CHAPTER-I

INTRODUCTION

1.1 INTRODUCTION

Human society has witnessed that some human beings are born with mental inability. This may be generic or due to injury caused to the new born at the time of delivery. The mental disorder may develop to a mentally able person due to extreme shock, injury and poisoning.\(^1\) Today, the mental disorders stand among the leading causes of the diseases and disability in the world. It has become necessary to generate the awareness of mental health especially in countries like India where too many misconceptions are existing to deal with. For example, the most common misconception, that India has low percentage of the population suffering from mental disorder needs to be handled first so that the approachability to mental health services can be enhanced. Though, the morbidity rate of mental disorders is surprisingly high in India, the concept of mental health encompasses only the treatment of seriously mentally ill persons admitted in the mental hospitals, otherwise it has no implications to them. In India, it is a very recent change that few people have started acknowledging the relevance of general mental health.\(^2\)

Mental disease is observed as a stigma in most of the culture. People of different age, gender or socio-economic status may suffer from mental illness. At least twenty percent of people pass through mental disorders in some way or the other during their lifetime. Stigma towards mentally ill people is a matter of great concern. This affects on their ability to perform duties, their revival, treatment procedure and support they receive, and their recognition in the group of people.\(^3\)

Concept of mental disability occurs due to insanity, which implies a degree of mental disturbance so menacing and so disabling that the person may be considered

\(^2\)Id. at 15-16.
from the legal point of view to be immune from certain responsibilities and may
disallow him certain privileges that may require a degree of competence.⁴

*Mental Illness* under the Mental Healthcare Act, 2017 means a substantial
disorder of thinking, mood, perception, orientation or memory that grossly impairs
judgment, behaviour, capacity to recognize reality or ability to meet the ordinary
demands of life, mental conditions associated with the abuse of alcohol and drugs, but
does not include mental retardation which is a condition of arrested or incomplete
development of mind of a person, specially characterised by sub-normality of
intelligence.⁵

The expression *mental disorder* under the Hindu Marriage Act, 1955, means
mental illness, arrested or incomplete development of mind, psychopathic disorder or
any other disorder or disability of mind and includes schizophrenia.⁶ The word *Mental
illness* under the Persons with Disabilities (Equal Opportunities, Protection of Rights
and Full Participation) Act, 1955,⁷ means any mental disorder other than mental
retardation.⁸

*Mentally ill Person* under the Mental Health Act, 1987,⁹ means a person who
is in need of treatment by reason of any mental disorder other than mental
retardation.¹⁰

*Person with Disability* under the Rights of Persons with Disabilities Act, 2016,
means a person with long term physical, mental, intellectual or sensory impairment
which, in interaction with barriers, hinders his full and effective participation in
society equally with others.¹¹

*Lunatic* has been defined under the Indian Lunacy Act, 1912¹² an idiot or
person of unsound mind.¹³ In *Smt. Anima Roy v. Probodh Mohan Roy*,¹⁴ the Court

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⁵The Mental Healthcare Act, 2017, s. 2(s).
⁶The Hindu Marriage Act, 1955, s. 13(1).
⁷This Act is now repealed by the Rights of Persons with Disabilities Act, 2016.
⁹The Mental Health Act, 1987 is repealed by the Mental Healthcare Act, 2017.
¹¹The Rights of Persons with Disabilities Act, 2016, 2(s).
¹²The Indian Lunacy Act, 1912, s. 3(5).
observed, that the definition thus says that *lunatic* means (it does not say “includes”) an idiot or a person of unsound mind. It is, therefore, a hard and fast definition and we cannot give any other meaning to the word “lunatic” than that which is mentioned in the definition itself. Hence, going by the language of the Hindu Marriage Act, it is not possible to make room for different degrees of lunacy. No doubt, while Section 5, Clause (ii) of the Hindu Marriage Act 1955, makes a difference between an idiot and a lunatic, Section 3 Clause (5), of the Lunacy Act, 1912 regards an idiot as much a lunatic as a person of unsound mind. In a decree for annulment, by a decree of nullity, of a marriage on the ground of lunacy of the spouse, the burden to prove lunacy at the time of marriage lies on the petitioner.

The expression *psychopathic disorder* means persistent disorder or disability of mind, whether or not including sub-normality of intelligence which results in an abnormally aggressive or seriously irresponsible conduct on the part of the other party, and whether or not it requires or is susceptible to medical treatment.\(^\text{15}\)

A *psychotic disorder* involves distorted awareness and thinking. Two of the most common symptoms of psychotic disorders are hallucinations (the experience of images or sounds that are not real such as hearing voices) and delusions which are false beliefs that the ill person accepts as true, despite evidence to the contrary. Schizophrenia is an example of a psychotic disorder.\(^\text{16}\)

*Depression* can be defined as a clinical disorder which may be caused by various social factors. Most experts agree that while depression disorders decrease with age, depression symptoms decrease. The relationship between age and depression symptoms is curvilinear: younger and older people have the highest number of depression symptoms whereas middle aged people have the lowest.\(^\text{17}\)

The term *Mental Infirmity* and *Mental Unsoundness* has been discussed in the case of *Jai Prakash Goel v. State*.\(^\text{18}\) The Court observed that a person may not be adjudged as of unsound mind yet the court may nevertheless consider it appropriate to

\(^{13}\)The Indian Lunacy Act, 1912 was repealed by the Mental Health Act, 1987 which is further repealed by The Mental Healthcare Act, 2017.

\(^{14}\)AIR 1969 Cal 304.

\(^{15}\)The Hindu Marriage Act, 1955, s. 13(1)


\(^{17}\)Sumita Saha and Ruby Sain, *Depression among the Elderly* 39 (2012).

\(^{18}\)AIR 2005 Delhi 83 at 84 and 87.
appoint a guardian ad litem under Order xxxii Rule 15. However, the Court is not bound to make a rigorous or formal enquiry as contemplated by the Lunacy Act, 1912 and is competent to pass an order as soon as it is satisfied as to the party’s mental competence. There is a vast difference between mental unsoundness and incapacity by reason of mental infirmity, the latter being of a lesser degree. The Collins/Cobuild English Dictionary defines “infirm” as weak or ill and usually old. The Concise Oxford Dictionary states that “infirm” refers to a person who is not physically strong, especially through age. In Black’s Law Dictionary “infirm” has been defined as weak, feeble, lacking moral character or weak of health. Incapacity has been defined in the same treatise as want of legal ability of act. A person suffering from a low intellectual quotient (IQ) may not be viewable as of unsound mind, but there can be no gainsaying that he would be incapable of protecting his interests in litigation. The Mental Health Act, 1987, in Section 2(1) defines “mentally ill person” as one who is in need of treatment by reason of any mental disorder other than retardation, thereby drawing a distinction between these states of health. The Court held that there is no manner of doubt that Respondent, Shri Brahmparaksh is incapable of protecting his interests in the litigation by reason of his infirmity and infliction of an abnormally low IQ. Accordingly, the Court appointed Mrs. Meena Goel, wife of Shri Brahmparaksh, as his guardian ad litem.

The problem is not prevalent in adults but is also emerging in the children. Despite the strong commitment to child protection enshrined in the Indian Constitution and child related policies; the country’s progeny is at profound risk. The mental health problems cause great suffering to the child, their families, and communities and great loss to the society and nation. A healthy childhood lays the foundation for a healthy adulthood. Children and adolescents are valuable assets to families and nations and thus their overall wellbeing is a matter of a grave concern.19

Vignettes of depression and dementia were widely recognized. However, neither condition was thought to constitute a health condition. Dementia was construed as a normal part of ageing and was not perceived as requiring medical care. Thus, primary health physicians rarely saw this condition in their clinical work, but community health workers frequently recognized individuals with dementia. Depression was a common presentation in primary care, but infrequently diagnosed.

Both late-life mental disorders were attributed to abuse, neglect, or lack of love on the part of children towards a parent. There was evidence that the system of family care and support for older persons was less reliable than has been claimed. Care was often conditional upon the child’s expectation of inheriting the parent’s property. Care for those with dependency needs was almost entirely family-based with little or no formal services. Unsurprisingly, fear for the future and in particular dependency anxiety was commonplace among elderly.  

The competence of the psychiatrist to fill the role of mental hygienist raises additional questions. Within the field of mental hygiene, psychiatrists face new functions and goals; occasionally they assume or are assigned responsibilities which they are poorly equipped to fulfill. They have been trained as medical practitioners, but they are moving from their therapeutic role to invade such areas as education, social science and community organization. Indeed many of the weaknesses in the mental hygiene movement reflect the deficiencies that psychiatrists have brought to it.  

The crux of the problem here is that our model of medical education and training is not adequate to meet the demands of the rising burden. The psychiatrist community is aware of the problem, but the problem has not been addressed seriously.  

Marriage has also emerged as one of the important reason resulting into the increase of mental health problems. The relationship between marriage and mental health can be explored in several ways. Few important dimensions to this issue are as follows:

- Marriage as a stressful life event can lead to development of mental-health problems.
- Effect of marriage on mental health of men and women in the direction of protecting them against mental disorders.

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- Effect of marriage on pre-existing mental illness, e.g., Psychoses, alcohol use disorders.
- Outcome of marriage in major psychiatric disorders like schizophrenia.\textsuperscript{23}

Another prominent reasons are the process of urbanization and industrialization which is occurring at a rapid pace, a substantial number of persons would be experiencing such a transition (from rural to urban and/ or joint to nuclear) in their life time and therefore, being subjected to the stresses in terms of readjustments, reorientation and the making-breaking of human ties. It is known that urbanization is affecting the entire gamut of population especially the vulnerable sections of society - elderly, children and adolescents, and women.\textsuperscript{24}

The disability rights movement in India has achieved laudable goals on various fronts, but its greatest pitfall has been the neglect of the rights of persons with mental disabilities. This is a direct outcome of the lack of a strong leading organization, it is also due to the absence of a collective voice of several service focused organizations. This trend in the movement has created the lacunae in the law, both in letter and spirit. The gist of this prime criticism is that the law currently in force has not done and cannot do justice to the mentally disabled.\textsuperscript{25} The history of mental health legislations in India clearly demonstrate that though this need has long been recognized, legislative attempts to address the problem have not been satisfactory.\textsuperscript{26}

All persons with disabilities are largely thought of as having similar issues and facing similar violations, which assumes they need similar remedies. Access, housing, non-discrimination, violation of human rights, medical care, assistive aids and appliances may be amongst those concerns where both the mentally and the physically disabled stand on common ground. However, persons with mental disabilities have distinct and unique requirements, which can be classified into two line of thought.\textsuperscript{27} Firstly, the law has to provide the option of institutional care, subject to the need and informed consent of a mental health service user. This necessitates a

\textsuperscript{24}Ajit Avasthi, “Preserve and Strengthen Family to Promote Mental Health”, \textit{Indian J Psychiatry} 2010 Apr-Jun; 52(2):113–126.
\textsuperscript{25}Shruti Pandey, Priyanka Chirimar, \textit{et. al.}, \textit{Disability and the Law} 373 (2005).
\textsuperscript{26}Seshadri Harihar and Hiramalini Seshadri, “Needed: New Mental Health Act”, \textit{The Hindu}, Jan. 30, 2005.
\textsuperscript{27}Supra note 25.
complex analysis of the nature and extent to which institutional care and protection is required. It is as critical to study the element of consent involved in supervisory care and medication for which an independent legislation is required, which specifically and directly addresses the legal complexities of the issue. Secondly, the need is to address the vulnerability of the mentally ill and disabled who are constantly exposed to abuse and exploitation in their daily life. While addressing these needs it is important that the various aspects of human rights are kept in focus.\textsuperscript{28}

In India, as in other parts of the world, the traditional approach to the care of the mentally ill, during the last 200 years, was custodial rather than therapeutic. This system was built by the then rulers in the mould of the mental health care delivery system of contemporary Britain. To build a chain of mental hospitals and to introduce Western healing practices in them were conceived and executed by the East India Company. In the early phase of their development, (in late 18th century), mental hospitals were meant exclusively for the soldiers, who fought for their British masters against the Indian princes, the civilian officers of the East India Company and the white settlers.\textsuperscript{29}

In the early 19th century, experts and administrators believed that the tropical climate was one of the causes of mental disorders among the Europeans living in India. Accordingly European patients, who did not improve within six months after their admission in a mental hospital in India, were sent to England for treatment. The passage money and other expenses were paid by the East India Company as loan to be repaid by the recovered patient. The practice began in 1818. In course of time the cost-effectiveness of this exercise was called into question. In order to regulate the selection of such patients the need for enactment of a law became apparent. In 1851 the “Lunatics Removal Act” was passed. This Act has the dubious distinction of being the first mental health legislation in British India. In pursuance of this Act and the rules framed thereunder, the flow of patients gradually dwindled, till it came to an end in 1891.\textsuperscript{30}

The administration of justice in India during the colonial era was based on the British model. Political, social and philosophical ideas prevalent in the British public

\textsuperscript{28}Ibid.
\textsuperscript{30}Ibid.
life exerted a major influence on the contemporary legal system in Britain. The growing public awareness about the plight of mental patients in custody was instrumental in enacting laws for the regulation of asylums, prisons and the legal system as a whole. Thus the English Act of 1774 was replaced by the country Asylum Act of 1808 which in turn was replaced by Lunatic Act and Lunatic Asylum and Pauper Lunatics Act of 1845 as amended by (a) Lunacy Regulation Act, 1853 (b) Lunatic Care Treatment (Amendment) Act, 1853 and (c) Lunatic Asylums (Amendment) Act. 1853.\textsuperscript{31}

After the takeover of the administration of India by the British Crown (in 1858) a large number of laws were enacted in quick succession for controlling the care and treatment of mentally ill persons in British India. These enactments were modeled under the three English Acts of 1853.\textsuperscript{32} These were (a) The Lunacy (Supreme Court) Act, 1853 (Act 34 of 1858) (b) The Lunacy (District Courts) Act, 1858 (Act 35 of 1858) (c) The Indian Lunatic Asylums Act (Act 360 of 1858), (d) The Military Lunatics Act 1877 (Act 11 of 1877) (e) The Indian Lunatic Asylums (Amendment) Act, 1886 (Act 18 of 1886) (f) The Indian Lunatic Asylums (Amendment) Act 1889 (Act 20 of 1889).

In essence these Acts gave guidelines for establishment of mental asylums and codified the procedures of admitting patients. The aim of establishing asylums\textsuperscript{33} was to segregate those who were considered dangerous to the society by reasons of mental illness and not for treatment.\textsuperscript{34} During the second half of 19th century, along with the proliferation of mental health legislation, number of mental hospitals also increased in different parts of India. They fail to match the need of the community. Patients were incarcerated in these asylums for an indefinite period with very little chance of recovery and release. Consequently, by the end of the century overcrowding and its impact on the living condition of patients made these asylums a veritable inferno.\textsuperscript{35}

In the 20\textsuperscript{th} century awareness about the pitiable conditions of mental hospitals accentuated as a part of the growing political awareness and nationalistic views

\textsuperscript{31}\textit{Ibid.}
\textsuperscript{32}\textit{Ibid.}
\textsuperscript{33}Asylums were the places where insanes were kept for safe custody and not for proper treatment.
\textsuperscript{34}\textit{Supra} note 29.
\textsuperscript{35}\textit{Ibid.}
spearheaded by the Indian intelligentia. It resulted in the next phase of development of mental health legislation in India.36

Public resentment over the plight of mental patients was expressed through adverse criticism in the Indian press. It found its echo in the contemporary British press as well as in the British parliament. The government of India, thereupon, decided to tone up the administrations of the mental hospitals and the procedures of admission and discharge of inmates of those hospitals through a comprehensive Act. In 1911 a new bill was introduced in the council of the Governor General (Viceroy) of India with the intention to consolidate the various lunacy laws in force in India (those enacted during the period between 1858 and 1889) and to introduce certain amendments and especially to bring the law in certain important particulars in line with the modern English law i.e. the Lunacy Act 1890 as amended by the Lunacy Act 1891. After a careful consideration of all details by a Select Committee the bill was passed as the Indian Lunacy Act, 1912.37

The enactment of India Lunacy Act, 1912 had a far-reaching consequence and impact on the whole system of mental health services and administration in India. Under this new legislation the central supervision of all mental hospitals became a reality. This is a fundamental change in the management of mental hospitals. These hospitals were thus removed from the grip of the Inspector General of Prisons. The next most important change was the recognition of the role of specialists in the treatment of mental patients. Psychiatrists were appointed as full time officers in mental hospitals.38

These beneficial features apart, a dispassionate analysis of the Indian Lunacy Act, 1912 will lay bare the legacy of its predecessors enacted in the previous century. This Act also was obsessed with a persistent concern for the protection of the public from those who were considered dangerous to the society. Provisions of this Act have paid more attention to increase the legal safeguard against wrongful detention and proposed rigorous criteria for certification of the mentally ill. The law ensured an overriding power of the magistrate in the certification process. Thus an essentially clinical issue was over shadowed by a legalistic approach. The adverse effects of

36 Ibid.
37 Ibid.
38 Ibid.
these procedures were not far to seek. The condition of mental hospitals rapidly
deteriorated during the following three decades.\textsuperscript{39}

In 1946 Col. M. Taylor, Superintendent of European Mental Hospital at
Ranchi, as a member of the Health Survey and Development Committee, popularly
known as “Bhore Committee” was asked to survey the mental hospitals. According to
his report, there were 19 mental hospitals with bed strength of 10,181. He summed up
his observation in the following words. “The majority of mental hospitals in India are
quite out of date, and are designed for detention and safe custody without regards for
curative treatment.” Besides making several recommendations for the upliftment of
these hospitals, he observed that the Indian Lunacy Act, 1912 had outlived its utility.
Col. Taylor’s view must have been shared by his contemporaries in the psychiatric
fraternity.\textsuperscript{40}

It was in 1949 that the first editor of the Indian Journal of Psychiatry (then
known as the Indian Journal of Neurology and Psychiatry) Prof. N. De wrote
editorials to highlight the need of amending the Indian Lunacy Act, 1912. In the same
year the Indian Psychiatric Society in its second annual conference held at Allahabad,
passed a resolution (at the insistence of Prof. De) to move the Government of India to
repeal the Indian Lunacy Act, 1912 and to introduce a new mental health bill. As a
follow up of this resolution the IPS appointed, in 1949, an ad-hoc Committee of three
distinguished psychiatrists, namely, Dr. J. Roy of Nagpur, Dr. R.B. Davis and Dr. S.A.
Hasib of Ranchi. They met at Ranchi and prepared a draft “Indian Mental Health
Act.”\textsuperscript{41}

In 1959-60 an attempt was made, under instruction from the Government of
India, to suggest amendment to the 1912 Act. But the experts failed to reach a
consensus.\textsuperscript{42}

For about two decades the Government made no further efforts for enactment
of a new law on mental health. During this period great strides were taken in the
advancement of knowledge and understanding of the nature of mental disorders.
Attitudes of the society towards mentally ill persons had changed remarkably. Stigma

\textsuperscript{39}Ibid.
\textsuperscript{40}Ibid.
\textsuperscript{41}Ibid.
\textsuperscript{42}Ibid.
associated with mental disorders also was on the wane. There was growing demands and aspirations of the people to get better facilities and less rigid procedures for admission, treatment and discharge of mental patients. As far as possible mentally ill persons should be treated at par with any other sick person and the environment should be natural and familiar. This collective view was bolstered up by the principles of Alma Ata Declaration of 1978. The Government could hardly ignore this changed climate of opinion and responded to the concerted pressure of the people, professionals and policy makers by introducing the Mental Health Bill in parliament in 1981. It was referred to a joint Committee of Members of Parliament in 1982. Before the Committee could come to a decision the Lok Sabha was dissolved on 31st December, 1984. In 1985 a new Joint Committee went into the Bill, elicited public opinion, suggested some amendments and adopted it on 24th April, 1986. This amended Bill was passed by the Rajya Sabha on 26th November, 1986 and by the Lok Sabha on 19th March, 1987. The amendments made by the Lok Sabha were agreed to by the Rajya Sabha on 22nd April, 1987. The president’s assent was received on 22nd May, 1987, and it became the Mental Health Act, 1987.43

The continuing discrimination between the mentally and physically disabled has not yet been adequately addressed through legislation. The guarantee against discriminating between persons with mental disabilities and those with physical disabilities, discrimination amongst various forms and degrees of disabilities, and discrimination between the disabled and the non-disabled have all to be regarded as equally sacrosanct and inviolable. In the absence of a comprehensive anti-discriminatory law, the Mental Health Act continues to legalize involuntary treatment and institutional care.44

A statute of a similar nature was proposed in England, where the law society, the Royal college of Psychiatrists and 50 other organizations vehemently opposed it, as a result of which it could not be enacted. The lack of a cohesive and collective voice in the area of the rights of mentally disabled persons is probably why the Mental Health Act remains unchanged in India.45

43Ibid.
44Supra note 25 at 373-374.
45Id. at 374.
The advantages of a law like Mental Health Act were those provisions that do safeguard the interests of persons with mental illnesses. The statute had defined in detail the qualifications and duties of a legal guardian and/or manager of a mentally ill person. The Act also clarified that this is necessary only in those cases where the person is unable to manage his/her own property affairs. In several judgements, both under the Indian Lunacy Act and the Mental Health Act, the Courts have paid sufficient heed to the legal consequences and gravity of declaring a person to be of “unsound mind” and have directed that the inquisition must be conducted with as much as caution as possible. Nonetheless, the Courts have continued to adjudicate on the issue of the mental capacity of persons at the behest of litigants who vary from family and friends to distant relatives.

There is no doubt that the legislative intention was to protect the person and property of the mentally ill. This clarity of intention has not been lost on the judiciary, which has weighed applications for inquisition, appointment of guardians or managers and other applications under the Mental Health Act with befitting seriousness. However, this has not relieved the natural guardians, i.e. the parents, of the burden of having to approach the Courts to be appointed guardians of their own children upon them attaining the age of majority. The major shortcoming in this enactment is that government medical officers are not liable or responsible for making wrong or biased assessments. This single omission compromises the very persons that the Act seeks to protect – by not affixing any penalty for a falsified medical opinion, it permits the pivotal authority to go scot free for misuse its powers.

The Persons with Disabilities Act of 1995 rolled out a charter of rights to ostensibly empower and mainstream disabled persons as defined in Section 2(i) read with Section 2(t). But since the enactment, serious doubts have been raised whether the inclusion of mental retardation and mental illness in the definition of disability is


\(^{47}\)Ibid.

\(^{48}\)Ibid.
by accident or by intent. The definition of mental illness in Section 2(q) as “any mental disorder other than mental retardation” bears ample evidence of this. The definitions mentioned under the Act are not exhaustive in nature, and can only be regarded as an illustrative list of categories under mental disability.49

While the inclusion of mental illness and mental retardation in the list of the seven statutory disabilities is a victory for persons with mental disabilities, it seems more like an after-thought rather than an addition by intent. The Act on its own has never been used in any Court of law to fulfill any provision concerning persons with mental illness. This was merely an unconfirmed truth until research was undertaken for this compilation. During the exercise of screening various judicial pronouncements, it became apparent that collating judgments addressing the rights based issues of the mentally ill was going to be a far more difficult task than initially envisaged.50

The legal understanding of issues concerning mentally disabled persons is both limited and misguided.51 The Disabilities Act, 1995 entirely is also a big disappointment for persons with mental disabilities as a group. Not only does it met out step-motherly treatment, it fails to break free from the age-old definitions of mental disabilities that use terms such as ‘unsoundness of mind’ and ‘lunacy’. The absence of a category for learning disabilities has enforced a situation where persons with such disabilities are being added to the category of mental disabilities.52

In the Indian context, Article 14 of the Constitution provides that the State shall not deny to any person equality before law or the equal protection of the laws within the territory of India. It enjoins duty on the State not only to treat them at par but also it enjoins duty on it to bring them at par by taking remedial or assistive steps, if need be, so that both the categories of persons can exercise their fundamental rights on the footing of equality. Even the preamble of the Constitution contains solemn resolution securing to all its citizens justice, social, economic and political, liberty of thought, expression, belief, faith and worship and equality of status and opportunity. Similarly, Article 39-A provides that the State shall secure that the operation of the legal system promotes justice, on a basis of equal opportunity, and shall, in particular,

49Ibid.
50Id. at 374 -375.
51Id. at 375.
52Ibid.
provide free legal aid, by suitable legislation or schemes or in any other way, to ensure that the opportunities for securing justice are not denied to any citizen by reason of economic or other disabilities. Thus no one can be subject to any disadvantage because of any disability or disabilities. Article 41 also provides that the State, within the limits of its economic capacity development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age sickness and disablement, and in other cases of undeserved want.\(^{53}\) The Constitution of India, 1950 provides under Article 21 that no person shall be deprived of his life or personal liberty except according to procedures established by law. It has been held that right to life and personal liberty under this article includes “facilities for reading, writing and expressing oneself in diverse forms, freely moving about and mixing and comingling with fellow human beings.”\(^{54}\) The Constitution of India, 1950 does not expressly talks about mentally ill persons. The Mental Health Act also does not consolidate the laws governing persons with mental disabilities. Recent enactments, such as Medical Termination of Pregnancy Act, 1971 allow the termination of pregnancy on the grounds that the child may be born with a serious physical or mental disability. Of course mention has to be made of archaic laws such as the Prisons Act, which continues to apply the Indian Lunacy Act of 1912 to determine the procedure for dealing with mentally ill convicts. This continues despite the fact that the Criminal Procedure Code, 1973 (CrPC) lays down extensive procedural laws for when the accused is found to be mentally ill or disabled.\(^{55}\)

The Criminal Procedure Code, 1973 goes so far as to permit the acquittal of a person on those grounds, notwithstanding whether the person was found guilty or not - a finding which has to be stated in writing. The Criminal Procedure Code, 1973 provides for this considering that the accused may not have been in a position to know the nature of the act committed and may not be able to make out a proper case in his defense.\(^{56}\) For this reason, the Code also empowers the Magistrate with discretionary powers to release the mentally disabled accused into proper care and protection.


\(^{55}\)Supra note 25 at 375.

\(^{56}\)Sections 328-329 of chapter 25 of CrPC contains provisions as to the accused person of unsound mind.
pending trial, even in the absence of a bail application.\textsuperscript{57} Sections 328 and 329 of Criminal Procedure Code, 1973 require determination of unsoundness of mind at two intensities: one to initiate an enquiry into the state of mind of the accused and other to decide whether the trial should be postponed. For initiating an enquiry, a finding of unsoundness of mind is only a threshold requirement. A further determination that the disability renders the accused incapable of defending himself/herself is also required.\textsuperscript{58} The Magistrate is further empowered, in cases where the accused pleas “temporary insanity”, to stay the trial till the accused ceases to be so affected. However, it is precisely due to this very provision that mentally ill persons have sometimes languished in prisons for decades as their cases were forgotten till the media brought them alive again. It is also noteworthy that the inquisition into the mental illness or disability of the accused is considered to be a part of his trial and the findings are accordingly noted.\textsuperscript{59}

These are similar anomalies in the personal family laws governing marriage and divorce. “Unsoundness of mind” is a well accepted and a highly abused ground for seeking the annulment of marriage. Husbands looking for an easy way out have mostly exploited these provisions.\textsuperscript{60}

Other judgments concerning persons with the mental illness and disabilities are mostly in the form of Public Interest Litigation\textsuperscript{61} wherein eminent jurists and members of civil society have approached the Apex Court to intervene in the administration and maintenance of mental health service providers and institutions. Infact, when the rule of ‘locus standi’ was relaxed, the practice of filing Public Interest Litigation emerged with a number of cases being filed seeking the Courts intervention in the management of state-run mental health institutions, on behalf of the mentally ill inmates. The Apex Court has time and again inquired into the day-to-day running of government hospitals where the basic human rights of the patients were violated and their detention seemed unremitting due to the callous attitude of the authorities.\textsuperscript{62}

\textsuperscript{57}Supra note 25 at 375.
\textsuperscript{58}Amita Dhanda, \textit{Legal Order and Mental Disorder} 88 (1\textsuperscript{st}edn., 2000).
\textsuperscript{59}Shruti Pandey, Priyanka Chirimar, \textit{et. al.}, \textit{Disability and the Law} 375 (2005).
\textsuperscript{60}Ibid.
\textsuperscript{62}Id. at 376.
1.2 PROBLEM PROFILE

According to WHO’s Mental Health Atlas of 2005 a meta–analysis of 13 psychiatric epidemiological studies (n = 33,572) yielded an estimated prevalence rate of 5.8% in the world. Organic psychosis (0.04%), alcohol/drug dependence (0.69%), schizophrenia (0.27%), affective disorders (1.23%), neurotic disorders (2.07%), mental retardation (0.69%) and epilepsy (0.44%) were commonly diagnosed.\footnote{WHO, Mental Health Atlas (2005) available at: http://apps.who.int/globalatlas/predefinedReports/MentalHealth/Files/IN_Mental_Health_Profile.pdf (Visited on Aug. 31, 2013).} Epilepsy and hysteria were common in rural communities. According to Nandi et.al. in 2000 reported that psychiatric morbidity decreased from 11.7% to 10.5% over 20 years in a rural setting. Another author Rao reported that mental morbidity was present in 8.9% of the elderly (above 60 years), with depression being the most common disorder (6%). Psychiatric morbidity was associated with physical diseases.\footnote{Ibid.} The rate of dementia was reported to be in the range of 0.8% to 3.4% and that of Alzheimer’s disease in the range of 0.6% to 1.5%. Gender (female) and age were associated with higher prevalence rates.\footnote{Ibid.} Almost 6.9% of children were assessed as having disabilities. There are 50 million children under 18 years who could benefit from specialist services. As regards adolescents, 20 million are projected to have a severe mental disorder. Unfortunately 90% of children with a mental health disorder are not receiving any specialist services.\footnote{Usha S. Nayar (ed.), Supra note 19.} There are limited child and adolescent mental health services in India. Mostly such services are restricted to urban areas.\footnote{P. C. Shastri, “Promotion and Prevention in Child Mental Health”, Indian J Psychiatry, 2009 Apr-Jun; 51(2):88–95.} In India, neuropsychiatric disorders are estimated to contribute to 11.6% of the global burden of disease (WHO, 2008).\footnote{WHO, Mental Health Atlas (2011). available at: http://www.who.int/mental_health/evidence/atlas/profiles/ind_mh_profile.pdf (Visited on Aug. 31, 2013).}

We are facing a global human rights emergency in mental health. All over the world people with mental disabilities experience a wide range of human rights violations. In many countries people do not have access to basic mental health care and treatment they require. In others, the absence of community based mental health care means the only care is available in psychiatric institutions which are associated
with gross human rights violations including inhuman and degrading treatment and living conditions. Even outside the health care context, they are excluded from community life and denied basic rights such as shelter, food and clothing, and are discriminated against in the fields of employment, education and housing due to their mental disability. Many are denied the right to vote, marry and have children. As a consequence, many people with mental disabilities are living in extreme poverty which in turn, affects their ability to gain access to appropriate care, integrate into society and recover from their illness.\(^{69}\) In the empirical study data also supports that they are neither ill nor well, neither dead nor alive, neither really excluded nor really included in society.\(^{70}\) These failures of inclusion or integration that may be experienced by disabled people translate into loss of, or difficult access to, a place in society, a permanent move to the sidelines.\(^{71}\)

The researcher has observed during the research that mental illness is extremely common in society. Mental problems are increasing part of health problems. We all have a social responsibility to tackle the issue of mental health problems.

### 1.3 REVIEW OF LITERATURE

The topic of mental health needs urgent and deserving attention. It requires in-depth understanding and research. The existing available literature is not much in abundance but significant material in print which could be laid hands on, has been studied for the review.

#### 1.3.1 Books

**Dr. S. K. Awasthi and R. P Kataria**, in their book “*Law Relating to protection of Human Rights*”,\(^{72}\) in chapter-4 entitled “*Human Rights and Disability*”\(^{73}\) have discussed the human rights of persons with disability. They have examined the rights of disabled persons under the Persons with Disabilities Act, 1995. The textbook is divided into 42 chapters. The book is of little help as only one chapter in this book


\(^{70}\)Renu Addalakha, Stuart Blume, et. al. (eds.), *Disability and Society: A Reader* 27 (2009).

\(^{71}\)Ibid.


\(^{73}\)Id. at 113-139.
is relating to my thesis work. As my research work focuses on the law relating to mental health the book helps me to understand the rights under Persons with Disabilities Act, 1955.


**S.P. Singh Parmar and Shreyas S. Desai**, in their book entitled “Law of Disability”, have dealt with all important topics and principles relating to legislation of all kinds of disability. The book is divided into 11 chapters. Chapter-3 and 4 dealt with mental illness. In chapter-3, entitled “Mental Health” authors have defined terms such as “mental disorder”, “insanity”, “psychopathic disorder”, “lunacy”, “unsound mind”, “idiot” etc. The authors have made a distinction between legal insanity and medical insanity. After discussing about the classification of mental diseases, symptoms of mental disability available laws and programmes in the field of mental health the authors have given a detailed exposition about the civil and criminal responsibilities of mentally disabled person in chapter-4 entitled “Responsibility of a Mentally Disabled Person.” They have stated that the person and property of a mentally ill person has been protected by various statutes. Guardian or manager can be appointed for the property of mentally ill person under the Mental Health Act, 1987. As my research work focuses on Law relating to mental health in India the book help to understand the present legal provisions relating to mental disability in India.

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75. *Id.* at 102-142.
77. *Id.* at 15-24.
78. *Id.* at 25-29.

Sumita Saha and Ruby Sain, in their book entitled “Depression among the Elderly”, have exhaustively discussed about the problem of depression in old age. The book is divided into 6 chapters. The book is the outcome of research work based on Kolkata Metropolitan city. The authors have examined depression as a rampant problem in the neo-liberal globalised world. They have stated that depression is a clinical disorder but is grounded in social factors. It is the commonest and most reversible mental health problem in old age. With the advent of industrialization and globalization joint family system has crumbled down and along with it the traditional care system of the elders has been disturbed. In this book best of efforts have been made by the authors to explore the rampant incidence of depression among the affluent urban elderly. They have stated that despite the decrease in suicide rates since 1990, however older adults, specifically, older men, commit suicide more often than younger men. The book helps to understand the problem of depression among the elderly which is a part of my thesis.

79Shruti Pandey, Priyanka Chirimar, et. al., Disability and the Law (Human Rights Law Network, New Delhi, 2005).
Id. at 321-369.
81SumitaSaha and Ruby Sain, Depression among the Elderly (Serials Publications, New Delhi, 2012).
The book entitled, “Disability and Society: A Reader”, edited by Renu Addalakha, Stuart Blume, Patrick Devlieger, Osamu Nagase and Myriam Winance examines the issue of disability and rehabilitation in Europe, North America and Asia. The book is divided into 5 parts. It comprised of 20 articles written by different writers. The first part of the book deals with some of the social and cultural factors that shape impairment and provided resources with which to analyse those factors have been introduced. The articles in part one made it clear that impairment cannot be reduced to a biological reality, that it is also a social and cultural reality. In this book Jean Francois Ravand and Henri Jacques Striker, in an article in part 1, entitled “Inclusion/Exclusion: An Analysis of Historical and Cultural Meaning” have stated that the failures of inclusion or integration that may be experienced by disabled people translate into loss of, or difficult access to, a place in society, a permanent move to the sidelines. Studies of the historical treatment of disability, as well as anthropological studies on the same theme, show that the exclusion of disabled persons through time and across civilisations has assumed, and assumes, extremely diverse forms within the society. They have tried to draw up a typology of different forms of exclusion, whether they are social, geographical, cultural, judicial, while comparing the forms of inclusion that seek to offset them. The book helps to understand the role of society in the life of a disable person and help me to propose the reforms needed in the thesis.

The book entitled, “Child and Adolescent Mental Health” edited by Usha. S. Nayar, exhaustively dealt with mental health and well-being of children and adolescents. The book is divided into 22 sections. The book addresses to the evolving notion of childhood and its complexities all over the world, vulnerable to tension, stress, fear, stigma, anxiety, and violence; and at the same time also provides solution in overcoming difficulties and influencing action as an agent of change. The authors emphasize about the critical role of the family, of care givers, and of professional services in the prevention and treatment of children’s mental health

82Renu Addalakha, Stuart Blume, et. al., (eds.), Disability and Society: A Reader (Orient Blackswan Private Limited, New Delhi, 2009).
83Inclusion here means acceptance by the society and full participation in normal activities of the society and exclusion means detaching groups and individuals from social relations and institutions and preventing them from full participation in the normal, normatively prescribed activities of the society in which they live.
84Usha. S. Nayar (ed.), Child and Adolescent Mental Health (Sage Publications India Private Limited, New Delhi, 2012).
85Chapters are referred in this book as sections.
problems. The authors also have discussed about the risk of pressure, stress, violence, and abuse these institutions may provoke on children. In section 22 entitled, “Mental Health of Children and Adolescent in Contemporary India” the authors, Usha S. Nayar and Shankar Das have discussed about the position of mental health of children and adolescent in India. They have pointed out that the mental health services for child and adolescent are very low in India and such services are restricted to urban areas only. The book is helpful in chapter pertaining to mental health where it is necessary to mention the problems of child mental health.

The book entitled, “Meeting the Mental Health needs of Developing Countries: NGO innovations in India”, edited by Vikram Patel and R. Thara, exhaustively dealt with the innovative NGO programmes on mental health in India. The book is divided into 6 parts. Numerous issues related to NGO sector in general such as sustainability of programmes, accountability, transparency, credibility, fundraising issues, attitudes and skills of staff, staff burnout, replicability of programmes etc. have been discussed in this book. The authors Vikram Patel and R. Thara begins by discussing the role of NGO’s in the field of mental health. The founding, objective, experience, programmes etc. of some of the NGO’s like SCARF, Medico-Pastoral Association, RFS, Paripurna, Ashagram, Samadhan, Sangathan, Research Society for the Care Treatment and Training of Children in Need of Special Care, Antarnad, IFSHA, SNEHA, Prerana, AMEND, ARDSI etc. have been dealt in this book. Finally in the concluding chapter Vikram Patel and R. Thara have given an overview of the rest of the chapters with specific focus on generating a consensus on the role, contributions and future strategies/plans of NGO’s working in mental health and allied fields. They have examined the strength and weaknesses of NGO framework for meeting the mental health needs of the community. The book helps me in understanding the role of NGO’s in the field of mental health which is very important for my research work as it help me propose a reform needed in the thesis.

The book entitled, “The Community Mental Health Centre: Strategies and Program”, edited by Allan Beigel and Alan I. Levenson, have treated primarily the problems related to community mental health centre planning, organisation, and

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86 Vikram Patel and R. Thara (eds.), Meeting the Mental Health needs of Developing Countries: NGO innovations in India (Sage Publications India Pvt Ltd, New Delhi, 2003).
programming. The book comprised of 13 chapters. Its contents serves as a record of achievement; but perhaps even more importantly, it may serve as an impetus for future development of community mental health services within the far broader context of human services required and increasingly demanded by the population. The book is mainly concerned about the community mental health centres in America and related legislation i.e Community Mental Health Centres Act of 1963. While discussing about the community Mental Health Centres Act, the authors Allan Beigel and Alan I. Levenson in their article entitled “The Community Mental Health Centre: Origin and Concepts” in chapter-1 have explained the basic concepts embodied in the Community Mental Health Centres Act of 1963. These are: community oriented programs with accessibility of care; comprehensive services; continuity of care; and emphasises on prevention and treatment. Each of these had to be operationally defined for the purposes of the act and the federal program authorised by it. They have also suggested that the allocation of funds to each state was to be determined on the basis of a formula which took into account the total population size of the state and its socio-economic status. In chapter-2 the author, Jack Zusman, in his article entitled “Community Mental health Centre Planning” has explained the concept of catchment area.\textsuperscript{88} The book helps to understand as to how the community mental health centres work in America and how much the community mental health centre and related legislation are successful there and it helps me to provide a solution needed in the thesis.

Roger Bastide, in his book entitled, “Sociology of Mental Disorder”,\textsuperscript{89} has explained that there are two schools of thought which are still in conflict today: the first looks for social factors in mental disorder and second school rejects social factors and tries to define the social effects of the increase in mental illness. There are total 11 chapters in this book. The book is the result of research work undertaken in America, Chicago, Paris, Scotland, Israel and Perth. The author has defined the term “social psychiatry”. While explaining the importance of sociogenesis in aetiology of mental disorder, he has discussed the role of social factors. The author has also examined certain variables, such as sex, age or race, which are biological categories, to see whether they really behave like biological categories or more like social ones and if

\textsuperscript{88}The catchment area may be defined as the geographical area containing the population which a community mental health centre serves.

these biological categories act as social categories. He has pointed out that paranoid schizophrenia occurs primarily in families where the child is rejected by his parents, and that catatonic schizophrenia tends to occur in over protective families. He has discussed about the role played by insane in the society. He has stated that they are part and parcel of society. He has tried to bridge a gap between the mentally ill and society. He has stated that the crises of the society or crises in the family within which delusions or depressions of the adult are shaped. The traumas or contradictions of religious, ethnic or economic groups, even if they are not considered causes of disorder, introduce themselves into psychic mechanisms and disturb their functioning. The neurotic and psychotic do not remain unaffected, any more than the sane person, by these subtle, unconscious influences, these pressures or constraints from the environment. But what is more important, even if we do not accept admission to a mental hospital as the sole criterion of mental illness, we have become aware that the definition of madness is always a social phenomenon; it varies according to place and time. The author in this book have dealt with the issue of insanity as essentially a social phenomenon which provides me the concept of role of society in the field of mental illness in my thesis work.

Steven P. Segal and Uri Aviram, in their book entitled, “The Mentally ill in Community Based Sheltered Care: A Study of Community Care and Social Integration”, have dealt with the very important question of whether it is most efficient, most effective, and in the best interest of mentally ill individuals to have them in mental institutions or asylums which are state owned or whether we should care for our mentally ill in local, privately owned community facilities, which are subsidized by local or state government. The book is composed of 7 parts. The authors have examined the life of the mentally ill in community sheltered care and offer some insight into the factors that may help move the system toward offering better care. The findings on community care of the mentally ill reported in the book are taken primarily from the situation in California. These findings and the insights the authors offers us are not, however, unique to California; they may be used to develop an understanding of the mentally ill in community based sheltered care facilities in other countries also, wherever a similar community based care for the

90Steven P. Segal and Uri Aviram, The Mentally Ill in Community Based Sheltered Care: A Study of Community Care and Social Integration (A Wiley Interscience Publication, 1978).
mentally ill is being made. In this book the authors have discussed about the community response as a major unanticipated consequence of the move to the community care. They have also examined the facilities themselves, the neighbourhoods in which they are situated and the relationships between these facilities and their neighbourhoods. They have highlighted the facilities and drawbacks of community based shelter based system. They concluded by stating that with all the drawbacks the community shelter care system has and it offers an opportunity to explore a new and untried mode of caring for the chronic mentally ill. At least shelter care environment is a place where there is more freedom to determine one’s personal life then there was in the hospital. The book helps to understand about the Community Shelter Care System in California which would help me to deduct a reform which forms the ground for my thesis.

Ivan Belknap, in his book entitled “Human Problem of a State Mental Hospital”,\(^9\) has presented a 3- year study of the social organisation of one hospital of America i.e. Southern State Hospital by a sociologist and his staff. It is of particular interest as it is an important study of its extent and kind to be made of a state mental hospital. The book composed of 12 chapters. The author has proposed recommendation for reorganization of the hospital based on interpretation of findings. The author pointed out difference between psychiatric theory and practice from the patient’s admission to discharge. The problems of overcrowding, deficits of staff, the indifferent attitude of hopelessness relating to patient’s recovery, neglect, abuse and animosity of personnel towards each has also been discussed in the light of the historical development of the hospital. The author presents a detailed exposition of the formal and informal organisation for all levels of administration. The informal system exercises the control. The informal system is viewed as a survival by the persons who worked as attendants and volunteers. Dr. Berknap holds that, all human problems outlined in the report are directly or indirectly the result of a failure of those concerned with mental health to see and upon the incompatibility of centralization, large size and residential welfare responsibility of the hospital with the spirit and most of the technique of modern psychiatry. He has recommended for the reduction in patient load in hospitals by exclusion of those patients who do not have specific mental disorder and a thorough alteration in the administration of the hospital. The

book helps to understand the problems in the administration of hospitals which is also a part of my thesis work.

Dr. Nandita Adhikari, in her book entitled “Law and Medicine”,92 has discussed in chapter-12 entitled “Mental Health” about the historical background, types, causes, prevention and treatment of mental illness. The book is divided into 14 chapters. The author has stated the factors of mental illness as: 1. Organic, 2. Heredity 3. Socio-economic factors such as 1.Toxic substance— Intake of toxic substances like carbon disulfide, mercury, manganese, tin, lead compounds etc. may cause mental disorder. 2. Psychotropic drugs—Barbiturates, alcohol and griseofulvin. 3. Nutritional wants—Deficiency of thiamine and pyridoxine. 4. Mineral wants—Deficiency of iodine. This has been corrected by adding iodine to cooking salt. 5. Infective agents—Infectious disease (e.g., measles, rubella) during prenatal, perinatal and post-natal periods of women's life may have adverse effects on the development of brain and integration of mental functions of the child. 6. Traumatic impact—Injury to brain caused by road and occupational accidents. Physical violence causing head injury may lead to mental illness. 7. Radiation—Nervous system is impaired by radiation during the period of neural development. Pregnant women are barred from x-ray procedure. The author has mentioned stages of human life cycle important for the mental growth of human beings. During these stages due care is needed. These are: 1. During Pregnancy:-For the well being of both the mother and the child all out help is to be provided. Maternal malnutrition and anaemia lead low birth weight (less than 2.5). In India, about 30% babies are born with low birth weight. 2. Childhood:-It is during childhood that mental health develops. Not only nutritional food, milk, parental love, worth company and care. 3. School life:-Teacher-student relationship and easy classroom climate build mental health of the child and he learns with eagerness. 4.Adolescence:- For children of uncaring parents and bad company, the transition may be stormy leading to mental illness. Affectionate parents can guide them to tide over this difficult stage of life. Failure to recognise their basic needs may prevent even growth of mental health. 5. Old age:-Ageing and diseases related to old age cripple human beings both physically and mentally. Old age needs sympathy, care and love. As my research focuses on mental health it helps me to deduct the basic factors of mental illness.

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The book entitled, “Mental Health: An Indian Perspective”,\textsuperscript{93} edited by S. P. Agarwal, has discussed at length the position of Mental Health in India from 1946-2003. The authors have discussed about the affects of mental illness. The negative implications such as include alcohol and substance abuse, delinquent behaviour and impaired quality of life. Inappropriate risk-taking behaviour patterns contribute to major public health problems such as HIV/AIDS and road accidents. The development of National Mental Health Programme has been discussed in this book. The National Mental Health Programme (NMHP), launched in 1982, with the objective of the treatment of mental disorders within the community, using the existing primary health centre and community health centre staff. Unfortunately, however, the subsequent progress in the implementation of this programme was not satisfactory. After the incident of the Ramanathapuram district of Tamil Nadu, where 25 mental patients who had been kept chained in a asylum were burnt to death, drew national attention to the plight of the mentally ill, a small group was constituted in the Directorate General of Health Services to analyse the causes of this under-performance and to suggest corrective measures. The Supreme Court issued directions to collect the information. Then NMHP completely reviewed. The book describes exhaustively about the research and training at different levels in the field of mental health and the issues like mental health of special groups like children, women and old age. The book provides recommendations for important changes in this field and directions for the future planning. The book is useful to understand fully the historical development of mental health programmes which is relevant for my thesis work.

George Rosen, in his book entitled “Madness in Society: Chapters in the Historical Sociology of Mental Illness”,\textsuperscript{94} has discussed the historical sociology of mental disorder. The book is divided into 3 parts and which is further divided into 18 chapters. The book is the product of research undertaken in London. The author has discussed the place of mentally ill person in societies at different historical periods. He has discussed mental disorder considering it within a society. He examined mental disorder as a problem in the community, the causes and factors of mental disorder and


development of institutions for the control and treatment of mental illness. This book is very helpful to me in understanding the relationship of mental disorder and society.

B.S. Chavan, Nitin Gupta, Priti Arun, Ajeet Sidana and Sushant Jadhav in their book entitled “Community Mental Health in India”, have discussed about the practice of community mental health services in India. The focus in the book has been on Community Mental Health and not specifically restricted to Community Psychiatry. The book is divided into xiii Sections and 62 chapters. Chapter 2 of the book titled as “Psychiatry in India: Historical Perspective” in which historical development of Psychiatry has been discussed and Section iv of the book titled as “Legislative Aspects” which deals with the law on mental health. The book is useful to understand fully various aspects of community mental health in India which is relevant for my research.

1.3.2 Articles

Choudhary Laxmi Narayan and Deep Shikhali in their article entitled, “Indian legal System and Mental Health”, has discussed important legal provisions in respect of the mental illness in the Indian legal system. They have stated that as most of the laws were either framed during the colonial period or their origin can be traced to the period, British influence is clearly visible. Laws in respect of the mental health are presently on crossroad as most of them are under revision to bring them harmony with the UNCRPD-2006.

According to Indian Contract Act, 1872, any person of sound mind can make a contract. Section 12 of the Act stipulates that a person is said to be of sound mind for the purpose of making a contract, if, at the time when he makes it, he is capable of understanding it and of forming a rational judgment as to its effect upon his interest. A person, who is usually of unsound mind, but occasionally of sound mind, may make a contract when he is of sound mind. A person, who is usually of sound mind, but occasionally of unsound mind, may not make a contract when he is of unsound mind. It means a PMI who is currently free of the psychotic symptoms can make a contract.

95B.S. Chavan, Nitin Gupta, et. al.,Community Mental Health in India (Jaypee Brothers Medical Publishers,2012).
whereas a person who is currently intoxicated or delirious cannot make a contract.\textsuperscript{97} Under the Hindu Marriage Act, 1955, conditions in respect of mental disorders, which must be fulfilled before the marriage is solemnized under the Act, are: 1. Neither party is incapable of giving a valid consent as a consequence of unsoundness of mind. 2. Even if capable of giving consent, must not suffer from mental disorders of such a kind or to such an extent as to be unfit for marriage and the procreation of children. 3. Must not suffer from recurrent attacks of insanity. According to the Section 13 of the Act, divorce or judicial separation can be obtained if the person has been incurably of unsound mind, or has been suffering continuously or intermittently from mental disorder of such a kind and to such an extent that the petitioner cannot reasonably be expected to live with the respondent.\textsuperscript{98} Testamentary capacity is the legal status of being capable of executing a Will, a legal declaration of the intention of a testator with respect to his property, which he desires to be carried into effect after his death. Section 59 of the Indian Succession Act, 1925, stipulates that: 1. Any person of sound mind can make a Will. 2. Persons, who are ordinarily insane, may make a Will during an interval while they are of sound mind. 3. No person can make a Will while he is in such a state of mind, whether arising from intoxication or from illness or from any other cause, so that he does not know what he is doing.\textsuperscript{99} Indian Penal Code, 1860, Section 84 states that “Nothing is an offence, which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law.”\textsuperscript{100} The article helps me to understand the rights available to persons with mental illness under various legislations in the Indian legal system which is quite relevant for my research work.

\textbf{Gauranga Banergee} in his article entitled “\textit{The law and mental health: an Indian perspective}”,\textsuperscript{101} has discussed about the mental hospitals of late 18\textsuperscript{th} century, 19\textsuperscript{th} century and 20\textsuperscript{th} century and early legislations relating to mental health. He enumerates instances of early legislation relating to mental health which includes: (a) The Lunacy (Supreme Court) Act, 1853 (Act 34 of 1858) (b) The Lunacy (District Courts) Act, 1858 (Act 35 of 1858) (c) The Indian Lunatic Asylums Act (Act 360 of

\textsuperscript{97}Ibid.  
\textsuperscript{98}Ibid.  
\textsuperscript{99}Ibid.  
\textsuperscript{100}Ibid.  
\textsuperscript{101}Supra note 29.
1858), (d) The Military Lunatics Act 1877 (Act 11 of 1877) (e) The Indian Lunatic Asylums (Amendment) Act, 1886 (Act 18 of 1886) (f) The Indian Lunatic Asylums (Amendment) Act 1889 (Act 20 of 1889). He has widely discussed the history and scope of The Indian Lunacy Act, 1912 and The Mental Health Act, 1987. The author contends that during the last four or five years the Mental Health Act, 1987 has been subjected to incisive scrutiny in many regional and national seminars. As a result, imperfections, lacunae, absurdities and discriminations have been detected in it. Finally he concluded that the Mental Health Act, 1987 is essentially a social welfare measure. Like any social welfare measure it has an in–built mechanism for improvement of its functioning and checks and balances for regulation of its malfunctioning. The outmoded Indian Lunacy Act, 1912 and the Lunacy Act 1977 have already been repealed. Mental Health Act, 1987 should be given a fair trial which has been enacted with the aim of creating conditions for treatment of mental disorders according to modern methods and concepts where human rights would be protected. This article provides me great help in my thesis work as it deals with the historical development in the field of mental health.

P. C. Shastri, in his article entitled, “Promotion and Prevention in Child Mental Health”102 has discussed about the limited child and adolescent mental health services, clinical preoccupation of the available mental health professionals of the country and the delay of these professionals to spearhead work towards promotion, prevention, identification and early intervention in child mental health in India. He has pointed out that around 90% of children with a mental health disorder are not currently receiving any specialist service. He has given a list of areas need attention for promotion, prevention, identification and intervention in child mental health. He has discussed the major national policies and legislations formulated in the country to ensure child rights and improvement in their status. They include: National Policy for Children, 1974, National Policy on Education, 1986, National Policy on Child Labour, 1987, National Nutrition Policy, 1993, National Health Policy, 2002, National Charter for Children, 2004 and National Plan of Action for Children, 2005. There is neither an independent nor integrated child mental health policy in India. He has discussed the role of in preschool and school environment for the prevention of behaviour disorders in children. His significant contribution is in the fact that he

102 Supra note 67.
suggested for the prevention, promotion, early identification and intervention in child mental health. He has suggested about the need of a multi-disciplinary team or service working in a community mental health clinic or child psychiatry outpatient service, providing a specialised service for children and adolescents with more severe, complex and persistent disorders. This team may include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists. Finally, he has concluded by stating that there is a wide gap between identifying needs, planning, developing policies and effective implementation. But there is a hope when concerned authorities continue to take the matter seriously and address the preliminary rights that aid in child’s mental health issues. The article is about the child’s mental health and it is helpful to me as it also a part of my research.

For tracing the international laws and policies on mental disorder, the researcher has taken the help of website Wikipedia,\textsuperscript{103} the free encyclopaedia, Wikipedia defines ‘mental disorder’ as a psychological pattern or anomaly, potentially reflected in behaviour, that is generally associated with distress or disability, and which is not considered part of normal development in a person's culture. In the article dealing with “society and culture” explains that three quarters of countries around the world have mental health legislation. Compulsory admission to mental health facilities (also known as involuntary commitment) is a controversial topic. It can impinge on personal liberty and the right to choose, and carry the risk of abuse for political, social and other reasons; yet it can potentially prevent harm to self and others, and assist some people in attaining their right to healthcare when they may be unable to decide in their own interests. All human rights oriented mental health laws require proof of the presence of a mental disorder as defined by internationally accepted standards, but the type and severity of disorder that counts can vary in different jurisdictions. The two most often utilized grounds for involuntary admission are said to be serious likelihood of immediate or imminent danger to self or others, and the need for treatment. Applications for someone to be involuntarily admitted usually come from a mental health practitioner, a family member, a close relative or a guardian. Human-rights-oriented laws usually stipulate that independent medical

practitioners or other accredited mental health practitioners must examine the patient separately and that there should be regular, time-bound review by an independent review body. The individual should also have personal access to independent advocacy. In order for involuntary treatment to be administered (by force if necessary), it should be shown that an individual lacks the mental capacity for informed consent (i.e. to understand treatment information and its implications, and therefore be able to make an informed choice to either accept or refuse). Legal challenges in some areas have resulted in Supreme Court decisions that a person does not have to agree with a psychiatrist’s characterization of the issues as constituting an “illness”, nor agree with a psychiatrist’s conviction in medication, but only recognize the issues and the information about treatment options. Proxy consent (also known as surrogate or substituted decision-making) may be transferred to a personal representative, a family member or a legally appointed guardian. Moreover, patients may be able to make, when they are considered well, an advance directive stipulating how they wish to be treated should they be deemed to lack mental capacity in future. The right to supported decision-making, where a person is helped to understand and choose treatment options before they can be declared to lack capacity, may also be included in legislation. There should at the very least be shared decision-making as far as possible. Involuntary treatment laws are increasingly extended to those living in the community, for example outpatient commitment laws (known by different names) are used in New Zealand, Australia, the United Kingdom and most of the United States. The World Health Organization reports that in many instances national mental health legislation takes away the rights of persons with mental disorders rather than protecting rights, and is often outdated. In 1991, the United Nations adopted the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, which established minimum human rights standards of practice in the mental health field. In 2006, the UN formally agreed the Convention on the Rights of Persons with Disabilities to protect and enhance the rights and opportunities of disabled people, including those with psychosocial disabilities. The term insanity, sometimes used colloquially as a synonym for mental illness, is often used technically as a legal term. The insanity defense may be used in a legal trial (known as the mental disorder defence in some countries). The article helps me to understand the concept of mental disorder and legislative measures relating to mental disorder at the
international level which will further help me in chapter relating to international law relating to mental health.

James T. Antony, in his article entitled, “On Drafting a New Mental Health Act”,\(^\text{104}\) has advanced arguments in favour and against Mental Health Act, 1987 and scope of Mental Health Act, 1987. He has stated that the two words in the Act, namely ‘Licensing’ and ‘Inspectors’ are the ones that are totally unacceptable to many critics. But we cannot do away completely, with regulatory mechanisms, in vital sectors. It is true that a licensing system could be a source of corruption. But the mentally ill are different. They would need some legal provisions, to protect their basic human rights. Any licensing system needs to be rational and must have a clear purpose of realizing objectives of the Act. Another thing is that the present flaws in the matter of appointing inspectors must be removed. Non-professionals from having access to confidential medical records regarding patients, in the name of inspection should be bared. The government departments are to have permanent inspectors, with defined geographic jurisdictions. As per Section 3 and 4 of the Act, it is the Central and the State Governments, on their own that nominates members to respective Mental Health Authorities. It is stated in Section 22(6) of the Act that the Magistrate shall personally examine the alleged mentally ill person. The same position is repeated in Sections 24 and 25 as well. Priests, policemen and politicians all are supposed to have their expertise in Psychiatry. In Chapter 1 on definitions, Section 2, Clause (l) says: ‘Mentally ill person means a person who is in need of treatment by reason of any mental disorder other than mental retardation’. Such an exclusion of mentally retarded persons from its preview is one more serious defect in the Act. The words ‘excluding those with mental retardation’, in the definition of ‘psychiatric patients’ Section 2 (l) must be deleted. Finally he concludes by stating merits of the Mental Health Act 1987. Section 19 of the Act for admission against a patient's free-will, is indeed a great improvement from the old Lunacy Act. Another important provision is Section 23 where the powers and duties of police officers in respect to certain mentally ill persons have been laid down. All those patient-friendly provisions in the Law must be retained. And by framing State Mental Health Rules with a clear-cut vision, we could certainly strive to give more teeth to the new Act. The article analyses the Mental

Health Act and provides some solution to the loopholes in Mental Health Act which helps me to propose a reform needed in my research.

Seshadri Harihar and Hiramalini Seshadri, in their article entitled, “Needed: New Mental Health Act”, put emphasis on the need of a new Mental Health Act. They have critically evaluated the Mental Health Act, 1987. They have stated that First, it appears to have been drafted on the basic premise that the mentally ill are violent, that they are a danger to themselves and others, that mental illness is incurable and that the subject loses his/her reasoning and power of judgment and therefore loses his/her fundamental rights under the Constitution. Secondly, the Mental Health Act is very lenient on government general hospitals and mental hospitals, but it bars private nursing homes from treating the mentally ill and to get a licence empowering one to run a private hospital for the mentally ill one has to satisfy impossible criteria. They suggested that in a majority of cases all the symptoms can be brought under control just as in the case of diabetes, hypertension, etc., But under Mental Health Act these patients risk losing their fundamental rights guaranteed by the Constitution. This has to change. Finally, they concluded by highlighting the need for a humane practical and progressive Mental Health Act. The article describes the loopholes in the Mental Health Act and suggests me a reform which form a ground for my thesis.

Shruti Pandey, Priyanka Chirimar and Dr. Nirmala Srinivasan in their paper entitled “A Comparative Analysis of The UN Convention on Rights of Persons with Disabilities, 2007 vis-à-vis Indian Mental Health Act, 1987 - Gaps, Inconsistencies & Way Forward”, have analysed the gaps and inconsistencies in Mental Health Act in relation to UN Convention on Rights of Persons with Disabilities. The authors have stated that India is a country that has, in last two decades, enacted considerably progressive special legislations on and around the rights of persons with disabilities and also amended archaic legislations to bring them in line with the new evolving standards on these rights. The first category of newly

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enacted laws is led by the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 and in the latter category lies the Mental Health Act, 1987 which was a law to amend and consolidate a pre-existing law. On 30 March 2007 India also joined the community of 82 countries to have signed the UN Convention on Rights of Persons with Disabilities on the very day it was adopted and opened for signature. India has ratified the convention on 1 October 2007. At this point in time, therefore, became necessary for all the disabilities related stakeholders in India to understand what are the meaning and implications, in letter and spirit, of the above developments. There was also a pending litigation in the Supreme Court in which ACMI (Action for Mental illness) was seeking amendments to the Mental Health Act. It was hoped by the authors that this paper would assist the Court in that respect as well. The agreed purpose and scope of this work is to attempt such understanding specifically for persons with mental illness. For this the authors have attempted to understand and explain the mandate of Convention on Rights of Persons with Disabilities as well as the mandate of Mental Health Act, the existing domestic law on mental health in the country, to understand the impact of ratification of the former on rights of the persons with mental illness as laid down under the Mental Health Act. As major thrust of the research, the Convention on Rights of Persons with Disabilities and the Mental Health Act have been separately fine-combed, examined and then juxtaposed against each other to reveal two kinds of interplay – first, the overt and covert tensions and conflicts (the inconsistencies - between the provisions of the two) and second, to bring to fore the gaps in India’s existing mental health law revealing the deficiencies in the latter in light of the substantive rights that have been mandated by the Convention on Rights of Persons with Disabilities. The structure of this paper is as follows: it first examined the Convention very broadly and gives an overview of its history, ideology and philosophy. Thereafter a detailed examination into the substantive rights created in the convention has been carried out, especially the components most relevant to persons with mental illness. Next they have summarized the inconsistencies or areas of conflict between the Convention and the Mental Health Act and the deficiencies in the Mental Health Act, when pitted against the Convention. Finally, the research concluded with their views on the way forward for a comprehensive implementation of the Convention on Rights of Persons with Disabilities. The paper helps me to
understand the gaps between Mental Health Act and Convention on Rights of Persons with Disabilities which is quite helpful in my research work.

**Joseph Goldberg**, in his article entitled, “Types of Mental Illness”\(^{107}\) has defined different types of mental illness. They include anxiety disorders, mood disorders, psychotic disorders, eating disorders, impulse control and addiction disorders, personality disorders, adjustment disorder, dissociative disorders, factitious disorders, sexual and gender disorders, somatoform disorders and tic disorders. The article dealt with the types of mental disorders that prevail in a society, which further helps me to understand the concept of mental illness deeply.

**Jayakumar Menon**, in his article entitled, “Don’t shrink the scope of the Mental Health Act”\(^{108}\) while discussing the scope of Mental Health Act has tried to explain that India needs to look at the experience of countries that have moved away from asylum-based treatments and embraced community integrated psychiatry as the treatment model. He also has explained the position of Australia as per Mental Health Act. He has stated that in Australia, acutely ill patients are admitted using an Inpatient Treatment Order (ITO), if any doctor feels that the patient requires specialist psychiatric care, but is unable to seek care on his own. The involuntary order is reviewed by a psychiatrist within 24 hours of its issuance and it is decided if the patient needs to remain on it. Once made involuntary, the responsibility of patient safety and treatment is under the treating team. Another important aspect in Australia is the presence of the Guardianship Board (a body with judicial powers) that needs to be notified of every involuntary treatment order soon after it is made. Patients, who feel the ITO was uncalled for, can appeal to the board against it. The board conducts a hearing in the next few days. After hearing the evidence from the treating team and the patient, it decides if the ITO is to continue. This prevents the misuse of power by the treating team. Most developed countries have provisions in their MHA to protect patient interests and to make a mental health-care plan after discussing the merits and demerits of the treatment with patients, their family or friends. He also has pointed out some demerits of Mental Health Act, 1987 and gives some suggestions to prevent the

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\(^{107}\) *Supra* note 16, available at:  

misuse of Mental Health Act. The article describes the position of Mental Health Act in Australia and correlates it with Mental Health Act, 1987 of India which is useful for my research work.

Ragini Sinha in her article entitled, “Society Affix Stigma with Mental Illness”, has discussed at length about the factors and effects of stigma which is attached to the person by the society with mental illness. She has stated that people with disabilities face social rejection is evident all through history and across the culture. Society viewed mentally ill people as either morally wrong or they were being punished by God, or as being possessed by demonic spirits requiring some religious interventions. Persons with mental illness were taken as a being on which society can laugh at and society can tease them also. Finally has concluded by stating that such stigma is slowly deteriorating our social structure and inviting other dangerous problems. It is the responsibility of intellectuals, medical professionals and government administration to look at the issue seriously and educate people to give fair treatment to such patients. The author has suggested that if public deal such mentally ill people with affection and realizing them that they are part of society, significant change will be observed. Mental patients need attention, affection and support from common people. Good response from people will definitely improve their mental status. We all have to erase stigma from our mental dictionary and must make positive efforts to enhance the level of mental patient in third millennium as a healthy society. As this article presents a study of mental illness and social impact on it, it is very relevant in my research.

Ashish Srivastava, in his article entitled, “Marriage as a Perceived Panacea to Mental Illness in India: Reality check”, has discussed about the relation between marriage and mental illness. He has explained that marriage as a stressful life event can lead to development of mental-health problems. He has dealt with the issues of effect of marriage on mental health of men and women in the direction of protecting them against mental disorders, effect of marriage on pre-existing mental illness, e.g., Psychoses, alcohol use disorders and outcome of marriage in major psychiatric disorders like schizophrenia. He has stated that specific situations related to married life like impotence, discovery of extramarital affair, problems with children, an

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109 Supra note 3.
110 Supra note 23.
announcement of intent to divorce can be the major trigger to psychological problems. In the National Survey of mental health and well-being of adults in Australia (1997), it was found that when a range of types of mental disorders are considered, marriage reduces the risk of mental disorders for both men and women (mood disorders, anxiety disorders, drug and alcohol use disorders). The potential of marriage to reduce certain kinds of mental-health problems probably owes itself to the beneficial effects it confers in terms of increasing personal and social support. Marriage adds to social status and may decrease stigma. In the presence of mental illness, if marriage is done under pressure, there exists a strong possibility of deterioration of mental condition. The book helps to understand the effects of marriage on mental health which is relevant for my research work.

Ajit Avasthi in his article entitled, “Preserve and Strengthen Family to Promote Mental Health”, ¹¹¹ has dealt exhaustively with the role of family as the key resource in the treatment and rehabilitation of persons with mental illness. While explaining the features of traditional India, he has discussed about the merits of joint family system. He has stated that psychologically, family members feel an intense emotional interdependence with each other and there is strong interpersonal empathy, closeness, loyalty, and interdependency. He advocated the participation of family members in the treatment of patients. He has stated that the traditional joint family that exists in India is seen as a source of social and economic support and is known for its tolerance of deviant behaviour and capacity to absorb additional roles in times of crisis. The nuclear family structure is more likely to be associated with psychiatric disorders than the joint family. Family-based intervention is the most significant contribution of family research to psychiatric practice. The focus of family interventions, has been to build a relationship with caregivers based on understanding and empathy, to promote medication compliance, to promote early identification of problem, to guide families to reduce social and personal disability, to guide families to reframe expectations and moderate the affect in the home environment, to guide families to improve vocational functioning of the patient, emotional support to caregivers and development of self-help groups for mutual support and networking among families. Successful family intervention reduces rates of mental illness and

improves quality of life for patients with schizophrenia, bipolar disorder, major depression, borderline personality disorder and alcoholism. He has suggested that in developing countries, caregivers have a major role to play in the resocialization, vocational and social skills training of the patient, not only because of close family ties that exist in these traditional societies, but also because developing countries lack rehabilitation professionals to deliver these services. The article is valuable in my research work as it helps me to understand the role of family in relation to mental health.

M. Thirunavukarasu and P. Thirunavukarasu in their article entitled “Training and National Deficit of Psychiatrists in India - A Critical Analysis”,¹¹² have dealt with the issue of deficit of psychiatrists in India in relation to epidemiological burden of mental illness, propose short-term and long-term strategies to tackle the deficit and emphasize the importance of modifying the curriculum of undergraduate medical education to enable the proposed strategies. They have stated that our undergraduate education does not prepare our future generation of doctors to handle the herculean burden of psychiatric illnesses. This is a direct result of the less amount of teaching and clinical experience in psychiatry. Psychiatry, as a subject of study has been offered a disproportionately small amount of time during the undergraduate course. Psychiatry, as a subject of study, is offered only a minimum of 20 hours of clinical lecturing. This constitutes to only 1.4% of the total amount of lecturing hours. When realistic aspects of lecturing are taken into account, this miniscule amount of time devoted to psychiatry seems to appear more like a ritual for the achievement of political correctness in adequacy of training, than an honest wilful attempt to educate the medical students. The authors suggested that the best strategy to tackle this problem of huge burden and deplorable deficit is to actually train the general public. Awareness about mental illness, remove the myths and misconceptions of mental disorders and educating the general public of the scope and importance of mental health care will probably work more quickly, more effectively and will be long lasting. The article deals with the issue of deficit of psychiatrists which is a part of my research.

¹¹²Supra note 22.
The researcher has made a humble attempt to review relevant extracts of the available literature on the subject. However, a complete and more detailed study and critical evaluation of the subject and the literature would be pursued while writing the thesis.

For the fulfillment of the research study besides the articles, books and national and international reports, several international conventions/treaties, statutes, Journals, newspapers and websites have been taken into account. The details of these reviews have been given in table 1 and chart.

**Table No.1**

**Number of articles, books and national and international reports, several international conventions/treaties, statutes, Journals, newspapers and websites which are studied in the present research are as follows:**

<table>
<thead>
<tr>
<th>Title</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Articles</td>
<td>48</td>
</tr>
<tr>
<td>Books</td>
<td>33</td>
</tr>
<tr>
<td>National and International Reports</td>
<td>18</td>
</tr>
<tr>
<td>International Conventions/Treaties</td>
<td>42</td>
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<tr>
<td>Journals</td>
<td>9</td>
</tr>
<tr>
<td>Newspapers</td>
<td>2</td>
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<tr>
<td>Statutes</td>
<td>20</td>
</tr>
<tr>
<td>Websites</td>
<td>8</td>
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</tbody>
</table>
1.4 OBJECTIVES OF STUDY

The main objectives of the research were as follows:

- To study and analyse the human rights of mentally ill persons.
- To study international conventions and protocols related to mental health of human beings.
- To study and analyse the existing laws relating to mental health in India and loopholes in the same or need of reformulation.
- To study the problems faced by mentally ill persons and the attitude of society towards these persons.
- To study the role of community participation in various countries to rehabilitate these mentally ill persons in society.

1.5 RESEARCH HYPOTHESES

The researcher has undertaken two hypotheses while doing the research which are as follows:

- The society treats persons with mental illness at par with lunatic persons.
- The present statutory framework is insensitive towards the need of mentally ill persons.\textsuperscript{113}

1.6 RESEARCH METHODOLOGY

The researcher’s present study focuses both on theoretical and empirical research. The theoretical research will include both primary and secondary sources. The primary sources include study of international instruments, constitutional and legislative provisions, government reports, health policies and other official documents such as judgments of higher judiciary. The secondary sources include journals, articles, books, magazines, newspapers and websites etc. The theoretical study failed to highlight the status of mentally ill persons in the society, so an empirical study conducted to substantiate the research. For the purpose of empirical study the universe of study is Chandigarh. Chandigarh being a capital of two states and Union Territory includes population of migrants and nuclear families which one

\textsuperscript{113}In the present research the researcher has proved this hypotheses but the present Act has been sensitive towards the need of mentally ill persons but how far it work only time will tell and what will be practical difficulties in enforcing the Act is still to be highlighted.
of the important and crucial factor of increasing mental illness. The empirical research is in the form of questionnaires and sample surveys. The combined i.e. theoretical and empirical study helped us to identify the problems faced by mentally ill persons in society so to find out the ways to strengthen their mental health.

It is important to express here that the present study is an attempt to know about the human rights and socio-legal status of persons with mental illness in India. Firstly, the concept of mental illness, its meaning and categories are discussed. The study is a modest presentation of international, constitutional and statutory framework and attitude of judiciary towards the protection of rights of persons with mental illness. In addition for the universe of study, data is collected with the help of properly drawn questionnaires from the Psychiatrists, general public viz. literate and illiterate, academicians viz. law and non-law(three hundred and fifty) which were formulated keeping in mind the variable to be explored by the study keeping in view its objectives. Questions were close-ended, giving possible alternate answers to make classification easy. For this purpose, all possible answers and one section of ‘other’ is accommodated whenever necessary in the questionnaire. Beside, the information pertaining to persons with mental illness is also collected through information under Right to Information Act, 2005, from PGIMER, Chandigarh; GMCH, Chandigarh; GMSH, Chandigarh. In this way a set of 84 questions from PGIMER, 84 questions from GMCH and 86 questions from GMSH were asked which were related to indoor patients with mental illness were treated during the last three year, patients with mental illness were treated through Electroconvulsive Therapy during the last three years, patients admitted in the community residential facilities in during the last three years etc.

After editing classification, tabulation and processing of both primary sources, secondary and data and applying suitable statistical and mathematical methods report is written and inferences are drawn which are spread over in different chapters and decided the outcome of this research study.

The research work is divided into 7 chapters:

Chapter I deals with the ‘Introduction’ which tells about the problem of persons with mental illness, enlist the research methodology and objectives of the research study.
Chapter II deals with the ‘Mental Illness: A Conceptual Framework.’ This chapter refers to the definition and different categories of mental illness.

Chapter III deals with the ‘International Legal Framework towards Mentally Ill Persons.’ This Chapter refers to human rights of persons with mental illness under international instruments and conventions. It also refers to the role of W.H.O for the protection of persons with mental illness.

Chapter IV deals with the ‘Constitutional and Legal Framework on Mental Health.’ In this chapter an attempt is made to see whether existing legislations are adequate to give the minimum protection, safety and social security to persons with mental illness.

Chapter V deals with the ‘Judicial Attitude towards Mental Illness.’ There, judicial decisions interpreted various legislations in favour of persons with mental illness have been discussed.

Chapter VI deals with the ‘Empirical study with Reference to the Union Territory, Chandigarh.’ In this chapter, through the analysis of survey study, an attempt has been made to see whether persons with mental illness are getting the benefits of existing laws, policies and schemes in the Union Territory, Chandigarh. The empirical data was collected when the Mental Health Act, 1987 was in force, and the significance of the data compiled is of importance inspite of the passage of the Mental Healthcare Act, 2017.

Chapter VII deals with the ‘Conclusion and Suggestions.’ A summarization of the present study is attempted and a few suggestions are proposed therein.