental Health Establishments and Mental Health Review Boards (Chapter X-XI)*: In addition to mental health establishments, the Act of 2017 also envisages the setting up of Mental Health Review Boards (comprising of a district judge, district collector, medical practitioner and a person suffering from a mental illness/ caregiver) for acting as appellate authorities against any decision taken by a mental health establishment and for generally ensuring that the rights

31 Gostin, L., and Gable, L., "Global Mental Health: Changing Norms, Constant Rights" 9(1) *Georgetown Journal of International Affairs* 83-92 (2008).

32 Sharma, S., "Human rights of mental patients in India: a global perspective" 16(5) *Current Opinion in Psychiatry*, 547-551 (2003).

guaranteed to mentally ill persons under the Act of 2017 are not violated. The order passed by such a Board is appealable directly to the high court and the board has been given ample powers to require the attendance and record testimony of witnesses.

The setting up of such a board, which is not provided for in the Act of 1987, will not only increase the accountability of mental health establishments but also make it easier for persons to challenge decisions taken by mental health establishments, for which, earlier, the only remedy available was approaching the high court or the Supreme Court by filing a writ petition.

f) *Admission, Treatment and Discharge (Chapter XII)*: The provisions relating to admissions, treatment and discharge have been changed so as to promote the value of consent of the patient. Section 85 makes it clear that to the extent possible, all admissions will b e 'independent admissions', i.e. admissions of persons who have the ability to make decisions. The discharge of such patients also is to be immediately on their request and their treatment has to be as per their 'informed consent'.[33] In case a person is unable to make independent decisions, the Act of 2017 provides for a detailed procedure for admission of such a person on an application by a nominated representative and on the formation of an opinion by the medical officer/ mental health professional in charge of a mental health establishment that that the said person is suffering from a mental illness of such severity that there is a chance that he will cause bodily harm to himself/ others around him. Furthermore, such admission cannot normally exceed 30 days unless the threat to bodily harm/violent behavior continues.

The Act of 2017 also prohibits certain procedures involving the use of electricity such as electro convulsive therapy, sterilization and putting the patient in chains and also provides for the informed consent of the patient for carrying out a psycho surgery. Further, the Act of 2017 permits the use of seclusion or solitary confinement in very limited circumstances, when no alternatives are available.

g) *Role of Police and Magistrate (Chapter XIII)*: Under the Act of 1987, in case a police officer was to come across a mentally ill person (to an extent that she cannot take care of herself or is a risk to herself or others), the said person was to be produced before a magistrate within 24 hours.[34] The Act of 2017 changes the said position and instead mandates production of such a person before a

33 Amer A. B., "Informed consent in adult psychiatry" 28(4) *Oman medical journal* 228–231(2013).

34 Castellano, U., "The Politics of Benchcraft: The Role of Judges in Mental Health Courts" 42(2) *Law and Social Inquiry* 398-422 (2017).

mental health establishment who shall determine if admission is required. The Act of 2017 makes it clear that such a person shall not be detained in police lock up or prison at am time. The aforesaid changes will also reduce mis-treatment of mentally ill persons, as was noticed in the judgments cited above.[35]

IV Suggestions and way forward

Section 102 (Act of 2017) versus Section 24 and 28 (Act of 1987)

Section 102 of the Act of 2017 that corresponds to sections 24 and 28 of the Act of 1987 do not allow a magistrate before whom a mentally ill person is produced to have the said person be taken home by his friends/family on furnishing of a surety that the person will be taken care of and that the said person will not cause any injury to herself or others. Section 102 mandates that the Magistrate to either send such a person for admission to a mental health establishment or for testing (of whether she is in fact suffering from a mental illness) to a mental health establishment. Furthermore, the mandatory inquiry to be carried out by the magistrate under section 24 (1) and (2) has been omitted from section 102.

In the view of this author, the view taken by a division bench of the High Court of Delhi in judgment and order dated October 26, 2018, passed in '*Ravinder* v. *Govt. of NCT of Delhi*'[36] ought to be followed and the mandatory inquiry to be conducted by a magistrate under section 24 as also the ability of friends/family of a mentally ill person to take a mentally ill person to her home as provided for in Section 24 and 28 of the Act of 1987 ought to be read into section 102 of the Act of 2017. A SLP against the said decision is pending before the Supreme Court and leave has also been granted by the Supreme Court. The author was an advocate for the Institute of Human Behavior and Allied Sciences (IHBAS) in the said matter.

Liability of Mental Health Establishments for following orders

In cases where a patient is brought before a mental health establishment by a police officer or a magistrate, an issue that arises is the liability of the mental health establishment and the standards to be adopted by it in treating such a patient. The said issue was also raised in the aforementioned judgment titled '*Ravinder* v. *Govt. of NCT of Delhi*', which is presently pending before the Supreme Court. That while the Act of 1987 was silent on the said aspect, the Act of 2017 makes it clear that in such cases, the mental health establishment will treat the patient as per the provisions of the Act

35 Wood, J. D., Watson, A. C., & Fulambarker, A. J., "The "Gray Zone" of Police Work During Mental Health Encounters: Findings from an Observational Study in Chicago" 20(1) *Police quarterly* 81–105 (2016).
See also- van den Brink, R. H., Broer, J., Tholen, A. J., Winthorst, W. H., Visser, E., & Wiersma, D., "Role of the police in linking individuals experiencing mental health crises with mental health services" 12 *BMC psychiatry* 171(2012). doi:10.1186/1471-244X-12-171.

36 WP (GI.) No. 3317/2017.

governing Admission, treatment and discharge, thereby obviating some of the confusion that was prevalent as a result of the Act of 1987.

Advance Directive: The said mechanism is prone to abuse since no guidelines have been formulated on how an advance directive can be issued/ modified. At present, section 6 only states that an advance directive shall be made in the manner as may be specified in the advance regulations. That in case someone wishes to take advantage of a person suffering from mental illness, at present, and in the absence of any guidelines whatsoever, it will be extremely easy for them to forge/fabricate an advance directive for a mentally ill person, after which they will be entitled to exercise wide-reaching powers over the treatment of the person suffering from a mental illness. It is therefore imperative that urgent regulations be framed to address this lacuna.[37]

Admission under Section 89: As stated above, in case a person is unable to make independent decisions, section 89 of the Act of 2017 provides for a detailed procedure for admission of such a person on an application by a nominated representative. However, the Act of 2017 fails to adequately address a situation where the person does not have a nominated representative (as defined in section 14(4)) or a relative or care giver willing to act as a nominated representative. In such a case, the board will have to decide on a nominated representative, in exercise of powers under section 80(2)(a), however, for making such a decision, the board will have a period of seven days. The said period though not long, is more than capable of causing irreparable injury to the patient, whose admission and treatment will have to be deferred by a period of seven (7) days. The mental health establishment will also be wary of by-passing the statutory requirement of there being an application by a nominated representative.

One simple solution to the above problem may be the creation of a panel of nominated representatives for each mental health establishment, who will be required to be present at the hospital (and who may even be existing doctirs of the hospital) and who will, upon being approached by a mentally ill person who satisfies the criteria of section 89, and if they so deem fit, make an application as the nominated representative of the patient for the purpose of section 89, till the Board can pass necessary orders under section 80 (2)(a).

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37 Widdershoven, G., and Berghmans, R., "Advance Directives in Psychiatric Care: A Narrative Approach" 27(2) *Journal of Medical Ethics* 92-97 (2001).

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