THE EVOLUTION OF MENTAL HEALTHCARE LEGISLATION IN INDIA: A HISTORICAL AND LEGAL INQUIRY

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Abstract
This paper traces the historical development of mental healthcare legislation in India, examining the shift from colonial- era custodial frameworks to contemporary rights- based approaches. Beginning with the Indian Lunacy Acts of the 19th and early 20th centuries, the study analyzes how early laws reflected a custodial and stigmatizing view of mental illness. The post- independence Mental Health Act, 1987 introduced basic regulatory structures but remained inadequate in safeguarding patients' rights. A significant legislative advancement came with the Mental Healthcare Act, 2017, which marked a paradigm shift by aligning Indian laws with international human rights obligations under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). The objective of the paper is to: a) trace the historical development of mental health legislation in India from the colonial period to the present day b) analyze the key features and limitations of the major legislative instruments, including the Indian Lunacy Act, 1912, the Mental Health Act, 1987 and the Mental Healthcare Act, 2017, and c) identify gaps and challenges in the implementation of mental healthcare laws.

Introduction

History is a screen through which the past lightens the present and the present brightens the future.[1] Mental health by virtue of its ability to deal with human thoughts and emotions, and to provide a pathway for healthy minds is a vital resource for our development, and its absence represents a great burden to the economic, political and social functioning of human beings and nation.[2] A concern with mental health has long been a part Indian culture, which has evolved in a variety of ways, attempting to understand and negotiate mental disorder. The scope of mental health laws is not only confined to admission and treatment of mentally ill persons in mental health care centres, but it is related to a whole range of activities.[3] In this chapter, the researcher has attempted to study the foundations of modern psychiatry in India which has sailed through tides of times, ultimately culminating in to the rights- based Mental Healthcare Act, 2017.

Similar to medical traditions worldwide, Indian medicine too has had an awareness of mental illness. Various literature in ancient India have illustrated about mental disorders. The Charaka Samhita by Charaka designated Psychiatry as Bhuta Vidya. Bhuta Vidya treated mental derangements by prescribing prayers, oblations, exorcism, drugs and so forth as remedies.[4]

Agastya, one of the great profounder of Siddha system of medicine formulated a treatise on mental diseases called as Agastiyar Kirigai Nool.[5]

In Unani medicine too, Nafsiyati Amraz or mental disorders have been described in detail by great physicians like Hippocrates, Abu Bakr Bin Zakria Razi and Ali Bin Rabban Tabri.[6]

References for institutions or asylums for the sick can be found during the reign of Ashoka (268-231 B.C.). Inscriptions on the walls of a Lord Venkateswara temple built during the Chola period in Tamil Nadu mentioned a hospital comprising of 15 beds named as Sri Veera Cholaeswara hospital..[7] However, the traditionally and culturally accepted medical diagnosis and management of mentally ill persons was similar to general medical care in India. There was no segregation or seclusion of persons with mental illness. Mental hospitals, as they exist today in India, is entirely a British concept. The early institutions for the mentally ill in the Indian subcontinent was greatly influenced by ideas and concepts as prevalent in England and Europe. Basic function of these asylums were to provide basic necessities such as food and shelter to the affected while securely keeping them away from the society so that they did not cause any harm to the public.

[1] S.H. Nizamie and N. Goyal, "History of Psychiatry in India" 52 *Indian Journal of Psychiatry* 7 (2010).
[2] *Ibid.*
[3] *Ibid.*
[4] S.R. Parker, V.S. Dhawan, *et.al*., "History of Psychiatry in India" 47 *Journal of Postgraduate Medicine* 73 (2001).
[5] Supra note 4
[6] M. Usman and S. M. Safdar Ashraf, "Unani Perspective in the Prevention and Treatment of Psychiatric Disorders" 6(4) *Journal of Integrated Community Health* 26 (2017).
[7] *Supra* note 1 at 8

Early Mental Healthcare in India

In 1745, one of the earliest mental hospitals in India was established with around 30 beds in Bombay.[8] This was followed by a mental hospital in Calcutta started by Surgeon George M. Kenderline with around 50-60 European patients.[9] The first government run lunatic asylum for insane soldiers was opened on 17th April, 1795 in Bihar.[10] Asylums within Bengal, Madras and Bombay were also set up during this period.[11]

These asylums were mainly set up to cater to the British and Indian sepoys employed by the British. The interest of these asylums was to protect the society from the so called dangerous mentally ill.[12] Thus their function was less curative and more custodial in nature, so much so that Waltraund Ernst called these asylums a "less conspicuous, measures of social control".[13]

Early Mental Health Legislations in India

The first piece of mental health legislation introduced was the Lunatic Removal Act, 1851 which comprised of seven sections.[14] It facilitated the removal of mentally ill offenders of European birth from India to any part of the United Kingdom at the expense of the East India Company. The Indian climate was often blamed for mental illness and it was felt that returning people to the United Kingdom could remedy this.[15]

Also after the British crown took over the control of the Indian administration from the East India Company, three mental health laws were introduced for the care of people with mental illness. First, the Lunacy (Supreme Courts) Act, 1858 dealt with the judicial evaluation of mental health in presidency towns namely Madras, Calcutta and Bombay. Secondly, the Lunacy (District Courts) Act, 1858 provided similar legal framework for cases outside of presidency towns. Thirdly, the Indian Lunatic Asylum Act, 1858 governed detention in asylums.[16]

These acts were the first pan- Indian legislation addressing native lunacy in India. The new government of India did not write the Lunacy Acts *de novo*; they were based in great measure on the English Lunacy Acts of 1845. The three Acts represented the trifecta of Crown rule in India: one at the Supreme Court level in Presidency Towns, one at the District or local level in outlying territories, and one at the institutional level, for the care of lunatics in asylum settings.[17]

Under Indian Lunatic Asylum Act, 1858, the government could now establish asylums for the reception and detention of lunatics. The government may also grant a license to any private persons for the establishment of such asylums. Additionally, the Act empowered the Government to lay down rules related to the management of asylums. Thus, the 1858 Act was a significant legislative move for the establishment and management of asylums in India.[18]

In 1860, the Indian Penal Code criminalized attempt to suicide, stating that 'whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both'.[19] This provision remains in place even today and is being employed from time to time. However, there has been a noted shift in perceptions concerning the criminalization of suicide in the years leading up to the Mental Healthcare Act, 21017.[20]

Consequently, despite Section 309 remaining in the Penal Code, the new MHCA takes significant steps to decriminalize suicide, stating that 'notwithstanding anything contained in Section 309 of the Indian Penal Code any person who attempts to commit suicide shall be presumed, unless proved

[8] *Supra* note 1 at 8

[9] L. P. Varma, "History of Psychiatry in India and Pakistan"4 *Indian Journal of Psychiatry* 32 (1953).

[10] *Supra* note 11 at 34

[11] S. Jain "Psychiatry and Confinement in India", in R. Porter and D. Wright (eds.), *The Confinement of the Insane: International Perspectives, 1800- 1965* 273-298 (Cambridge University Press, Cambridge, 2003).

[12] S. D. Sharma "Mental Health: The Pre- Independence Scenario", in S.P. Agarwal (ed.), *Mental Health: An Indian Perspective 1946-2003* 25-29 (Directorate General of Health Services/ Ministry of Health and Family Welfare, New Delhi, 2004).

[13] Waltrund Ernst, "The Establishment of 'Native Lunatic Asylums' in Early Nineteenth- Century British India", in G. Meulenbeld, Wujastyk Jan, *et. al*. (eds.), *Studies on Indian Medical History* 155-190 (Motilal Banarsidas Publishers Pvt. Ltd., Delhi, 2001).

[14] M. M. Firdosi and Z. Z. Ahmad, "Mental Health law in India: Origins and proposed reforms" 13(3) *British Journal of Psychiatry International* 65 (2016).

[15] *Ibid*.

[16] S. Nambi, S. Ilango, et. al., "Forensic psychiatry in India: Past, present and future" 58(2) *Indian Journal of Psychiatry* 175 (2016).

[17] Anouska Bhattacharyya, *Indian Insanes: Lunacy in the 'Native' Asylums of Colonial India, 1858- 1912* (2013) (Doctoral dissertation, Harvard university).

[18] Shilpi Rajpal, "Colonial Psychiatry in Mid- nineteenth century India: The James Clark Enquiry" 35(1) *South Asia Research Journal* 64 (2015).

[19] The Indian Penal Code, 1860 (Act No. 45 of 1860), s. 309.

[20] L. N. Vadlamani and M. Gowda, "Practical implications of Mental Healthcare Act, 2017: Suicide and suicide attempt" 61 *Indian Journal of Psychiatry* 312 (2019).

otherwise, to have severe stress and shall not be tried and punished under the said Code.'[21] In addition, 'the appropriate government shall have the duty to provide care, treatment and rehabilitation to a person, having severe stress and who attempted suicide, to reduce the risk of recurrence of attempt to suicide'.[22]

In 1905, at the initiative of Lord Morley, the control of mental hospitals was transferred from the Inspector General of Police to the Directorate of Health Services and, at the local level, to the Civil Surgeons. The posting of specialist psychiatrists and medical officers as full time officers was acknowledged. Another very important development during this period, was the intent of the government in 1906 to have a central supervision system of all the lunatic asylums by legislation, which resulted in the Indian Lunacy Act, 1912.[23]

The Indian Lunacy Act,1912

The Indian Lunacy Act 1912 amended, consolidated, revised and replaced existing mental health legislation in an attempt to bring Indian legislation in line with the English Lunacy Act, 1890.[24] The 1912 Act was instrumental in establishing asylums in India as archetypal colonial institutions. This revision of the legislation was motivated by a general outcry at the conditions in which people with mental illness were being kept. The Act was a substantial legislation comprising of 101 sections divided into four parts and consisting of eight chapters.

One of the major concerns of that period, and an issue carefully addressed in the 1912 Act, was the improper detention of sane people for nefarious reasons. The Act clearly laid down that no person other than a criminal lunatic or a lunatic found by inquisition shall be received or detained in an asylum without a reception order. The application for reception order had to be made by a petition to the Magistrate accompanied by two medical certificates on separate sheets of paper. Despite this measure, if someone was detained inappropriately, it was very difficult to get the detention order revised. While it could be done, it required the person who signed the initial order to agree that the order should be revoked and two or more of the visitors of the said asylum had to sanction the revocation.[25] Each asylum had at least three visitors, one of whom was a doctor. These people inspected the asylum and met the patients monthly. These monthly inspections were the closest thing in the Act to a review process for detained patients.[26]

The 1912 Act had many progressive features. It was, for example, one of the first pieces of mental health law to consider voluntary admissions (Section 4). The status of voluntary patients was not recognized in the English and Welsh law until 1930.[27] The 1912 Act also addressed 'wandering or dangerous lunatics', mentally ill in the armed forces, and mentally ill offenders and prisoners.

Mental Healthcare in independent India

A new phase of development of mental hospitals started after India's independence in 1947. Keeping in view the international trend toward deinstitutionalization and persisting poor conditions in mental hospitals, Government of India concentrated on creation of psychiatric units in general hospitals rather than building new mental hospitals. A series of conferences were held in Agra (1960), Ranchi (1986), Bangalore (1988 and 1999), Delhi (1995), in which the state of existing mental hospitals was reviewed and recommendations for their improvement were made. Also, considering the experience of the Indian Lunacy Act, 1912 as outdated, the Mental Health Act, 1987 came to replace it.

Mental Health Act, 1987

The Mental Health Act, 1987 is divided into 10 chapters and has 98 sections. The Act had been drafted in 1950, but took 37 years to receive presidential assent.[28] It did not come into effect in all states and union territories until 1993.[29]

Despite the delays with implementation, India's 1987 Act introduced many positive changes to mental healthcare in India. It adopted a more human rights- based approach to care, replaced much of the stigmatizing terminology, created the Central and State Mental Health Authorities, simplified admission and discharge policies and facilitated proxy consent for involuntary admission

[21] The Mental Healthcare Act, 2017 (Act No. 10 of 2107), s. 115(1).
[22] The Mental Healthcare Act, 2017 (Act No. 10 of 2107), s. 115(2).
[23] *Id.* at 15
[24] O. Somasundaram, "The Indian Lunacy Act, 1912: The historic background" 29 *Indian Journal of Psychiatry* 3 (1987)
[25] The Indian Lunacy Act, 1912 (Act No. IV of 1912), s. 27.
[26] Richard M. Duffy and Brendan D. Kelly, *India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights* 55 (Springer, Singapore, 2020)
[27] *Id.* at 32
[28] J. K. Trivedi, "The mental health legislation: An ongoing debate" 44 *Indian Journal of Psychiatry* 95 (2002).
[29] P. Rastogi, "Mental Health Act, 1987- An analysis" 27 *Journal of Indian Academy of Forensic Medicine* 176 (2005).

and the admission of minors.[30] It was also the first of India's mental health Acts to consider outpatient treatment and thus helped shift the focus of psychiatric care from psychiatric hospitals to the community, at least in theory. The Act also introduced separate inpatient services for people with addiction- based problems and provided children with separate mental health services.

2.4.2 The Challenges in Mental Health Act, 1987

Despite these advances, the 1987 act was heavily criticized for a number of reasons. The following are the challenges or issues with the legislation-

- **Unrealistic minimum standards for private psychiatric hospitals/ nursing homes**

The most frequent criticism voiced against the Mental Health Act, 1987 relates to the unrealistic minimum standards prescribed for private psychiatric hospitals/ nursing homes.[31] The sense of injustice is compounded by the fact that government hospitals, are excluded from the purview of these provisions.[32]

- **Exclusion of government mental hospitals:**

As discussed above, The Mental Health Act, 1987 excludes government hospitals from the purview of licensing and as such these hospitals does not have to implement the prescribed minimum standards as provided in State Mental Health Rules 1990, Rules 20 and 22. As a result, the condition of the mentally ill patients in the government hospitals have been pitiable as observed in the Quality Assurance in Mental Health report of National Human Rights Commission 1999. Due to the poor standards in the government hospitals, a number of public interest litigations have also been filed against them.

- **Poor knowledge and insensitive attitude of law enforcing agencies**

The Mental Health Act, 1987 gave excessive power to the judges and the police to exert their control over admissions and discharge of non-criminal mentally ill persons. Unfortunately, due to the lack of comprehensive awareness, sensitivity and knowledge of these law enforcing agencies regarding the issues of mentally ill persons, it has been time and again seen that the Act has been poorly implemented and utilized, which ultimately leads to the infringement of rights and liberties of the mentally ill persons.

- **Appeals from orders of Magistrate**

As discussed above, under the Act, the Magistrates had the power to order the admission and discharge of involuntary mentally ill persons to and from the psychiatric hospitals. However, if any person is aggrieved with such an order of the Magistrate has to appeal against the order in the District Court. It is a well-known fact that the procedure in the Court is tedious, costly and time consuming and therefore cannot be said to be easily accessible to a person who is involuntarily admitted to a mental hospital. Hence, it can be said that the appeal mechanism prescribed by the Mental Health Act, 1987 is arbitrary and unreasonable and a serious drawback in the Act.

Apart from the issues mentioned above, the Mental Health Act, 1987 has also been heavily criticized for a number of other reasons. Firstly, it failed to align with government policy, India's National Mental Programme and also many World Health Organization guidelines. Secondly, the Act approached mental illness from a legal perspective rather than a clinical one and consequently placed excessive power in the hands of law enforcing agencies rather than clinicians. Thirdly, the Act did little to address the stigma attached to mental illness or to raise awareness and educate the society as a whole about mental illness. In fact, under the Act, the police were often the only means of transporting involuntary patients to hospital, which added to stigma, rather than reducing it.[33] Thus in view of the aforementioned reasons, as well as the non-conformity of the Mental Health Act, 1987 with the United Nations Convention on the Rights of the Persons with Disabilities which India ratified on October 1, 2007, finally led to its replacement with the new Mental Healthcare Act, 2017 as the previous Act failed to adequately protect the rights of persons with mental illness.

2.4.3 Mental Healthcare Act 2017

The Convention on the Rights of Persons with Disabilities which was adopted by the United Nations on 13th December, 2006 and came into force on 3rd May, 2008 makes a paradigm shift in attitudes and approaches to persons with disabilities and views them not as 'objects of charity', but 'subject with rights'. India signed the CRPD and ratified it on 1st October, 2007, and in pursuance of its obligation to bring its existing laws in congruence with this Convention, developed the new mental health legislation, the Mental Health Care Act, 2017. The following are some of the salient features of the Mental Healthcare Act 2017

[30] *Ibid.*

[31] S. B. Math, Pratima Murthy, et. al., "Mental Health Act (1987): Need for a paradigm shift from custody to community care" 133 *Indian Journal of Medical Research* 246 (2011).

[32] *Ibid.*

[33] *Supra* note 22 at 179

Rights of persons with mental illness: Every person will have the right to access mental healthcare services. Such services should be of good quality, convenient, affordable, and accessible. This act further seeks to protect such persons from inhuman treatment, to gain access to free legal services and their medical records, and have the right to complain in the event of deficiencies in provisions

Advance Directive: This empowers a mentally ill person to have the right to make an advance directive toward the way she/he wants to be treated for the requisite illness and who her/his nominated representative shall be. This directive has to be vetted by a medical practitioner.

Mental Health Establishments: The government has to set up the Central Mental Health Authority at national level and State Mental Health Authority in every state. All mental health practitioners (clinical psychologists, mental health nurses, and psychiatric social workers) and every mental health institute will have to be registered with this authority. These bodies will (a) register, supervise, and maintain a register of all mental health establishments; (b) develop quality and service provision norms for such establishments; (c) maintain a register of mental health professionals; (d) train law enforcement officials and mental health professionals on the provisions of the act; (e) receive complaints about deficiencies in provision of services; and (f) advise the government on matters relating to mental health.

Admission of persons with mental illness: The act also outlines the procedure and process for admission, treatment, and subsequent discharge of mentally ill persons.

Decriminalizing suicide and prohibiting electroconvulsive therapy: It decriminalizes suicide attempt by a mentally ill person. It also imposes on the government a duty to rehabilitate such person to ensure that there is no recurrence of attempt to suicide. A person with mental illness shall not be subjected to electroconvulsive therapy (ECT) therapy without the use of muscle relaxants and anesthesia. Furthermore, ECT therapy will not be performed for minors.

Responsibility of certain other agencies: A police officer in charge of a police station shall report to the Magistrate if he has reason to believe that a mentally ill person is being ill-treated or neglected. It also imposes a duty on the police officer in the charge of a police station to take under protection any wandering person; such person will be subject to examination by a medical officer and based on such examination will be either admitted to a mental health establishment or be taken to her residence or to an establishment for homeless persons.

Financial punishment: The punishment for violating of provisions under this Act will be imprisonment up to 6 months or Rs. 10,000 one or both. Repeat offenders can face up to 2 years in jail or a fine of Rs. 50,000–5 lakhs or both.

However, there are multiple challenges with the implementation of the act-

1. **Lack of Awareness**: Many people are still unaware of their rights under the Mental Healthcare Act.
2. **Limited Resources**: Mental healthcare facilities, staff, and resources are inadequate and underfunded. For instance, India has only 0.29 psychiatrists per 100,000 population as per World Health Organization. "Mental Health Atlas 2017."
3. **Stigma**: Mental illness is still stigmatized in many cultures, with 47% believing it should be kept in isolation. (The Live Love Laugh Foundation. "How India Perceives Mental Health.")
4. **Inadequate Training**: Healthcare professionals may not have adequate training in the diagnosis and treatment of mental illness. For example, a study published in the Indian Journal of Psychological Medicine in 2020 found that only 21% of medical colleges provided adequate training in psychiatry.
5. **Limited Accessibility**: Marginalized groups, including women, those living in rural regions, and members of the LGBTQ+ community, may not have access to mental healthcare services. Due to a lack of funding and poor infrastructure, rural populations had limited access to mental healthcare services.
6. **Weak Monitoring and Oversight**: The Mental Health Review Commission has not been established in many states, which weakens oversight of mental healthcare facilities. For example, as of 2019, only 18 of India's 29 states had set up the Commission
7. **Resistance to Change**: Resistance to change can be a barrier to the implementation of the Act. For instance, mental healthcare professionals may resist changes in treatment approaches or the adoption of modern technology in mental healthcare.

Conclusion

The evolution of the mental healthcare laws in India reflects a broader transition from custodial approach to one that increasingly recognizes the rights, autonomy and dignity of individuals with mental illness. Beginning with the colonial era,

Lunacy Acts which emphasized confinement, India's legal framework for mental health remained stagnant for decades. However, the post-independence period, especially after the enactment of the Mental Health Act, 1987, marked the beginning of a shift towards more humane treatment, although limited in its rights- based focus.

The landmark Mental Healthcare Act, 2017 represents a pragmatic shift in India's approach, aligning domestic legislation with international human rights standards, particularly the united Nations Convention on Rights of Persons with Disabilities. Nevertheless, despite its progressive framework, the implementation of the Act faces significant challenges. A comprehensive, inclusive and rights- oriented mental health system must not only exist on paper but be actively enforced at all levels.