
HISTORICAL AND LEGAL DEVELOPMENT OF MENTAL HEALTH LEGISLATION IN INDIA

Ankita Khamari & Dulamani Padhan, Faculty, PG Department of Law, Sambalpur University.

ABSTRACT

Mental health regulation in India dates back to the mid-nineteenth century, with the objective of ensuring appropriate treatment for individuals experiencing mental disorders and accountability among medical professionals for the quality of care provided. The current legal framework is governed by the Mental Healthcare Act, 2017, which replaced the Mental Health Act, 1987 following India's ratification of the United Nations Convention on the Rights of Persons with Disabilities. While the 1987 law largely emphasized institutional custody and regulation, the 2017 statute adopts a rights-based approach, prioritizing access to treatment, dignity, and autonomy for persons with mental illness. The newer law introduced significant structural reforms, including the creation of regulatory authorities, establishment of Mental Health Review Boards to safeguard patient rights, mandatory registration of mental health establishments, provision of legal aid, and access to free treatment for individuals from economically weaker sections. Despite these progressive measures, the effective enforcement of the 2017 Act continues to face practical barriers such as limited infrastructure, financial constraints, persistent social stigma, and discrimination. Nevertheless, the legislation represents a transformative shift in India's mental health regime by strengthening patient rights, promoting autonomy, expanding access to services, and attempting to reduce stigma. This study seeks to critically examine the development, implementation, and overall impact of mental health laws in India.

Keywords: Implementation, Mental health law, Mental Healthcare Act, 2017, Stigma, Supreme Court of India.

Introduction

The expression “mental illness” often triggers immediate bias in the mind of an ordinary person an attitude rarely seen when illnesses such as Cancer, Tuberculosis, are mentioned. All of these are medical conditions, largely beyond the voluntary control of those affected, and each is amenable to treatment. Yet, unlike other physical ailments, mental illness continues to carry a unique burden of social stigma and prejudice,¹ which is not the case for other diseases. A large reason for this is the comparatively limited understanding, both of experts and laymen, on the cause for ‘mental illness’, its symptoms and its treatment.²

The limited public understanding of mental illness does not arise from indifference or insufficient scientific inquiry into the brain. Rather, it stems from the extraordinary complexity of the human brain itself. With more than 100 billion neurons constantly transmitting and processing signals that regulate thought, perception, emotion, and movement, the brain remains one of the most intricate organs in the human body. Nevertheless, the purpose of this article is not to explore the scientific intricacies of the brain, fascinating as they may be, but to outline the historical evolution of mental health law in India. The distress experienced by individuals with mental illness is distinct because it is largely internal and may not produce visible physical symptoms. Unlike conditions such as Cancer, Tuberculosis, or Jaundice, where physical signs and diagnostic tests often reveal clear abnormalities, mental illness may not manifest in outward bodily dysfunction. The organs of the body may function normally and medical reports may appear routine, yet the individual’s mental and emotional state may be deeply disturbed. This invisibility of suffering leads to two particularly unfortunate consequences,³

- a) the patient feels isolated, alone and unable to relate or reach out to others; and
- b) the patient’s actions are seldom understood by others and are viewed as being caused as a result of some personality trait or other weakness in the patient as opposed to a mental illness, that is beyond the control of the patient.

These circumstances intensify the negative stereotypes associated with mental illness.

¹ Byrne, P., “Stigma of mental illness and ways of diminishing it” 6(1) *Advances in Psychiatric Treatment* 65-72 (2000).

² Mental Health Foundation, *Stigma and Discrimination*, available at: [https:// www.mentalhealth.org.uk/a-to-z/s/stigma-and-discrimination](https://www.mentalhealth.org.uk/a-to-z/s/stigma-and-discrimination).

³ Laungani, P., “Cultural Influences on Mental Illness” 24(43) *Economic and Political Weekly* 2427- 2430 (1989).

Consequently, many cases remain unidentified and untreated, continuing to disrupt the lives of those affected. A further difficulty lies in the hesitation of individuals to acknowledge their condition, often shaped by personal fears and societal judgment. In several regions of India, mental health concerns are still addressed through practices such as “jaadutona,” where families seek help from faith healers or “tantriks” instead of trained psychologists or psychiatrists. Such approaches, sometimes dramatized in popular culture, reinforce misconceptions rather than promote scientific treatment.

The isolating nature of mental illness, limited awareness about its causes and remedies, and the stigma surrounding it interact to create a self-perpetuating cycle, leaving patients to bear the greatest burden. Over the past few decades, however, perceptions have gradually evolved both globally and within India. International advocacy, particularly by the United Nations, has played an important role in promoting awareness and a rights-based understanding of mental health. In India, this shift is reflected in the enactment of the Mental Healthcare Act, 2017, which replaced the 1987 law and marked a progressive step toward protecting the dignity and rights of persons with mental illness.⁴

Before proceeding further, it is crucial to note that the basic principle underlying the Mental Healthcare Act, 1987 and also the Act of 2017⁵ is to ensure that persons suffering from mental illness are able to fully exercise the rights guaranteed to them under part–III of the Constitution, including the right against discrimination, right to freedom of speech and expression and the right to life and dignity and its many manifestations as have been enumerated by the Supreme Court in a catena of judgments.⁶

Accordingly, these enactments must be evaluated on the basis of how far they genuinely empower persons with mental illness to claim and exercise their fundamental rights, and whether they facilitate a life of autonomy, equality, and dignity. The concept of dignified living has been firmly embedded within the scope of the right to life under Article 21 of the Constitution of India, as reaffirmed by the nine-judge Bench of the Supreme Court of India in **Justice K.S. Puttaswamy (Retd.) v. Union of India**⁷The first section of this article traces the

⁴ The Mental Health Act, 1987.

⁵ The Mental Health Act, 2017.

⁶ AK Gopalan v. State of Madras, AIR 1950 SC 27; Maneka Gandhi v. Union of India, AIR 1978 SC 597 (personal liberty); Olga Tellis v. Bombay Municipal Corpn., AIR 1986 SC 180 (Livelihood); Shantistar Builders v. Narayan Khimalal Totame, AIR 1990 SC 630 (Shelter); Parmananda Katara v. Union of India, (1995) 3 SCC 248 (Medical Care), etc.

⁷ (2017) 10 SCC 1.

historical evolution of mental health legislation in India, beginning with the Indian Lunatic Asylums Act, 1858 and culminating in the Mental Healthcare Act, 2017. The second section examines the significant reforms introduced by the 2017 statute, while the final section offers recommendations aimed at strengthening its practical implementation.⁸ by provides an interesting insight into the history of practice of psychiatry ⁹and how the State and the law perceived it. According to the said paper, the earliest form of a mental hospital was a Greek¹⁰ sanctuary at Epidaurus. In subsequent periods, persons with mental illness were often sheltered and attended to in makeshift settings, including camps run by Christian and Muslim missionaries. One of the earliest institutions regarded as a “modern” mental hospital was the Bethlem Royal Hospital in London, established during the thirteenth century. Until the beginning of the eighteenth century, individuals with mental disorders were frequently subjected to harsh treatment and neglect. The dominant objective was confinement rather than recovery, leading to widespread use of chains and other physical restraints. A significant transformation occurred during the eighteenth and nineteenth centuries, when approaches to mental healthcare began to shift toward compassion and reform. Much of this change is attributed to Philippe Pinel, who advocated for humane treatment and the removal of physical restraints. Contemporary psychiatric practice traces many of its foundational principles to Pinel and subsequent reformers who emphasized dignity and therapeutic care over mere detention.

In the Indian context, one of the earliest references to mental health conditions is found in the Atharva Veda. This Vedic text contains descriptions of psychological states that resemble what are today identified as schizophrenia and bipolar disorder. Vedic understanding of mental illness involved observation through the five senses, combined with reflective inquiry as part of diagnosis and healing practices. Mental disorders were also discussed within the Unani system of medicine, which classified several major categories of psychological ailments. However, historical accounts suggest that mental illness was often attributed to moral failings, sin, or supernatural forces such as witchcraft. Unfortunately, traces of these beliefs persist even today, where mental health conditions are sometimes wrongly linked to sorcery or addressed through faith healers, commonly referred to as “tantriks,” rather than medical professionals.¹¹

⁸ Authored by Haque Nizamue and Nishant Goyal and reported in Indian Journal of Psychiatry, Jan 2010 – 52 (Suppl. 1).

⁹ Psychiatry refers to the study and treatment of mental illness, emotional disturbance, and abnormal behaviour.

¹⁰ Blue, A., “Greek Psychiatry’s Transition from the Hospital to the Community” 7(3) Medical Anthropology Quarterly, 301-318 (1993).

¹¹ Nizamie, S. H., and Goyal, N., “History of psychiatry in India” 52(Suppl 1) Indian journal of psychiatry 7–12 (2010).

Development of Mental Health Law during the British and Post-Independence Period

According to the recorded history of the pre-colonial era, there were several centers/hospitals established by the king/sultan to look after the mentally ill. When the British arrived, they brought with them the western concept of psychiatry, which was in the process of shifting from being persecutory to being humane.¹²

During the British colonial era, mental health institutions in India were initially established to serve European civilians and members of the British army. Over time, however, these institutions expanded and contributed to the gradual institutional growth of psychiatry in India. Several asylums were set up across different regions, marking the beginning of a structured, though custodial, approach to mental healthcare.

The first codified legislation in this field was the Indian Lunatic Asylums Act, 1858. This statute was narrow in scope and primarily dealt with judicial proceedings relating to persons declared “lunatic.” Its focus was not on treatment or rehabilitation but on empowering courts to determine mental incapacity and regulate the legal consequences, particularly in relation to property, contracts, and pending legal matters. Medical professionals had a limited role, as the ultimate authority rested with the judiciary.

The 1858 Act was later replaced by the Indian Lunacy Act, 1912. Unlike its predecessor, the 1912 legislation incorporated provisions relating to care and treatment. It introduced the requirement of a “reception order,” meaning that no individual could be admitted to or detained in an asylum without judicial authorization, supported by a medical certificate. Although this represented procedural advancement, the law continued to reflect a custodial mindset. It was largely premised on the assumption that persons with mental illness posed a danger and required confinement. The terminology used—such as “lunatic” and “criminal lunatic”—further reinforced stigma and social exclusion.

Following independence, developments in psychiatric science and changing societal attitudes highlighted the inadequacy of colonial-era laws. Recognizing the need for reform, Parliament enacted the Mental Health Act, 1987, which came into force in 1993 under Entry 16 of the Concurrent List of the Constitution of India. This Act marked a significant shift in language

¹² Rajpal, S., “Colonial Psychiatry in Mid-nineteenth Century India: The James Clark Enquiry1” 35(1) *South Asia Research* 61–80 (2005).

and approach. It replaced derogatory expressions with terms such as “mentally ill person” and sought to regulate psychiatric hospitals and nursing homes through licensing requirements. It also laid down procedures for admission, detention under specified conditions, and management of the property of persons with mental illness. Importantly, it emphasized that such individuals must be treated with dignity and protected from physical or mental cruelty.

Although the 1987 Act represented a progressive step compared to earlier statutes, it still retained elements of institutional control and did not fully adopt a rights-based framework. Nevertheless, it reflected a gradual transformation in India’s legal approach—from mere confinement toward regulated care and recognition of the inherent dignity of persons with mental illness.

Judicial Developments and International Influence under the 1987 Framework

Several significant judicial pronouncements under the Mental Health Act, 1987 exposed serious gaps in its ground-level implementation and highlighted the need for a more rights-oriented approach.

In **Sheela Barse v. Union of India**,¹³ the petitioner brought to the Court’s attention the disturbing practice in West Bengal of confining individuals in jails after labeling them as “non-criminal lunatics,” even when many were not suffering from mental illness. These persons were deprived of liberty under the guise of treatment and were repeatedly remanded without meaningful judicial scrutiny. The Supreme Court of India declared that lodging non-criminal mentally ill persons in prisons was unconstitutional. It directed that only judicial magistrates not executive magistrates should conduct inquiries, ensure medical examination by qualified professionals, and send such persons to appropriate treatment facilities. Quarterly reporting to High Courts was also mandated, and the directions were circulated to all States for nationwide compliance.

Similarly, in **Nathalie Vandenbyvanghe v. State of Tamil Nadu**¹⁴, the Madras High Court dealt with the wrongful detention of a foreign national who, despite not being mentally ill, was issued a reception order along with numerous others in a routine manner. The Court criticized the mechanical issuance of such orders and emphasized that persons with mental illness are

¹³ (1993)4 SCC 204.

¹⁴ MANU/TN/2091/2008.

entitled to dignity and fundamental rights under Part III of the Constitution. It stressed strict adherence to statutory safeguards before categorizing anyone as mentally ill.

In *Death of 25 Chained Inmates in Asylum Fire in T.N. v. Union of India*, the Supreme Court took suo motu cognizance of a tragic fire in a Tamil Nadu asylum where chained inmates lost their lives. The Court directed all States and Union Territories to conduct district-wise inspections of mental health institutions, ensure compliance with minimum standards, and establish at least one government-run mental hospital in each State. It also ordered awareness campaigns, particularly in rural areas, regarding the rights of persons with mental illness.

Further, in *Reena Banerjee v. Government of NCT of Delhi*, judicial attention was drawn to the deplorable conditions prevailing in psychiatric hospitals and shelters. Authorities were directed to submit detailed evaluations of mental health establishments and ensure improvements in infrastructure and care.

Sukdeb Saha v. State of Andhra Pradesh (2025): The Supreme Court framed student suicides as a systemic failure rather than individual weakness, placing responsibility on institutions to provide psychological safety and dignity.¹⁵ **"Saha Guidelines" (2025)**: The Supreme Court introduced guidelines requiring schools and coaching centers to implement mental health support systems, prevent bullying, and establish district-level monitoring.¹⁶

Insurance Parity (Feb 2025): The Jharkhand High Court ruled that medical insurance, such as the Coal India Limited scheme, must cover psychiatric treatment equally with physical ailments, forbidding discrimination.

Employee Rights (Oct 2025): The Allahabad High Court criticized the denial of transfers to government employees caring for children with mental disabilities, highlighting the need for administrative sensitivity.

Institutional Accountability (2025): The Rajasthan High Court demanded updates from state/central authorities on appointing counselors in schools, strengthening the legal focus on early intervention.

¹⁵ 2025 LiveLaw (SC) 740.

¹⁶ 2025 INSC 893 (or 2025 SCC OnLine SC 631)

International and National Developments

The post-1987 period also witnessed crucial international and domestic advancements. In 1991, the United Nations General Assembly adopted the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, emphasizing least restrictive treatment and periodic review of institutionalization. In 1996, the World Health Organization formulated the *Ten Basic Principles of Mental Health Law*, underscoring informed consent and patient autonomy.

Domestically, the Protection of Human Rights Act, 1993 established the National Human Rights Commission and broadened the enforceability of rights relating to life, liberty, equality, and dignity. A further milestone was India's ratification of the Convention on the Rights of Persons with Disabilities in 2007, which reinforced the principles of autonomy, non-discrimination, and protection against unlawful deprivation of liberty. This international commitment ultimately influenced the enactment of the Rights of Persons with Disabilities Act, 2016 and paved the way for a more comprehensive rights-based mental healthcare regime in India.¹⁷

The Mental Healthcare Act, 2017

The Statement of Objects and Reasons of the Mental Healthcare Act, 2017 makes it clear that the legislation was enacted to fulfill India's obligations under the Convention on the Rights of Persons with Disabilities (CRPD), which India ratified in 2007. The Act came into force on July 7, 2017, and represents a decisive shift from a custodial framework to a rights-based model of mental healthcare.¹⁸

1. Definition of Mental Illness

The 2017 Act introduces a more precise and objective definition of "mental illness" in chapter I & II. It describes the term as a substantial disorder affecting thinking, mood, perception, orientation, or memory that significantly impairs judgment, behavior, recognition of reality, or the ability to meet daily life demands. It also includes mental conditions associated with

¹⁷ Chaturvedi, S., Basavarajappa, C. and Ahamed, A., "Mental Health Care Bill, 2013 and United Nations Convention on the rights of persons with disability: Do they go hand in hand?" 31(2) Indian Journal of Social Psychiatry 107 (2015).

¹⁸ The Mental Healthcare Act, 2017, No. 10 of 2017, Acts of Parliament, 2017 (India)

substance abuse but excludes intellectual disability. This marks a departure from the broader and less structured definition contained in the 1987 statute.

Section 3 clarifies that diagnosis must conform to internationally accepted medical standards, including classifications issued by the World Health Organization, and cannot be based on social, cultural, religious, or moral considerations.¹⁹ Section 4 further strengthens patient autonomy by presuming that every individual has the capacity to make decisions regarding treatment, provided they can understand, evaluate, or communicate their choices in any form. This approach seeks to minimize arbitrary institutionalization, a concern previously highlighted by courts.²⁰

2. Rights of Persons with Mental Illness

For the first time in Indian mental health legislation, access to government-funded mental healthcare is recognized as a legal right. The Act guarantees affordable, quality services, including inpatient and outpatient treatment, community-based rehabilitation, child and geriatric mental health services, and supported living facilities. It affirms the right to dignity, protection from inhuman or degrading treatment, confidentiality, access to medical records, legal aid, personal communication, equality, and non-discrimination.

3. Nominated Representative

The Act presumes decision-making capacity unless proven otherwise. However, where an individual lacks such capacity, they may appoint a nominated representative to support or make decisions on their behalf. This mechanism is designed to respect autonomy while ensuring continuity of care in severe cases.²¹

4. Advance Directives

The legislation permits individuals to draft advance directives specifying their treatment preferences in the event of future incapacity. These legally binding documents enhance self-determination and reduce coercive interventions.

¹⁹ The Mental Healthcare Act, 2017, § 3.

²⁰ The Mental Healthcare Act, 2017, § 4.

²¹ Mahomed, F., Stein, D. J., Sunkel, C., Restivo, L., & Patel, V. (2022). *Nominated representatives and supported decision-making in mental healthcare*.

5. Duties of the Government

The appropriate government is obligated to promote mental health awareness, prevent illness, reduce stigma, and develop adequate human resources. This includes training professionals and ensuring sufficient infrastructure.²²

6. Admission and Treatment Safeguards

The Act classifies admissions into voluntary, minor, supported (without consent), and extended supported admissions. Informed consent is central to treatment decisions. It prohibits practices such as chaining, solitary confinement, and certain coercive procedures, reinforcing humane standards of care.²³

7. Mental Health Review Boards

The statute mandates the establishment of Mental Health Review Boards comprising judicial, medical, and community representatives. These Boards oversee advance directives, nominated representatives, and complaints regarding rights violations.²⁴

Implementation and Impact

The Act has led to the expansion of mental health establishments and institutional accountability mechanisms.²⁵ Facilities are required to display helpline numbers and grievance redressal systems, and professional training initiatives have been undertaken to ensure compliance. The law also enables free treatment for persons below the poverty line, recognition of advance directives, and appointment of nominated representatives.

Non-governmental organizations have played a supportive role in service delivery, rehabilitation, research, and capacity-building. The broadened definition of “mental health establishment” under the Act allows such organizations to participate more effectively.²⁶

²² Government of India, Ministry of Law and Justice. (2017). *The Mental Healthcare Act, 2017*.

²³ Sharma, S., Singh, M., & Bhattacharjee, D. (2018). *Admission procedures under the Mental Healthcare Act, 2017*.

²⁴ Duffy, R., & Kelly, B. D. (2020). *Mental Health Review Boards and rights protection*.

²⁵ Math, S. B., Gowda, G. S., Sagar, R., Desai, G., & Jain, S. (2022). *Implementation trends of the Mental Healthcare Act, 2017*.

²⁶ Thara, R., & Patel, V. (2010). *Role of NGOs in mental healthcare in India*.

A landmark reform associated with the Act is the effective decriminalization of suicide attempts, shifting the approach from punishment to care. The law also prohibits degrading practices and strengthens institutional regulation.

Challenges in Implementation

Despite its progressive intent, several challenges remain. The presumption of universal decision-making capacity has generated debate among practitioners, who express concern about refusal of treatment in severe cases.²⁷ Additionally, the practical application of advance directives and nominated representatives may be limited by socio-economic and educational barriers.²⁸

Resource constraints pose another serious hurdle. India faces a shortage of psychiatrists and psychiatric beds, as documented by the World Health Organization. Public expenditure on health remains modest, with mental health receiving only a small fraction of overall allocation.²⁹

Critics also argue that the Act, while inspired by international standards, may insufficiently account for the central caregiving role of families in India. Further, delays in constituting fully functional Mental Health Review Boards due to workforce shortages may hinder timely implementation.³⁰

Overall, while the 2017 Act establishes a strong rights-based foundation, its success depends largely on effective infrastructure, funding, awareness, and administrative commitment.

Suggestions and Way Forward under the Mental Healthcare Act, 2017

While the Mental Healthcare Act, 2017 marks a progressive shift toward a rights-based framework, certain provisions require reconsideration and clarification to ensure balanced implementation.

1. Reform of Section 102

Section 102 of the 2017 Act, which corresponds to Sections 24 and 28 of the earlier Mental

²⁷ Math, S. B., et al. (2019b). *Key features and implications of the Mental Healthcare Act, 2017*.

²⁸ Nayak, M. B., Panja, S., & Das, S. (2003). *Cultural barriers in mental health decision-making*.

²⁹ Bagchi, S. (2014). *Public expenditure and mental health in India*.

³⁰ *Ibid.*

Health Act, 1987, does not permit a Magistrate to release a person alleged to be mentally ill into the care of family members or friends upon furnishing of surety. Under the 1987 Act, a Magistrate could allow such a person to be taken home, subject to assurance that adequate care would be provided and that no harm would be caused to the individual or others.

However, Section 102 mandates that the Magistrate must either direct admission to a mental health establishment or order an assessment at such an establishment. Additionally, the mandatory judicial inquiry previously required under Section 24(1) and (2) of the 1987 Act has been omitted.

In this regard, the reasoning adopted by the Division Bench of the High Court of Delhi in **Ravinder v. Govt. of NCT of Delhi** (Judgment dated October 26, 2018) merits consideration. The Court emphasized procedural safeguards and suggested that the protective mechanisms under the 1987 Act should inform the interpretation of Section 102. A Special Leave Petition against the said judgment is presently pending before the Supreme Court of India, and leave has been granted.

A balanced approach would involve either legislative amendment or authoritative judicial clarification restoring judicial inquiry safeguards and permitting family-based care where appropriate, subject to safeguards against misuse.

2. Liability of Mental Health Establishments

Another issue concerns the liability and standard of care applicable to mental health establishments when a patient is brought pursuant to police or Magistrate orders. The earlier 1987 Act was largely silent on this issue, leading to uncertainty.

The 2017 Act clarifies that in such cases, the establishment must adhere strictly to statutory provisions governing admission, treatment, and discharge. This ensures that even where the individual is brought involuntarily, treatment must comply with procedural safeguards, informed consent norms (where applicable), and review mechanisms.

However, clearer operational guidelines and standard operating procedures would help institutions avoid legal ambiguity and ensure uniform compliance across states.

3. Regulation of Advance Directives

The mechanism of Advance Directives under Section 5–13 is a progressive feature that strengthens patient autonomy. However, the absence of detailed procedural regulations poses risks. Section 6 merely states that an advance directive shall be made in the manner prescribed by regulations, but comprehensive safeguards regarding authentication, registration, modification, and revocation remain essential.

Without clear procedural safeguards, there is potential for misuse, including forgery or undue influence, particularly where vulnerable individuals are involved. It is therefore imperative that detailed regulations be framed specifying:

- Standardized formats
- Mandatory registration before a designated authority
- Medical certification requirements
- Safeguards against coercion
- Clear procedures for modification and revocation

Such regulatory clarity would strengthen the credibility and functionality of the advance directive mechanism.³¹

Conclusion

The Mental Healthcare Act, 2017 represents a landmark reform in India’s mental health jurisprudence. By aligning domestic law with international human rights standards such as the Convention on the Rights of Persons with Disabilities, it promotes dignity, equality, autonomy, and non-discrimination for persons with mental illness. The decriminalization of suicide attempts, recognition of the right to mental healthcare, and institutionalization of advance directives mark transformative shifts in policy.

³¹ Widdershoven, G., and Berghmans, R., “Advance Directives in Psychiatric Care: A Narrative Approach” 27(2) *Journal of Medical Ethics* 92-97 (2001).

Nevertheless, effective implementation requires:

- Strengthening judicial safeguards under Section 102
- Clarifying institutional liability standards
- Framing comprehensive regulations on advance directives
- Enhancing infrastructure, funding, and trained human resources
- Increasing public awareness to reduce stigma

With sustained legislative refinement, administrative commitment, and societal participation, the Act has the potential to meaningfully transform India's mental healthcare system and foster a more humane and inclusive approach to mental illness.