

Unshackling Minds: A Critical Analysis of Mental Health Laws, Social Stigma and Selected Cases in Contemporary India

Dr. Sampadika Mohanty

Vice principal, Rourkela Law College, Rourkela, Odisha

Abstract—This chapter provides a comprehensive analysis of the intricate relationship between mental health law and social stigma in India. The study critically examines the evolution of Mental Health Laws and Programmes in India, both pre and post-independence, shedding light on their response to societal perceptions of mental health, particularly the pervasive stigma associated with mental illnesses. Beginning with an exploration of the historical context, the paper scrutinizes the impact of British colonial-era laws and their stigmatizing language and practices. It then transitions to the post-independence era, analyzing the shift towards community-based care and the National Mental Health Programme's efforts to mitigate stigma. To assess the contemporary landscape, the study analyzes five seminal cases from Indian High Courts and the Supreme Court, offering valuable insights into the practical implications of these legal frameworks in addressing social stigma. These cases highlight the challenges faced by individuals with mental illnesses within the Indian judicial system, emphasizing the urgent need for legal reforms. The findings of this research reveal a complex interplay between mental health laws, societal attitudes, and the judicial system. In conclusion, the paper provides comprehensive recommendations for reform, emphasizing the importance of destigmatizing language and practices within legislation, ensuring access to mental healthcare, and addressing the socio-economic determinants of mental health. This research contributes to the ongoing discourse on mental health law and its role in combating social stigma, ultimately aiming to create a more inclusive and equitable society for individuals with mental health disorders in India.

I. INTRODUCTION

References to mental illness possess a complex historical backdrop, characterized by cyclical rather than linear development. The classification of

behaviors as either typical or deviant depends on the prevailing context and evolves in sync with changes in time and culture. Throughout history, behaviors that deviate from societal norms have been employed as tools of domination and manipulation. As a result, there has been a transition away from a purely culturally relative perspective on unusual behavior, towards an assessment focused on determining whether such conduct poses risks to individuals or others, or causes substantial distress and disruption in one's personal and professional life.

II. MENTAL HEALTH THROUGHOUT THE AGES

Throughout history, three overarching paradigms have shaped mental illness etiology: the supernatural, somatogenic, and psychogenic perspectives. Supernatural doctrines ascribe mental disorders to malevolent spirits, divine displeasure, celestial phenomena, planetary influences, curses, and moral transgressions. Somatogenic theories pinpoint physiological disruptions stemming from illness, genetic predisposition, or cerebral anomalies. Conversely, psychogenic theories focus on traumatic experiences, maladaptive learned behaviors, distorted perceptions, and high-stress contexts. These etiological frameworks profoundly shape therapeutic approaches for afflicted individuals, a person perceived as haunted differing vastly from one perceived to possess an overabundance of yellow bile. Despite temporal elapse, these theories persist and intertwine, emblematic of a cyclically recurring pattern (Farreras, 2013).

Among the earliest supernatural explanations, trephination, dated to 6500 BC, involved cranial perforations to expel malevolent spirits. Around 2700

BC, Chinese "yin and yang" concepts emphasized equilibrium for mental and physical well-being. Approximately 1900 BC witnessed "hysteria" among Egyptian and Greek women, attributed to uterine misalignment, leading to somatogenic remedies involving fragrances. In the 4th century BC, Hippocrates heralded somatogenic explanations, attributing mental disorders to humoral imbalances, and advocating compassionate care. Galen in AD 130–201 introduced psychogenic factors but was overshadowed by somatogenic doctrines.

During the late Middle Ages, supernatural explanations thrived in Europe, fueled by plagues and famines, fostering superstitions, astrology, and witch hunts, persecuting mentally ill individuals. In the late 18th century, American asylums adopted somatogenic treatments, later shifting to psychogenic methods but succumbing to overcrowding. Dorothea Dix championed state hospitals by the late 19th century, influenced by the mental hygiene movement and germ theory. In Europe, the 18th and 19th centuries witnessed debates between somatogenic and psychogenic explanations for hysteria, culminating in Freud's psychoanalysis.

The 20th century saw somatogenic approaches resurge with psychotropic medications, replacing restraints, electroshock therapy, and lobotomies, ushering in the pharmaceutical era for mental illness. Preceding the 20th century, references to mental health as a discipline are scarce. Notably, in 1946, the establishment of the World Health Organization (WHO) and the inception of the Mental Health Association in London marked pivotal milestones. Prior to this, the concept of "mental hygiene" emerged in English literature in 1843, emphasizing the interplay of intellect and passions on health and longevity. Even earlier, in 1849, the pursuit of "healthy mental and physical development of the citizen" was enshrined as the primary goal of public health in a proposal to the Berlin Society of Physicians and Surgeons. The seminal year 1948 saw the birth of the WHO, coinciding with the inaugural International Congress on Mental Health in London. Subsequently, the WHO's Expert Committee on Mental Health in 1950 provided definitions: "Mental hygiene" encompasses activities fostering mental well-being, while "mental health" denotes a condition influenced by biological and social factors, enabling individuals to harmonize instinctive drives, maintain interpersonal

harmony, and engage in constructive societal and environmental transformations (Bertolote, 2008).

Mental illness understanding has traversed a labyrinthine path, marked by cyclical paradigms that intertwine, from supernatural to somatogenic and psychogenic perspectives. These historical foundations profoundly shape contemporary mental health care, illuminating the enduring complexities of this field.

III. THE RELATIONSHIP BETWEEN MENTAL HEALTH AND SOCIAL STIGMA

The relationship between mental health and social stigma is a complex and multifaceted one, encompassing both public and self-stigma. Public stigma manifests when society at large endorses prejudiced beliefs concerning individuals with mental illnesses, perpetuating negative stereotypes. Such stigmatization occurs when individuals with mental health conditions are unfairly labeled as 'dangerous,' 'crazy,' 'incompetent,' or 'weak' for seeking help. Inaccurate stereotypes often portray them as more violent, cowardly, or lacking the capacity to manage their conditions. Such characterization can lead to social exclusion and marginalization, depriving them of opportunities afforded to others and exacerbating their mental health challenges. The distress caused by prejudice and discrimination can be more daunting than the mental illness itself, potentially undermining self-esteem and prompting feelings of shame and embarrassment. Consequently, individuals may refrain from seeking treatment, withdraw from society, resort to substance abuse, or contemplate suicide.

Moreover, public stigma can have pervasive consequences, including discrimination in employment, housing, bullying, exclusion from social circles, and even violence. Certain cultural contexts may exacerbate mental health stigma, making it difficult for individuals to seek help while fostering shame. Recognizing these issues, initiatives like Mental Health Australia's Embrace Project strive to provide resources and support for consumers and carers from diverse cultural backgrounds, aiming to mitigate the impact of cultural stigma (Mental Health Council of Australia).

Furthermore, self-stigma is an equally significant concern. It occurs when individuals internalize the negative perceptions held by society about their

mental health conditions. This internalization can further deter help-seeking behaviors and adherence to treatment, compounding the challenges faced by those affected. Given its adverse effects on treatment outcomes, the stigma associated with mental illness is a substantial public health problem, necessitating a comprehensive understanding of its determinants, sources, and forms (Venkatesh et. al, 2015).

Notably, the impact of stigma varies across age groups, with young people being particularly vulnerable. Young individuals with mental health issues often face greater social distance from the public, influenced by fears related to confidentiality, peer pressure, self-reliance, and a lack of awareness about mental health services. Adolescents may find it more challenging to disclose their mental health concerns compared to young adults. In India, home to the world's largest young population, this issue is of paramount significance, given the substantial burden of untreated mental health problems among the youth. India's national mental health policy emphasizes the need to reduce public stigma, and legal measures have been enacted to protect the rights of individuals with mental illness. Nevertheless, there remains a dearth of data on mental-health-related stigma in the country, particularly among young people. A systematic review and meta-analysis seek to address this knowledge gap, aiming to estimate the prevalence of mental-health-related public stigma among young individuals in India, identify knowledge gaps, attitudes, and behaviors related to mental health, and provide recommendations for reducing such stigma (Gaiha et al., 2020).

The relationship between mental health and social stigma is a critical issue that has far-reaching consequences for individuals, who may face significant barriers to seeking help and achieving their social and economic potential in India. Addressing this issue necessitates comprehensive efforts, including legal protections, awareness campaigns, and research initiatives, to combat both public and self-stigma and ensure that individuals with mental health conditions receive the support and care they need.

According to Shetty (2023), in 2023, India faces a critical mental health crisis. Despite its vast population, India lacks mental health resources. Mental illness is a major public health issue here, with a rising burden. By 2030, India may lead in depression and anxiety cases globally. Limited awareness, social

stigma, and inadequate treatment compound this challenge.

IV. NEED FOR THE LAWS

The need for mental health laws at both universal and national levels, such as in India, is paramount due to the pervasive issue of social stigma associated with mental health conditions (Venkatesh et. al, 2015; Gaiha et al., 2020). At the universal level, mental health law is essential to establish a global framework that recognizes and protects the rights of individuals with mental illnesses. Stigmatization, as outlined in previous discussions, is a prevalent concern that often results in discrimination, exclusion, and social marginalization (Mental Health Council of Australia; Venkatesh et. al., 2015). Universal mental health laws can help standardize the approach to mental health, foster awareness, and reduce the stigma associated with these conditions on a global scale. They can emphasize the importance of equitable access to mental health services, promoting the idea that mental health is as significant as physical health. Such laws can serve as a catalyst for international collaboration and shared best practices in addressing mental health challenges. On the national level, like in India, mental health laws are indispensable due to the unique social, cultural, and economic contexts that influence the experience of mental health stigma (Gaiha et al., 2020). India, with its diverse population and cultural nuances, faces specific challenges in combating mental health stigma among its young population. Mental health laws can provide a legal foundation for protecting the rights of individuals with mental illnesses, ensuring that they receive equal treatment and access to services. These laws can also support public health campaigns to raise awareness and combat stigmatizing beliefs and behaviors.

The necessity for mental health laws at both universal and national levels is intrinsically linked to the imperative to address the pervasive issue of social stigma surrounding mental health conditions. Such laws can serve as crucial tools to promote awareness, protect the rights of individuals with mental illnesses, and reduce the discrimination and exclusion they often face in society.

The legal window and mental health

There existed a profound interconnection between the legal framework governing mental health and

prevailing societal attitudes. The legal apparatus of the era exhibited significant shortcomings in safeguarding the rights of those afflicted with mental disorders, thereby fostering an environment where individuals grappling with such conditions were subjected to pronounced social stigmatization and exclusion. These societal attitudes, often rooted in religious convictions and a dearth of comprehensive comprehension, cast a shadow of ostracization upon those affected. However, it is crucial to note that a transformational shift in the narrative commenced gradually with the emergence and advancement of modern medical and psychological disciplines. This transformative trajectory ushered in an era marked by evolving attitudes and legal provisions that ultimately culminated in more compassionate and inclusive approaches to the treatment of mental health issues, thereby ameliorating the prevailing stigma associated with them.

This work delves into the intricate relationship between mental health law and social stigma in India, offering a critical comparative analysis of the Mental Health Laws and Programmes before and after India's independence. This chapter examines how these legal frameworks have evolved in response to societal perceptions of mental health, particularly the pervasive stigma associated with mental illnesses.

Beginning with an exploration of the historical context, I scrutinize the impact of British colonial-era laws and their stigmatizing language and practices. We then transition to the post-independence era, analysing the shift towards community-based care and the National Mental Health Programme's attempt to mitigate stigma.

To assess the contemporary landscape, I scrutinize five seminal cases from Indian High Courts and the Supreme Court, illuminating the practical implications of these legal frameworks in addressing social stigma. These cases provide valuable insights into the challenges individuals with mental illnesses face within the Indian judicial system and highlight the urgent need for legal reforms.

The findings reveal a complex interplay between mental health laws, societal attitudes, and the judicial system. We conclude with comprehensive recommendations for reform, emphasizing the importance of destigmatizing language and practices within legislation, ensuring access to mental

healthcare, and addressing the socio-economic determinants of mental health.

V. MENTAL HEALTH LAWS IN INDIA: A HISTORICAL CONTEXT AND CRITICAL ANALYSIS

Mental Health Law Programs in Pre-Independence India

The emergence of mental health legislation in India finds its roots in the 19th century, during British colonial rule, coinciding with the transfer of authority from the East India Company to the British Crown (Duffy and Kelly, 2020). In 1858, the British Crown introduced a set of statutes known as the 'lunacy acts,' which closely mirrored contemporary English laws. These enactments were heavily influenced by the prevailing legal perception of mental disorders during the 18th and 19th centuries, characterized by the 'psychiatrisation of criminal danger.' This conceptualization equated 'dangerousness' with 'insanity' or mental ailment, thereby deeming the 'insane person' as inherently hazardous. Consequently, these laws established a connection between legal and psychiatric institutions, serving as mechanisms for social control, encompassing both punitive and remedial measures (Foucault et. al, 1978).

These legislative actions primarily focused on the 'segregation' or 'detention' of European 'insanes,' who were repatriated to England, as well as indigenous individuals perceived as threats to others. Such measures were primarily executed through institutional disciplinary frameworks like prisons and asylums (Mills, 2001; Ernst, 1997).

Subsequently, these colonial enactments were replaced by the Indian Lunacy Act of 1912 [ILA], modeled after the English Lunacy Act of 1890, which governed the confinement of individuals with mental disorders in asylums and the administration of their private estates (Duffy and Kelly, 2020). The ILA employed stigmatizing language by defining a 'lunatic' as 'an idiot or a person of unsound mind,' categorizing those with mental illnesses. These terms not only perpetuated stigma but also reflected the prevalent perception that individuals with mental disorders lacked rationality, mental competence, or the capacity to manage their own affairs. Although the ILA allowed for voluntary admission to asylums for treatment, all other detentions required reception orders issued by

magistrates, a practice upheld until 2017. The ILA predominantly revolved around judicial procedures, including 'inquisitions' to determine mental unsoundness, granting courts authority over the property of affected individuals, appointing managers and guardians, or specifying maintenance for the person or their dependent family members (Duffy and Kelly, 2020).

The role of social stigma in shaping these laws is evident in the stigmatizing language and beliefs embedded within them. The use of terms like 'lunatic' and 'idiot' reinforced negative stereotypes and discrimination against individuals with mental disorders. Furthermore, the legal focus on confinement and property management further marginalized this vulnerable population, perpetuating social stigma.

Mental Health Law Programs in Post-Independent India:

In the post-independence era, spanning over four decades, mental health legislation and initiatives in India exhibited a persistent adherence to colonial-era custodial statutes and Western biomedical approaches to interventions. At the dawn of India's independence, health sector planning was significantly influenced by committees such as the Bhole Callard et al. (2012) committee, along with the Mudhaliar Committee (1967) and the Srivastava Committee (1975), which played pivotal roles (Bhole Callard et al., 2012). In the realm of mental health, the initial two decades post-independence primarily focused on enhancing infrastructure, expanding bed capacities, establishing dedicated child psychiatry units, and addressing the shortage of human resources within the mental health domain.

Legally, the Indian Lunacy Act of 1912 continued to be in effect following India's independence in 1947, persisting for over three decades.

However, the latter half of the 1970s witnessed a shift spurred by international developments, prominently the rise of community psychiatry in India. These global advancements included the Alma Ata declaration of 1978, which emphasized strengthening primary healthcare services, and the WHO-supported initiative 'Strategies for Extending Mental Health Services into the Community' (1976–1981). This momentum led to the establishment of the National Mental Health Programme (NMHP) in 1982, a

pioneering state-driven mental health initiative among low- and middle-income nations (Shastri, 2021). The NMHP's initial objectives were to ensure the availability and accessibility of essential mental healthcare for all, particularly vulnerable and marginalized communities, promote the integration of mental health care into primary healthcare, and advocate for community involvement in mental health service development.

Subsequently, the NMHP sought to expand its reach through the District Mental Health Program (DMHP), initially launched in four districts in 1997 and now covering 704 districts nationwide (Shastri, 2021).

The DMHP aimed to provide foundational mental health services to the community, integrate these services with other healthcare provisions, facilitate early identification and treatment of patients within the community, reduce the necessity for patients and their families to travel long distances to access urban healthcare facilities, mitigate the stigma associated with mental illness through attitudinal transformation and public awareness, and deliver treatment and rehabilitation to individuals with mental illnesses within the community post their discharge from hospitals or institutions.

Upon careful examination and comparison of the objectives of the NMHP (1982) and DMHP (1996), it becomes evident that the vision of 'minimum' mental healthcare outlined in the NMHP aligns with 'sustainable basic' care in the DMHP, as well as the integration of mental health with healthcare services. However, there is a notable shift in the perception of 'the community.' In the NMHP, the community was envisioned as active participants in program development, recognizing their specific vulnerabilities and marginalization. In contrast, the DMHP portrays the community as recipients of actions, primarily focusing on providing education related to the biomedical model of mental illness, early detection, treatment, and rehabilitation.

Although the explicit equating of minimum mental health services with psychotropic medication is absent in the objectives, it is discernible from the program's operationalization over the past four decades. Ecks (2005) warns us that within the realm of biomedicine, withholding access to medications believed to 'reintegrate a patient into society' may be perceived as an act of marginalization. Providing medications to those deprived of them can be seen as an intervention

aimed at dismantling marginality. This rationale for de-marginalization, achieved through the widespread availability of medication, along with arguments rooted in health economics, which highlight the potential for restoring productivity and wealth through the treatment of mental illnesses, collectively provide impetus for mental health investments at both the global and national levels.

The Mental Health Care Bill of 2013, subsequently enacted in 2017, marks a significant milestone in establishing fundamental rights and entitlements in the realm of mental healthcare (MHCB 2017). According to the MHCB 2017, all individuals have an unequivocal entitlement to access mental healthcare services, including the provision of psychotropic medications, without encountering financial barriers. The legislation also mandates insurance coverage for mental illnesses and extends financial support for private consultations in cases where district mental health services are unavailable. Furthermore, the statute emphasizes the administration of therapeutic and rehabilitative measures with utmost leniency, while maintaining a scrupulous regard for the rights and intrinsic dignity of patients.

MHCB 2017 introduces innovative constructs such as advanced directives and nominated representatives, granting individuals with mental disorders a degree of autonomy regarding their prospective treatment in the event of incapacity to make informed decisions. Simultaneously, the legislation prescribes the establishment of central and state mental health authorities, with a mandate to register all mental health establishments with the relevant regulatory bodies.

Notably, the bill advocates for the decriminalization of suicide, asserting that individuals who succumb to suicide shall be presumptively deemed to have been afflicted with a mental ailment at the time of their demise, thereby exempting them from punitive measures under the Indian Penal Code. Additionally, the bill regulates the use of electroconvulsive therapy without anesthesia, categorically prohibiting its application on minors. This legislative stride reflects a concerted effort to provide humane, evidence-grounded care to individuals facing mental health challenges. The statute encompasses a comprehensive array of service provisions, including community-based rehabilitation, and assigns the state the responsibility of suicide prevention, the promotion of

mental well-being, the training of mental health practitioners, and the facilitation of care delivery.

The Act empowers individuals suffering from mental disorders to create advance directives, validated by a medical practitioner or the Mental Health Board, specifying their preferences for treatment modalities and explicitly demarcating the treatments they refuse to undergo. Additionally, it grants the government the authority to establish a Mental Health Authority at both the Central and State levels, responsible for registering and overseeing all mental health establishments and providing counsel to the government on mental health matters. A Mental Health Review Board is mandated to safeguard the rights of individuals with mental illness, ensuring compliance with statutory provisions.

The Act categorically prohibits the administration of electroconvulsive therapy without anesthesia to individuals with mental illness and explicitly prohibits its application on minors. It unequivocally forbids practices such as chaining, seclusion, or solitary confinement of individuals with mental illness. The Act's provision for the decriminalization of suicide represents a significant step forward. It presumes that individuals who attempt suicide are grappling with mental illness, thereby absolving them of punitive measures under the Indian Penal Code. The government is entrusted with the responsibility of providing comprehensive care, treatment, and rehabilitation to individuals who have attempted suicide, presuming that they have experienced severe psychological stress, thus reducing the risk of recurrent suicide attempts.

Nevertheless, the Bill has garnered critical scrutiny. Certain provisions, particularly advanced directives and nominated representatives, have faced reservations from segments of the psychiatric community, who perceive these measures as encroachments upon clinical decision-making prerogatives. Mental health advocates argue that the legislation falls short of aligning with the principles outlined in the United Nations Convention on the Rights of Persons with Disabilities (CRPD). It is crucial to acknowledge that mental health is a matter of political significance intricately intertwined with socio-economic dynamics. In this context, the Bill has been criticized for its perceived inadequacy in recognizing and addressing the socio-economic

determinants that underlie mental health issues affecting a significant portion of the population.

The development and significance of mental health laws in India, both pre and post-independence, have been significantly influenced by social stigma surrounding mental illness. Pre-independence laws employed stigmatizing language and perpetuated negative stereotypes, while post-independence initiatives sought to mitigate stigma through community-based care and awareness programs. The Mental Health Act of 2017 represents a substantial leap forward in recognizing the rights of individuals with mental illnesses and addressing the role of social stigma in mental healthcare. However, challenges and critiques remain, underscoring the intricate interplay between mental health, legislation, and societal attitudes.

VI. COURTS' JUDGMENTS ON CASES INVOLVING INDIVIDUALS WITH MENTAL HEALTH DISABILITIES

"... while the stigma and discrimination against persons with mental health disorders are rampant in society, as the highest constitutional court of the country, it falls upon us to ensure that societal discrimination does not translate into legal discrimination." Hon'ble Supreme Court of India in "Ravindra Kumar Dhariwal v. Union of India, 2021" The issue of stigma and discrimination against individuals with mental health disorders has long plagued society. This chapter also delves into several pivotal and selected judgments of the Supreme Court of India and a few High Courts of India that have addressed the rights and challenges faced by individuals with mental health disabilities. These cases underscore the Court's commitment to upholding the rights of such individuals, emphasizing that an individual's capacity to perform professional duties should be the determining factor, regardless of the nature or potential manageability of the disability through medical means.

Case 1: Akanksha Singh v. High Court of Delhi, WP(CIVIL) APPEAL NO. 6113/2021

In the matter of Akanksha Singh v. High Court of Delhi, the Hon'ble Supreme Court of India delivered a momentous judgment addressing the rights of individuals with mental health disorders and their

entitlement to reservation benefits under the Rights of Persons with Disabilities Act (RPWD Act). The case revolved around the appointment of an individual with Bipolar Affective Disorder, supported by a disability certificate indicating a 45% disability. However, the appointment was denied, citing the temporary nature of the mental illness, as mentioned in the disability certificate.

The Supreme Court unequivocally rejected this reasoning, affirming that an individual's capacity to perform professional duties should be the paramount factor in determining eligibility for reservation under Section 34 of the RPWD Act. The Court emphasized that the ability to manage the disability through medicinal intervention did not negate entitlement to reservation. This landmark judgment underscores the Court's commitment to upholding the rights of individuals with disabilities, asserting that the nature or potential manageability of the disability through medical means should not overshadow one's capability to fulfill professional duties.

Case 2: Ravinder Kumar Dhariwal v. Union of India, (2023) 2 SCC 209

In the case of Ravinder Kumar Dhariwal v. Union of India, a three-judge bench of the Supreme Court deliberated upon a crucial matter concerning disciplinary proceedings within the Central Reserve Police Force (CRPF). The appellant, Mr. Dhariwal, had a documented medical history, encompassing obsessive compulsive disorder and depression, necessitating continuous therapeutic intervention since 2009. The Court recognized that individuals with mental disabilities, like Mr. Dhariwal, were more susceptible to disciplinary actions due to their disabilities, thereby manifesting indirect discrimination.

The judgment highlighted the imperative need to protect the rights of individuals with mental disabilities and prevent discrimination in disciplinary matters. It underscored the importance of considering the unique challenges faced by individuals with mental disabilities in such proceedings and ensuring that their rights were safeguarded.

Case 3: Syed Bashir-ud-Din Qadri v. Nazir Ahmed Shah, SLP(C)Nos.10669-70 of 2008

In the matter of Syed Bashir-ud-Din Qadri v. Nazir Ahmed Shah, the Supreme Court of India addressed

the employment rights of individuals with disabilities, particularly focusing on cerebral palsy. The appellant, a B.Sc. graduate with cerebral palsy, faced initial objections from the state government regarding his appointment as a 'Rehbar-e-Taleem' or 'Teaching Guide' in Jammu and Kashmir due to his disability.

The Court, in its sensitive handling of the case, recognized the significance of social legislation that empowers individuals with disabilities to lead a life of purpose and dignity. It emphasized that the ability to perform the job efficiently should be the primary criterion for employment, rather than rigidly adhering to physical norms. The Court ordered reasonable accommodations, including providing an electronic external aid, to enable the appellant to carry out his duties effectively.

This judgment exemplified the Court's commitment to ensuring equal opportunities and protection of the rights of individuals with disabilities, reinforcing the principle that individuals should not be denied employment opportunities solely based on their disabilities.

Case 4: Ranjit Kumar Rajak v. State Bank of India (2009) 5 Bom CR 227

In *Ranjit Kumar Rajak v. State Bank of India*, the Bombay High Court set a significant precedent by introducing the concept of "reasonable accommodation at the workplace" in India. The case involved Mr. Rajak, who had undergone a renal transplant and was deemed medically fit to perform his duties as a probationary officer in the State Bank of India. However, the bank rejected his appointment, citing the potential financial burden due to his medical condition.

The Division Bench of the Bombay High Court relied on the Convention on the Rights of Persons with Disabilities (CRPD), which India had ratified, recognizing the right of persons with disabilities to be accepted in an inclusive and accessible work environment. The Court emphasized that the State had a duty to provide reasonable accommodation in employment, subject to a hardship test.

This judgment marked a significant milestone in Indian jurisprudence, acknowledging the importance of reasonable accommodation and the duty of employers to create an inclusive and accessible work environment for individuals with disabilities.

Case 5: Suchita Srivastava v. Chandigarh Administration, 2009 (9) SCC 1

The case of *Suchita Srivastava v. Chandigarh Administration* centered on the reproductive rights of a woman with mental retardation residing in a government-run welfare institution in Chandigarh. The woman, who had become pregnant due to rape by an in-house staff member, expressed her wish to continue the pregnancy and raise the child. However, the Chandigarh Administration sought permission from the high court to terminate her pregnancy under the Medical Termination of Pregnancy Act, 1971 (MTP Act), citing her inability to care for the child.

The Supreme Court, in a landmark judgment, upheld the legal capacity of the woman and her right to decide on her pregnancy. It distinguished between 'mental illness' and 'mental retardation,' affirming that the MTP Act required the explicit consent of the pregnant woman for termination. The Court highlighted the importance of respecting the personal autonomy of individuals with mental retardation in reproductive decisions.

This judgment not only protected the reproductive rights of women with disabilities but also emphasized India's commitment to international norms and principles under the CRPD. It affirmed that individuals with mental retardation have the right to make independent decisions about their pregnancies, ensuring their legal capacity is upheld.

These Courts' judgments collectively represent a significant shift in the Indian legal landscape towards safeguarding the rights of individuals with mental disabilities. They underscore the principles of non-discrimination, reasonable accommodation, and the protection of legal capacity. By prioritizing an individual's capability to perform professional duties and make autonomous decisions, these judgments contribute to reducing societal stigma and ensuring equal opportunities for individuals with mental health disorders. The legal framework established through these cases sets a crucial precedent for a more inclusive and equitable society.

VII. CONCLUSION

The historical evolution of mental health laws in India, from the colonial era to the present day, reflects a journey marked by significant changes and evolving perspectives. In the pre-independence period, the

British colonial authorities implemented laws that stigmatized individuals with mental disorders, perpetuating negative stereotypes and emphasizing confinement and property management as a means of control. These laws were steeped in the era's psychiatric and legal perceptions, leading to the marginalization of those suffering from mental illnesses.

Post-independence India witnessed a gradual shift towards recognizing the importance of mental health care and reducing the stigma associated with mental disorders. The establishment of the National Mental Health Programme (NMHP) and the subsequent District Mental Health Program (DMHP) marked significant milestones in promoting community-based mental health care and raising public awareness. However, it is essential to acknowledge that the shift towards community-based care also introduced challenges in addressing the socio-economic determinants of mental health issues.

The Mental Health Care Bill of 2013, enacted in 2017, was a watershed moment in Indian mental health legislation. This comprehensive legislation laid the foundation for fundamental rights and entitlements in mental healthcare, emphasizing access to services, insurance coverage, and humane treatment. It introduced innovative concepts like advance directives and nominated representatives, emphasizing individual autonomy in treatment decisions. While the Act has been widely appreciated for its progressive stance, it has also faced criticism for not fully aligning with the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and for not adequately addressing the socio-economic factors contributing to mental health issues.

The intersection of mental health laws and social stigma is evident throughout India's legal history. Stigmatizing language and beliefs have been embedded within legislation, perpetuating discrimination against individuals with mental disorders. However, recent legal developments, as highlighted by the selected court cases, demonstrate a growing commitment to upholding the rights of individuals with mental health disabilities and challenging societal prejudices.

The Supreme Court of India and various High Courts have played a pivotal role in shaping a more inclusive and equitable society for individuals with mental disabilities as we have seen in the mentioned cases.

These courts have emphasized that an individual's capacity to perform professional duties should be the primary consideration, irrespective of the nature or potential manageability of their disability through medical means. These judgments underscore the principles of non-discrimination, reasonable accommodation, and the protection of legal capacity. They not only protect the rights of individuals with mental health disabilities but also contribute to reducing societal stigma and ensuring equal opportunities.

VIII. SUGGESTIONS AND RECOMMENDATIONS

In light of the historical context, recent legal developments and studied / mentioned cases, several suggestions and recommendations can be made to further strengthen mental health laws in India and promote a more inclusive and stigma-free society:

1. **Comprehensive Mental Health Education:** Incorporate mental health education into school curricula and public awareness campaigns to increase understanding and reduce stigma surrounding mental disorders. This can contribute to early intervention and destigmatization.
2. **Alignment with CRPD:** Ensure that mental health laws are fully aligned with the principles outlined in the United Nations Convention on the Rights of Persons with Disabilities (CRPD). This includes recognizing the rights of individuals with disabilities to make autonomous decisions about their treatment and addressing socio-economic determinants of mental health.
3. **Strengthen Community-Based Care:** Continue to invest in community-based mental health care programs, like the District Mental Health Program (DMHP), with a focus on involving the community in program development and implementation. This approach can reduce the need for long-distance travel to access care and further destigmatize mental health services.
4. **Capacity Building:** Provide training and capacity building for mental health practitioners, law enforcement agencies, and legal professionals to enhance their understanding of mental health issues and the rights of individuals with mental disabilities.

5. Research and Data Collection: Promote research on mental health issues, especially focusing on the socio-economic determinants and regional disparities. Collect comprehensive data to inform evidence-based policies and interventions.
6. Monitoring and Oversight: Establish rigorous monitoring and oversight mechanisms to ensure the effective implementation of mental health laws and policies. This includes the registration and regulation of mental health establishments and the protection of patients' rights.
7. Public-Private Partnerships: Encourage public-private partnerships to expand access to mental health services and reduce the burden on government healthcare facilities.
8. Sensitization Campaigns: Launch nationwide sensitization campaigns to combat stigma associated with mental health disorders, emphasizing that mental health is an integral part of overall well-being.
9. Accessibility: Ensure that mental health services are accessible to all, including marginalized communities and rural areas, by addressing infrastructure gaps and improving transportation options.
10. Legal Aid and Advocacy: Promote legal aid services and advocacy organizations that can support individuals with mental disabilities in asserting their rights and navigating the legal system.

In conclusion, India's journey in mental health legislation reflects both historical challenges and recent strides towards destigmatization and inclusion. By aligning mental health laws with international standards, investing in community-based care, and fostering awareness, India can continue to advance its commitment to the rights and well-being of individuals with mental health disorders, ultimately creating a more equitable and compassionate society.

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