MENTAL HEALTH AND LAW: AN OVERVIEW OF ITS AFFILIATION WITH THE INDIAN JUSTICE SYSTEM

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ABSTRACT

The significance of mental health has increased recently, changing societal perceptions of this vital component of wellbeing. Surprisingly, despite their seeming differences, this move has a strong connection to the Indian Justice System. It is crucial to comprehend this complex link since it shows how these two seemingly unconnected fields have a profound impact on one another.

People who are involved in legal proceedings, whether they be civil lawsuits or criminal trials, at times have underlying mental health problems. Socioeconomic inequalities, traumatic events, and the pressures associated with litigation might make these issues worse. Depending on how the legal system handles them, their mental health may be alleviated or deteriorated. While cruelty or neglect can make their illnesses worse, kind treatment can encourage rehabilitation.

Conversely, people who suffer from serious mental illnesses regularly come into contact with the judicial system, highlighting the urgent need for mental health reform in that setting. In India, discrimination, stigma, and poor access to mental health care are widespread problems that prevent individuals in need from receiving the necessary care. Individuals may wind up behind bars instead of obtaining psychiatric treatment, which is harmful to both their well-being and the effectiveness of the judicial system.

The Indian judicial system's case backlog also makes litigants feel more stressed and anxious, which might exacerbate pre-existing mental health issues. As delayed justice frequently corresponds to denied justice, this backlog not only hurts people but also has larger social ramifications.

In conclusion, despite what could appear to be a superficial lack of relationship, there is a significant one between the Indian Justice System and mental health. It is essential to understand and deal with how the legal system affects mental health and vice versa. Comprehensive changes are required to give mental health the attention it deserves within the judicial system, guaranteeing that everyone is treated with respect and compassion,

regardless of their legal or mental health status. In order to create a culture where mental health and justice are respected and preserved, a comprehensive approach is necessary.

Keywords: mental health, discrimination, stigma, rehabilitation, comprehensive changes

Introduction

Our emotional, psychological, and social well-being are all parts of our mental health. It influences our thoughts, emotions, and behaviours. Additionally, it influences how we respond to stress, interact with others, and make decisions. Every period of life, from infancy and adolescence to maturity, is vital for mental health.

Mental health issues include psychosocial impairments, mental illnesses, and other mental states linked to high levels of distress, functional limitations, or risk of self-harm. Although this is not always the case, people with mental health disorders are more likely to have lower levels of mental well-being.[1]

According to WHO estimations, India has a disability-adjusted life year burden of 2443 per 100,000 people and an age-adjusted suicide rate of 21.1 per 100,000 people. 1.03 trillion USD are projected to be lost in economic output between 2012 and 2030 as a result of mental health issues.[2]

The lack of understanding and sensitivity regarding the issue is the main factor contributing to India's decline in mental health. People who have any form of mental health disorders are heavily stigmatised. They are frequently labelled by society as “lunatics,” “mad,” “possessed,” “crazy,” and many other terms.

The criminal justice system over-represents those with mental disorders, even though there is no clear correlation between having a mental health problem and committing a crime. This significantly strains the entire system and jeopardises society's capacity to control crime.

Background of Study

The Lunatic Removal Act 1851, which was repealed in 1891, was the first piece of

[1] https://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response
[2] https://www.who.int/india/health-topics/mental-health

legislation pertaining to mental illness in British India. This regulation was primarily established to control the repatriation of British patients to England. Many regulations for the treatment of persons with mental illnesses were created following the British crown's seizure of Indian governance in 1858, including:

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

These laws allowed for the indefinite detention of patients in substandard housing with little to no possibility of rehabilitation or release. Due to this, a bill was introduced in 1911 that combined the various laws, resulting in the Indian Lunacy Act (ILA) of 1912.[3] Essentially the first law that controlled mental health in India was the ILA 1912. It brought about a major shift in how asylums—later referred to as mental hospitals—were run. However, this law was primarily concerned with safeguarding the general population from people who were seen to be a threat to society (i.e. patients with a mental illness). Human rights were disregarded by the ILA 1912 in favour of solely imposing jail punishments.

The Indian Psychiatric Society argued that the ILA 1912 was unsuitable and as a result it later assisted in the creation of a mental health bill in 1950.[4] The President ultimately gave his approval for this measure (in May 1987), and it wasn't until 1993 that it became an actual law. The Mental Health Act (MHA) of 1987 had the benefit of defining mental disease in a progressive manner and emphasising care and treatment over incarceration. It emphasised the need to defend human rights, guardianship, and the management of property of persons with a mental illness and offered comprehensive procedures for hospital admission under particular situations.

[3] Somasundaram, O. *The background of Indian Lunacy Act*, 1912. Indian Journal of Psychiatry, (1987) 29, 3–14
[4] Trivedi, J. K. *The mental health legislation: an ongoing debate*. Indian Journal of Psychiatry, (2002) 44, 95–96.

Scope of Study

The licensing, admission, and guardianship legal processes are the major targets of critiques of the MHA 1987. Additionally, this Act does not effectively address the delivery of mental healthcare and human rights.[5] Since the MHA of 1987 involves the restriction of personal freedom without the possibility of judicial review, human rights advocates have questioned the law's constitutionality. Additionally, the MHA of 1987 included no mention of the rehabilitation and care of patients after they were discharged from hospitals.[6] Insufficient treatment facilities may put a strain on family members, caregivers, and finances.

These criticisms prompted the MHA 1987 to be amended, which ultimately resulted in the Mental Health Care Bill 2013, which was presented to the Rajya Sabha (upper house of parliament) on August 19, 2013. Although the MHA 1987 is repealed by this measure, it has not yet become law.

According to estimates, there are 70 million people with serious mental and behavioural illnesses in India, or 65 per 1,000 people.[7] There is tremendous room for improvement in India's capacity to treat, care for, and rehabilitate individuals with mental illnesses. People with mental illnesses are frequently locked away, treated with little to no dignity, and seldom ever taken seriously.[8]

According to a study published by the National Institute of Mental Health and Neurological Sciences (NIMHANS), only 20% of people with mental health issues receive any kind of treatment. This is due in part to a severe lack of trained professionals. For every 100,000 persons who suffer from a mental disorder, there is only one professional psychiatrist available while the recommended ratio is 250 per 100,000 people. The majority (75%) of mentally ill individuals reside in rural areas, where even access to basic medical care is challenging. The majority (53%) of state-run mental facilities lack a rehabilitation strategy.

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[5] Narayan, C. L., Narayan, M. & Shikha, D. *The ongoing process of amendments in MHA-87 and PWD Act-95 and their implications on mental health care.* Indian Journal of Psychiatry, (2011) 53, 343–350.
[6] Dhandha A. *Status Paper on the Rights of Persons Living with Mental Illness in Light of the UNCRPD. In Harmonising Laws with UNCRPD*. Report prepared by the Centre of Disability Studies. Human Rights Law Network (2010)
[7] Reddy MV, Chandrashekar CR., *Prevalence of mental and behavioural disorders in India: a meta-analysis*. Indian Journal of Psychiatry 1998;40:149–57
[8] Kumar S., *Indian mental-health care reviewed after death of asylum patients*. Lancet 2001;358(9281):569.

Less than 1% of all healthcare costs in the nation are spent on mental health. Although the National Mental Health Programme was designed to serve both rural and urban communities, 80% of rural residents are unable to use its services. The general public, insurance firms, and decision-makers in the fields of health and labour discriminate against those with physical and mental health issues. Patients who suffer from mental illness are often disregarded and deprived of the social rights they are due.

Research Problem

The concept "mental illness" encompasses a variety of illnesses, including schizophrenia, bipolar disorder, anxiety, and psychotic disorders. These circumstances have a significant influence on a person's emotions and social interactions. In the end, branding a group of individuals with major medical illnesses as "violent" or "dangerous" simply serves to further alienate them from the society and ignores the reality that "mental illness" is a broad phrase that encompasses a variety of disorders.

Three factors often increase the likelihood that a person with a mental illness may interact with the criminal justice system, namely being:[9]

1. *Mental illness might be misinterpreted for crime or perversity:*

   The judgement that someone has participated in crime or perversity may fail to take into consideration how mental illness may have influenced this act when mental illness is not adequately diagnosed or accounted for.

2. *People with certain mental conditions are more likely to conduct crimes and as a result, be incarcerated for said crimes:*

   This is especially true for those suffering from psychotic illnesses, in which agitation, delusions, or hallucinations can serve as direct impetuses for criminal behaviour. Particular mental disorders that are accompanied by psychotic episodes might cause a person to act in a criminal manner. Studies have also shown a connection between criminal activity and bipolar illness symptoms. A person is also more likely to act violently when they are experiencing anxiety

[9] https://www.gallantlaw.com.au/mental-illness-and-crime-whats-the-link/

or acute stress because they are more likely to become agitated, angry, and/or impulsive.

3. *The prison environment contributes to mental illnesses, such as depression:*

   Prisoners have worse mental health than the general public. With its harsh culture, inferior healthcare standards, and limited visitation hours, the prison atmosphere can exacerbate mental health issues including depression, stress, and anxiety. In many instances, the jail setting can make these conditions worse. Mental illness can also be triggered or made worse by violence and abuse from staff members or other convicts.

Research Hypothesis

Regardless of the provisions made in favour of assisting those suffering with mental illnesses, the implementation of aforementioned provisions is subpar and requires revision.

Research Objectives

This research paper aims to dispel such preconceived assumptions and emphasise the necessity of regulatory legislations when it comes to mental health and/or disorders prevalent in criminal behaviour.

Research Questions

1. What is the economic burden of mental disorders?
2. What are the existing legislations influencing mental health care?
3. What is the relevance of forensic psychiatry?
4. What are the conditions of mentally ill offenders/convicts?
5. Have any provisions been made to tackle these issues?

Economic Burden of Mental Disorders

The NMHS (2015-16) reported that the typical out-of-pocket cost by families for

treatment and travel to obtain care was Rs. 1,000-1,500 per month. Mental disorders inflict a significant financial burden on individuals affected by them. Discussions with respondents also highlighted that the costs associated with treating mental illnesses frequently put families in a difficult financial situation. In the case of middle-aged people, who were also the most afflicted by mental diseases, this burden was more evident since it reduces their productivity, which amplifies the burden on both the person and the economy.

The World Health Organization (WHO) estimates that mental health issues have cost India $1.03 trillion in economic losses. The NMHS also discovered that households with poorer incomes, less education, and lower employment rates are disproportionately affected by mental health issues. Due to their socioeconomic circumstances, these vulnerable groups confront budgetary constraints, which are made worse by the scarcity of resources for treatment. When treatment is sought, the majority of costs are out-of-pocket charges due to a lack of State services and insurance coverage, which exacerbates the financial burden on the poor and disadvantaged.[10]

Legislations Governing Mental Health Care

Laws that are enforceable both locally and globally are referred to as "hard" laws. On the other hand, "soft" laws are not enforceable. Albeit they can serve as models for future legislation if they are well crafted and represent a broad agreement.[11]

There have been several international treaties, declarations, covenants, etc. throughout the past 70 years that make mention of mental diseases and/or an individual's mental health.

The Universal Declaration of Human Rights (UDHRs)[12] was adopted in 1948. Article 1 of the UDHRs, adopted by the United Nations in 1948, provides that “all people are free and equal in rights and dignity” – “establishing that people with mental disabilities are protected by human rights law by virtue of their basic humanity”

As a signatory to several of these international agreements, India is required to adapt her laws to comply with them. The Mental Health Act of 1987, the Protection of Human Rights

[10] International Labour Organization, *‘Youth and Covid-19: Impact on jobs, education, rights, and mental well-being’*, (2020) Survey Report.
[11] Rosenthal E, Sundram CJ., *The Role of International Human Rights in National Mental Health Legislation.* Department of Mental Health and Substance Dependence, World Health Organization. 2004.
[12] https://www.un.org/en/about-us/universal-declaration-of-human-rights

Act of 1993, the Persons with Disabilities Act of 1995, the National Trust Act of 1999, the Protection of Women from Domestic Violence Act of 2005, the Protection of Children from Sexual Offences Act of 2012, and other related laws are some of the strict laws pertaining to mental health in India. The Narcotic Drugs and Psychotropic Substances (NDPS) Act of 1985 is a well-known statute that governs drugs.[13]

In essence, "soft" laws are more like regulations or policies that are quasi-legal but not legally enforceable. They are referred to as having "hortatory" duties, which are characterised as claims that resemble promises. It is asserted that eventually, these may become legally binding. The National Mental Health Program and the 2014 National Mental Health Policy are two examples (with its operational arm, the District Mental Health Programme).[14]

Mental Health Act, 1987 (MHA-87)

Main features of the act being:

- Modern principles of mental disease definition and treatment are introduced, with a focus on care and treatment rather than on custody.
- The creation of a Central/State Mental Health Authority to control and oversee psychiatric institutions and nursing homes and to provide guidance to the Central/State Governments on issues relating to mental health.
- Admission to mental institutions or nursing homes under certain conditions. Provisions of voluntary admission and admission on the reception orders were retained.
- Person with Mental Illnesses (PMI) instances involving wandering and brutally handled PMI are within the purview of the police and the magistrate.
- Protection of human rights of PMI.
- Guardianship and Management of properties of PMI.

[13] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5282613/
[14] Ministry of Health and Family Welfare, Government of India. *New Pathways New Hope, National Mental Health Policy of India*. New Delhi; October. 2014

- Penalty measures in the event that the Act's provisions are broken.

The Mental Healthcare Act of 2017 attempts to repeal the Mental Healthcare Act of 1987, which was criticised for failing to recognise the rights and agency of persons with mental illness and provides a number of measures to improve the situation of mental health in India.[15] This includes establishing Central and State Mental Health Authorities (SMHA), which would concentrate on establishing a solid infrastructure, including the registration of mental health practitioners and the implementation of service-delivery norms, and declaring access to mental healthcare as a "right." Even though the Act mandated that states establish SMHAs within nine months of the Act's passage, as of 2019, only 19 out of 28 states had done so.[16]

National Trust Act, 1999

This law was passed for the welfare of people with autism, cerebral palsy, mental retardation, and multiple disabilities in order to give them the ability and empowerment to live as independently and nearby their community as possible, as well as to make it easier to realise equal opportunities and rights protection. The Act includes several welfare provisions. Additionally, this Act is being updated to comply with UNCRPD-2006 and broaden it. The modified Act is designed to apply to PMI's property management.[17]

Persons with Disabilities Act, 1995 (PDA-95)

PDA-95 was enacted in order to end discrimination in the distribution of developmental benefits between handicapped and non-disabled people and to stop the exploitation and abuse of people with disabilities (PWD). It outlined the government's duties to establish plans for comprehensive development programmes and to provide particular provisions for integrating people with disabilities into society at large. It also provided for a barrier-free environment. Mental disease and mental retardation are within the umbrella of disabilities under PDA-95. The benefits accessible to PWD as specified by the Act are thus eligible to PMI. 3% of positions in the government are reserved, however the PMI is not eligible for this benefit. Following the UNCRPD-2006, this Act is also presently being revised.

[15] Mishra, Abhisek and Abhiruchi Galhotra, *"Mental Healthcare Act 2017: Need to Wait and Watch"*, International Journal of Applied and Basic Medical Research, (2018) 8(2): 67-70
[16] https://www.ideasforindia.in/topics/human-development/understanding-india-s-mental-health-crisis.html
[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3705679/

United Nations Convention for Rights of Persons with Disabilities, 2006

Adoption of UNCRPD occurred in December 2006. In May 2008, the Indian Parliament approved it. The UNCRPD requires all signatory and ratifying nations to align their laws and policies with it. Therefore, India has been revising all of its laws pertaining to people with disabilities. With the treaty, the perception of impairments has changed from one of social welfare to one of human rights. The presumption of legal ability, equality, and dignity form the foundation of the new paradigm.

Article 2 of the agreement states that PWD would have equal access to legal capacity in all spheres of life. According to Article 3, the state must take the necessary steps to grant PWDs access to assistance so they can exercise their legal competence. Article 4 demands measures to stop misuse of the PWD-required support system.

The UNCRPD does not expressly forbid forced interventions, but it also does not enable forced mental health treatment.[18]

Forensic Psychiatry

According to Pollack, "broad general field in which psychiatric theories, concepts, principles and practises are applied to any and all legal issues" is what Forensic Psychiatry is. The American Board of Forensic Psychiatry's definition of forensic psychology has the support of the American Academy of Psychiatry and the Law. “Forensic Psychiatry is a subspecialty of psychiatry in which scientific and clinical expertise is applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters; forensic psychiatry should be practised in accordance with guidelines and ethical principles enunciated by the profession of psychiatry.”[19]

The Indian Penal Code (IPC), which was created in the middle of the 19th century by Thomas Babington Macaulay, is where forensic psychiatry first emerged in India. The Mc Naughten's guidelines, which serve as the foundation for the insanity defence, were included

[18] Dhandha A. *Status Paper on Rights of Persons living with Mental Illness in light of the UNCRPD, in Harmonizing Laws with UNCRPD,* Report prepared by the Centre of Disability Studies. Human Right Law Network. May, 2010

[19] Prentice SE. *A history of subspecialization in forensic psychiatry.* Bull Am Acad Psychiatry Law. 1995;23:195–203

into the IPC, Section 84, about the same time. This is still the case today. However, there have been several landmark judgements using Section 84 of the IPC.[20]

It is now clear that forensic psychiatry covers a variety of civil aspects of mental health as well as issues related to the treatment of mental illness. Over time, the narrow idea that forensic psychiatry primarily deals with criminal responsibility and fitness to stand trial has long since faded away.

Mental illness is significant in many contexts when it comes to civic duties. For instance, marriage, divorce, testamentary capacity, contracts, voting, consent, suitability for keeping and maintaining occupations, succession of property rights, guardianship, and social welfare benefits all include direct or indirect mention of mental health and sickness. A paradigm change in how mental health issues are treated is anticipated as a result of the new provisions in the Mental Healthcare Bill, 2016, and the Rights of Persons with Disabilities.

However, forensic psychiatry in India lacks both infrastructure and formal training. A specific forensic psychiatry ward or unit is uncommon in psychiatric units. The treating psychiatrist, who has little to no formal training in forensic psychiatry, does the majority of forensic assessments. As a result, rather than being founded on expertise and competence, judgments are frequently made by trial and error or in good faith.

Condition of criminal offenders/convicts

Although the majority of prisons do have resources to address fundamental physical health concerns, mental health services provided in prisons in India are at a very primitive level. Many prisons have visiting psychiatrist services available, but not permanent ones. A psychiatrist is often only consulted if a prisoner or convict shows any indications of mental illness. Routine evaluations for mental problems or substance use are rarely conducted. The absence of routine assessments of mental state in those who are facing the death penalty is another grave problem.

Following a major discovery of "noncriminal lunatics" being imprisoned in appalling circumstances in the 1980s, such a practice was deemed unlawful and a violation of human

[20] Math SB, Kumar CN, Moirangthem S. *Insanity defence: Past, present, and future.* Indian J Psychol Med. 2015;37:381–7

rights.[21] These results show that it is urgently necessary to divert mentally ill convicts to mental health treatment facilities.[22] The current state of mental health care settings prevents them from fulfilling their duty.

Section 84 of the Indian Penal Code, 1860 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." The Supreme Court has ruled that a defence based on insanity must be supported by evidence since the law presumes everyone who is of legal age to be sane. According to section 471 (i) of the Cr.P.C., 1973, such individuals are committed to psychiatric hospitals if a defence of insanity is proved.

However, this merely scratches the surface of how mental health and the criminal justice system are related. In spite of the Penal Code's provision, those with mental disabilities have a harder time. Due to their mental state, individuals are more prone to conduct crimes, which increases the likelihood that they will be apprehended and locked up.

This is in spite of the Chairman of the National Human Rights Commission ordering that people with mental disabilities not be housed in prisons and urging the state governments to give them appropriate treatment. The worst location for someone who lacks mental stability is a prison. Living conditions that are unhealthy and overcrowded, combined with an established class system in Indian prisons where prisoners from higher social classes typically receive better treatment, make for an awful place for many prisoners and are made even worse for the mentally disabled who require more care.[23]

Mental Health Care Bill, 2013 (MHCB) - Provision in the right direction

Every individual has the right to use government-funded or government-run services for mental healthcare and therapy under the MHCB 2013. As a result, a patient with a mental disease will have access to facilities and services like: free delivery of necessary psychotropic drugs; insurance coverage for mental illness; and financing for a private consultation in the

[21] Shah LP. *Forensic psychiatry in India current status and future development.* Indian Journal of Psychiatry. 1999;41:179–85.
[22] Chadda RK, *Amarjeet Clinical profile of patients attending a prison psychiatric clinic.* Indian Journal of Psychiatry. 1998;40:260–5.
[23]https://www.legalserviceindia.com/legal/article-8536-mental-health-and-criminal-justice-system-an-extensive-analysis-within-indian-jurisdiction.html

absence of a district mental health programme. The MHCB 2013 also guarantees that treatment and rehabilitation would be provided in the least restrictive setting while respecting patients' rights and dignity, particularly those from low socioeconomic statuses. These suggestions will have the effect of significantly lessening the financial and mental strain that caregivers must bear.[24]

Advanced directives and nominated representatives are two brand-new ideas that the MHCB 2013 introduces. These concepts give people with mental illnesses some autonomy over how they want to be treated in the future should they lose the capacity (i.e., mental capacity) to make informed decisions and over who their nominated representative will be to handle their affairs. The measure mandates the creation of national and regional mental health agencies. Additionally, each mental health facility must register with the appropriate central or state mental health authority.

A commission for mental health reviews will serve in a quasi-judicial capacity, reviewing advance directive usage and practises on a regular basis and advising the government on how to protect the rights of those with mental illnesses.

Despite the fact that suicide is still a crime in India, this bill advocates for its decriminalisation.[25] Decriminalizing suicide will lessen the strain on patients and caregivers as well as the already overcrowded Indian judicial system by reducing the stress brought on by societal and legal issues.

Finally, it has recommended outlawing the use of direct (unmodified) electroconvulsive treatment (ECT). In other words, anaesthesia and muscle relaxants will be required to perform ECT.[26]

Given the lack of infrastructure, manpower, and resources, there are worries that the new law is overly ambitious and unrealistic and may not be able to accomplish what is requested.[27] Nevertheless, the MHCB 2013 is a step in the right direction toward enhancing

[24] Gopikumar, V. & Parasuraman, S. *Mental illness, care and the bill: a simplistic interpretation.* Economic and Political Weekly, (2013) 48(9), 69–73
[25] Bhaumik, S. *Mental health bill is set to decriminalise suicide in India.* BMJ, (2013) 347, f5349.
[26] Narayan, C. L., Narayan, M. & Shikha, D. (2011) *The ongoing process of amendments in MHA-87 and PWD Act-95 and their implications on mental health care*. Indian Journal of Psychiatry, 53, 343–350.
[27] Antony, J. *Mental Health Care Bill 2013: a disaster in the offing?*, Indian Journal of Psychiatry, (2014) 56(1), 3–7.

access to mental health services and harmonising the law with international mental health laws and human rights norms. The legislation protects and empowers people with mental illness, which is a considerable advance above the current MHA-87.

Conclusion

Effective adoption will need a significant overhaul of the existing system and major manpower and financial involvement. The MHCB 2013 has certain flaws that call into question its relevance and application to the Indian populace. However, the altered legislation may also herald the beginning of a new era for anti-stigma efforts; it may result in increased funding for mental health, as well as the recruitment and retention of mental health specialists including psychiatrists, psychiatric nurses, and other associated professions.

Therefore, if properly implemented and funded, in addition to enhanced access to mental health treatments, the new act, when it comes into effect, might better protect the human rights of those who suffer from mental disorders.

The necessity of treating mental health illnesses cannot be overstated. It urges the adoption of comprehensive, cross-government initiatives for promotion, prevention, treatment, and rehabilitation. The availability and accessibility of affordable primary care for common mental diseases should be advocated among policymakers.

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