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Has Bollywood exposed Indians to mental health issues? – A critical study

Gururaj Devarhubli
Assistant Professor of Law Institute of Law, Nirma University
Mobile No.: +91 98989 04046
Email: gururajdd95@gmail.com

Abstract---The year 2020 exposed the world to the COVID-19 Pandemic. People were locked inside their homes and everything went online, from education to entertainment. In 2018, renowned Hindi film actress Deepika Padukone expressly spoke about mental health issues. This led to a widespread debate among Indians as to mental health problems. But with the death of actor Sushant Singh Rajput, Indians felt the problem was their own. This made them feel the problems and companies started offering psychological counseling to their employees on regular basis. Especially during COVID-19, it was reported that continuously using online mediums led to mental health problems not only among youth but also among adults. Against this backdrop, through the present article, the author attempts to highlight the problem of mental health, and the various steps taken for mental health, both at the international and national levels. Also, the author discuss the salient features of the Mental Health Care Act, 2017 and the various challenges in delivering mental health care, finally concluding with suggestions and recommendations.

Keywords---Deepika Padukone expressly, COVID-19, mental health.

Introduction

Poor mental health frequently creates personal distress for the individual and those around that individual. It often has social causes as also significant social costs in the form of dependency, incapacity, and unemployment, and may also lead, in some cases, to social disturbance and disruption. Also, social stigma is attached to mental illness, particularly in Indian society.

Mental Health and Human Rights

There exist three relationships between mental health and human rights: (1) mental health policy affects human rights; (2) human rights violations affect

mental health; (3) positive promotion of mental health and human rights are mutually reinforcing. The first relationship is that mental health policies, programs, and practices can violate human rights. The second relationship is that mental health affects severe human rights violation, such as torture, rape, genocide, and inhuman and degrading treatment are obvious and inherent. The third relationship is that mental health and human rights are complementary approaches to the betterment of human beings.[*]

The United Nations Convention on the Rights of Persons with Disabilities, 2006 (CPRD)

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) and its optional protocol were adopted by the UN General Assembly and it explicitly recognizes the importance of the human rights of persons with physical, mental, and intellectual disabilities in a distinct international legal instrument.[†] Enumerated rights include guarantees of equality and non-discrimination (Article 5), accessibility (Article 6), rights to life (Article 10), equal recognition before the law (Article 12), access to justice and liberty (Article 13), and security of person (Article 14). The CRPD also mandates freedom from torture or cruel, inhuman, or degrading treatment or punishment (Article 15), freedom from exploitation, violence, and abuse (Article 16), and maintaining the integrity of the person (Article 17) as well as freedom of expression, opinion, and access to information (Article 21). The text sets out several rights integral to the ability of persons with mental disabilities to fully participate in society: liberty of movement and nationality (Article 18), personal mobility (Article 20), the right to live independently and to be included in the community (Article 19), respect of privacy, home, and the family (Article 20 and 23) and participation in political, public, and cultural life, as well as recreation, leisure, and sport (Article 20 and 30). Also protected are a wide range of additional economic, social, and cultural rights to education; health; habilitation and rehabilitation, work and employment, and an adequate standard of living and social protection (Articles 24 and 28).

The United Nations designated the years 1983 to 1992 to be the Decade for Disabled persons.[‡] General Assembly adopted a detailed international statement of the rights of persons with mental illness Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (MI Principles).[§]

The MI Principles begin by enunciating fundamental freedoms and rights to the best available mental health care; respect for inherent dignity; protection from

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[*] Lawrence Gostin et al, *Principles of Mental Health Law and Policy,* Oxford University Press (1st Ed. 2010) p. 106

[†] Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106, U.N. Doc. A/RES/61/106 (Dec. 13, 2006).

[‡] UN General Assembly, *United Nations Decade of Disabled Persons: Resolution/Adopted by the General Assembly,* November 23, 1984, A/RES/39/26.

[§] Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, G.A. Res. 119, U.N. GAOR, 46th Sess., Supp. No. 49, Annex, Princ. 1, at 188-92, U.N. Doc. A/46/49 (1991)

exploitation, physical abuse, and degrading treatment; non-discrimination; natural justice prior to a finding of incapacity; and, more generally, the right to exercise all rights in the International Bill of Human Rights (Principle 1). The MI principles recognize the inherent difficulties of protecting human rights in institutions; care should, as often as possible, be in the community (Principles 3 and 7). This preference for community care is reinforced by the duty to treat in the least restrictive environment and to preserve and enhance autonomy (Principle 9).

The MI Principles adopt a set of legalistic standards and procedures for involuntary admission to a hospital. A person may be involuntarily admitted only if:

(1) he or she had a mental illness diagnosed under internationally accepted medical standards; and

(2) there is a serious likelihood of immediate harm to the person or others; or

(3) if the person is severely mentally ill and has impaired judgment, there will be serious deterioration of his/her condition. (Principle 16).

Procedural safeguards include a fair hearing by a judicial or other independent review body, with representation, independent experts, right to information and attendance, and reasons for the decision. (Principles 17 and 18).

In India, a national mental health program was adopted in 1982 following the lead of WHO's call for 'organisation of mental health services in developing countries'. In 2014, the revised mental health policy was also implemented. The objectives of the national mental health policy[**] are:

(i) to provide universal access to mental health care;

(ii) to increase access to and utilization of comprehensive mental health services;

(iii) to increase access to mental health services to vulnerable groups;

(iv) to reduce the prevalence and impact of risk factors associated with mental health problems;

(v) to reduce the risk and incidence of suicide and attempted suicide;

(vi) to ensure respect for rights and protection from harm of persons with mental health problems;

(vii) to reduce stigma,

[**] Ministry of Health & Family Welfare, Government of India, *New Pathways New Hope: National Health policy of India*, October 2014, available at: https://nhm.gov.in/images/pdf/National_Health_Mental_Policy.pdf (last accessed July 11, 2022).

(viii) to enhance availability and equitable distribution of skilled human resources;

(ix) to progressively enhance financial allocation;

(x) to identify and address the social, biological and psychological determinants of mental health problems and to provide appropriate interventions.

The strategic areas identified for action are effective governance and accountability, promotion of mental health, prevention of mental disorders and suicide, universal access to mental health services, enhanced availability of human resources for mental health, community participation, research, monitoring and evaluation.

The Mental Health Care Act, 2017

WHO published a Resource Book on mental health, human rights, and legislation[††] including a checklist of 175 specific items to be addressed in mental health legislation or policy in individual countries? Mental Health Care Act, 2017 addresses 96/175 of the WHO-Resource Book standards examined.[‡‡]

The objective of the Act is to provide for mental health care and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental health care and services. This Act contains 16 chapters and 126 sections.

Salient Features of the Act

(a) new definitions of 'mental illness' and 'mental health

(b) revised consideration of 'capacity' in relation to mental health care;

(c) 'advance directives' to permit persons with mental illness to direct future care;

(d) 'nominated representatives, who need not be family members;

(e) the right to mental health care and broad social rights for the mentally ill;

(f) establishment of governmental authorities to oversee services;

(g) Mental Health Review Boards to review admissions and other matters;

[††] World Health Organization, *WHO Resource Book on Mental Health Human Rights and Legislation: Stop Exclusion, Dare to Care,* 2005 available at: https://ec.europa.eu/health/sites/health/files/mental_health/docs/who_resource_book_en.pdf (last accessed July 12, 2022).

[‡‡] R.M. Duffy & B.D. Kelly, *Concordance of the Indian Mental Health Care Act 2017 with the World Health Organization's Checklist on Mental Health Legislation,* International Journal of Mental Health Systems Vol. 11 (August 18 2017) p. 48.

(h) revised procedures for 'independent admission' (voluntary admission), 'supported admission' (admission and treatment without patient consent), and 'admission of minor';

(i) revised rules governing treatment, restraint, and research; and

(j) de facto decriminalization of suicide.[§§]

Mental illness means a substantial disorder of thinking, mood, perception, orientation, or memory that grossly impairs judgment, behavior, 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, especially characterized by sub normality of intelligence.[***] The Mental Healthcare Act of 2017 affirms that 'every person, including a person with mental illness, shall be deemed to have the capacity to make decisions regarding his mental health care or treatment if such person has the ability to (a) understand the information that is relevant to take a decision on the treatment or admission or personal assistance; or (b) appreciate any reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance; or (c) communicate the decision under sub-clause (a) by means of speech, expression, gesture or any other means.'[†††]

The Indian approach to defining capacity differs significantly from that in England and Wales where the Mental Capacity Act 2005 defines lack of capacity, stating that 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.[‡‡‡]

The Mental Health Care Act (MHCA), 2017 has specified the details of the information a person with mental illness (PMI) is entailed while obtaining informed consent. It entitles the patient to seek the information on the nature of mental illness and the proposed treatment plan, including the known side effects of the proposed treatment, prognosis of the disorder with and without the treatment offered, right to refusal of treatment, criteria of admission and related provision/section, and the right to withdraw consent. He/she should receive the information in a language and form that they can understand.[§§§]

A person who has appointed a nominated representative 'may revoke or alter such appointment at any time' and a Board may replace the representative if it is of the

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[§§] R.M. Duffy & B.D. Kelly, *India's Mental Health Care Act, 2017: Content, Context, Controversy,* International Journal of Law and Psychiatry Vol .62 p. 169-178 (2019)

[***] Section 2 (s) of the Mental Health Care Act, 2017.

[†††] Section 4 (1) of the Mental Health Care Act, 2017.

[‡‡‡] R.M. Duffy & B.D. Kelly, *India's Mental Health Care Act, 2017: Content, Context, Controversy*, International Journal of Law and Psychiatry Vol .62 p. 169-178 (2019)

[§§§] Section 2 (s) of the Mental Health Care Act, 2017.

opinion that it is in the interest of the person with mental illness to do so.[****] While fulfilling their duties under this Act, the nominated representative shall (a) consider the current and past wishes, the life history, values, cultural background and the best interests of the person'; (b) 'give particular credence to the views of the person with mental illness to the extent that the person understands the nature of the decisions under consideration'; and (c) 'provide support to the person with mental illness in making treatment decisions', among other roles.[††††] The concept of the 'nominated representative' is an important one because the 'nominated representative' is likely to play many of the roles currently assumed by families. It is probable that many 'nominated representatives' will be family members but this is not necessarily the case, leading to suggestions that the Act does not reflect the role of family in India and even undermines the fabric of Indian society as a result. Nonetheless, these measures give the individual receiving treatment a mechanism for preventing inappropriate coercion by their family.[‡‡‡‡]

Authorities under the Act

As per the MHCA Act, the law bestows authority on the Central Mental Health Authority (CMHA) (under the central government) and the State Mental Health Authority (SMHA) (under the state government), to carry out the necessary proceedings as per the Act. The SMHA is also required to constitute the Mental Health Review Board (MHRB) for the purpose of this Act. All mental health practitioners (MHPs - clinical psychologists, mental health nurses (MHNs), and psychiatric social workers) and every MHE will have to be registered with this authority. Statutory bodies as per the MHCA 2017 are CMHA, SMHA, MHRB, High Court and Supreme Court.

Central Mental Health Authority

Central Mental Health (CMH) Authority comprises 20 members (3-year term) who are required to meet every 6 months. CMH comprises of Secretary and Joint Secretaries of Department of Health and Family Welfare, Director General of Health Services, Director of Central Institutes of Mental Health, MHP with 15 years' experience, psychiatric social worker, clinical psychologist, MHN, two members of a person with mental illness (PMI), caregivers, persons of non-governmental organization (NGO), and persons relevant to mental health.
The CMHA oversees the regulation, development, direction, and coordination with respect to mental health services in the country. They also have been entrusted to register, regulate and monitor mental health establishments under their jurisdiction. Respective authorities have the role of advising the government in matters relating to mental health.

State Mental Health Authority

[****] Section 14(6) & 14(7) of the Mental Health Care Act, 2017.
[††††] Section 17 of the Mental Health Care Act, 2017.
[‡‡‡‡] R.M. Duffy & B.D. Kelly, *India's Mental Health Care Act, 2017: Content, Context, Controversy*, International Journal of Law and Psychiatry Vol .62 p. 169-178 (2019)

SMHA takes up the important task of protecting the human rights of inmates of all MHES, or even outside, its geographic jurisdiction. SMHA shall meet not less than 4 times a year and comprises a principal secretary, joint secretary, head of mental health institute, eminent psychiatrist, MHP, psychiatric social worker, clinical psychologist, MHN, two members of PMI, caregivers, and persons of NGO. These bodies will (a) register, supervise, and maintain a register of all MHES; (b) develop quality and service provision norms for such establishments; (c) maintain a register of MHPs; (d) train law enforcement officials and MHPs on the provisions of the Act; (e) receive complaints about deficiencies in the provision of services, and (f) advise the government on matters relating to mental health.

Mental Health Review Board

MHRB will be set up mostly in every district as per the CMH/SMH recommendation and will be for a term of 5 years. Review board members can hold office up to the maximum age of 70 years, and members comprise a district judge (retired also considered), a representative of the district collector, a psychiatrist, a medical practitioner, and two persons can be either person with mental illness (PMI) or caregivers or persons of NGO Functions of the MHRB include- to register and review advance directives (ADs), to appoint a nominated representative, to decide objections against MHP and MHE, to decide for nondisclosure of persons with mental illness information, to visit jails, and to protect human rights.

Rights of Persons with M*ental Illness*

Section 115 of the Mental Health Care Act decriminalized the attempt to die by suicide, thereby reducing further stress on the victim.[§§§§] The Act provides for the following rights:

(i) Right to access mental health care [Section 18(1)].

(ii) Right to community living [Section 19(1)],

(iii) Right to protection from cruel, inhuman and degrading treatment;

(iv) Right not to be treated under prohibited treatment,

(v) Right to equality and non-discrimination, (vi) Right to information (Section 22); (vii) Right to confidentiality and access to medical records (Section 23);

(viii) Right to legal aid and complain [Section 27(1)]

Advance Directive

Advance directive is a legal document explaining one's wishes about medical treatment if one becomes incompetent or unable to communicate.[*****] Section 5 of

[§§§§] L.N. Vadlamani & M. Gowda, *Practical Implications of Mental Health Care Act, 2017: Suicide and Suicide Attempt,* Indian Journal of Psychiatry Vol. 61 p. 750-755 (2019).

the Mental Health Care Act 2017 recognizes advance directive as a right of every person who is not minor who can make advance directive in writing specifying any or all of the following condition

(a) the way the person wishes to be cared for and treated for a mental illness; (b) the way the person wishes not to be cared for and treated for a mental illness, But the term has not been defined in the Act.

An Advance Directive is not to be confused with a normal "will", which becomes operational after the death of an individual An AD becomes operational when the individual is still alive, albeit incapacitated, and is, therefore, also known as the “living will”.

Section 6 and 7 of the Act entails that the Board shall maintain an online register of all advance directives registered with it and make them available to the concerned mental health professionals as and when required Section 8 also provides that an advance directive made may be revoked, amended or canceled by the person who made it at any time.

The procedure for revoking, amending or cancelling an advance directive shall be the same as for making an advance directive. Section 9 states that the advance directive shall not apply to the emergency treatment. As per Section 10 of the MHC Act, it shall be the duty of every medical officer in charge of a mental health establishment and the psychiatrist in charge of a person's treatment to propose or give treatment to a person with mental illness, in accordance with his valid advance directive. Where a mental health professional or a relative or a care giver of a person desires not to follow an advance directive while treating a person with mental illness, such mental health professional or the relative or the care giver of the person shall make an application to the concerned Board to review, alter, modify or cancel the advance directive in accordance with section 11 of the Act. Upon receipt of the application the Board shall, after giving an opportunity of hearing to all concerned parties (including the person whose advance directive is in question), either uphold, modify, alter or cancel the advance directive after taking into consideration the following, namely, whether the advance directive was made by the person out of his own free will and free from force, undue influence or coercion, or whether the person intended the advance directive to apply to the present circumstances, which may be different from those anticipated; or whether the person was sufficiently well informed to make the decision; or whether the person had capacity to make decisions relating to his mental health care or treatment when such advanced directive was made; whether the content of the advance directive is contrary to other laws or constitutional provisions. The person writing the advance directive and his nominated representative shall have a duty to ensure that the medical officer in charge of a mental health establishment or a medical practitioner or a mental health professional, as the case may be, has access to the advance directive when required. The legal guardian shall have right to make an advance directive in writing in respect of a minor and all the provisions relating to advance directive, mutatis mutandis, shall apply to such minor till such time he attains majority.

***** B.A. Garner (Ed.), *Black’s Law Dictionary,* Thomson Reuters (11th ed. 2019).

Duties of Appropriate government are provided in Chapter VI of the act. Section 29 provides that the appropriate government shall have a duty to plan, design and implement programmes for the promotion of mental health and prevention of mental illness and to reduce suicides and attempted suicides in the country. Section 30 directs the governments to take measures to create awareness about mental health and illness and reducing stigma associated with mental illness. Human resource development and training is envisaged under section 31 and coordination within appropriate government is contemplated in Section 32.

Admission under the Act

The 2017 Act outlines four admission statuses: 'independent admission' (voluntary admission), 'admission of a minor, 'supported admission' (admission and treatment without patient consent), and 'supported admission beyond 30 days'.

According to Section 85 (1) of the Mental Healthcare Act 'Independent admission' refers to the admission of a person with mental illness, to a mental health establishment, who has the capacity to make mental health care and treatment decisions or requires minimal support in making decisions'. As per Section 85 (2) all admissions in the mental health establishment shall, as far as possible, be independent admissions except when such conditions exist as make supported admission unavoidable. Independent admission' occurs at the person's request in accordance with Section 86 and once 'the medical officer or mental health professional in charge of the establishment is satisfied that:

(a) the person has a mental illness of severity requiring admission';

(b) is likely to benefit from admission and treatment'; and

(c) has understood the nature and purpose of admission', 'has made the request for admission of his own free will, without any duress or undue influence, and possesses mental capacity.

An 'independent patient', as per Section 86(4) shall be bound to abide by the order and bye-laws of the mental health establishment but 'shall not be given treatment without his informed consent' Discharge must occur immediately on request made by such person or if the person disagrees with his admission' unless 'the mental health professional is of the opinion that':

(a) such person is unable to understand the nature and purpose of his decisions and requires substantial or very high support from his nominated representative; or

(b) has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself; or
(c) has recently behaved or is behaving violently towards another person or has caused or is causing another person to bodily harm from him; or fear

(d) 'has recently shown or is showing an inability to care for himself to a degree that places the individual at risk of harm to himself.†††††

Under these circumstances, a mental health professional may prevent discharge of an independent patient for a period of 24 hours so as to allow his assessment necessary for 'supported admission'. Section 88 (4) of the act also provides that the person shall then 'be either admitted as a supported patient or discharged within 24 hours.

Section 87 of the act provides for the admission of a minor (not yet 18 years of age), 'the nominated representative of the minor shall apply to the medical officer in charge of a mental health establishment for admission." Admission may occur if two psychiatrists, or one psychiatrist and one mental health professional or one psychiatrist and one medical practitioner, have independently examined the minor on the day of admission or in the preceding seven days and both conclude that the minor requires admission, admission is in the minor's best interest 'taking into account the wishes of the minor if ascertainable' 'and there is no alternative, community treatment to meet the minor's needs' 'A minor so admitted shall be accommodated separately from adults, in an environment that takes into account his age and developmental needs. The nominated representative or an attendant appointed by the nominated representative shall under all circumstances stay with the minor in the mental health establishment for the entire duration of the admission'. 'A minor shall be given treatment with the informed consent of his nominated representative' and if the nominated representative no longer supports admission' or requests discharge, 'the minor shall be discharged". Admissions of minors are to be notified to the Mental Health Review Board within 72 hours and, if continued beyond 30 days, reviewed by the Board.

'Supported admission' (admission and treatment without patient consent)-Section 89(1) of the Act states that a person 'shall' be admitted as a 'supported admission' 'upon application by the nominated representative of the person' if:

(a) "The person has been independently examined on the day of admission or in the preceding seven days, by one psychiatrist and the other being a mental health professional or a medical practitioner, and both independently conclude based on the examination and, if appropriate, on information provided by others, that the person has a mental illness of such severity that the person:

(i) has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself; or

(ii) has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(iii) has recently shown or is showing an inability to care for himself to a degree that places the individual at risk of harm to himself;

††††† Section 88(3) of the Mental Health Care Act, 2017.

(b) "The psychiatrist or the mental health professionals or the medical practitioner, as the case may be, certify, after taking into account an advance directive, if any, that admission to the mental health establishment is the least restrictive care option possible in the circumstances'; and

(c) The person is ineligible to receive care and treatment as an independent patient because the person is unable to make mental health care and treatment decisions independently and needs very high support from his nominated representative in making decisions'.

The initial supported admission' must end when the person no longer meets these criteria or after 30 days. At this point, the person is discharged; the person can remain as an 'independent patient' or the 'supported admission' can continue under certain circumstances provided under Section 90 of the Act. The 'supported' patient 'shall be provided treatment after taking into account:

(a) an advance directive if any; or

(b) informed consent of the patient with the support of his nominated representative'.

If the person 'requires nearly 100% support from his nominated representative in making a decision in respect of his treatment, the nominated representative may temporarily consent to the treatment plan of such person on his behalf. As per Section 89 (8) of the Act, the medical officer must 'review the capacity of the patient to give consent every seven days'. Supported admissions' must be notified to the Mental Health Review Board within three days (for 'a woman or a minor) or seven days (others). 'A person admitted under Section 89 or his nominated representative or a representative of a registered nongovernmental organization with the consent of the person, may apply to the concerned Board for review of the decision' to admit the person. The Board will perform binding review within seven days.

If a 'supported' patient 'requires continuous admission and treatment beyond 30 days' (or readmission within seven days of discharge) 'the medical officer or mental health professional in charge of a mental health establishment, upon application by the nominated representative of a person with mental illness, shall continue admission of such person' if relevant criteria are still 'consistently' fulfilled, following independent examinations by two psychiatrists. The medical officer must 'review on the expiry of every fortnight, the capacity of such person to give consent'. Such admissions must be reported to the Mental Health Review Board within seven days and 'the Board shall, within a period of 21 days from the date of last admission or readmission permit such admission or readmission or order discharge of such person', bearing in mind '(a) the need for institutional care to such person; and (b) 'whether such care cannot be provided in less restrictive settings based in the community'. "The Board may require the medical officer or psychiatrist in charge of the treatment of such person with mental illness to submit a plan for community-based treatment and the progress made, or likely to be made, towards realizing this plan'. The 'non-existence of community-based services' locally does not justify such an admission which is, in

the first instance, limited to 90 days but can be extended for 120 days and periods of 180 days thereafter, if criteria are met. These provisions for extending a 'supported admission' place welcome emphasis on active consideration of community-based alternatives. The patient 'or his nominated representative or a representative of a registered non-governmental organization with the consent of the person, may apply to the concerned Board for review of the decision of the medical officer or mental health professional in charge of medical health establishment to admit such person in such establishment and as per Section 90 of the Act, the decision of the Board thereon shall be binding on all parties'.

The psychiatrist is expected to be responsible for patient care and treatment in the future after discharge. Medical treatment can be given for mental illness by registered medical practitioner to a mentally ill person either at Mental Health Establishment or at community for a maximum period of 72 hours with informed consent of NR to prevent death or irreversible harm to health of person or person inflicting serious harm to himself or person causing serious damage to property Electroconvulsive therapy (ECT) shall not be used as form of treatment in this section of emergency treatment.

Issues and Challenges in delivering Mental Health Care

A study regarding the perceived stigma and discrimination of mental illness in India by analyzing data from five metropolitan cities revealed a significant influence of gender on the perceived stigma of mental illness.[‡‡‡‡‡] Treatment gap exists in mental health care in India. In order to effectively address the treatment gap in mental health care, the following considerations need to be tackled. popularizing psychiatry (inducting more medical students to specialization), providing culturally sensitive training to mental health care professionals (taking into account cultural, geographical, and demographic diversity), increasing telemedicine practices and links (to reduce the cost of travel and stay at referral hospitals), providing psychosocial support for patients and caregivers (to reduce the indirect costs of mental illness), involving governmental and non-governmental organizations (NGOs) for community-based care (to prevent delays in seeking treatment and to spread awareness at the grass-roots level), and reducing stigma and discrimination (to improve treatment-seeking and adherence). Policy and research reflect that mental illness in India contributes significantly to the global occurrence of mental illness, and the treatment gap leads to substantial losses to individuals and families in particular, and society and the nation at large. The treatment gap can be addressed by utilising locally available resources, combining biomedical resources with locally relevant and feasible resources, and targeting primary and secondary care. As a socio-culturally diverse and populous nation, India must adopt the models that fit well with the local contexts, needs, and conceptualizations of mental health. A partnership between psychiatrists, local healers (especially religious healers), psychiatric social workers, anthropologists, NGOs, and local volunteers could play

[‡‡‡‡‡] A.B. Zieger et al, *Perceived Stigmatization and Discrimination of People With Mental Illness: A Survey-Based of the General Population in Five Metropolitan Cities in India,* Indian Journal of Psychiatry Vol. 60 pp. 24-31 (2018).

an important role in making mental health services effective and accessible to a larger population.§§§§§

There are no specific provisions that address issues related to the elderly with mental illness. There is a need for clarification about the implementation of the provisions of the Mental Health Care Act, 2017 with regard to advance directives in comparison to the guidelines issued by the Supreme Court in *Common Cause (A Registered Society) v. Union of India.*[******] If there is a dispute among family members regarding the responsibility of caring for the elderly as to who will be appointed as nominated representative is another issue. There is an urgent need to sensitize the law implementing agencies regarding their role and responsibilities related to Mental Health Care Act, 2017.††††††

Role of Judiciary in Protecting the Right of the Mentally Ill

In *Dr. Upendra Baxi (I) v. State of U.P.*,‡‡‡‡‡‡ the Supreme Court issued various directions in order to ensure that the inmates of the Protective Home at Agra do not continue to live in inhuman and degrading conditions and that the right to live with dignity enshrined in Article 21 of the Constitution is made real and meaningful for them. In *Chandran Kumar Banik v. State of West Bengal*§§§§§§, the Supreme Court observed: that management of an institution like the mental hospital requires a flow of human love and affection, understanding, and consideration for mentally ill persons; these aspects are far more important than a routinized, stereotyped and bureaucratic approach to mental illness in the Mental Hospital at Mankundu in the District of Hooghly. In *Rakesh Chandra Narayan v. State of Bihar*[*******], a writ petition in regard to the Mental Hospital at Ranchi has been considered a public interest application and the Supreme Court called upon the Chief Judicial Magistrate of Ranchi to visit the hospital and submit a report. The report indicated maladministration, naked patients or patients with torn shirts and pants, no stock of medicines, no working toilets, no doors, and windows for wards, and also indicated an abrupt rise in the graph of a death rate.

The report indicated the inhuman condition and mismanagement of the hospital. The court observed that the report bought out a clear picture of the shocking and savage conditions that prevail in the mental hospital. The court directed the constitution of a Committee of Management for the Mental Hospital and gave directions regarding the financial contribution from the States of West Bengal, Orissa and Bihar and laid down guidelines regarding the functioning and management of the hospital.

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§§§§§ R. Kaur & R.K. Pathak, *Treatment Gap in Mental Healthcare Reflections from Policy and Research,* Economic and Political Weekly (EPW) Vol. III Issue 31 (2017).

[******] (2018) 5 SCC 1

†††††† P.T. Sivakumar et al, *Implications of Mental Health Care Act 2017 for Geriatric Mental Health Care Delivery: A Critical Appraisal,* Indian Journal of psychiatry Vo. 61 Issue 10, pp. 763-67 (2019).

‡‡‡‡‡‡ (1983) 2 SCC 308

§§§§§§ (1995) Supp 4 SCC 505

[*******] AIR 1989 SC 348

In *re: Death of 25 chained Inmates in Asylum Fire in Tamil Nadu*[†††††††], on the basis of submission note of the Registrar (Judicial) to a news item published in all leading dailies about a gruesome tragedy in which more than 25 mentally challenged patients housed in a mental asylum at Ervadu in Ramanathapuram district were charred to death, the patients could not escape the blaze as they had been chained to poles or beds, the Supreme Court took *suo motu* action and issued various directions. The Directions issued by the Supreme Court are as follows:-

(i) Every State and Union Territory must undertake a district-wise survey of all registered/ unregistered bodies by whatever name called, purporting to offer psychiatric mental health care. All such bodies should be granted or refused license depending upon whether minimum prescribed standards are fulfilled or not. In case the license is rejected, it shall be the responsibility of the SHO of the concerned police station to ensure that the body stops functioning and patients are shifted to Government Mental hospitals. The process of survey and licensing must be completed within 2 months and the Chief Secretary of each State must file a comprehensive compliance report within 3 months from the date of this order. The compliance report must further state that no mentally challenged person is chained in any part of the State.

(ii) The Chief Secretary or Additional Chief Secretary designated by him shall be the nodal agency to coordinate all activities involved in the implementation of the Mental Health Act, 1987, the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 and the National Trust for Welfare of Persons with Autism, Cerebral Palsy Mental Retardation, and Multiple Disabilities Act, 1999. He shall ensure that there are no jurisdictional problems or impediments the effective to implementation of the three Acts between different ministries or departments. At the Central level, the Cabinet Secretary, Government of India, or any Secretary designated by him shall be the nodal agency for the same purpose.

(iii) The Cabinet Secretary, Union of India shall file an affidavit in this court within one month from the date of this order indicating-

(a) the contribution that has been made and that is proposed to be made under section 21 of the 1999 Act which would constitute the corpus of the National Trust.

(b) Policy of the Central Government towards setting up at least one Central Government-run mental hospital in each State and Union Territory and definite time schedule for achieving the said objective.

(c) National Policy, if any, framed u/s. 8(2)(b) of the 1995 Act.

(iv) In respect of States/Union Territories that do not have even one full-fledged State Government run a mental hospital, the Chief Secretary of the State/Union Territory must file an affidavit within one month from the date of this order

[†††††††] AIR 2002 SC 979

indicating steps being taken to establish such full-fledged State Government run mental hospital in the State/Union Territory and a definite time schedule for establishment of the same.

(v) Both the Central and State Governments shall undertake a comprehensive awareness campaign with a special rural focus to educate people as to provisions of law relating to mental health, rights of mentally challenged persons, and that mental patients should be sent to doctors and not to religious places such as temples or dargahs.‡‡‡‡‡‡‡

(vi) Every State shall file an affidavit stating clearly; (a) whether the State Mental Health Authority under section 3 of the 1987 Act exists in the state and if so, when it was set up. (b) If it does not so exist, the reasons therefore and when such an Authority is expected to be established and operationalized. (c) The dates of the meeting of those Authorities, which already exist, from the date of inception till date, and a short summary of the decisions taken. (d) A statement that the state shall ensure that a meeting of the Authority takes place in the future at least once every four months or at more frequent intervals depending on exigency and that all the statutory functions and duties of such Authority are duly discharged. (e) The number of prosecutions, penalties, or other punitive/coercive measures taken, if any, by each State under the 1987 Act.

In *Joseph v. The State of Kerala*,§§§§§§§ the Writ Petitioner pointed out on the basis of reliable information that there were cases of admission to Mental Health Centers without proper assessment and audit and this is being abused to generate matrimonial discord, including separation and also for various other matters, relating to assets of persons who are admitted to such Centers. The Court issued a direction that those in management and control of the mental health centers under the Government, as also other psychiatric hospitals and psychiatric nursing homes shall ensure that Sections 15, 16, 17, and 19 of the Act are strictly adhered to.

Thus, the public interest litigations in this area mainly focus on giving adequate facilities in mental hospitals so that mentally ill people can also live as human beings. Writ petitions focus on the right to employment of mentally ill people. In *Anil Kumar Mahajan v. Union of India*,******** it was held that mental illness is one of the disabilities under sec. 2(i) of the persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, under Section 47 of the Act, it was not open to the respondents to dispense with, or reduce in rank of the appellant, who acquired a disability during his service. If the appellant, after acquiring disability was not suitable for the post he was holding, he should have been shifted to some other post with the same pay scale and service benefits. Further, if it was not possible to adjust the appellant against any post, the respondents ought to have kept the appellant on a supernumerary post until a suitable post is available, or until the appellant attained the age of superannuation whichever was earlier.

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‡‡‡‡‡‡‡ AIR 2002 SC 979
§§§§§§§ 2013 (3) KLT 707
******** 2013 (3) KLT SC 34 SC

Role of the National Human Rights Commission

The National Human Rights Commission prepared a plan of action for improving the conditions in mental hospitals in the country and enhancing awareness of the rights of those with mental disabilities.†††††††† The Commission undertook a project on 'Quality Assurance in Mental Health Care' and ended with a series of recommendations. The Commission's recommendations include steps to improve physical facilities, treatment and care of patients, occupational therapy as a tool of rehabilitation, training, and research, and community outreach programs. The recommendations included immediate abolition of cell admissions; gradual conversion of closed wards into open wards; construction of new wards of smaller capacity (not more than 20) for use as open wards; streamlining admission and discharge procedure in accordance with provisions of the Mental Health Act, 1987; upgradation of investigation facilities; in-service training of all staff members; providing each patient a cot, mattress, pillow, bed sheet and adequate clothing for change; improving the supply of water and electricity; ensuring the supply of nutritive food in calories per day to each patient, developing occupational therapy facilities; improving recreational facilities; developing rehabilitation facilities including daycare centers.

The Commission also constituted a Central Advisory Group (CAG) headed by its Chairperson with a view to suggesting an appropriate course of action in the area of mental health. The National Human Rights Commission prepared a report on mental health institutions after visiting thirteen Government Mental Institutions all over the country. The Commission assessed physical infrastructure; out-Patient Department; living Conditions of patients in Mental Health Centers; Human Resources; and administration and financial management. The Commission also assessed the basic minimum needs of the patients like the right to food; right to potable water; and (ii) right to personal hygiene and supporting services like occupational therapy, telephone services; recreational and cultural activities; and library services are also inspected by the Commission.

The Commission identified the fact that there exists a gap between human, material, and financial resources needed on account of the growing demand for mental health services and the available resources. The major recommendations of the Commission include the following:

(i) The infrastructure of Mental Health Hospitals should ensure a balanced combination of arrangements for teaching, training, research, and treatment.

(ii) Mental health centers should display three boards-one in English should be about Citizen's Charter, the hospital timings, and services provided; the second board consisting of eleven instructions in the local language needs to be meant for

†††††††† National Human Rights Commission, *Care and Treatment in Mental Health Institutions: Some Glimpses in the Recent period*, available at: https://nhrc.nic.in/sites/default/files/Care_and_Mental_Health_2012.pdf (last accessed on July 23, 2022).

family members of the patient on the care, concern, and attention towards a mentally ill person; and

the third one should spell out the provisions of the Mental Health Act, 1987 along with admission and discharge procedures. (ii) With the increase in incidences of mental illness and consequent increase in a number of mentally ill persons it is necessary and desirous to create a database for analysis and drawing conclusions.

(iv) A school mental health program for sensitization of parents, teachers and students.

(v) A cell phone from the hospital establishment may be made available to the person to talk to their relatives. The problem of noncompliance of medicines needs to be handled through strong and effective counselling; the management of hospital need to involve self help groups for making home visits and providing counselling for better drug complaints.

(vi) There should be a proper staffing pattern by sanctioning essential posts and filling up the sanctioned post lying vacant for a long time.

(vii) State government should take a decision to make mental health care hospitals autonomous.

Conclusion

In India, the number of people suffering from mental illness is on the increase. The present mental asylums in India are not adequate. There is a severe shortage of psychiatrists and paramedics. People depend on faith healers and quacks. National budget for mental health care is not sufficient. The Medical Council of India should make mental health a separate subject in the MBBS curriculum.‡‡‡‡‡‡‡‡

‡‡‡‡‡‡‡‡ Gunjan Sharma, *Damned Lives and Statistics,* The Week (May 27, 2022).