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PAPER III · VOLUME FIVE

MD and DNB psychiatry, theory revision

Speciality Psychiatry

Mental Health Law and the Courtroom

The law the psychiatrist works inside, across the criminal, civil and family questions. Then consent, capacity and confidentiality as legal acts.

Dr. Wilfred D'souza · Dr. Niharika Reddy

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WEAVE SPRINT · PAPER III

Speciality Psychiatry

THE WEAVE SPRINT SERIES

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WRITTEN BY

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First compiled 2026. Free to read, share and print for study.

The clinical content is written for doctors and doctors in training. It is a study and revision aid, not a substitute for current guidelines or clinical judgement. Verify doses and thresholds against the current references and your local protocols before any clinical use.

For every resident who has ever sat up the night before,
afraid it will not be enough.

ACKNOWLEDGEMENT

A word of thanks

I want to begin by thanking something I cannot quite name. Call it whatever you like. I have never been certain what to call it, and I have stopped needing to be. There is a part of this work that does not feel like mine. The line that arrives before I have thought of it, the connection I did not plan, the steadiness on a morning I had no reason to be steady. I only hold the pen. Something moves through the holding, and I have learned to thank it without asking it for a name.

Someone once asked me why I give all of this away. Why hand out the notes I sat up making, to the very people sitting the same exam beside me. It is a fair question. If I had kept them, I would probably have scored a few marks more than the next person, and I might have been thought of as the better student. I have turned that over honestly, and I have decided it is a small thing to want. What I get instead, by putting the work in your hands, is the chance to take a little of the fear out of a great many nights. That trade is not close. Easing that fear is not a detour on the way to becoming a good psychiatrist. It is the thing itself. I did not come here to be the best student in the room. I came here to be a good psychiatrist.

And to Niharika, who reads everything first and knows when to be honest and when to wait; and to the residents who study from these pages and write back with the corrections and the questions: thank you. The book is better for you, and so am I.

Dr. Wilfred D'souza

Foreword

This fifth volume is psychiatry practised where somebody else sets the rules. It moves from the statutes that govern admission and treatment into the courtroom, where consent and capacity stop being clinical judgements and become legal ones that a psychiatrist may be asked to defend in writing, under questioning, by a person who is not a doctor.

The notes were written to be understood, not just revised. Each chapter is a full account of its subject, from the mechanism up to the point the exam tests, so that you can read to learn the first time and read to recall every time after. Where a fact is worth holding exactly, it is marked. Where a mistake is easy to make, it is named before you make it. The colour code on the next pages tells your eye what kind of fact it is looking at before your mind has to decide, and after a few pages it stops being a key you consult and becomes a sense you carry.

Read it in order if you are meeting the material, or open it anywhere if you are returning to it. The contents at the front and the index at the back both jump to the page you want. However you use it, the hope held in these pages is plain: that one ordered, trustworthy place to study from makes the work a little lighter, and that you walk into the hall steadier than you would have otherwise.

HOW TO USE THIS BOOK

The colour memory code

Every note in this volume speaks one visual language, so once you learn it in the first chapter you read the rest without thinking about it.

Concept and rule	The core idea and the principle that follows from it. When a line is petrol, it is the thing to understand, and the thing worth being able to state.
Key number	A figure to hold exactly: a dose, a threshold, a prevalence, a cut-off. Amber means memorise this number, not just the shape of it.
Trap	The mistake the exam is waiting for. When a line is coral, it is warning you off an error that looks right until it costs you the mark.

Hold this is the single line from a topic you must carry out of it. **Good to remember** gathers, for each named thing, what it is, when it matters, and the one number or formula worth keeping. Both help a tired brain find the centre of a dense page fast.

The contents at the front is clickable, and so is the index at the back: every entry jumps to its page. Read to learn once, and to recall as often as you need.

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PART VI

VI

Mental Health Legislation and Forensic Psychiatry

The law the psychiatrist works inside: the mental health statutes, and the criminal, civil and family forensic questions.

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02 The Mental Healthcare Act 2017

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09 Apply and consolidate

PAPER III

Mental health legislation and forensic psychiatry

Eight bands . one complete notes document

Orientation: mental health law and the forensic questions

1 · Orientation: mental health law and the forensic questions

Why these marks are here. Mental health law and forensic psychiatry is the one part of the paper that asks you to reason as a clinician and as a party to the legal system in the same breath. On the wards you already work inside a statute book that decides whom you may admit, what you may treat, and how far your authority reaches; and every so often a court reaches into that clinical world and puts a question only a psychiatrist can answer - was this act excused, is this person competent to this particular legal step, is this patient a risk the law must weigh. Candidates lose marks here less because the material is obscure than because the two worlds are usually taught apart, are easy to confuse under time pressure, and turn on fine distinctions that are either read straight from the statute or badly reconstructed from a half-remembered lecture. What this opening section gives you is the chapter's advance organizer: a single map to carry in your head, so that each later provision arrives as a marked place on ground you already hold rather than as one more law to be memorised in isolation.

The map has one shape, and fixing it is worth more than any single provision. The chapter runs on two spines, with one idea threaded down the length of both. The first spine is legislation, the statutes you operate inside; the second is the run of forensic questions a court reaches in to ask; and the idea beneath both is **capacity** - whether a particular person, faced with a particular decision, at a particular moment, could do the thing the law asked of them. Every statute in the chapter is worked from its own enacted text rather than from a summary, because a paraphrase drifts and a digest goes out of date; and one of those texts has been recodified recently, which makes the currency of a citation itself an examinable point. Hold the two spines, look for the capacity under whatever question sits in front of you, and the topics that follow stop competing for memory and begin to reinforce one another.

Inside	Across	Beneath
THE LAW YOU PRACTISE WITHIN	THE QUESTIONS A COURT ASKS	CAPACITY, THE SINGLE IDEA

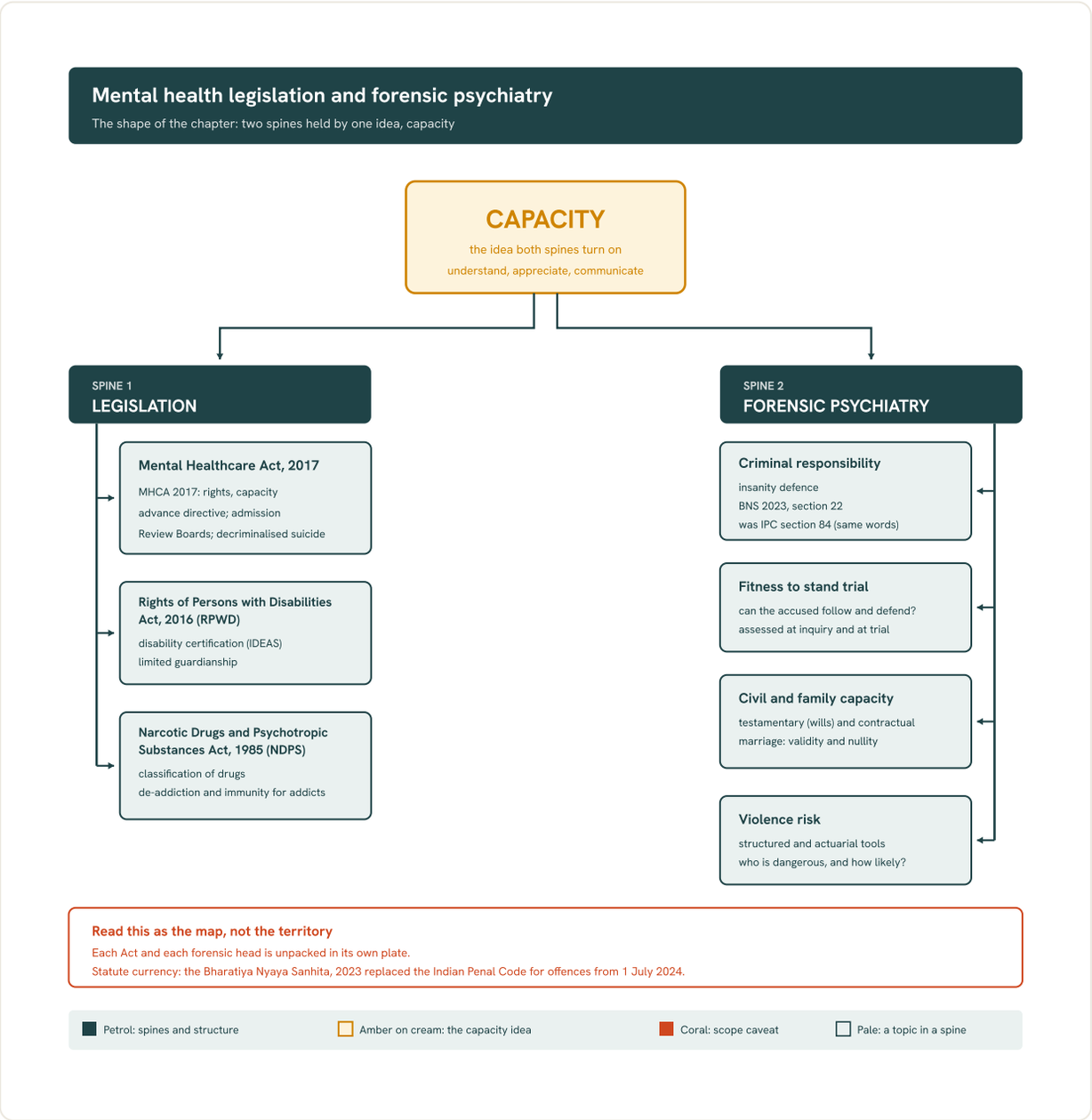


Fig 25.1. The chapter runs on two spines. Legislation (the Mental Healthcare Act 2017, the RPWD Act 2016 and the NDPS Act 1985) sits on one side, and the forensic questions of criminal responsibility, fitness to stand trial, civil and family capacity, and violence risk on the other. Both turn on a single organising idea, capacity, so read this as the shape of the chapter and study each head in its own plate.

1.1 The whole chapter on one map

Read as a flat list, the mental health legislation, the disability law, the narcotics law, the tests of criminal responsibility, the several civil and family capacities and the assessment of violence risk look like unrelated statutes to be learned in parallel, each with its own numbers to be crammed. They are not unrelated. They sort into two columns - the law a psychiatrist works within, and the questions a court puts from outside - and one construct runs down both columns and ties them together. Seeing this before any single provision is not decoration: it converts memorising into placement, and a new rule is learned far faster when there is already a labelled slot waiting to receive it.

The table below sets the two spines against shared axes so the parallel is visible at a glance. It teaches no rule of its own, and every provision it names is developed in the section that owns it.

The accompanying figure carries the same map in a single view, to keep beside the text as the picture the words are describing.

SPINE	WHAT IT IS	THE QUESTION BENEATH IT	WHERE THE PSYCHIATRIST MEETS IT
First spine: legislation	The statutes you practise inside - the Mental Healthcare Act, the Rights of Persons with Disabilities Act and the narcotics law	May I admit, treat and protect this person, and on what lawful authority	On the ward and in the clinic, and in the certificates the law asks you to sign
Second spine: forensic	The questions a court reaches in to ask - about responsibility, civil and family competence, and risk to others	Was this act excused, is this person competent to this legal act, is this patient a danger the law must weigh	In the report to the court and in the witness box, on the court's timetable rather than the clinic's

1.2 The first spine: the law you practise inside

The first spine is the **mental health legislation** a psychiatrist works within, and its centre of gravity is the Mental Healthcare Act. What makes the Act the natural opening of the whole chapter is that it is **rights-based** and capacity-based rather than custody-based: it starts from the person's rights and their ability to decide, and builds its powers of admission, treatment and protection on that foundation, instead of around a bare power to detain. Its definition of illness, its consent and admission machinery, its review boards, its authorities, and its limits on procedures such as electroconvulsive therapy and restraint are each taught in their own place. For the map it is enough to see that all of them descend from the same rights-and-capacity root, which is why a question on any one of them can be reasoned toward from that root when the exact section will not come.

Two further statutes stand beside it. The disability legislation, the Rights of Persons with Disabilities Act, recognises mental illness among the disabilities it protects and carries its own machinery of certification, benefit and guardianship - a logic aimed at inclusion and entitlement rather than at treatment, and therefore a different instrument doing a different job. The third is the narcotics law, which this chapter reads purely as law: how it classifies controlled substances, how it scales its penalties, and what it provides for treatment and for immunity. The clinical management of dependence and its de-addiction belongs to another chapter and is named at the border below. What unites the three is that each is an instrument you operate from the inside, not a question put to you from without.

IN INDIA

Every statute in this chapter is an Indian primary Act, and you are examined on the Indian book, not on a Western framework a general textbook might describe. The Mental Healthcare Act is rights-based and capacity-based by deliberate design, a clean break from the older custodial model; the disability and narcotics statutes are likewise Indian instruments, with Indian thresholds and Indian certifying authorities. One of the criminal statutes has moreover been recodified recently, so a candidate working from an older text must confirm that the provision cited is the one currently in force. Reading each Act from its own words, and checking that those words are still the law, is the whole discipline the chapter rewards.

1.3 The second spine: the questions a court asks

The second spine is **forensic psychiatry** proper: not a body of statute you practise inside, but a set of questions the law reaches in to ask, to which your clinical assessment is the answer it needs. They gather into three families. The first is **criminal responsibility** - whether unsoundness of mind at the time of an act should excuse it - together with the neighbouring questions of fitness to stand trial, of diminished responsibility and automatism, of the legal concepts of intent, of the legal standing of deception-detection methods, and of the detection of malingering. The second is civil and family capacity - whether a person is competent to make a will, to enter a contract, to marry or to be divorced, to keep custody of a child, to manage property, or to be certified fit for work. The third is the assessment of violence risk - how dangerousness is conceived, and how the risk of future violence is estimated, by structured clinical judgement and by actuarial method.

These are questions with forums and timetables that are not the clinic's. The court sets the question, fixes the moment at which it must be answered, and receives the answer as evidence rather than as treatment - which is why a forensic opinion is written and defended quite differently from a ward note, and why the audience for it is a judge and not a patient. Where a forensic question brushes against child law - the protection of a child, or a juvenile in conflict with the law - the governing statutes are taught in another chapter and are only named, at the border below. The ethics of giving evidence, the confidentiality owed, and the certification of a report for a court are a subject of their own, and are placed with their own chapter below. This chapter keeps the clinical questions; it does not absorb the statutes and the professional duties that neighbour them.

1.4 Capacity: one idea seen from many benches

Why one construct carries the whole chapter. The reason the two spines belong in one chapter, rather than in two, is that a single question sits beneath almost every topic on either of them. Whether the setting is a ward or a courtroom, the law is finally asking whether a specified person could make a specified decision. On the legislation spine it asks in order to protect and to empower - may this person decide their own treatment, and if not, who decides for them and how. On the forensic spine it asks in order to attribute or to withhold - may this person be held responsible for what they did, may this will stand, may this marriage be undone. The asking is the same act in different robes, and once that is seen the chapter reads as one subject rather than as a dozen.

Capacity in this sense takes a recognisable set of forms, each a full topic in its own right and each owned and taught in its own place. It is worth naming them here, as a set, precisely so that you meet each later one as a member of a family you already recognise:

- the capacity to consent to treatment, under the mental health legislation;
- the capacity to make a valid will, the testamentary capacity;
- the capacity to enter a binding contract;
- the capacity to be held criminally responsible for an act;
- and the capacity to stand trial, the fitness to plead.

Two properties make this family behave as it does, and the chapter's cross-cutting synthesis draws them out in full where it is owned. Capacity is **decision-specific**, so the same person may hold it for one decision and lack it for another at the very same moment; and it is **time-specific**, so it is judged as at a fixed instant - the time of the act, the time of the will, the time of the trial - and can change between one moment and the next. The work of this opener is only to plant that idea; the individual tests, and the grid that contrasts them, are developed where they are owned and are not restated here.

TRAP **Treating capacity as a single global switch a person either has or lacks.** The examiner watches for the candidate who writes that a patient "lacks capacity" full stop, or who reads one capacity off another - competent to consent, therefore competent to make a will. Capacity is asked of a named decision at a named moment. An opinion that omits the decision or the moment is not an incomplete opinion but no opinion at all, and every individual test in this chapter is built to be applied to one decision, at one moment, at a time.

1.5 Every statute from its primary source, and why currency now matters

The habit that separates a reliable answer from a merely plausible one is reading each statute from the **primary source** - the Act as enacted - rather than from a secondary summary, a coaching note or a half-remembered lecture. A paraphrase softens the exact word the law turns on; a summary drops the proviso that decides the hard case; and a textbook written a few years ago may faithfully describe a provision that has since been amended or replaced. This chapter therefore works every statute from its own text, quotes the operative words where they carry the point, and treats the precise wording, not the gist of it, as the thing to be learned.

RULE **Read the law from its primary source, and find the capacity beneath the question.** Two habits carry this chapter: go to the Act itself for the words that decide a point, and, when a question empties your head, ask which spine it sits on and which capacity lies under it. The first keeps your citation accurate; the second keeps your reasoning organised when the exact section will not come to you cold.

Currency is part of that same discipline, and it is why the substantive criminal law of this chapter now needs particular care. The long-standing penal code has been recodified into a new statute, and the insanity exception, together with the rule that places the burden of proving it, have moved with it into the new penal code and the new law of evidence, carried across in substance

rather than rewritten from scratch. The new code's own transition provisions decide which text actually governs a given case: the recodified provision applies to an offence committed on or after the recodification's commencement date, while the superseded provision remains the operative law for an offence committed before that date and for a proceeding already pending when the new code commenced, because the new code expressly saves it for that purpose. An answer forfeits the currency mark when it cites a provision that does not govern the offence or proceeding in front of it, in either direction; it does not forfeit the mark for correctly citing the superseded provision to a case the savings clause keeps under it. The precise sections, the effective date, the savings provisions, and the names of the current and the historical provisions are taught where the criminal-responsibility topic owns them; for the map, the only point is that the citation must match where the offence or proceeding actually falls.

PITFALL

The recurring real-world error is citing whichever provision does not govern the case at hand - reciting the recodified section for an offence committed before its commencement date, or reciting the superseded section for an offence or a proceeding the new code has already moved forward, or stating an immunity or a presumption without the conditions the statute attaches to it. The wording of the insanity exception survived its recodification almost unchanged, so the doctrine usually survives the slip; the citation does not, and an opposing advocate who spots a report resting on the wrong side of that line has an easy way to weaken the witness before a word of substance is heard. Confirm which provision the offence date or the proceeding's pendency actually selects, then cite it.

1.6 What is named here and taught elsewhere

A map is as much its borders as its interior, and four subjects a reader might reasonably expect to find in a law-and-forensic chapter are deliberately kept outside it, named at the edge and cross-referred so that the pointer is never lost. Each belongs to a chapter that teaches it in full, and the reason to keep them out is that answering a border question with the neighbour's material is one of the commonest ways to lose marks here:

- the child-protection statutes, including the provision for trying certain juveniles as adults, belong to the Child psychiatry: assessment, treatment, services and protection notes;
- forensic ethics, consent and confidentiality, the certification of a report for court testimony, and disaster and prisoner psychiatry belong to the Forensic ethics, consent and legal procedure notes;
- the clinical technique of electroconvulsive therapy and other neurostimulation belongs to the ECT and neurostimulation notes, while this chapter keeps only the statute's consent rules for it;
- and the clinical side of the narcotics law, the substance use disorders themselves and their de-addiction pharmacology, belongs to the Substance use disorders notes.

The boundary is not arbitrary, and the fitness-to-work certificate makes the logic plain. A single occupational-fitness certificate signed for an employer is this chapter's business; the report and

certificate written for a court are the forensic-conduct chapter's, because the duty owed and the audience addressed are different. Keeping these lines clean is itself examinable, and a candidate who can say where a topic stops has usually understood where it belongs.

1.7 Carrying the map into the hall

The value of an advance organizer is that it can be rebuilt from almost nothing when memory fails under pressure, and this one reduces to three phrases that regenerate the whole chapter between them.

MNEMONIC

Law inside, court across, capacity beneath

Rebuild the whole chapter from three phrases. **Law inside** is the legislation you practise within - the Mental Healthcare Act, the Rights of Persons with Disabilities Act and the narcotics law. **Court across** is the run of questions a court reaches in to ask - responsibility for an act, competence to make a will, to contract, to marry or to be tried, and risk to others. **Capacity beneath** is the one foundation carrying both, because each of those is finally a question of whether a particular person, for a particular decision, at a particular time, could do what the law asked of them. Recall the two spines, then the foundation under them, and the chapter reassembles itself from memory.

GOOD TO REMEMBER

When a legislation-or-forensic question empties your head in the hall, run the map before you panic. Ask which of the two spines the question belongs to, then find the capacity beneath it and name the decision, the moment and the forum the question is really about. That almost always surfaces the section, the test or the instrument you could not summon cold; and on the ward the same three-part habit - which decision, which moment, which forum - is what keeps a real opinion from being quoted later for a question it never actually answered.

Read the chapter now with the map already in place, and each statute and each test arrives as a named location rather than a loose fact. The detail - the sections, the durations, the criteria, the cases and the instruments - is taught, and cited to its source, in the topics that own it. What this opener leaves you with is the frame those details hang on.

This chapter has two spines, the law you practise inside and the questions a court asks, held together by one idea, capacity: name the decision, name the moment, name the forum, and every section and test in the chapter finds its place.

The Mental Healthcare Act 2017

2 · Salient features and objectives of MHCA 2017

This is the statute a psychiatrist in India actually practises inside, and the examiner opens the whole law paper with it because everything downstream is a working-out of the reorientation

it announces. The Mental Healthcare Act, 2017 did not simply update the machinery of admission and licensing that had governed the field for a generation. It changed the question the law asks. Where the older regime asked how an unwell person could be taken into care and kept there, the new statute asks what rights that person holds and whether they retain the capacity to decide, and it builds every other mechanism around the answer. A candidate who grasps that single reversal can reconstruct most of the Act from first principles; a candidate who misses it will recite features without a spine.

The marks here reward two things done together: a precise statement of what makes the Act a **paradigm shift**, and the enactment facts that fix it in time and place. Salient features answered as a shopping list read thin, and objectives answered without the primary Act read as opinion. The safe answer reads the Act as a coherent design, names the enactment facts that pin it down, and shows why the design is what it is.

10 of 2017	7 Apr 2017	29 May 2018	30 Oct 2019
ACT NUMBER	PRESIDENTIAL ASSENT	BROUGHT INTO FORCE	UNION-TERRITORY EXTENSION

2.1 The paradigm shift: from custody to rights

The organising idea of the statute is that it is **rights-based** rather than custody-based. The law it replaced approached mental illness through the lens of confinement and management: its central acts were reception, detention and the appointment of someone to hold authority over the unwell person and their property. The person at the centre of that scheme was, in law, largely an object of decisions made for them. The current Act inverts that posture. It treats the person with mental illness as a **rights-holder** whose entitlements the State must protect and whose own will and preferences the system must seek before it overrides them.

Calling the Act rights-based is not decoration; it is a description of how the statute is engineered. A rights-based law starts from what is owed to the person and treats every power to act against their expressed wishes as an exception that must justify itself. The older **custodial** model ran the other way: the power to detain and treat was the starting point, and the person's objection was a problem to be managed. This is why an answer that lists admission categories and licensing rules, however accurate, misses the examiner's point. Those mechanisms exist in the new Act too, but they now sit downstream of a prior commitment to rights, and their whole shape is bent by it.

TRAP **The Act is a rights statute, not a rebadged custody-and-licensing law.** The commonest error is to answer "salient features" with a catalogue of admission routes and registration rules, as though the reform merely modernised its custodial-era predecessor. That misreads the question. The Act reorganises mental-health law around the person's rights and capacity, and the admission and licensing machinery is a consequence of that reorientation, not the substance of it. State the reversal first, then the features that flow from it.

2.2 Capacity and autonomy as the organising logic

If rights are the destination, **capacity** is the road the Act builds to reach them. The statute keys the lawfulness of acting for a person to whether that person has the capacity to make the

particular decision at hand, and it protects the person's **autonomy** by requiring that their capable choices be respected and that their earlier or represented wishes be sought when capacity is impaired. The precise legal test for capacity, and the definition of mental illness that sits beside it, are set out in full where this chapter treats the definition of mental illness and the capacity to make treatment decisions; the point to hold here is architectural rather than definitional. Capacity is the hinge on which the entire Act turns.

Two design consequences follow, and they are worth seeing as consequences rather than as separate features. First, decision-making about a person is meant to be **supported** before it is substituted: the law prefers helping a person to decide over deciding for them, and it provides instruments to make that support real. Second, when the system must act despite a person's wishes, it is meant to reach for the **least restrictive alternative** consistent with safety and care. Care becomes the default and coercion the guarded exception, and every coercive power in the Act carries conditions precisely because the design treats coercion as something to be justified and limited, never assumed.

A useful way to feel the size of the shift is to watch where the burden sits. Under a custodial law the unwell person effectively had to earn their liberty back: the authority to hold and treat them was assumed, and the onus lay on the patient to displace it. A capacity-based law moves that burden the other way. The person's decisional autonomy is the starting position, and it is the system that must show why a particular choice may be taken out of their hands rather than left with them. That inversion is what turns a catalogue of features into a rights statute, because it makes every power to act against a person's wishes answerable for itself rather than automatic.

RULE **The Act is built around capacity and autonomy: care is the default and coercion the guarded exception.** Read any provision by asking what it does to the person's decisional autonomy and how tightly it conditions any power to override it. Provisions that support the person's own decision are the rule; powers that substitute for it are exceptions hedged with conditions. That single lens organises the whole statute and is what the examiner is really testing.

2.3 The objectives: why Parliament enacted it

The objectives of the Act are best read against the pressures that produced it. India had bound itself to an international obligation to align its domestic law with a rights-based conception of disability, and the older custodial statute could not be reconciled with that conception. The Act is the instrument that closes the gap. Its preamble frames its purpose in the language of provision, protection and the fulfilment of rights, and the working objectives can be stated plainly:

- To protect, promote and fulfil the rights of persons with mental illness during the delivery of mental healthcare and services.
- To align domestic law with India's obligations under the international disability-rights framework, which the older custodial statute could not satisfy.
- To provide for mental healthcare and services and to regulate the establishments that deliver them, so that care meets a national standard.

Read together, these objectives explain the temper of the whole statute. It is simultaneously a charter of entitlements and a scheme of regulation: it tells the State what it owes the person, and it tells providers what they must meet. The rights language is not aspirational preamble that the operative sections then ignore; the operative sections are the machinery by which the objectives are meant to be delivered, which is why the objectives and the salient features are two views of the same design.

IN INDIA

India enacted this statute to bring its mental-health law into line with its obligations under the international disability-rights framework, retiring a custodial-era predecessor in favour of a rights-based scheme. Because public health is administered by the States, the Act sets a national floor of rights while the bodies that carry it - the health authorities, the review boards and the registered establishments - are stood up unevenly across the country. The distance between the right guaranteed on paper and the service available on the ground is therefore itself part of the Indian reality a psychiatrist works within, and a realistic answer acknowledges it rather than describing the Act as if it were fully operational everywhere.

2.4 Enactment, commencement and extent

Because this is a statute read from the primary Act, the enactment facts are examinable in their own right and are easy marks when stated exactly. The law is **10 of 2017** and it received the assent of the President on **7 April 2017**. Its commencement provision, section **1(3)**, is a two-limbed rule and its verbs matter: the Act shall come into force on such date as the Central Government may appoint by notification, or on the completion of **nine** months from the date of assent. The coming-into-force is mandatory; what is discretionary is only the choice of the appointed date.

In the event, the Central Government exercised that power and the Act was brought into force on **29 May 2018** by notification, well past the nine months from assent that the alternative limb described above would otherwise fix; this chapter flags that gap between the statutory text and the notification record as an anomaly rather than resolving it. Its extent provision, section **1(2)**, applies the Act to the whole of India; the reach was later widened to the union territories of Jammu and Kashmir and Ladakh by a further notification. Keeping the extent point in view matters clinically, because it fixes the territorial scope within which the rights and duties the Act creates are enforceable.

The fallback commencement limb is not a technicality worth skipping over. Reform statutes are sometimes passed and then left unnotified, so that a law sits on the books yet binds no one because no commencement date is ever appointed. On its face, a nine-month fallback limb of this kind is meant to guard against exactly that hazard, an ambitious statute that a reluctant administration might prefer not to switch on; but the Act's actual commencement date on the official record runs past that nine-month mark, so the limb should not be taught here as an unqualified outer bound that was in fact honoured.

PITFALL

Reading the date of assent as the date the Act took effect. The Act received Presidential assent on **7 April 2017**, but it did not operate until it was brought into force by notification more than a year later. Citing the Act as effective from its assent, or loosely from its year of passage, mis-states the law that governed any event in the interval and confuses a mandatory duty to commence with the discretionary choice of when. It is exactly the kind of statute-currency error that a clinician giving evidence, and a candidate under examination, cannot afford.

2.5 The salient features as a single system

The features of the Act are best learned as expressions of the one design, each named for the right or value it serves rather than memorised as an unconnected list. The mechanics of each feature are developed in full in its own place in this chapter; what belongs here is the map that shows how they hang together. The accompanying survey sets each pillar beside the entitlement it delivers.

PILLAR OF THE ACT	WHAT IT ESTABLISHES	THE RIGHT OR VALUE IT SERVES
RIGHTS OF PERSONS WITH MENTAL ILLNESS	A statutory charter of enforceable rights during care	Dignity, non-discrimination, access to services
CAPACITY TO MAKE TREATMENT DECISIONS	Decisions keyed to the person's decisional capacity	Autonomy
ADVANCE DIRECTIVE	A means to record wishes ahead of a future loss of capacity	Prospective autonomy
NOMINATED REPRESENTATIVE	A personally appointed, or absent appointment, statutorily deemed or Board-appointed representative	Supported decision-making
ADMISSION CATEGORIES	Consent-led and safeguarded routes to inpatient care	Least restrictive care
MENTAL HEALTH REVIEW BOARDS	An independent body to oversee and adjudicate	Protection from arbitrary detention
MENTAL HEALTH AUTHORITIES	Registration and standards for establishments	Regulation and accountability
ATTEMPTED SUICIDE	Met as a matter for care rather than prosecution	Compassion over criminalisation
REGULATION OF COERCIVE TREATMENTS	Statutory control of electroconvulsive therapy, psychosurgery, restraint and seclusion	Protection from harm
PENALTIES FOR CONTRAVENTION	Defined consequences for breach of the Act	Enforceability

Two cautions attach to the last two rows. The Act sorts the regulated treatments into those it forbids outright and those it permits only under safeguards, and the placement of each into its category is set out where this chapter treats the prohibited and restricted procedures; the clinical

technique, dosing and mechanism of electroconvulsive therapy are not this chapter's at all and belong to the ECT and neurostimulation notes. Naming a feature is the work of this section; teaching its inner rules is the work of the sections that own it.

MNEMONIC

Rights, not custody; capacity, not status

The paradigm in one breath. The Act treats the person as a rights-holder rather than an object of custody, and capacity is a central organising principle for admission and treatment decisions rather than diagnostic status or another's authority, though some emergency, safety and prohibited-procedure provisions turn on their own statutory criteria, not on capacity. The directive written in advance, the representative the person nominates, the review boards and the regulation of coercive treatment are all consequences of those two reversals, not separate inventions.

2.6 The State's positive obligations

A distinctive feature of the Act, and one candidates routinely underweight, is that it does not only restrain the State from wronging the person; it obliges the State to act for them. A rights-based statute of this kind carries positive duties as well as negative limits, and the Act places several of them squarely on government:

- To provide mental healthcare and services and to work towards their availability and accessibility.
- To regulate mental health establishments through registration and enforceable standards of care.
- To reduce reliance on coercion by favouring supported decision-making and the least restrictive option.

These duties are what give the rights their teeth. A right of access to care means little without a State obligation to provide it, and a right against arbitrary detention means little without an independent body empowered to test detentions. The Act's ambition, then, is not merely to draw a boundary the State must not cross but to commit the State to a programme it must deliver, which is also the source of the reform's central practical tension, taken up below.

GOOD TO REMEMBER

On the ward the change is concrete. The opening question is no longer whether a person can be admitted and managed, but whether they have the capacity to decide, what they set down in any advance directive, and whom they nominated to speak with them. Default to the least restrictive option, record the capacity assessment in the notes, and involve the nominated representative early. The statute expects the person's own voice to be sought first, and the record is what shows that it was.

2.7 Currency, controversy and the implementation gap

The reform is genuine and the ambition is real, and the exam rewards seeing both the achievement and its unfinished edge. The central controversy is the distance between the rights

the Act guarantees and the services needed to honour them. A statute can declare a duty to provide care in a single clause; building the crisis services, the review boards and the trained workforce that discharge that duty is the work of years, and it proceeds unevenly because public health is administered by the States. The result is a law whose promise on paper outruns its delivery on the ground, and commentators reasonably ask whether a rights-based statute that is only partly resourced can secure the rights it names.

A second live point is one of currency at the statute's edges rather than its core. The Act sits alongside the wider disability-rights legislation and interacts with a criminal law that has since been recodified, so the exact provisions bordering the Act shift over time and are treated where those neighbouring laws are owned; this section flags that movement rather than settling it. What the Act itself decides is not in doubt, and that is what an answer should assert without hedging: a rights-based, capacity-based statute that reframes the person with mental illness as a rights-holder, keyed to capacity, defaulting to care, and conditioning coercion at every turn.

> The Mental Healthcare Act, 2017 is a rights-based, capacity-based statute that reframes the person with mental illness as a rights-holder: care is the default, coercion the guarded exception, and decisional capacity, not another person's custody, is a central organising principle across the Act's admission and treatment provisions.

3 · Definition of mental illness and capacity to make treatment decisions

Why the marks concentrate here. Two threshold questions decide everything the Mental Healthcare Act 2017 then does to a person: is this a **mental illness** the Act recognises at all, and does this person have the capacity to make their own treatment decisions. Every later power and protection in the statute - the advance directive, the choice of admission route, the consent to a treatment such as electroconvulsive therapy, the limits on restraint - hangs off these two definitions. Examiners return to them because they are compact, they are frequently misremembered, and each carries a cluster of traps that separate a candidate who has read the Act from one who is paraphrasing half a memory of it.

The difficulty is that both concepts sound familiar and are not what a clinician assumes. The definition of mental illness is not a list of diagnoses but a functional description with a deliberately drawn boundary, and where it draws that boundary - substance-associated conditions inside it, intellectual disability outside it - is exactly what is examined. Capacity is not a global attribute a patient either has or lacks; it is a rebuttable presumption, attached to a particular decision, tested against a short functional standard whose bare statutory wording surprises most readers. Alongside these sits a third provision that keeps the clinical determination of illness from being read as a legal verdict on the person.

2(1)(s)	3	4
MENTAL ILLNESS DEFINED	DETERMINATION OF ILLNESS	CAPACITY TO DECIDE

3.1 The definition of mental illness

The definition sits at section **2(1)(s)**, and its structure is worth dissecting rather than reciting, because the structure is where the reasoning lives. Mental illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life. Read it as two joined requirements. First, there must be a substantial disturbance in one of a named set of faculties - thinking, mood, perception, orientation or memory. Second, that disturbance must grossly impair one of a named set of functions - judgment, behaviour, the capacity to recognise reality, or the ability to meet the ordinary demands of life. A disturbance without gross functional impairment does not satisfy the definition, and impairment without an underlying substantial disorder does not either.

The Act has chosen a **functional** definition rather than a categorical one, and the choice is deliberate. It does not enumerate diagnoses, so it does not go out of date each time a classification is revised, and it does not turn on a label but on severity and consequence. Only a disorder grave enough to grossly impair one of those core functions satisfies the definition. This matters because the provisions expressly predicated on an established mental illness - the coercive powers as much as many of the safeguards - are reserved for illness of that gravity, and a milder disturbance that leaves judgment, behaviour, reality-testing and everyday functioning broadly intact is, by the Act's own words, outside the definition. The definition does not gate the Act as a whole: provisions built around suspected or self-perceived mental illness, taught in their own place elsewhere in this chapter, engage without waiting on that threshold. The word doing the heavy lifting is "grossly": the definition is built around gross impairment, not any impairment.

3.2 What the definition takes in, and what it keeps out

Two boundary rules inside the same definition are the most heavily examined lines in this topic, and they run in opposite directions. The definition expressly *includes* mental conditions associated with the abuse of alcohol and drugs. It expressly *does not include* **mental retardation**, which it describes as a condition of arrested or incomplete development of mind specially characterised by subnormality of intelligence. So substance-associated mental conditions are in, and intellectual disability, standing alone, is out.

Hold the direction of each, because candidates routinely reverse them. The inclusion of alcohol- and drug-related conditions means a person whose mental state is disordered in association with substance use falls within the Act's definition and may draw on its protections and be subject to its provisions; the clinical management of substance use disorders themselves is a separate subject, taught in the Substance use disorders notes, and is not the concern here. The exclusion of intellectual disability means that a person whose only condition is arrested or incomplete development of intelligence is not, by that fact, a person with mental illness for the Act's purposes. That exclusion is not a withdrawal of rights: the framework that recognises and certifies intellectual disability, and confers benefits and safeguards on that basis, is the disability legislation dealt with elsewhere in this chapter. The Act simply keeps the two constructs in separate boxes. A person with intellectual disability who also develops a substantial disorder of

mood or perception can, of course, have a mental illness on the ordinary meaning of the definition; what the exclusion denies is that subnormality of intelligence is itself the illness.

MNEMONIC

Substance in, subnormality out

The two boundary rules of the definition, in the order they trip candidates. A mental condition associated with the abuse of alcohol or drugs is **included**; mental retardation, a condition of arrested or incomplete development of mind characterised by subnormality of intelligence, is **excluded**. If you can only carry one line on this definition into the hall, carry the two directions.

TRAP **The definition includes substance-associated conditions and excludes intellectual disability - not the reverse.** Because addiction is so often spoken of as a "vice" and intellectual disability as a lifelong "mental" condition, candidates flip the two. The statutory text is explicit and settled: conditions associated with the abuse of alcohol and drugs are within the definition of mental illness, and mental retardation is expressly outside it.

3.3 How mental illness is determined

A definition needs a method of application, and section 3 supplies it. Mental illness *shall* be determined in accordance with such nationally or internationally accepted medical standards, including the latest edition of the World Health Organisation's International Classification of Diseases, as may be notified by the Central Government. The verb is mandatory and it anchors the clinical judgment to recognised diagnostic standards rather than to idiosyncratic opinion. The **determination of mental illness** is thus a disciplined exercise: the clinician works from accepted nosology, not from personal conviction about who is or is not ill.

The provision then does something a purely clinical statute need not do: it fences off the reasons that may *not* be used. A determination *shall not* be made on the basis of a person's political, economic or social status, or membership of a cultural, racial or religious group, or for any reason not directly relevant to that person's mental health status. Nor may it rest on non-conformity with the moral, social, cultural, work or political values or the religious beliefs prevailing in the person's community. And a past history of treatment or hospitalisation, by itself, is not a ground for determining that a person is presently or will in future be mentally ill. Each clause closes a historically abused route by which unpopular, eccentric or merely inconvenient people were declared ill. The section is, in effect, a bar against psychiatry being used as an instrument of social control, and its clauses are best learned as the specific abuses they were written to prevent.

- not political, economic or social status;
- not membership of a cultural, racial or religious group;
- not non-conformity with prevailing moral, social, cultural, work, political or religious values.

IN INDIA

This is a distinctively rights-based drafting choice and a deliberate break from the older custodial law. By tying determination to notified medical standards and to the current International Classification of Diseases, and by forbidding determination on social, cultural, religious or political grounds, the Act aligns Indian practice with an internationally recognised evidence base and writes the safeguard against misuse into the statute itself. For the practising psychiatrist the working discipline is simple: the record should show that a determination rests on recognised diagnostic criteria and on the person's mental health status, and never on their beliefs, conduct or standing in the community.

3.4 Mental illness is not unsound mind

The most consequential firewall in this whole topic is the rule that a clinical finding of mental illness is not a legal finding of **unsound mind**. The determination provision states it plainly: the determination of a person's mental illness *shall* alone not imply, or be taken to mean, that the person is of unsound mind, unless they have been declared as such by a competent court. The modal is mandatory and the effect is a hard separation of two spheres. Mental illness is a medical construct, determined by a clinician against accepted standards. Unsound mind is a legal status, and it can be conferred only by a court.

Why this earns its place is that the two are constantly conflated, to a patient's cost. A diagnosis does not, of itself, strip a person of the legal capacities that unsoundness of mind would affect. Whether a person is criminally responsible for an act, whether they are fit to stand trial, whether they can make a will or a contract or manage their property - these are decided on their own tests, by the appropriate legal process, and are set out elsewhere in this chapter; none of them follows automatically from a psychiatrist's determination that a mental illness is present. The clinician determines illness; the court, on the relevant legal test, determines unsoundness of mind and its consequences. Keeping the two apart is not a technicality but the point of the provision.

PITFALL

A recurring clinical and medico-legal error is to let a diagnosis do a court's work - to write or imply that because a person has a mental illness they are therefore of unsound mind, incompetent, or not responsible. The Act forbids that inference: determination of mental illness alone does not mean unsound mind unless a competent court has so declared. A report that slides from a clinical diagnosis to a legal conclusion about capacity or responsibility oversteps the clinician's role and misstates the law.

3.5 Capacity to make mental-healthcare and treatment decisions

This is the required core of the topic. Section **4** sets the test of **capacity to make** mental-healthcare and treatment decisions, and its architecture must be learned exactly. Every person, including a person with mental illness, *shall* be **deemed** to have capacity to make decisions regarding their mental healthcare or treatment if they have the ability to do the following:

- understand the information relevant to taking the decision on treatment, admission or personal assistance;
- appreciate any reasonably foreseeable consequence of a decision, or of a lack of decision, on treatment, admission or personal assistance;
- communicate the decision, by means of speech, expression, gesture or any other means.

Two features of that text are examined again and again, and both cut against the way capacity is usually taught. The first is the deeming clause. The Act does not ask the clinician to establish that a patient *has* capacity; it deems every person to have it, so the presumption runs in the patient's favour and it is incapacity that must be demonstrated. This is a rebuttable presumption of capacity, and the burden sits with whoever asserts that the person cannot decide. The second is the connector. In the bare statutory text the three abilities are joined by the disjunctive word "or", not by "and" - a wording that is identical across the authoritative sources of the Act and that differs from the familiar functional model of capacity, imported from other jurisdictions and general teaching, in which a person must understand, retain and weigh the information and then communicate a choice, all elements being required together. The Indian provision, read literally, lists three abilities and joins them disjunctively. Whatever the interpretive debate about how those limbs are best applied at the bedside, the examinable textual fact is that the statute uses three limbs and the word "or".

A third clause completes the picture and guards the presumption from a common abuse. A decision that others regard as inappropriate or wrong does not, by itself, mean the person lacks capacity. Capacity is about the *process* of deciding - understanding, appreciating consequences, communicating a choice - and not about whether the choice matches what the clinician or family would prefer. An unwise decision by a capacitous patient is still that patient's decision. The generous means-of-communication clause points the same way: a decision expressed by gesture or any other means counts, so a person is not treated as incapable merely because they cannot speak in the expected register.

RULE **Capacity is presumed, decision-specific and functional - it turns on the decision, not the diagnosis.** Every person, including a person with mental illness, is deemed to have the capacity to make mental-healthcare and treatment decisions, and that presumption is displaced only by showing, against the statutory abilities, that this person cannot make this decision now. A diagnosis does not rebut it, and a decision the team dislikes does not rebut it.

3.6 Capacity as the switch the rest of the Act turns on

The capacity test is placed early in the Act because it is the switch several later provisions depend on. Whether a person is admitted on their own request or on another's application, whether an advance directive lies dormant or comes into operation, and whether consent to a treatment such as electroconvulsive therapy can be given by the patient themselves - each of these begins by asking whether the person presently has the capacity to make the relevant decision. Physical restraint is not on that list: it is authorised on its own statutory conditions, tied to imminent and immediate harm and to psychiatrist authorisation rather than to the patient's capacity, and is

taught under prohibited and restricted procedures elsewhere in this chapter. Those provisions invoke this test and are taught in their own right elsewhere in this chapter; none of them redefines it. What must be carried across all of them is that capacity here is **decision-specific** and time-specific: a person may have capacity for one decision and not another, and may regain it as their state changes, so it is assessed for the decision in front of the clinician at the moment it must be made, not settled once and recorded as a global finding.

It is worth naming, without teaching them here, that this treatment-decision capacity is one of a family of capacities the law recognises - the capacity to make a will, to enter a contract, to be held criminally responsible, to stand trial - each decision-specific, each with its own test, and each examined in its own place in this chapter. The thread that runs through all of them, that capacity is asked of a particular decision at a particular time rather than of the person in general, is drawn together in this chapter's cross-cutting synthesis. For the Act's own purposes the point stays contained: the capacity this section defines is the one the definition of mental illness and the rest of the statute are built to serve.

3.7 Four statuses candidates merge, kept apart

The commonest way this topic is lost is by treating four distinct statuses as one. The definition, the determination, the capacity test and the legal status of unsound mind answer different questions, are settled by different actors, and carry different consequences. Setting them on shared axes shows why each must be cited to its own provision and why one cannot be read off another.

STATUS	WHAT IT ASKS	WHO SETTLES IT, AND HOW	WHAT IT DOES NOT IMPORT
Mental illness (the definition)	Is there a substantial disorder that grossly impairs a core function?	Set by the definition provision; substance-associated conditions in, intellectual disability out	Does not by itself mean incapacity or unsound mind
Determination of mental illness	Is this person, now, mentally ill on that definition?	A clinician, against notified national or international standards including the current International Classification of Diseases	May not rest on social, cultural, religious or political grounds, or on past treatment alone
Capacity to make treatment decisions	Can this person make this mental-healthcare decision now?	Presumed for everyone; rebutted only against the statutory abilities, decision by decision	Not rebutted by the diagnosis, nor by an unwise choice
Unsound mind	Is this person, in law, of unsound mind?	A competent court, on the relevant legal test	Does not follow automatically from a determination of mental illness

Read across the last column and the discipline is clear: nothing on this list is a licence to infer the next. Mental illness does not import incapacity; determination does not import unsound mind; and capacity, presumed for all, is displaced only for the decision actually in issue. A clinician who keeps these four apart, and cites each to its own provision, has understood not just the definitions but the design.

GOOD TO REMEMBER

Assess capacity for the specific decision in front of you, and start from the presumption that the patient has it. Document the determination of illness against recognised diagnostic criteria, and keep it separate from any statement about the patient's legal capacity or responsibility, which is not yours to pronounce. A refusal you consider unwise, made by a patient who can understand, appreciate the consequences or communicate the choice, is a capacitous refusal - not evidence of incapacity.

Mental illness is a substantial disorder grossly impairing a core function - substance-associated conditions included, intellectual disability excluded - determined against accepted medical standards; and every person, including a person with mental illness, is deemed to have the capacity to make mental-healthcare and treatment decisions, tested by the ability to understand, appreciate or communicate, a presumption that a diagnosis alone does not rebut.

4 · Rights of persons with mental illness under MHCA

Why the marks cluster here. Of everything the Mental Healthcare Act sets out to do, its catalogue of rights is the part an examiner can turn into a one-line question and the part a clinician answers for on every ward round. The statute rewrote the relationship between the psychiatrist and the person in their care: where the earlier, custodial legislation treated the patient largely as an object of detention and management, this Act makes the same person the bearer of enumerated, enforceable rights that the appropriate Government, the mental health establishment and the treating professional are all bound to honour. To know these rights is to know the spine of the whole Act, because admission, treatment, the advance directive and the review machinery all exist to give them effect.



Fig 25.2 The Mental Healthcare Act 2017 is rights-based: the person with mental illness holds enforceable rights, and government, establishments and professionals carry corresponding duties. Admission and treatment mechanisms exist to give those rights effect.

The rights are gathered in Chapter V of the Act, and reading them at origin rather than from a summary is what separates a safe answer from a vague one. Two features organise the entire chapter. First, every right is written in the mandatory voice: the person shall have the right, never may, so each clause is a duty and not a discretion. Second, each right is a duty placed on a named actor, and identifying that duty-bearer is often the real content of the question.

4.1 A rights-based statute: the architecture of Chapter V

Chapter V does not create rights in the abstract. It follows a person from the door of the service to the ward and back into the community, attaching a duty at each step: a right to reach care at all, a right not to be warehoused once well, a right to be treated decently while admitted, a right to be treated as the equal of a person with a physical illness, a right to know what is happening, and a right to have it kept private. The examiner's favourite move is to give the guarantee and ask for

the section, or to give the section and ask whose duty it creates, so the map below is worth holding whole before the detail.

RULE **Every entitlement in this chapter is a mandatory duty, not a courtesy the service extends.** Each clause is drafted with "shall", which binds the appropriate Government, the establishment and the individual professional; a right the service could grant or withhold at will would not be a right. When you answer, name the guarantee, the section that carries it and the actor on whom the duty falls, because the mark usually sits in the duty-bearer, not the slogan.

RIGHT	SECTION	CORE GUARANTEE	WHOSE DUTY
Access to mental healthcare	Section **18**	Affordable, good-quality, sufficient, geographically reachable, non-discriminatory care from Government-run or funded services	Appropriate Government
Community living	Section **19**	To live in and not be segregated from society; not to be detained merely for want of family, home or community facilities	Government and establishment
Protection from cruel, inhuman and degrading treatment	Section **20**	To live with dignity, with enumerated protections inside the establishment	The establishment and its staff
Equality and non-discrimination	Section **21**	Parity with physical illness across all healthcare, including insurance	Providers and every insurer
Information	Section **22**	Understandable information on admission, review, illness and treatment	The treating team
Confidentiality	Section **23**	Confidentiality of mental and physical health information, with defined exceptions	All health professionals

18 ACCESS TO CARE	**21** INSURANCE PARITY	**23** CONFIDENTIALITY	**3** CHILD WITH MOTHER

4.2 The right to access mental healthcare

The chapter opens with its most ambitious guarantee. Every person shall have a **right to access mental healthcare** and treatment from services run or funded by the appropriate Government. The Act does not leave "access" as a slogan; it defines its content. Care must be affordable, of good quality, available in sufficient quantity, geographically accessible so that a person need not travel

unreasonably far, and provided without discrimination on any ground. A service that exists only in a distant city, or only for those who can pay, does not satisfy the section even if what it offers is excellent.

The section does not stop at principle; it adds concrete, enforceable promises. A minimum range of mental health services is to be available in every district, which is the statutory hook for decentralised, district-level care rather than a handful of state asylums. Persons who are below the poverty line, destitute or homeless are entitled to treatment free of charge, so poverty may not be the reason a person goes untreated. And medicines on the Essential Drug List are to be provided free of cost from Community Health Centres upwards, which matters directly for the person on maintenance antipsychotic or mood-stabiliser treatment who would otherwise default for want of money.

The clinical significance is that this section reframes treatment from charity to entitlement: the person does not petition for care, the State owes it. Its honest limit, and a fair examination point, is that a positive socio-economic right of this kind is only as real as the budget and the workforce behind it, which is where Indian implementation is still catching up with the text.

4.3 The right to community living

Every person with mental illness shall have a **right to community living**: to live in, be part of and not be segregated from society. The section's sharpest clause is the one an examiner loves, because it targets a real and documented abuse. A person shall not continue to remain in a mental health establishment merely because they do not have a family, are not accepted by their family, are homeless, or because there are no community-based facilities to receive them. Clinical readiness for discharge is not to be defeated by a social problem; want of a home is not a psychiatric reason to detain.

To make the right achievable rather than aspirational, the Government is to support less restrictive, community-based establishments such as half-way homes and group homes, so that a person who no longer needs hospital care has somewhere to go. This is the statute's embrace of deinstitutionalisation and of care in the least restrictive setting, and it is the natural counterpart to the access right: one gets the person into care, the other stops that care from hardening into indefinite custody.

IN INDIA

The community-living right collides with a long-standing reality. Government mental hospitals still hold long-stay residents who are clinically fit for discharge but have nowhere to go, and community facilities such as half-way homes and supported accommodation remain scarce and unevenly distributed. District-level services under the national and district mental health programmes are the intended delivery route for both the access and the community-living guarantees, and the distance between the words of the sections and the services actually available on the ground is itself a favourite discussion question.

4.4 Protection from cruel, inhuman and degrading treatment

This section begins with a simple, powerful statement: every person with mental illness shall have a right to live with **dignity**, and shall be protected from cruel, inhuman or degrading treatment in any mental health establishment. It then refuses to leave "dignity" undefined and spells out what it means in the daily life of an admitted person: a safe and hygienic environment with adequate sanitation; access to leisure, recreation, education and the practice of religion; privacy; proper clothing and the right to wear one's own clothes; freedom from being forced to work, with appropriate remuneration where work is undertaken; freedom from compulsory tonsuring, that is forced head-shaving; and protection from all physical, verbal, emotional and sexual abuse.

Read against the history of custodial care in India, the chaining, the seclusion, the neglect and the stripping away of ordinary human texture that repeated inquiries have documented, each of those guarantees is an answer to a specific, remembered wrong. The protections candidates most often overlook are the most telling: the bar on forced labour without remuneration, and the bar on compulsory tonsuring. Both mark the line between a hospital and a place of confinement, and both were written in precisely because they had been ignored.

4.5 Equality, non-discrimination and the insurance-parity clause

Every person with mental illness shall be treated as the equal of a person with physical illness across the whole provision of healthcare. This **equality and non-discrimination** right forbids discrimination on grounds such as gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class and disability, and it demands emergency services, ambulance services and living conditions of a quality equal to those provided for physical illness. A protective clause adds that a young child shall ordinarily not be separated from a mother who is receiving care, preserving the mother-infant bond wherever it can be preserved; the section fixes that protection at a child below **three** years of age.

The clause that decides the mark. Set within the same equality section is the provision examined more than any other single line in this chapter: every insurer shall make provision for medical insurance for the treatment of mental illness on the same basis as is available for the treatment of physical illness. This is the statutory **mental health parity** mandate, and it is a mandatory "shall", not a recommendation. It is the clause that ended the routine exclusion of psychiatric illness from health insurance, and in practice it prompted the insurance regulator to direct insurers to bring their products into line.

TRAP **Candidates list the rights and forget that insurance parity lives inside the equality section.** The parity mandate is not a separate consumer-protection statute and it is not discretionary; it is a "shall" sitting within the non-discrimination right. That is exactly why an examiner can ask which provision made insurance cover for mental illness compulsory and watch half the room reach for the wrong chapter, or downgrade a binding duty into a mere recommendation.

4.6 The right to information

A person with mental illness, and their nominated representative, shall have a **right to information**. The pairing is deliberate: the person and the nominated representative hold the right together, because the section anticipates that a very unwell person may not be able to take everything in at the moment of admission. What must be disclosed is set out plainly. The person is entitled to be told the provision of law under which they have been admitted and the criteria for admission under that provision; their right to apply to the Mental Health Review Board for a review of that admission; and the nature of their illness together with the proposed treatment plan, including the treatment proposed and its known side effects. All of this must reach the person in a language and form they can actually understand.

The section then closes a familiar loophole. If full information cannot be given at the time of admission because the person cannot yet receive it, it must be provided promptly once they can, and it must be given to the nominated representative immediately in the meantime. The information right is therefore the practical substrate of informed consent and of the Act's separately defined test of the capacity to make mental-healthcare decisions: a person cannot exercise a treatment choice, or challenge a detention, on facts that have been withheld from them. The appointment and duties of the nominated representative, and the composition and powers of the Review Board, are provisions in their own right and are described elsewhere in this account of the Act.

GOOD TO REMEMBER

The information right is discharged, and defensible, only if it is documented. Record that the admission provision and its criteria, the right to seek a Review Board review, and the treatment plan with its known side effects were explained, and in what language and form. Where the person could not take it in, note that the nominated representative was informed and that the person was told again once able. A treatment plan the patient cannot understand has not been disclosed within the meaning of the section, however carefully it was written.

4.7 The right to confidentiality and its lawful exceptions

A person with mental illness shall have a right to **confidentiality** in respect of their mental health, their mental healthcare, their treatment and their physical healthcare, and all health professionals providing that care shall have a duty to keep the information confidential. The examination trap is to stop at the duty and call it absolute. It is not: the section itself enumerates the circumstances in which the duty yields, and knowing those circumstances is the substance of the answer. Disclosure is permitted, on necessary and limited terms:

- release to the nominated representative so that they can discharge their functions;
- disclosure to other mental health or health professionals for the person's care and treatment;
- disclosure to protect any other person from a real risk of harm or violence, confined to the information necessary for that purpose;
- disclosure to prevent a threat to the person's life;

- on the order of the Review Board, the Central Authority, a High Court or the Supreme Court, or another statutory authority competent to make such an order; and
- in the interests of public safety and security.

The exception permitting disclosure to protect a third party from harm supplies statutory permission for a necessary, proportionate disclosure; the section does not itself impose a positive duty to warn or protect, and any such duty arising under another law or professional standard must be analysed separately. The ethical reasoning around when and how confidentiality may be breached for the safety of another, together with the wider consent and certification duties of the psychiatrist, belongs to the Forensic ethics, consent and legal procedure notes and is not rehearsed here. What this section settles is the legal permission and its boundary: the duty is the rule, the enumerated grounds are the only exits, and disclosure under any of them is confined to what the situation genuinely requires.

PITFALL

Opposite errors flow from misreading the exceptions. The first is treating confidentiality as absolute and refusing to disclose even when a person is at credible risk of harm, when the section positively permits the necessary disclosure. The second is breaching confidentiality without an enumerated ground, or disclosing far more than the risk requires, on the loose assumption that a psychiatrist may share freely with family or police. State the exception you are relying on, and release only what that ground needs; a duty repeated without its conditions is how both mistakes are made.

4.8 Making the rights real: representative, Review Board and the ward

Rights on paper need a route to enforcement, and the chapter builds one into its own text. The information right points the person to the Mental Health Review Board to have an admission reviewed; the confidentiality section names the Board and the higher courts as the bodies that can order disclosure. The Board is the forum in which these entitlements are made justiciable, and running alongside it is the nominated representative, the person's appointed or statutorily identified voice, who co-holds the information right and receives disclosures the person cannot yet take in. Neither of those is taught here, because each is a substantial topic on its own; the point to carry is that the rights of this chapter are not merely declared, they are given a person to speak them and a body to enforce them.

Chapter V does not end with the six rights read here. It continues with further entitlements that the same rights-based logic generates, among them restrictions on releasing a person's information to the media, access to one's own medical records, rights to personal contact, communication and visitors, and access to legal aid. The exact section numbers of those later rights sit outside the provisions read at origin in this topic, so they are named rather than numbered; the reader should simply know that the chapter is broader than the core it is usually examined on, and that its later sections extend the same principle of dignity and self-determination.

MNEMONIC

A CoDE I Confide

The run of core rights in order: **A**ccess to care, **Co**mmunity living, **D**ignity and protection from cruel treatment, **E**quality with insurance parity, **I**nformation, and **C**onfidentiality. Recovering the phrase recovers both the guarantees and the order in which their sections run through the chapter.

Read every clause of this chapter in the mandatory voice, because the Act says the person shall have each right: a right the State could grant or refuse at its own discretion would not be a right at all.

5 · Advance directive under MHCA (making, revocation, override)

Why this earns marks. The **advance directive** is the Mental Healthcare Act's clearest break from substituted decision-making. It lets a competent adult record, ahead of time, how they wish and do not wish to be cared for and treated for a mental illness during a future period in which they can no longer decide for themselves. The marks sit here because the directive is a compact cluster of sections that pulls in almost every other theme of the Act at once: the capacity that triggers it, the nominated representative named inside it, the Mental Health Review Board that is the exclusive first-instance forum able to set it aside, and the liability of the clinician who follows or departs from it. A candidate who keeps the making, the operation, the revocation and the override apart, and who cites the correct section for each, has shown they can read a statute rather than paraphrase it.

The recurring difficulty is that the phrase sounds absolute, as though a directive, once signed, governs the person whatever happens next. It does not. The Act deliberately provides distinct routes by which a directive can be displaced or changed, and telling them apart is the commonest place candidates and clinicians go wrong: the person's own decision while they still have capacity, the person's formal revocation, and an override granted by the Board on application. Each has its own actor, its own section and its own modal verb, and the gap between a discretionary power and a mandatory duty is exactly what is being examined.

5	8	11	13
MAKING	REVOCATION	BOARD OVERRIDE	CLINICIAN LIABILITY

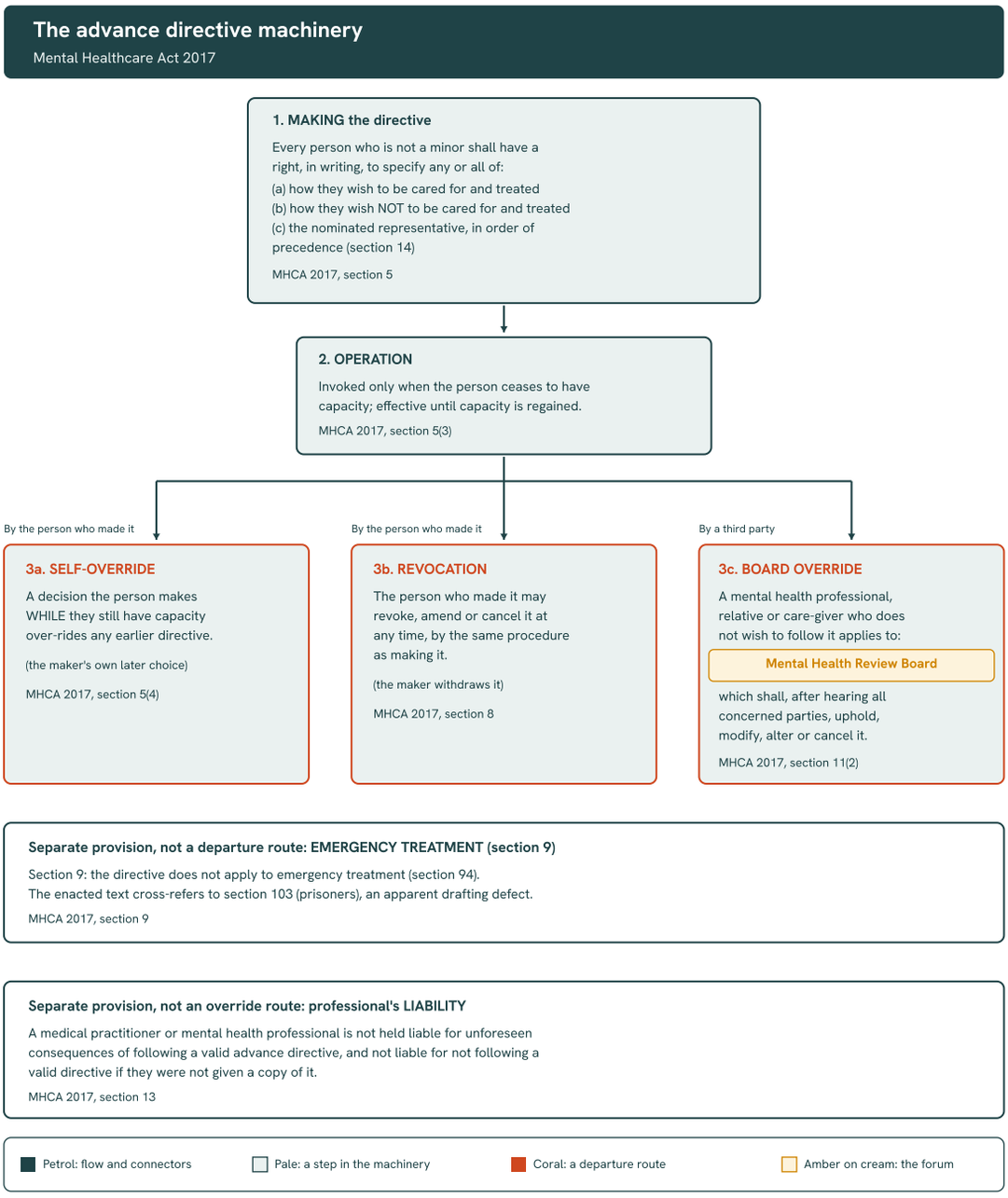


Fig 25.3. The advance directive under the Mental Healthcare Act 2017: every person who is not a minor shall have a right to make one in writing (section 5), it operates only once the person loses capacity (section 5(3)), and can be departed from by the maker's own later capacitous decision (section 5(4)), by revocation at any time (section 8), or by a Board override on the application of a professional, relative or care-giver, which the Board shall dispose of after hearing all concerned parties (section 11(2)). Separately, section 9 says the directive does not apply to emergency treatment; the enacted text cross-refers to section 103, though the Act's emergency-treatment provision is section 94 and section 103 concerns prisoners, an apparent drafting defect. Section 13 separately protects the professional from liability and is not an override route.

5.1 The right to make an advance directive

The right to make a directive is set at section 5. Every person who is not a minor shall have a right to make an advance directive in writing. The verb matters: this is a right conferred in mandatory terms, not a facility the establishment may extend at its discretion. What the directive may specify is stated in the person's own voice - the way they wish to be cared for and treated for

a mental illness; the way they wish not to be cared for and treated; and the individual or individuals, in order of precedence, whom they wish to appoint as their **nominated representative**. That last limb links the directive to the separate machinery of the nominated representative, whose appointment and duties this chapter treats in their own right; here it is enough that the directive is where the person may name, and rank, the people they trust to speak for them.

Beyond its contents, the making carries points that are commonly examined as one-liners. The right to make a directive exists irrespective of any past mental illness or past treatment: a history of illness neither bars a person from making a directive nor weakens one they have already made. The point is more than administrative. It refuses the assumption that a diagnosis, or a past spell of illness, strips a person of the standing to plan their own care; a directive made by someone with a psychiatric history is not thereby suspect, and the fact that a person was once unwell is not, by itself, a reason to look behind what they have set down. And a directive that is contrary to any law in force is **void ab initio** - void from the outset, not merely voidable later - so a directive cannot be used to demand something unlawful, and a clinician confronted with such a clause is not obliged to give it effect.

IN INDIA

Unlike an informal "living will," this is a statutory right of every adult who is not a minor, and it is enforceable: a clinician who sets aside a valid directive without taking the matter to the Mental Health Review Board is acting outside the Act. In day-to-day practice the directive is still newly established and under-used, so the working knowledge that actually protects a patient is simple - a valid, known directive is binding, and it is displaced only in the specific ways the Act allows.

5.2 When the directive operates: the capacity trigger

A directive is not a standing instruction that runs from the day it is signed. It is dormant while the person has capacity and comes alive only at a defined moment. It is invoked only when the person ceases to have the **capacity** to make mental-healthcare and treatment decisions, and it remains in effect until that capacity is regained. The statutory test of that capacity is not restated here - it is taught where this chapter defines mental illness and the capacity to make treatment decisions - but its structural role in this topic is decisive: capacity is the switch. While it is present, the directive is silent; when it is lost, the directive speaks; when it returns, the directive falls silent again.

Holding this clearly is what prevents the errors that follow. If the directive operates only during incapacity, then it cannot bind a person who still has capacity - which is the subject of the self-override rule - and it cannot be a permanent surrender of autonomy, because the person recovers the decision the moment capacity returns. The directive is therefore best understood as a bridge across a period of incapacity, built by the person while they have capacity and dismantled automatically when capacity is regained.

5.3 The self-override rule

The most examined point in the whole topic is that the maker can defeat their own directive simply by having capacity. Any decision made by a person while they have the capacity to make mental-healthcare and treatment decisions shall over-ride any previously written directive by that person. The verb is mandatory: the contemporaneous capacitous decision does not merely compete with the earlier directive, it prevails over it. This is not a loophole; it is the Act being consistent with itself. Autonomy is respected in the present tense, so the wishes a person actually holds while competent must beat the wishes they recorded earlier for a time when they expected not to be competent.

It is worth seeing why the Act declines to treat a directive as an unbreakable pre-commitment against the recovered self. A person may reasonably want to bind their own future - to guard against a relapse in which their judgement is impaired - and the Act honours that wish precisely by giving the directive force during periods of incapacity. What it will not do is let a past self overrule a present competent one. The instant capacity is present, the law treats the person as the best author of their own care, and the earlier document steps aside without ceremony or paperwork. The directive protects the person from their incapacitated future, not from their capacitated present.

TRAP **An advance directive does not bind a person who still has capacity.** Candidates assume a written directive governs from the moment it is signed, and clinicians occasionally invoke it to hold a patient to an earlier refusal. In law the directive operates only once capacity is lost, and even then a decision the person makes while capacitous over-rides it. Applying a directive against the present, capacitous wishes of the patient inverts the very provision it claims to rely on.

5.4 Revocation, amendment and cancellation

Separate from over-riding a directive by a present decision is the maker's formal power to unmake it. **Revocation**, amendment or cancellation of a directive sits at section **8**. A directive may be revoked, amended or cancelled by the person who made it, at any time. The precision that earns the mark lies in the actor and the procedure. The power belongs to the maker alone - not to a relative, not to the treating team, not to the establishment - and it is exercised at any time, which in practice means while the person has the capacity to take such a step. And the procedure for revoking, amending or cancelling shall be the same as the procedure for making a directive: the same formality that created the document is required to change or undo it, so a directive cannot be quietly set aside by an informal note.

It is worth fixing the difference from the previous rule. The self-override is automatic and situational - a capacitous decision simply prevails, with no paperwork - whereas revocation is a deliberate, formal act that alters or ends the document itself. Both are the person's own, and neither needs the Board; that is what separates them from the override route that does.

5.5 The override machinery and the Mental Health Review Board

This is the required core of the topic. Following a valid directive is a duty, not a preference: it is the duty of the medical officer in charge of the mental health establishment and of the treating

psychiatrist to follow a valid directive, and that duty gives way only to the review power described here. The override itself is set at section **11**. Where a mental health professional, or a relative, or a **care-giver** of the person desires not to follow a directive, that person shall make an application to the concerned **Mental Health Review Board** to review, alter, modify or cancel it. The modal verb is doing heavy work: the objector is not permitted to disregard the directive unilaterally; they shall apply. Unilateral departure from a valid directive is not an option the Act leaves open.

On receiving the application, the Board shall, after giving an opportunity of hearing to all concerned parties - expressly including the person whose directive is in question - either uphold, modify, alter or cancel the directive. In deciding, the Board takes into consideration -

- whether the directive was made of the person's free will and free of coercion;
- whether it was intended to apply to the circumstances that have actually arisen;
- whether the person had sufficient information when the directive was made;
- whether the person had the capacity to make the decision at the time the directive was made;
- whether the contents of the directive are contrary to law or to the Constitution.

Read together, the matters the Board weighs form a coherent test of whether the directive genuinely represents the person's authentic, informed and applicable choice. Free will and the absence of coercion go to whether the document is truly the person's own at all. Whether it was meant for the situation that has actually arisen guards against a general instruction being stretched to a case its maker never contemplated. Sufficiency of information asks whether the choice was a considered one rather than an uninformed reflex. Capacity at the time of making tests whether the maker could validly bind their future self in the first place. And the check for legality ensures the Act is not turned into a device to compel what no clinician could lawfully do. The override is therefore not a veto on directives a treating team finds inconvenient; it is a structured examination of whether a directive is authentic, informed, applicable and lawful before it is set aside, and the effort of persuading the Board falls on the party who wishes not to comply, not on the person who made the directive.

The composition and wider functions of the Board belong to this chapter's account of the Mental Health Review Boards; what matters here is its unique position - it is the exclusive first-instance forum that can set aside a valid directive against the maker's wishes, doing so only on application and only after a hearing. Its decision is itself appealable to the relevant High Court under section eighty-three, on application by any person or establishment aggrieved by it, within a prescribed window from the decision.

RULE **A valid advance directive must be followed - subject to the Board's power of review and to the statutory non-application to emergency treatment.** The duty to comply falls on the medical officer in charge and the treating psychiatrist, and outside emergency treatment it yields not to the clinician's own disagreement but only to a Board that has been asked, on application, to uphold, modify, alter or cancel the directive after hearing the parties.

Separate from the Board's review power is a statutory non-application rule. Section nine provides that an advance directive does not apply to emergency treatment. The enacted text describes that carve-out as emergency treatment under section one hundred and three, but the Act's own emergency-treatment provision is section ninety-four, and section one hundred and three in fact concerns prisoners - an internal cross-reference defect in the statute's own text, not a drafting choice for a reader to silently repair. During emergency treatment, therefore, the directive simply does not govern the situation; nothing is displaced by application or hearing, because the directive was never engaged for that treatment in the first place.

5.6 The clinician's liability, and the section that is not the override

The Act protects the clinician on both sides of the decision, and it does so at a section that is frequently misremembered. Liability in relation to a directive is set at section **13**. A medical practitioner or mental health professional shall not be held liable for any unforeseen consequences of following a valid directive; and shall not be held liable for not following a valid directive if he has not been given a copy of it. The symmetry is deliberate: the clinician who does the lawful thing, honouring a directive, is shielded from its unforeseen fallout, and the clinician who fails to honour one is excused only where the directive was never placed in their hands. Ignorance protects only genuine ignorance.

The provision is doing quiet policy work behind that symmetry. By shielding the clinician who follows a directive from its unforeseen consequences, it removes the defensive incentive to second-guess or quietly ignore a patient's recorded wishes. By withdrawing that shield the moment a copy has been supplied, it makes receipt of the directive the event that fixes the duty to act on it. The safe posture for the clinician is therefore an active one rather than a passive hope of never having seen the document: ask whether a directive exists, obtain a copy, and follow it unless and until the Board directs otherwise. A directive that sits unread in a family's possession protects no one, and the clinician who takes trouble to find it is the clinician the section rewards.

PITFALL

A surprisingly common error, repeated even in some question papers, is to name the liability provision as the source of the override power. They are different sections doing different work. The power to review, alter, modify or cancel a directive is the Board's, exercised only on application; the liability provision does something else entirely - it shields the clinician who follows a valid directive and the clinician who was never given a copy. Treating the liability section as the route to override, or telling a family that it lets them set a directive aside, misstates the law.

GOOD TO REMEMBER

At admission, ask whether the patient has made an advance directive and obtain a copy for the record. The liability provision excuses a failure to follow a directive only where no copy was given, so an unlocated directive is at once a clinical and a medico-legal gap: a directive can be honoured only once it is known, and the clinician's protection for not following one runs out the moment a copy reaches them.

5.7 The routes distinguished

The whole topic resolves into a single discrimination: who can change or displace a valid directive, and by what route. Setting the possibilities side by side shows why the section, the actor and the verb must be learned together rather than as a gist.

ROUTE	WHO ACTS	WHAT HAPPENS	BOARD NEEDED?
Contemporaneous capacitous decision	the person, while they still have capacity	their present decision over-rides the earlier directive	No
Revocation, amendment or cancellation	the person who made it, at any time	the directive is revoked, amended or cancelled, by the same procedure as making it	No
Review on application	a mental health professional, relative or care-giver who does not wish to follow it	the Board shall, after a hearing, uphold, modify, alter or cancel it	Yes - the only third-party route

Read down the last column and the architecture is clear. The person retains control by two means that need no one's permission - by deciding while capacitous, and by revoking formally. A dissenting third party has a single lawful path, and it runs through the Board, on application, after a hearing. There is no self-help override for a relative or a clinician who simply disagrees. This table covers only the three routes that change or displace a directive; it does not include section nine's separate rule that a directive has no application to emergency treatment at all.

> A valid advance directive governs care only while the person lacks capacity, and not at all during emergency treatment; their own capacitous decision over-rides it, the maker alone may revoke it, and the Mental Health Review Board, on application by a clinician, relative or care-giver, is the exclusive first-instance forum that may override it against the maker's wishes, subject to appeal to the High Court.

6 · Nominated representative (appointment, duties)

Why this earns marks. The **nominated representative** is the Mental Healthcare Act's answer to a hard practical question: when a person with mental illness cannot, for a period, make or communicate their own decisions about care and treatment, who stands beside them and, where necessary, acts on the record - and by what standard must that person reason? The topic is a compact cluster of provisions covering appointment, the default order where no appointment has been made, and the representative's duties, and it threads through almost every other mechanism of the Act: the advance directive names a nominated representative, supported admission is applied for by one, and the person's healthcare rights are exercised with one's support. A candidate who keeps appointment, default and duties apart, and who reads each modal verb exactly, has shown they can work with a statute rather than paraphrase its gist.

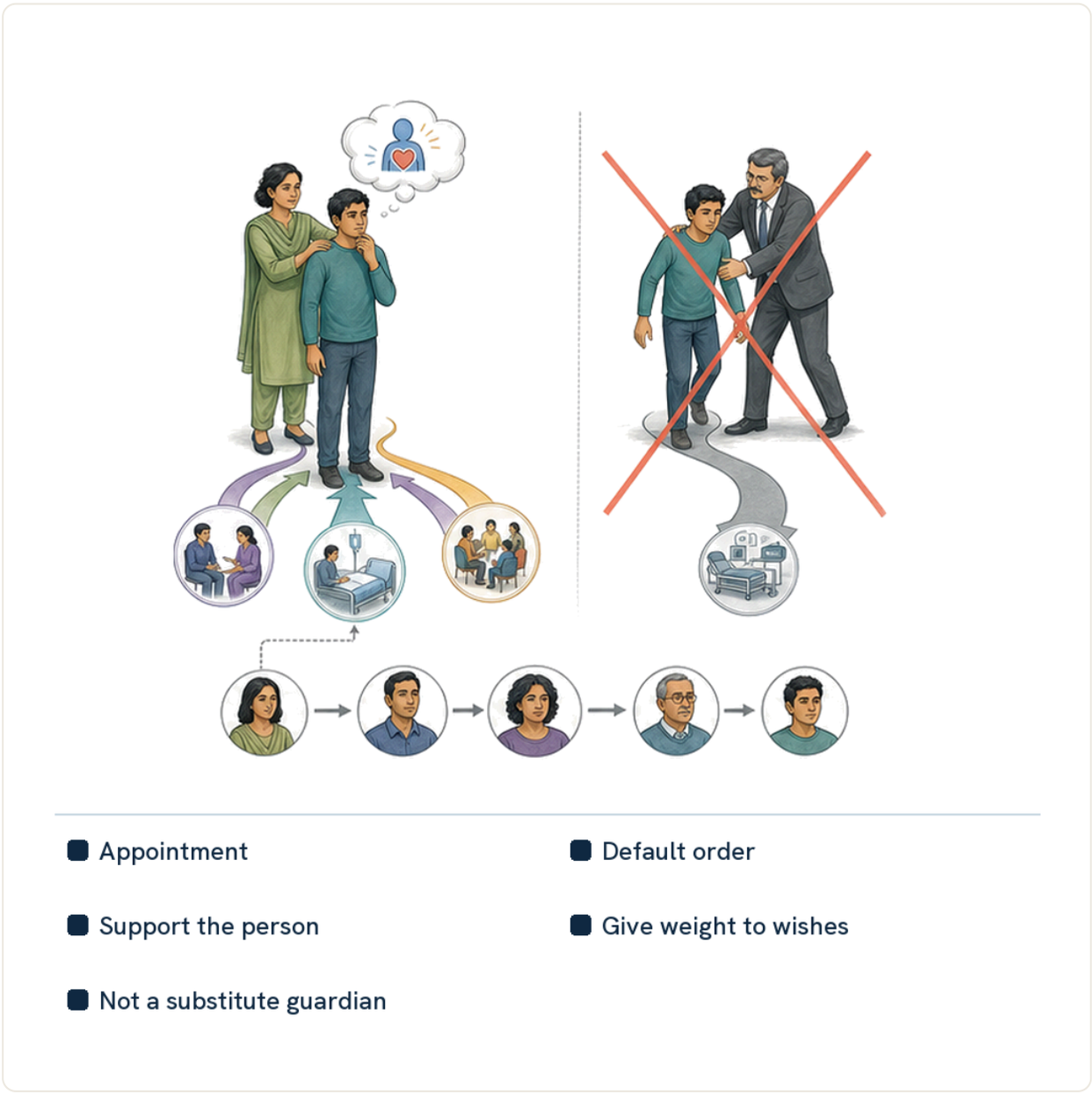


Fig 25.4 Under the Mental Healthcare Act, the nominated representative supports decision-making and gives weight to the person's own wishes. Appointment, the default order and statutory duties must be kept distinct; the role is not an unrestricted substitute guardianship.

The recurring difficulty is that the office is easily misread as a guardian or a next-of-kin who consents on the patient's behalf. The Act builds something narrower and more demanding. The representative is a supporter, not a substitute: their statutory task is to help the person decide and to give weight to the person's own wishes, not to decide in the person's place. Everything that earns a mark in this topic follows from that single distinction, so it is worth fixing before the mechanics: the appointment provision creates the office and supplies a fallback where none is chosen; the duties provision fixes the standard by which the holder must act.

14	5	17
APPOINTMENT	DEFAULT TIERS	DUTIES

6.1 The right to appoint a nominated representative

The right to appoint sits at section **14**. Every person who is not a minor shall have a right to appoint a nominated representative. The verb is doing real work: this is a right conferred in mandatory terms on the individual, not a facility that the establishment or the family may extend or withhold at its discretion. The appointment is deliberately low in formality so that the right is genuinely usable, but the Act is specific about what a valid one requires:

- it is made in writing, on plain paper, authenticated by the person's signature or thumb impression, and it needs neither a lawyer nor a registrar to be valid;
- the person appointed must be an adult and not themselves a minor;
- the appointee must be competent to discharge the role;
- the appointee must consent, in writing, to act.

Consent matters because the office carries duties, and a person cannot be conscripted into speaking for another without agreeing to do so. Each element is modest on its own, but together they mark the appointment out as a real legal act with a willing, capable holder, rather than a name casually written on a form.

Two points are commonly examined here as one-liners. First, the right belongs to the person and is exercised while they can exercise it: a competent adult sets down, in advance or at the time, whom they trust to support them. Second, the appointment can be undone and remade as the person's circumstances and relationships change, because the right that creates the office is a continuing one and not a single irreversible act. Holding this clearly prevents the error of treating a once-named representative as fixed for life.

IN INDIA

The signature-or-thumb-impression formality is a characteristically Indian piece of drafting: it makes the right real for a population with wide variation in literacy, so that a person who cannot sign is not thereby denied a voice in who supports them. In day-to-day practice the office is still newly established and under-used, and many families arrive at admission with no idea that the appointment is the patient's to make. The working knowledge that actually protects a patient is therefore simple - the choice of representative is the person's own, made informally but in writing, and it is not the hospital's to assign.

6.2 The default order of precedence where none is appointed

Most people never appoint anyone in advance, so the Act cannot let the office stand empty at the moment it is needed. Within the same appointment provision it supplies a default: where no representative has been appointed, the following persons shall be deemed to be the nominated representative, in a fixed **order of precedence**. The deeming verb is mandatory - the law does not merely permit one of these people to step in, it treats them as the representative in turn until an available and willing person is found.

ORDER	WHO IS DEEMED THE NOMINATED REPRESENTATIVE	HOW THEY COME TO THE ROLE
First	The individual the person named in their advance directive	The person's own prior choice, carried across from the directive
Then	A relative	Deemed only if available and willing to act
Then	A care-giver	Deemed only if no relative is available or willing
Then	A suitable person appointed by the concerned Board	Appointed where no relative or care-giver can act
Last	The Director, Department of Social Welfare, or a designated representative	The Board shall appoint this office where no other person is available

Read the column of conditions and the design becomes clear. The order runs from the most personal choice to the most institutional backstop, and it never leaves a person unrepresented: if family and community fail, the concerned Board picks a suitable person, and if even that fails, the Board shall appoint the **Director, Department of Social Welfare**, so that a representative always exists. There is a further safeguard for the gap before the Board can act: a person representing an organisation registered under the Societies Registration Act, 1860, or under any other law, and working for persons with mental illness, may be engaged as the representative pending the Board's appointment. That initial engagement is discretionary. But once the representing person makes a written application to act, the medical officer in charge of the establishment or the psychiatrist in charge of the person's treatment shall accept the application, so the person becomes the temporary representative as a matter of duty, not choice, until the proper appointment is made.

The single most useful thing to carry from the order is that it is a default, displaced entirely by an appointment. An appointed representative, even one who is not a relative, outranks the whole deeming list; a **care-giver** or relative is deemed to hold the office only in the absence of a valid appointment and only in their place in the queue. This is why appointment and default must be learned as two limbs of one provision rather than as a single rule about who speaks for the patient.

PITFALL

A common clinical error is to treat the nearest relative as automatically and always the representative, and to seek that relative's consent as though the office were a matter of kinship. It is not. Where the person has appointed someone, that appointee holds the office whatever the family's wishes; and even under the default, a relative ranks below the person's own advance-directive choice and is deemed to act only if available and willing. Reaching for the nearest relative by reflex can put the wrong person in the role and sideline the patient's own prior choice.

6.3 Appointment implies nothing about capacity

One provision within the same section removes a misunderstanding that would otherwise undo the whole reform. The Act is explicit that appointing, or failing to appoint, a nominated representative does not imply that the person lacks the capacity to make mental-healthcare and treatment decisions. The two questions are kept entirely separate. Naming a representative is a piece of forward planning that a fully capacitous person does precisely because they are thinking ahead; it is not a confession of present incapacity, and it does not lower the person's standing to decide for themselves here and now.

This matters because the older model it replaces ran the other way: to have someone speak for you was to be, in the law's eyes, someone who could not speak. The Mental Healthcare Act breaks that link on purpose. A person may have a representative in place and still make their own valid decisions across most of their care; the representative comes forward only for the decisions the person cannot presently make. The capacity that triggers that hand-over is the treatment-decision capacity defined where this chapter sets out the definition of mental illness and the capacity to make treatment decisions, and it is not restated here; what belongs to this topic is only the negative rule - representation and incapacity are not the same fact, and neither is evidence of the other.

6.4 The duties of the nominated representative

This is the required core of the topic. The standard by which the representative must act is set at section **17**, and its verbs are mandatory throughout. While fulfilling the role, the representative shall consider the person's current and past wishes, their life history, their values, their cultural background, and their **best interests**. The list repays attention because it refuses to collapse into a bare best-interests test. Wishes, history, values and cultural background are placed alongside best interests, not beneath them, so the representative cannot substitute a tidy external judgment of what is good for the person for the harder work of reconstructing what this particular person would want.

The second duty sharpens the first. The representative shall give **particular credence** to the views of the person, to the extent that the person understands the nature of the decisions under consideration. This is a sliding, decision-specific weighting rather than an all-or-nothing switch: the more the person grasps of a given decision, the more their own view must govern it, even during a period when they cannot make the decision unaided. The third duty states the purpose the first two serve - the representative shall provide support to the person in making treatment decisions. The office exists to enable the person's own decision-making wherever it can reach, and to speak in the person's voice, reconstructed from the first duty's materials, only where it cannot.

RULE **The representative's duty is to support the person's own decision-making, not to replace it.** The statute is framed in mandatory terms: the holder shall consider the person's present and past wishes, life history, values and cultural background; shall give particular credence to the person's own views in proportion to how well they understand the decision; and shall provide support in making treatment decisions. Best interests sits within that reconstruction of the person's will, not above it.

Beyond these core duties, the representative is the person the Act turns to at several other points in the patient's journey. The representative may apply for the person's admission and take part in decisions about discharge and discharge planning, may seek information about the diagnosis and the proposed treatment so that support is informed rather than nominal, and gives or withholds consent to research on the person's behalf within the limits the Act sets. The consent role also reaches the regulated treatments, including electroconvulsive therapy, whose consent machinery this chapter treats in its own right and which is not reopened here. The section anchors for these wider functions lie in provisions this topic does not own, so they are named as functions rather than pinned to numbers, but the shape is worth carrying: the representative is not a one-decision proxy but a continuing supporter across admission, treatment, information and discharge.

6.5 Supported decision-making, not substitute/best-interests decision-making

The conceptual heart of the office, and the point most often lost, is the model of decision-making the duties encode. The older tradition of guardianship worked by **substitute/best-interests decision-making**: a guardian decided in the person's place, asking what a reasonable person, or the guardian, would choose. The Mental Healthcare Act adopts **supported decision-making** instead. The representative's job is to furnish the support - information, presence, help in weighing options, and a faithful account of the person's own wishes and values - that lets the person decide as far as they are able, and to carry the person's reconstructed will only for the residue they cannot reach.

AXIS	SUPPORTED DECISION-MAKING (THE REPRESENTATIVE'S STANDARD)	SUBSTITUTE/BEST-INTERESTS DECISION-MAKING (THE OLDER MODEL)
Who decides	The person, supported; the representative fills only the gap the person cannot cross	The proxy, in the person's place
Weight of the person's own view	Given particular credence, in proportion to how far the person understands the decision	Often displaced once a proxy is appointed
Reference point	The person's wishes, history, values and cultural background, and their best interests together	A best-interests or reasonable-person judgment made for the person
Effect of having a representative	No implication that the person lacks capacity to decide	Appointment historically signalled incapacity

The contrast is not academic. It changes what the representative should actually do at the bedside: not announce a decision, but sit with the person, explain the options in terms the person can follow, and decide unaided only what genuinely cannot be reached with support. It also explains why the duties are drafted as they are - the emphasis on wishes, values and particular credence is the machinery that keeps support as the default, so that the representative consents on the person's behalf only where the person needs nearly total support to decide, and even then only as a temporary measure kept under frequent review of the person's capacity.

TRAP **Describing the nominated representative as a substitute decision-maker who consents on the patient's behalf.** Candidates equate the office with a guardian or next-of-kin proxy, and clinicians sometimes obtain the representative's consent as if the patient had dropped out of the picture. The statutory duties point the other way: the holder must give particular credence to the person's own views and provide support in the person's own decision-making. Treating the representative as a routine proxy inverts the standard the section actually imposes.

6.6 Reading the office correctly in practice

Pulling the provisions together, the office resolves into three questions a clinician can ask in order. Is there an appointed representative? If so, that person holds the office, whatever the family's preferences, provided the appointment was validly made and the appointee competent and consenting. If not, who is deemed to hold it under the default order, worked down from the advance-directive choice through relative and care-giver to the Board's appointee and, in the last resort, the Director, Department of Social Welfare? And once the holder is identified, are they discharging the duties the Act imposes - supporting the person's own decisions and giving particular credence to the person's views - rather than deciding in the person's stead? Each question maps onto a limb of the topic, and answering them in that sequence is how the statute is meant to be used.

The office also has to be kept in its lane. It is a healthcare-facing role: it supports the person's decisions within the mental-healthcare system and reaches neither the person's property nor their money, which are the concern of the separate guardianship and property-management machinery this chapter treats elsewhere. Conflating the two offices, so that a representative is asked to sign for an estate or a property manager to consent to treatment, is a standing source of error and a genuine safeguarding risk.

GOOD TO REMEMBER

At every admission and at each major treatment decision, establish who the nominated representative is before you seek anyone's involvement: ask whether the person has appointed one, and if not, walk the default order rather than defaulting to whichever relative is present. Record the answer. Then treat that person as a supporter of the patient's own decision-making, not as a consent-giver who displaces the patient - which is exactly what the duties require, and exactly what a hurried ward routine tends to forget.

Every non-minor has a mandatory right to appoint a nominated representative in writing; where none is appointed the Act deems one in a fixed order, from the advance-directive choice down to the Director, Department of Social Welfare; and the holder's duty is to support the person's own decisions and give particular credence to their views, not to decide in their place.

7 · Admission types (independent, supported admission and discharge procedures)

Why the marks cluster here. Admission is where the Mental Healthcare Act 2017 stops declaring principles and starts issuing procedure, and examiners return to it because it is the

point at which the Act's central idea becomes a set of hard rules a clinician can get wrong. That idea is that the route a person takes into inpatient care follows their capacity to make treatment decisions, not their diagnosis and not the convenience of the service. The Act therefore builds a graded ladder rather than a single admission order: an independent route the person asks for himself, a supported route that another person applies for on his behalf, and an emergency provision that holds a dangerous situation before either can be arranged. Each rung carries its own examiners, its own clock, its own reporting duty and its own modal verb, and the questions that separate a pass from a distinction live in the differences between them.

This section teaches those routes and the discharge procedures that close them. The capacity test itself, what it means to be able to understand, appreciate or communicate a treatment decision, is defined elsewhere in this chapter and is only invoked here. The point to hold is that capacity is the switch, and every provision below is a setting of that switch.

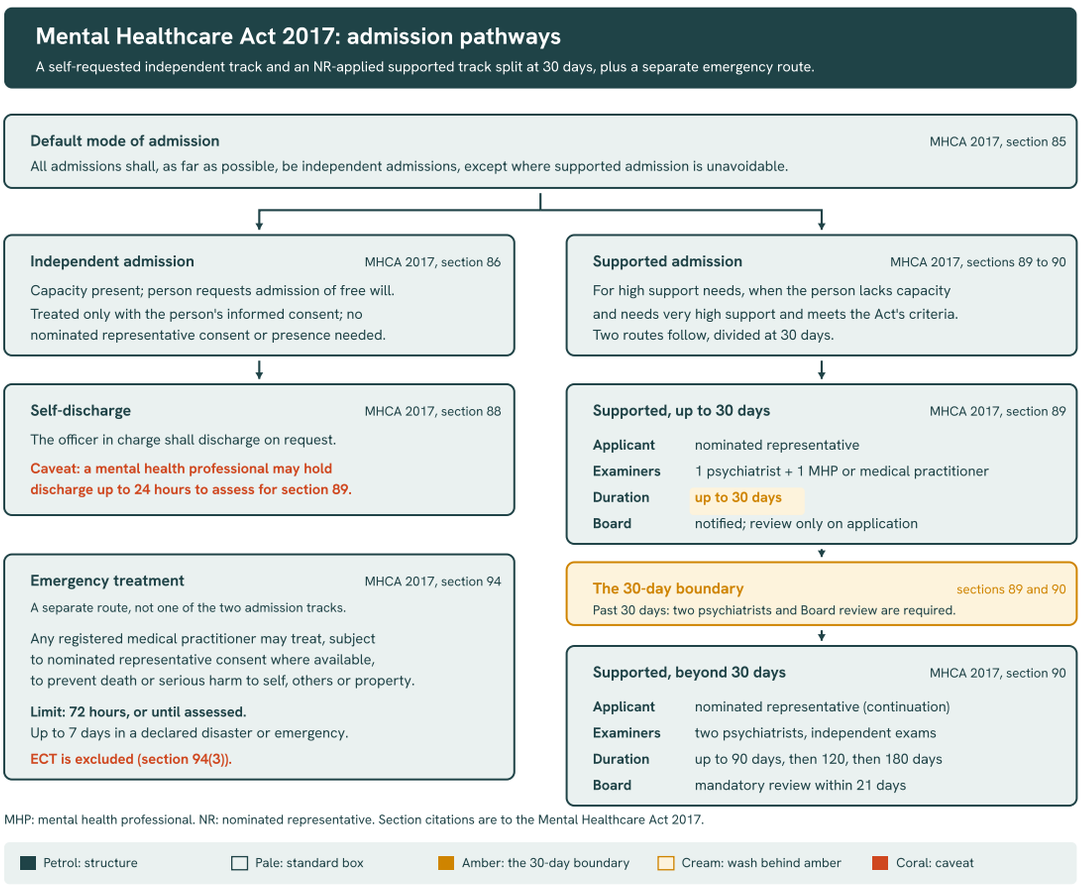


Fig 25.5. Admission under the Mental Healthcare Act 2017 runs on two tracks that differ in who initiates them: a self-requested independent admission (section 86, capacity present, on the person's own request and informed consent, with no nominated representative needed) and a supported admission for high support needs, applied for by the nominated representative, which the 30-day boundary divides into section 89 (one psychiatrist with one other professional; up to 30 days) and section 90 (two psychiatrists examine independently; mandatory Board review within 21 days). Emergency treatment (section 94) is a separate 72-hour route that excludes electro-convulsive therapy.

7.1 The default the Act commands (section 85)

The Act opens its admission scheme by defining the **independent patient** and, in the same breath, by making that status the default. An independent admission is the admission of a person who has the capacity to make his own mental-healthcare and treatment decisions, or who needs only minimal support to make them. The definitional provision does more than label a category. Its second limb lays down a rule of priority: all admissions to a mental health establishment *shall*, as far as possible, be independent admissions, and a supported admission is lawful only where conditions exist that make it unavoidable.

Read that modal verb precisely, because the examiner will. The Act does not say a clinician *may* prefer the independent route; it says every admission *shall* be independent so far as possible. Supported admission is the exception that has to be justified, not a parallel option of equal standing, and it is why the choice of admitting section is never a matter of clinical taste.

RULE **The mode of admission follows capacity, and independent admission is the default the Act mandates.** A supported admission is not an alternative a clinician may reach for out of convenience; it is the exception the statute permits only when the person's decision-making capacity, or a defined risk, makes the independent route unworkable. Every question about which section applies begins by asking what the person can decide, not what he is diagnosed with.

IN INDIA

The 2017 Act rebuilt admission around this default deliberately. For the practising psychiatrist the burden has shifted: the record must show why an independent admission was not possible before a supported admission is used, and a supported admission that could have been an independent one is a departure from what the Act commands, not a neutral choice.

7.2 Independent admission and treatment (section 86)

The operative provision for the independent route is the one under which a person who is not a minor, who considers himself to have a mental illness and who wishes to be treated, *may request* the medical officer or mental health professional in charge to admit him. The request is the patient's own, and the initiative sits with him. On receiving it the officer *shall* admit the person where satisfied that the illness is severe enough to need admission, that the person is likely to benefit from it, that he understands the nature and purpose of the admission and is asking of his own free will, and that he has the capacity to make the decision or needs only minimal support. The duty is expressed as a "shall", but it is a conditional duty: the officer admits if and only if those conditions are met, and refuses if they are not.

Two consequences of independent status are examined repeatedly. First, an independent patient *shall not* be given any treatment without his own **informed consent**. Admission does not import a power to treat, and a capacitous inpatient who refuses a specific intervention keeps that refusal. Second, the establishment *shall not* require the consent or the presence of a nominated representative, a relative or a care-giver in order to admit an independent patient. The person

stands on his own capacity, and inserting a family gatekeeper into an independent admission is not something the Act permits.

7.3 Self-discharge and the twenty-four-hour hold (section 88)

Because the independent patient is admitted on his own capacity, he keeps the key to the door. He *may* discharge himself without the agreement of the officer in charge, a right of **self-discharge** that follows directly from independent status, and on his request the officer *shall* discharge him immediately. This is the ordinary rule: a person admitted on his own decision may reverse that decision.

The provision then supplies the exception that examiners love, because it is a narrow, conditional power that candidates routinely overstate. Notwithstanding the right to self-discharge, a mental health professional *may* prevent the discharge of an independent patient for up to **twenty-four hours**, and for one purpose only: to allow the assessment needed to decide whether a supported admission is warranted. The power arises only where the professional is of the opinion that the person:

- is unable to understand the nature and purpose of his decisions and requires substantial or very high support from his nominated representative;
- has recently threatened or attempted, or is threatening or attempting, to cause bodily harm to himself;
- has recently behaved or is behaving violently towards another person, or has caused or is causing another person to fear bodily harm from him; or
- has recently shown or is showing an inability to care for himself to a degree that places him at risk of harm to himself.

At the end of that window the person *shall* either be admitted as a supported patient under the next provision or be discharged, within that window or on completion of the assessment, whichever is earlier. The hold is a bridge to a decision, not a decision in itself.

> **GOOD TO REMEMBER**
>
> The twenty-four-hour hold is an assessment window, not an authority to treat. It buys time to decide whether a supported admission is justified; it does not, by itself, let you medicate a refusing patient. If treatment genuinely cannot wait for that decision, the question is whether the separate emergency provision applies, not whether the hold has quietly turned into a treatment order.

7.4 Supported admission up to thirty days (section 89)

When the independent route is genuinely unworkable, the Act turns to **supported admission**, the mechanism for a person with **high support needs** who cannot presently make or communicate the admission decision himself. The first supported-admission provision governs shorter admissions, and it is initiated not by the patient but by an application from his nominated representative. The officer *shall* admit the person on that application only once a defined examination has been done: the person must have been independently examined, on the

day of admission or within the preceding **seven days**, by **one** psychiatrist together with a second examiner who is a mental health professional or a medical practitioner. Their task is not merely to confirm illness but to certify that a supported admission is the **least restrictive** option that meets the person's needs. The distinct admission procedure that applies to minors is a separate provision and is not set out here.

The admission this provision authorises *shall* be limited to **thirty days**. That ceiling is the defining feature of the shorter route and the hinge on which the whole supported-admission scheme turns. A reporting duty attaches to it: the officer *shall* report the admission to the concerned Board within **three days** where the patient is a woman or a minor, and within **seven days** for any other person. Note what that reporting is and is not. It informs the Board; it is not a requirement that the Board clear the admission before it takes effect. Under this shorter route the Board's review is not an automatic pre-authorisation, it is triggered when the patient, his nominated representative or a recognised organisation applies for it. That is the crucial contrast with the longer route below.

Finally, the provision carries its own escalation valve. If the officer forms the opinion that the person is likely to need treatment beyond that ceiling, he is duty-bound to *refer* the matter to be examined by **two** psychiatrists for admission beyond that period. The shorter route cannot simply roll over; crossing the ceiling demands a fresh and higher threshold of scrutiny, which is the subject of the next provision.

7.5 Supported admission beyond thirty days (section 90)

The second supported-admission provision is a genuinely different instrument, not a mere continuation, and collapsing the two is one of the commonest ways to lose the mark. It applies when a person already admitted under the shorter route needs continuous admission beyond that ceiling, or is being readmitted soon after a discharge. Several things change, and each of them tightens the test.

First, the examination is heavier. The person must have been independently examined in the preceding **seven days** by **two** psychiatrists, each of whom must independently reach the required conclusion. Second, the risk threshold is worded more stringently: where the shorter route spoke of a person who had *recently* threatened or attempted harm, this provision requires that the person has done so *consistently over time*. A single recent episode that would support the shorter admission does not, on its own, support the longer one.

Why the Board matters here. The third change is the one the examination cares about most: the Board's role turns from reactive to mandatory. The officer *shall* report every admission and readmission under this provision to the concerned Board within **seven days**. The Board then *shall*, within **twenty-one days** of the last admission or readmission, either permit the admission or order the person's discharge. This is not an optional review that someone has to ask for; it is a compulsory adjudication the Board must complete, and it is the real safeguard that separates long-term supported admission from short.

The durations are correspondingly longer and tiered. An admission under this provision *shall* be limited to **ninety days** in the first instance. Beyond that it *may* be extended by a further **one hundred and twenty days** at the first extension, and thereafter by **one hundred and eighty days** on each subsequent occasion. The lengthening intervals are matched to the mandatory Board oversight, so that a longer detention always sits under a heavier external check rather than a lighter one.

TRAP **Board review is automatic only for the longer supported admission, not for the shorter one.** Candidates write that "the Board must approve supported admission", flattening the two provisions into one. Under the shorter route the admission takes effect on the examiners' certificate and the Board is merely notified, reviewing only if someone applies; under the longer route the Board must, within its fixed period, positively permit the admission or order discharge. Always say which route you mean and match the Board's role to it.

7.6 The routes compared

Set against one another, the routes separate cleanly on who initiates them, who examines, how long they last and what the Board does. The accompanying table lays out the axes the examiner tests. Commit the pattern rather than the isolated numbers, because a viva question almost always asks you to move a patient from one column to the next.

AXIS	INDEPENDENT (SECTION 86)	SUPPORTED, UP TO THIRTY DAYS (SECTION 89)	SUPPORTED, BEYOND THIRTY DAYS (SECTION 90)
Who initiates	The patient's own request	Application by the nominated representative	Application by the nominated representative, for continuance beyond **thirty days** or qualifying readmission within **seven days** of discharge
Capacity assumed	Has capacity or needs minimal support	High support needs	High support needs, persisting
Examiners	Satisfaction of the officer in charge	One psychiatrist plus a second examiner	Two psychiatrists, independently
Harm threshold	Not applicable	Recently or currently: self-harm threat or attempt, violence or causing another to fear bodily harm, or inability to self-care at a degree of risk	The same three limbs, but shown consistently over time rather than recently or currently
Duration	Not time-limited by this provision	Capped at **thirty days**	**ninety days** first, then extensions
Board's role	None for admission	Notified, reviews on application	Must permit or order discharge within **twenty-one days**
Exit	Self-discharge on request	On expiry or clinical decision	Board may order discharge

7.7 Emergency treatment before admission (section 94)

Between the moment a crisis presents and the moment a formal admission can be arranged sits **emergency treatment**, and the Act keeps it deliberately separate from the admission provisions. Any registered medical practitioner, not only a psychiatrist, and whether at a health establishment or in the community, *may* provide any medical treatment, including treatment for mental illness, subject to the informed consent of the nominated representative where one is available. The power exists only where treatment is immediately necessary to prevent death or irreversible harm to the person's health, or the person inflicting serious harm on himself or others, or the person causing serious damage to property as a consequence of his mental illness. Emergency treatment in this sense expressly includes transporting the person to the nearest establishment so that a proper assessment can be made.

Two limits define the provision and are examined precisely. First, it is time-bound: emergency treatment is limited to **seventy-two hours**, or until the person has been assessed at a mental health establishment, whichever is earlier; only where the appropriate Government has declared a disaster or emergency may that period extend up to **seven days**. Second, and this is the line candidates miss, nothing in this provision permits the use of electro-convulsive therapy as a form

of treatment. Emergency powers are wide as to who may act and what ordinary treatment may be given, but they stop firmly short of ECT. The clinical technique and consent for ECT itself belong to the ECT and neurostimulation notes and are not taught here; what the admission law fixes is that the emergency route is not a back door to it.

PITFALL

A floridly catatonic or acutely suicidal patient can look like exactly the case for urgent ECT, and a clinician who reaches for it under emergency powers has misread the statute. The emergency provision authorises ordinary treatment to hold a dangerous situation; it excludes ECT outright. Urgent ECT must be routed through its own consent and authorisation machinery, never through the emergency window.

7.8 Discharge, escalation and the shape to memorise

Discharge mirrors admission. The independent patient, admitted on his own decision, is discharged on his own request, subject only to the narrow twenty-four-hour hold examined above. The supported patient's exit is governed instead by time and by oversight: the shorter admission ends when its ceiling is reached unless it has been lawfully escalated, and the longer admission sits under a Board that may order discharge at its mandatory review. Escalation and discharge are therefore opposite directions of the same supervised process, and the examiner's scenarios usually turn on moving a patient correctly from one rung to the next rather than on any single figure.

86	89	90	94
INDEPENDENT ADMISSION	SUPPORTED, SHORTER ROUTE	SUPPORTED, LONGER ROUTE	EMERGENCY TREATMENT

MNEMONIC

Ask, Apply, Escalate, and Bridge

The independent patient **asks** for himself; the shorter supported admission is one the nominated representative **applies** for; the longer supported admission is an **escalation** demanding a second examining psychiatrist and a mandatory Board decision; and emergency treatment is the **bridge** that holds a crisis until one of those routes is settled. The verbs map to the provisions in the order a real case moves through them.

Independent admission is the default the Act commands; supported admission is the justified exception, and it splits into a shorter provision and a longer, Board-supervised one, never collapsing into a single rule.

8 · Mental Health Review Boards (composition, functions)

A charter of rights is only as strong as the forum that enforces it. The Mental Healthcare Act is written, to an unusual degree for an Indian health statute, as a set of promises to the person with mental illness: a right to make an advance directive, a right to a nominated representative,

safeguards on how a person may be admitted and discharged, and a right to live in and be part of the community. A promise on paper is worth only as much as the body a patient can actually move when it is broken, and that body is the **Mental Health Review Board**. It is a standing, quasi-judicial forum, constituted for a district or a group of districts, that reviews involuntary care, holds and revisits advance instructions, appoints nominated representatives to support a person's own decisions and hears grievances against establishments. Examiners return to it because it is the cleanest single test of whether a candidate understands that the Act's rights are enforceable machinery and not a wish-list, and because candidates routinely confuse it with the regulatory Authority that shares the Act.

Read the Board as the hinge between the two halves of the Act. On one side sit the substantive rights and the admission architecture; on the other sits the question every rights instrument must answer, which is who decides when those rights are contested, how quickly, and with what consequence. The Board is that answer, and the Act deliberately places it close to the patient rather than in a distant court. Fix its constitution, its composition and its functions and a whole cluster of short-note and one-mark questions falls into place at once. This section teaches those three things from the primary provisions and marks the discriminations an examiner rewards.

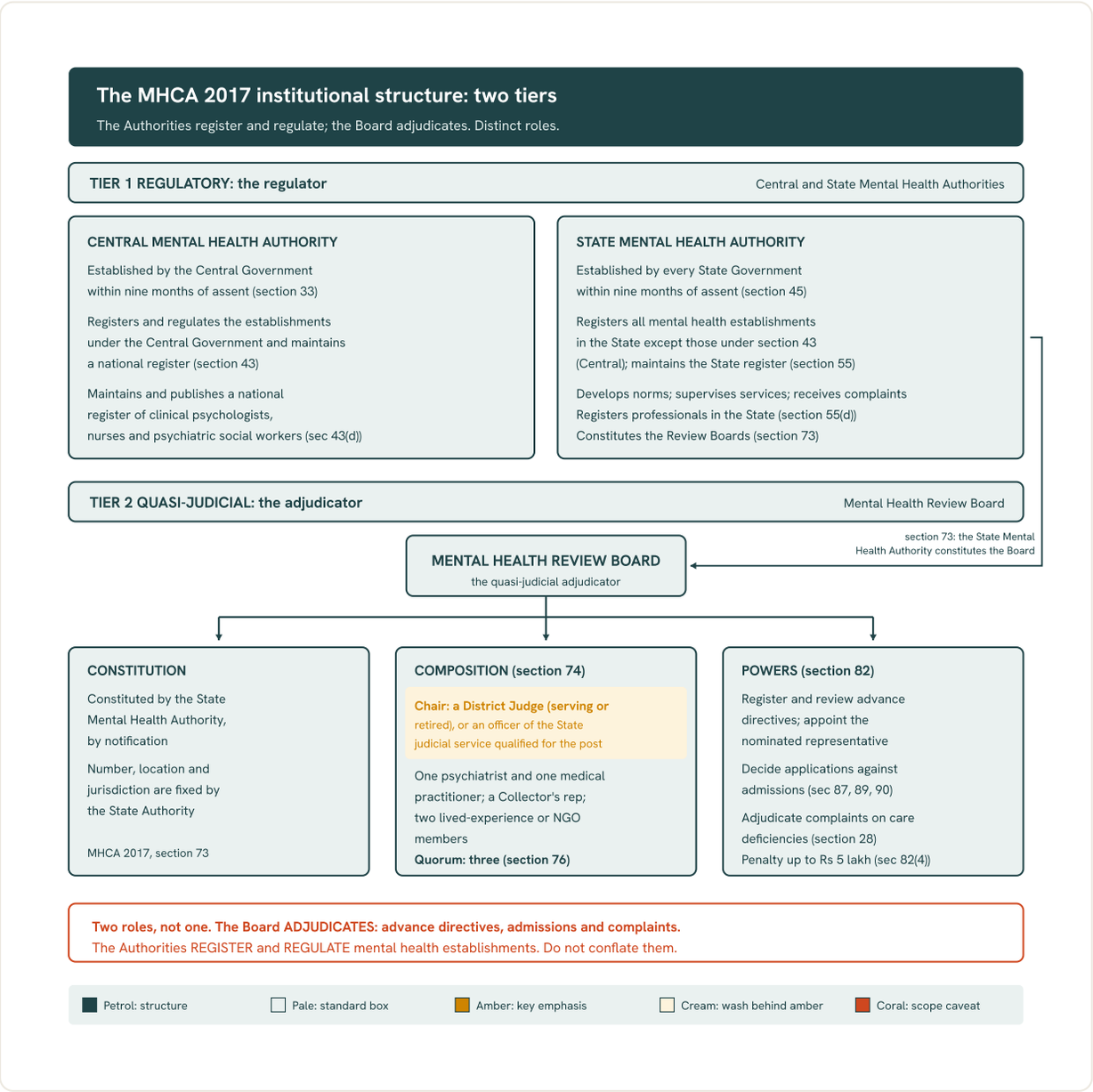


Fig 25.6. The MHCA 2017 divides its institutions into a quasi-judicial adjudicator (the Mental Health Review Board, sections 73, 74 and 82) and regulatory Authorities (Central section 33 and State section 45) that register and regulate mental health establishments; the State Authority constitutes the Board under section 73.

8.1 The rights-enforcement organ of the Act

Every rights statute faces the same design problem. A right that can be vindicated only in the higher courts is, for the person with a mental illness, a right that mostly cannot be vindicated at all, because cost, delay and distance defeat it before it begins. The Act takes the opposite decision and builds a permanent body of its own, for a district or a group of districts, to which a patient or a nominated representative can bring a grievance directly. That is why the Board is best understood not as an administrative add-on but as the enforcement organ without which the rest of the Act would be advisory.

The word that carries the most weight here is quasi-judicial. The Board does not treat patients and it does not manage services; it adjudicates. It receives applications, hears the parties, applies the provisions of the Act to the facts, and issues a reasoned order the parties are bound to obey. That places it in the family of statutory tribunals rather than clinical committees, and almost

every feature that follows, from the judicial officer in the chair to the power to impose a monetary penalty, is a consequence of that character. A candidate who fixes this one idea rarely gets the rest wrong.

RULE **The Board is a tribunal, not a clinical committee.** It is chaired by a judicial officer and it exists chiefly to decide questions of law, rights and compliance under the Act. It does not ordinarily prescribe treatment, but the Act gives it narrow, specific treatment-authorisation powers as well, including permission for ECT in a minor and approval of psychosurgery, which belong to this chapter's account of prohibited and restricted procedures and are not taught here. Its whole design - the judge in the chair, the application-and-hearing procedure, the power to bind and to penalise - follows from its adjudicating character, so sort any question by asking whether it concerns the standing of one patient's rights or the running of a service, and the answer, and the right body, follow.

8.2 Constitution of the Board (section 73)

A Board does not arise on its own, and the provision that creates it repays exact reading because it splits the responsibility across two levels of government. The duty to bring Boards into existence is mandatory and it rests on the State Mental Health Authority: it *shall*, by notification, constitute the Boards for the purposes of the Act. Read the modal verb precisely, because it is a duty and not a discretion; a State that has not notified its Boards is in default of the Act, not merely declining an available option. The requisite number of Boards, their location and their territorial jurisdiction are then specified by the State Authority in consultation with the State Government concerned, which is the mechanism that lets a populous State raise several Boards while a smaller one manages with fewer.

The third limb is the one candidates overlook. The constitution of a Board for a district, or for a group of districts, *shall* be as prescribed by the Central Government. The design is therefore split deliberately between the two levels: the Centre fixes the template and the shape of the body, uniform across the country, while the State decides how many Boards to raise and where to site them. That division buys national consistency in what a Board is and local control over how far a citizen must travel to reach one. Holding those two facts together, a central template with local reach, is what the provision is really testing.

IN INDIA

The choice to pitch the Board at the district is not incidental. A person detained against their will, or a care-giver acting for them, must be able to bring an application without crossing a State line. A body sitting only in the State capital would exist on paper and be unreachable in practice, whereas a tribunal sited within reach, in the district or group of districts it serves, turns the right to challenge a decision into a usable remedy rather than a theoretical one. The Board's authority flows down from the State Authority, but its blueprint is set centrally, and that combination of local access on a national template is a distinctively Indian federal answer to the problem of making rights reachable.

8.3 Composition: a mixed bench by design (section 74)

This is the most heavily examined provision in the group, and it is best learnt as a structure rather than a list. Each Board *shall* consist of four kinds of member, chosen so that the bench carries legal authority, administrative reach, clinical knowledge and the voice of the very people the Act exists to protect. The **chairperson** is a judicial officer, and the accompanying table sets the four seats against what each is there to bring.

SEAT	WHO HOLDS IT	WHAT IT BRINGS TO THE BENCH
Chair	A District Judge, an officer of the State judicial service qualified to be appointed a District Judge, or a retired District Judge	Judicial authority and the discipline of due process
Administrative member	A representative of the District Collector, District Magistrate or Deputy Commissioner	Administrative reach and the link to local government
Medical members	**two** members, one a **psychiatrist** and the other a **medical practitioner**	Specialist and general clinical judgement on the decisions under review
Community members	**two** members who are persons with mental illness, care-givers, or representatives of their organisations or of mental-health non-governmental organisations	Lived experience and civil-society oversight

Read the seats as functions rather than as names. The judicial chair is what makes the body quasi-judicial rather than clinical: it hears the parties, weighs the evidence and passes orders that bind, and it is led by someone trained to do exactly that. The administrative representative ties those orders to the machinery that must carry them out. The medical seats put the clinical facts of an admission or a treatment decision in front of the bench, and the deliberate pairing of a psychiatrist with a general medical practitioner, rather than two psychiatrists, guards against a purely specialist reading of a case. The community seats are the provision's most distinctive feature: by seating persons with mental illness, their care-givers and civil-society representatives on the reviewing body itself, the Act builds its participatory, rights-based ethos into the structure of the forum rather than leaving it to good intentions.

The bench does not need every seat filled to act. Its **quorum** is **three** members, so a validly constituted sitting can proceed with three present. That threshold keeps the Board workable, because a body that could meet only at full strength would stall, while still demanding a genuine plurality rather than a single decision-maker holding a person's liberty in one pair of hands.

MNEMONIC

Judge, Collector, Clinicians, Community

The four member-categories in the order the Act lists them: a **J**udge chairs the Board, the **C**ollector's office is represented, two **C**linicians sit (a psychiatrist and a medical practitioner), and two **C**ommunity members carry lived experience, the care-giver's perspective or a mental-health organisation's voice. Four Cs after the Judge, and the bench is complete.

TRAP **Do not seat a psychiatrist in the chair.** Candidates reflexively make the senior doctor the head of any mental-health body. The chair here is judicial; the psychiatrist is one of the medical members and never the chairperson. The Act deliberately separates the clinical voice from the adjudicating authority, and a script that inverts that has misread the whole design of the bench.

8.4 Powers and functions (section 82)

This is where the Act's rights become remedies. The powers and functions of the Board *shall* include all or any of the following, meaning these are its standing jurisdictions, exercised as cases arise rather than all at once. Taken together they are the mechanisms by which each protection the Act grants elsewhere becomes something the Board can test and enforce.

- to register, review, alter, modify or cancel an **advance directive**, the instrument in which a person records future treatment wishes; how it is made and when it may be overridden are dealt with where this chapter treats advance directives and are not reopened here;
- to appoint a **nominated representative** for a person who has not chosen one, the qualifications and duties of that role belonging to this chapter's account of the nominated representative;
- to receive and decide an application, brought by the person, the nominated representative or another interested person, against a decision on admission or treatment made by the medical officer or mental health professional in charge of an establishment;
- to decide applications about the non-disclosure of information to the person, where part of the record has been withheld and the withholding is contested;
- to adjudicate complaints about deficiencies in the care and services an establishment provides; and
- to visit and inspect prisons and jails.

The pattern across these functions matters more than the list. Somewhere in the Act a person is given a protection, to plan treatment in advance, to have a chosen person speak for them, to be admitted only on lawful grounds, to see their own record, to be cared for to a standard. Each of those protections is then handed a forum with the power to test it against the facts and to order a remedy. That is what converts the Act's language of rights into something a clinician and an establishment can be held to, and it is why the Board, and not the regulatory Authority, is the body a wronged patient turns to. The inspection of prisons and jails is the one function that reaches beyond the establishment; it anchors the Board's protective eye on persons with mental

illness held in custody, while the substantive psychiatry of prisoners and the report a psychiatrist prepares for a court belong to the Forensic ethics, consent and legal procedure notes and are not taught here.

PITFALL

The Board is neither the regulator nor a general grievance desk. Registering establishments and setting service standards sit with the State Mental Health Authority; criminal responsibility and fitness to stand trial sit with the courts. The Board's jurisdiction is the Act's own rights machinery - directives, representatives, admission and discharge, disclosure and standards of care - and a clinician who takes a registration question or a criminal-forensic question to the Board has picked the wrong body and lost time that a patient may not have. A rights complaint about care deficiencies is not automatically misdirected at the Authority either: it follows its own ladder, first to the establishment's medical officer or mental health professional, then to the Board, and only to the State Authority if the complainant remains dissatisfied with the Board's response.

8.5 Orders and enforcement: the Board's teeth

Because the Board adjudicates, it works by application and hearing, and an adjudicator without a sanction is only a suggestion box. The Act does not leave it there. Where a mental health establishment does not comply with the orders or directions of the Authority or the Board, or wilfully neglects them, the Authority or the Board, as the case may be, *may* impose a penalty which *may* extend up to **five lakh rupees** on the establishment. Cancellation of registration is a narrower power: only the Authority may cancel it, acting on its own or on the Board's recommendation, and only after giving the establishment an opportunity to be heard. Every element of that sentence is examinable and each can be dismantled in a stem.

Learn the structure element by element. The trigger is non-compliance with, or wilful neglect of, an order, not any breach at all. The response is discretionary, expressed as a permissive *may* and not a mandatory *shall*, so a script that makes the penalty automatic has overstated the law; this is exactly the modal error that turns a discretionary power into an invented duty. The monetary sanction is capped and not fixed, so the words up to are doing real work and the body is not obliged to levy the maximum. And cancellation of registration is gated behind a hearing, which keeps the enforcement power itself within the discipline of due process. Collapse any one of those - read the discretion as a duty, drop the ceiling, or forget the hearing - and you have described a harsher and different law than the one the Act actually writes.

8.6 The Board in day-to-day practice

Where the treating psychiatrist meets the Board. For the clinician the Board is not an abstraction. It is the body that can be asked to review a decision they have made, and it is also a body a psychiatrist may sit on, so the specialty stands on both sides of the process. When you admit a person on an involuntary, supported basis, that decision is reviewable by the Board on an application from the person, their nominated representative or another interested person, and the quality of your documentation is precisely what will be scrutinised if the decision is challenged. The Board decides on the record that exists, and a decision that was clinically sound

but poorly recorded is hard to defend once it reaches the bench. The same forum is where a contested advance instruction, or a dispute over who should act as a person's representative, is finally resolved, so the Board runs through a great deal of routine practice even when no one is thinking about it.

GOOD TO REMEMBER

If an involuntary admission is likely to be contested, prepare for the Board at the moment you admit, not when the notice arrives. Record the indication, the capacity finding and the less-restrictive alternatives you weighed, and confirm that a nominated representative is identified. Approaching the admission as something you may later have to justify before a judge-led bench, rather than as a purely clinical act, is the single habit that protects both the patient's rights and your own position.

73	74	82
CONSTITUTION OF THE BOARD	COMPOSITION OF THE BOARD	POWERS AND FUNCTIONS

The Mental Health Review Board is the Act's quasi-judicial guardian of the individual patient: constituted by the State Authority on a centrally prescribed template, chaired by a District Judge, a qualified officer of the State judicial service, or a retired District Judge, presiding over a mixed bench of administrative, clinical and lived-experience members, and empowered to hold advance directives, appoint nominated representatives, review involuntary care and enforce its orders by penalty.

9 · Central and State Mental Health Authorities

A statute of rights needs an office to enforce it. The Mental Healthcare Act sets out an ambitious charter - a capacity-based test for treatment decisions, advance directives, admission safeguards and a right to community living - but a charter on paper is only as strong as the administrative body that registers the services meant to deliver it, writes their standards and inspects them. The Act supplies that body in a deliberately two-tier form: a **Central Mental Health Authority** for the Union and a **State Mental Health Authority** in every State. Between them they are the regulatory and administrative spine of the Act, the machinery through which registration, quality norms, supervision, the workforce registers and training are actually delivered.

Marks cluster here for a reason the topic makes plain once you see its shape. There is a mandatory establishment duty with a fixed time-limit; a composition set by statute that seats particular officers and senior professionals, and deliberately seats service users too; a closed list of statutory functions; and, most examinable of all, a clean federal division of registration between the two tiers. None of it is discretionary decoration. The Authority is where the Act's principles are turned into an inspected, registered, standard-bearing system, and a candidate who can separate what the Central body does from what each State body does, and both from the case-by-case work that belongs to another body, has the topic in hand.

9.1 Where the Authorities sit: the regulator, not the adjudicator

The Act creates two quite different kinds of body and it is essential not to blur them. The Central and State Authorities are primarily administrative and regulatory: they register establishments, write the norms those establishments must meet, supervise them, hold the registers of the workforce, and train and advise. The case-by-case, quasi-judicial function - examining whether a particular admission is lawful, reviewing an advance directive, hearing a person's application against a decision made about him - belongs to the Mental Health Review Board, a separate body constituted under the Act and treated in its own right elsewhere in this chapter. That division is not absolute both ways, though: a rights complaint about deficiencies in care can escalate from the Board to the State Authority as the final statutory tier where the complainant remains dissatisfied, and both Authorities also carry their own power to inspect, inquire into and act on rights violations. The Authority builds and polices the system and stands as the last statutory word on a dissatisfied complaint; the Board adjudicates the individual case within it.

The second organising idea is federal. Public health is principally a State subject, but mental-health legislation also draws on the Concurrent List, which is why both the Union and the States can legislate here, and the Act reflects that by mirroring its structure at two levels rather than centralising it. The Central Authority governs the services under the Union's control; each State Authority governs the services within its State. The two are built on the same template - an establishment duty, a fixed composition, a list of functions - so the efficient way to learn them is as one design instantiated twice, with the differences (who chairs, who sits, and above all who registers what) as the examinable delta.

RULE **The Authorities regulate the system; the Review Board adjudicates the individual case.** Registration, norms, supervision, the workforce registers, training and advice are the Authorities' work; deciding whether a particular admission or advance directive is lawful is the Board's. Sort any question first by asking whether it concerns the standing of a service or the standing of one patient's decision, and the right body follows.

TRAP **Naming the Authority where the answer is the Review Board, or the reverse.** Registering a nursing home, framing service norms or maintaining a register of clinical psychologists is Authority territory; reviewing an involuntary admission, examining an advance directive or hearing a patient's application is the Board's. Both are created by the same Act, and under time pressure candidates swap them. State which function is in play and the body chooses itself.

9.2 The Central Mental Health Authority: the establishment duty (section 33)

The Act does not merely permit a Central Authority; it commands one. The Central Government shall, within **nine months** of the Act receiving the assent of the President, by notification establish the Central Authority for the purposes of the Act. Read the modal verb with care, because it is the kind of distinction the whole chapter turns on: the provision says the Government *shall* establish, not that it *may*. This is a positive statutory obligation carrying a fixed outer time-limit, not a discretionary power the executive is free to leave unused.

Two phrases in the provision do quiet work. "By notification" tells you how the body comes into legal existence - it is constituted on publication in the official gazette, not by mere executive

intention - and "for the purposes of this Act" fixes its remit to the Act's own scheme rather than to mental health administration at large. The point to carry is that the existence of the regulator is itself a legal duty with a clock on it. An Act that created rights but left their enforcement machinery optional would be hollow; by making the Authority mandatory and time-bound, the statute guarantees that the body responsible for registering and standardising services must exist, and must exist promptly.

9.3 Composition of the Central Authority (section 34)

Who sits on the Authority is fixed by statute, not left to the Government to compose at will. It is chaired **ex officio** by the Secretary or Additional Secretary in the Department of Health and Family Welfare - that is, the chair is held by whoever occupies that administrative post, by virtue of the office rather than by personal nomination. Alongside the chair sit a set of named ex officio members drawn from the relevant arms of government, and then the nominated members who give the body its professional and lay expertise.

The nominated professional members are the part examiners test. They include a **mental health professional**, a psychiatric social worker, a clinical psychologist and a mental health nurse, each required to have at least **fifteen years** of experience in the field. The seniority bar is deliberate: the people writing service norms and supervising establishments are meant to be seasoned practitioners rather than junior appointees. Just as deliberately, the composition reserves places for representatives of persons who have or have had mental illness, of care-givers and of non-governmental organisations. Seating service users and care-givers on the regulator itself is a design choice, not an afterthought - it is the participatory, rights-based logic of the Act made structural, so that the body standardising services is not composed only of officials and clinicians.

33	43	45	55
CENTRAL AUTHORITY ESTABLISHED	CENTRAL AUTHORITY FUNCTIONS	STATE AUTHORITY ESTABLISHED	STATE AUTHORITY FUNCTIONS

9.4 Functions of the Central Authority (section 43)

The Act sets out what the Central Authority shall do as a defined list of duties, and the verb throughout is mandatory. The functions are best held as a small set of roles the body performs across the services under the Union's control:

- register every **mental health establishment** under the control of the Central Government, and maintain a register of all such establishments in the country;
- develop **quality and service provision norms** for the different types of establishment it oversees;
- supervise those establishments and receive complaints about deficiencies in the services they provide;
- maintain a **national register** of clinical psychologists, mental health nurses and psychiatric social workers;
- train all relevant persons - including law-enforcement officials, mental health professionals and other health professionals - in the provisions and implementation of the Act; and

- advise the Central Government on all matters relating to mental healthcare and services.

Two of these deserve emphasis. The registration function makes the Authority the gatekeeper of legitimate practice: an establishment that is not registered is not lawfully operating, and the register the Authority keeps is the country's ledger of recognised services. The workforce register does the same for people - it is the national list of the allied mental-health professions, distinct from the registration of establishments and serving a different purpose. Both are national in scope, because the Central Authority's job is aggregation and standard-setting across the Union rather than the running of any single facility.

MNEMONIC

TRANS - the regulator's five verbs

The Authority's statutory job is to **T**rain the relevant officials and professionals, **R**egister establishments and keep the workforce register, **A**dvise the Government, set **N**orms of quality and service, and **S**upervise establishments while receiving complaints. Five verbs, one regulator: the letters recover the whole functional remit without adding anything the provision does not itself contain.

GOOD TO REMEMBER

The workforce register is not an abstraction when you build a team. Clinical psychologists, mental health nurses and psychiatric social workers are registered to work as mental health professionals under the Act, and their standing in that role flows from the register. If you are staffing an establishment or referring within a multidisciplinary team, a professional's registration is what places them lawfully in the role the Act recognises.

9.5 The State Mental Health Authority: establishment and composition (sections 45 and 46)

The State tier is built on the same template, and its establishment provision mirrors the Central duty exactly in force. Every State Government shall, within **nine months** of the Act receiving assent, by notification establish a State Authority for the purposes of the Act. Again the verb is *shall*, again there is a fixed window, and again the body is constituted by notification. The obligation lies on every State without exception, so the two-tier system is meant to be complete across the country rather than a Union body with optional State counterparts.

The composition follows the Central pattern with instructive differences. The State Authority is chaired ex officio by the Secretary or Principal Secretary in the State's Department of Health. Its nominated membership again carries senior professionals - a mental health professional, a psychiatric social worker and a clinical psychologist, each with at least **fifteen years** of experience - but it also brings in explicitly clinical and academic weight that examiners like to test. It includes the head of one of the mental hospitals in the State, or the head of the department of psychiatry at a Government medical college, nominated by the State Government, together with one eminent psychiatrist from the State who is not in Government service. Seating both a senior public-sector clinician-administrator and an independent private psychiatrist

anchors the State regulator in the actual service landscape of that State rather than in officialdom alone.

9.6 Functions of the State Authority and the registration split (section 55)

The State Authority's functions parallel the Central body's, and the parallel is exactly where the single most examinable distinction in this topic appears. The State Authority shall register all mental health establishments in the State, and here the operative word is *except*: it registers all establishments in the State except those that fall under the Central Authority's registration mandate, and it shall maintain and publish a register of them, including online. It shall likewise develop quality and service norms, supervise establishments and receive complaints, register clinical psychologists, mental health nurses and psychiatric social workers within the State to work as mental health professionals, and train the relevant officials and professionals.

The registration split is the high-yield line. Put the two registration functions side by side and the federal logic is exact. The Central Authority registers the establishments under the control of the Central Government; each State Authority registers everything else within its borders. There is no overlap and no gap - a given establishment is registered by one Authority or the other, decided by whether it is centrally controlled. The State register carries the added statutory feature of being published, including online, which turns it into a public instrument a patient or family can in principle consult rather than an internal list.

AXIS	CENTRAL AUTHORITY	STATE AUTHORITY
Who must establish it	The Central Government	Every State Government
Establishment duty	Mandatory, within a fixed window from assent	Mandatory, within the same window
Chairperson (ex officio)	Secretary or Additional Secretary, Department of Health and Family Welfare	Secretary or Principal Secretary, State Department of Health
Distinctive members	Senior professional members; representatives of persons with mental illness, of care-givers and of non-governmental organisations	Head of a State mental hospital or of psychiatry at a Government medical college; one eminent non-Government psychiatrist; senior professional members
Which establishments it registers	Those under the control of the Central Government	All other establishments in the State
Register of establishments	A national register of all establishments in the country	A State register, maintained and published (including online)
Register of professionals	Maintains the national register of clinical psychologists, mental health nurses and psychiatric social workers	Registers those professionals within the State

IN INDIA

The practical effect is that no mental health establishment operates lawfully without being registered by the appropriate Authority, and the State register is a published document, available online, rather than a closed file. For a patient or family this is a real safeguard: the recognised services in a State can be identified, and a complaint about deficiencies in a service has a defined statutory destination rather than nowhere to go. For the professions, the workforce registers give the allied mental-health disciplines a formal national footing.

PITFALL

A clinician opening a private psychiatric facility who assumes the Central Authority is the body to register with has misread the split. Unless the establishment is under the control of the Central Government, it is the State Authority that registers it. Taking the application to the wrong tier wastes time and, worse, can leave a service running unregistered in the belief that it has complied. Match the establishment to the Authority by asking one question first: is this a centrally controlled establishment or not?

Both Authorities are mandatory statutory bodies that must be established within a fixed window of assent; the Central Authority registers establishments under Central-Government control while every State Authority registers all other establishments in its State, and both are regulators, distinct from the quasi-judicial Review Board.

10 · Decriminalization of suicide under MHCA Section 115

This is where the law stops treating a survived suicide attempt as a crime and starts treating it as a medical emergency. A person who lives through an attempt on their own life reaches casualty in one of the most fragile states medicine ever encounters, and the older question of whether that same person is also a criminal defendant sat awkwardly on top of the clinical crisis for most of the last century. Section **115** of the Mental Healthcare Act settles that question by statute. It does not merely voice a sentiment about compassion; it lays down a rule of evidence and a public obligation, and the examiner wants that rule stated precisely, with its correct scope and its correct verbs.



- Presumption of severe stress
- No trial or punishment
- Care · treatment · rehabilitation
- Government duty
- Not a right to die

Fig 25.7 Section 115 of the Mental Healthcare Act presumes severe stress after a suicide attempt, protects the person from trial and punishment subject to the statutory rule, and places a duty on government to provide care, treatment and rehabilitation. It does not create a right to die.

The marks here are easy to shed because the provision is routinely over-stated. Candidates say the Act legalised suicide, or that the Act itself repealed the offence, and both are wrong. What the section actually does is narrower and more careful: it presumes a mental state, it bars trial and punishment, and it lays a duty of care, all without itself deleting a word of the older criminal law. That older offence, the attempt to commit suicide once punishable under Section **309** of the Indian Penal Code, is the historical provision the section is drafted around; the section decriminalises by presumption and bar rather than by repeal, and the later fate of that older Code is a separate matter taken up at the end of this topic. Holding that distinction is the whole of the question.

115	309	226
MENTAL HEALTHCARE ACT SECTION, THE OPERATIVE LAW	FORMER PENAL CODE OFFENCE, REPEALED 2024	BHARATIYA NYAYA SANHITA SECTION, THE ONLY CURRENT OFFENCE

10.1 Decriminalisation is not repeal

The single most important idea in this topic is a distinction between two things that sound alike and are not. **Decriminalisation** removes the criminal consequence that would otherwise attach to an act while leaving the underlying prohibition where it stands; **repeal** strikes the prohibition out of the law altogether. The section achieves the first and not the second. It works through a **notwithstanding clause**: the presumption and the bar on trial and punishment operate notwithstanding the older Penal Code offence, which is the legislative device for making a new rule prevail over an existing one without repealing that existing one. At the time the section was enacted the older offence therefore stayed on the book, its operation merely displaced, while a person who had attempted suicide was lifted out of its reach by the presumption the section erects around them.

The reason this matters beyond pedantry is that scope follows from it. Because the section works by decriminalising one specific act and not by rewriting the criminal law wholesale, it reaches exactly as far as its own words carry it, and no further. It lifts the person who has attempted suicide out of trial and punishment; it says nothing about anyone else and nothing about any neighbouring offence. A candidate who reads the reform as a sweeping repeal has, without noticing, claimed that everything the old law touched has fallen away, which both over-states the section and is the source of the classic scope errors examined later in this topic.

RULE **The section decriminalises the attempt; the section itself does not repeal the offence.** A rebuttable presumption and a statutory bar lift the person who has attempted suicide out of trial and punishment, operating notwithstanding the older Penal Code provision rather than striking it out. Reading the section itself as a repeal over-states what it does and misplaces its limits.

10.2 The presumption of severe stress

The first working part of the section is a presumption, and its wording is exact. Any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have **severe stress**, and shall not be tried and punished under the Indian Penal Code. Two features of that sentence carry the marks. First, the verb is mandatory: the person shall be presumed to be under severe stress, and shall not be tried and punished. This is not a discretion the court may exercise; it is a default the law imposes. Second, the presumption is a **rebuttable presumption**, signalled by the words unless proved otherwise. The law starts from the position that the attempt sprang from severe stress, but it leaves open the possibility that this can be displaced by proof to the contrary.

Understanding what a rebuttable presumption does to the burden of proof is what separates a precise answer from a vague one. Ordinarily the person invoking a defence must establish it. Here the statute flips the starting point: severe stress is assumed, so the effort of showing that it was absent falls on whoever wishes to argue that the person should nonetheless be tried. In practical terms this makes trial and punishment the exception rather than the rule, because the ordinary case is presumed into the protected category and stays there unless someone affirmatively proves otherwise. The legislature chose a presumption rather than a blanket, unconditional immunity for a reason: a presumption defaults every survivor into care while preserving a narrow

evidentiary route for the genuinely unusual case, without ever requiring the distressed person to prove their own distress.

One further nuance repays attention. What the section presumes is severe stress, not a diagnosed mental illness. The protection does not wait on a psychiatric label and is not confined to those who can be shown to be mentally ill; a person overwhelmed by circumstance who attempts suicide is presumed into the same protected position as one whose attempt arose from a formal disorder. This keeps the reform broad at the point where it matters, the moment of contact after an attempt, and it is why the section is drafted around stress rather than around illness. The clinician's later judgement about whether a mental illness is present shapes the care that follows, but it does not gate the presumption that shields the person from trial and punishment.

10.3 The duty to provide care, treatment and rehabilitation

The presumption is only half of the section, and a candidate who stops there has answered half the question. The second working part is an affirmative obligation. The **appropriate Government** shall have a duty to provide care, treatment and rehabilitation to a person who has severe stress and has attempted to commit suicide, so as to reduce the risk of recurrence of the attempt. Again the verb is mandatory: this is a duty the Government shall discharge, not a service it may choose to offer. Where the first part shields the person from the criminal process, the second part turns the State toward them, converting the removal of punishment into a positive commitment of care.

The triad the duty names is worth taking apart, because each word points somewhere different in time:

- **Care** is the immediate response, the safe holding and attention the person needs in the acute aftermath of the attempt.
- **Treatment** is the address of whatever underlies the severe stress, whether a mental illness, a crisis of circumstance, or both.
- **Rehabilitation** is the forward-looking limb, the work of restoring the person to a life in which the risk that brought them to the attempt is reduced.

The stated purpose of the duty, to reduce the risk of recurrence, is what ties the triad together and gives the reform its public-health character. The section is not content simply to decline to punish; it reframes a suicide attempt as an event that generates an obligation on the State to intervene therapeutically, precisely because a person who has attempted once carries a raised risk of attempting again. The presumption and the duty are therefore not two unrelated clauses that happen to share a section; they are the negative and positive faces of a single decision to move the survivor of an attempt from the criminal justice system into the care system.

MNEMONIC

Presume, do not try, then provide

The section in three moves. **Presume** severe stress in the person who has attempted suicide; **do not try** - they shall not be tried and punished under the Indian Penal Code; **then provide** - the appropriate Government shall have a duty to give care, treatment and rehabilitation to cut the risk of a repeat attempt.

AXIS	FIRST LIMB - THE PRESUMPTION	SECOND LIMB - THE DUTY
WHAT TRIGGERS IT	An attempt to commit suicide by the person	A person with severe stress who has attempted suicide
STATUTORY VERB	Shall be presumed; shall not be tried and punished	Shall have a duty to provide
NATURE OF THE RULE	A rebuttable presumption of severe stress, displaceable only by proof otherwise	A mandatory obligation, not a discretionary service
WHO IS ACTED ON	The person, who is lifted out of the criminal process	The appropriate Government, on whom the obligation falls
PURPOSE	To remove criminal liability and reframe the attempt as a mental-health event	To provide care, treatment and rehabilitation and reduce the risk of recurrence

10.4 What the section does not reach

Because the reform is so easy to over-read, the examinable core is as much about the section's limits as its content. It decriminalises the attempt by the person, and that is the boundary of what it does. It does not license **assisted dying**: the section speaks to someone who has survived an attempt on their own life, not to any right to be helped to end that life, which is a wholly separate legal and ethical question the section neither raises nor answers. Nor does it disturb the offence of **abetment of suicide**, which remains a distinct crime directed at the person who instigates or aids another's death; the protection runs to the one who attempted, not to a third party who drove them to it.

Stated as the three things the section does not do:

- It does not, by itself, repeal the older attempt-to-suicide offence; it works by presumption and bar, operating notwithstanding that offence rather than striking it out.
- It does not license assisted dying or create any right to be helped to die.
- It does not decriminalise the abetment of suicide, which remains a separate and live offence.

TRAP **The section did not itself repeal the older attempt-to-suicide offence, and it did not legalise suicide across the board.** The commonest examination error is to write that the Act struck out the attempt-to-suicide offence, or that suicide is now lawful. Neither is true of what the section does: a rebuttable presumption bars trial and punishment of the person who attempted, the section operates notwithstanding the older offence rather than deleting it, and abetment of suicide remains a crime. Collapsing a conditional presumption into a blanket repeal loses the mark every time.

PITFALL

Quoting the presumption as though it were absolute. Clinicians and candidates alike drop the words unless proved otherwise and describe the section as an unconditional immunity, so that no attempt could ever be tried and punished. The presumption is rebuttable, its protection is confined to the person who attempted, and it leaves assisted dying and abetment untouched. Stating a presumption without its condition is the same class of error as stating a statutory immunity without its conditions, and both are penalised.

The section raises a rebuttable presumption of severe stress that bars the trial and punishment of the person who attempted suicide, and it lays a mandatory duty on the appropriate Government to provide care, treatment and rehabilitation to reduce recurrence; it decriminalises the attempt by presumption and bar, working notwithstanding the older Penal Code offence rather than by repealing it.

10.5 Receiving the survivor: the clinical frame

The value of the section for a working psychiatrist is that it converts a legal principle into a default posture at the bedside. When a patient arrives after an attempt, the law has already decided, in advance and in mandatory terms, that this is a person under severe stress to be cared for, not a suspect to be processed. The clinician's task is therefore squarely medical: assess the mental state, stabilise the acute risk, identify and treat what underlies the stress, and plan for the follow-through that the rehabilitation limb contemplates. Documentation of that assessment and plan is what demonstrates that the survivor was received into the care pathway the section builds, rather than diverted into a criminal one.

Two practical points follow. First, the reflex of treating every self-harm presentation as a police matter is displaced by the section: the default is clinical care, and the record should show the mental-state assessment and the safety plan that the care pathway calls for. Second, the presumption does not dilute the clinician's own duties of assessment and risk management; if anything it sharpens them, because the person is now unambiguously a patient owed care rather than a suspect to be handed on. The section changes the frame of the encounter, not the standard of the clinical work carried out within it.

IN INDIA

Before this Act, an attempt to commit suicide was itself prosecutable under the Indian Penal Code, so a survivor could in principle be treated as an offender rather than a patient - a position long criticised as compounding distress with the threat of a criminal record. The Mental Healthcare Act reversed that default nationally, moving the survivor of an attempt from the criminal frame into a statutory presumption of severe stress backed by a Government duty of care. The everyday working knowledge that protects a patient is the simple version: the person who has attempted is presumed to be under severe stress, is not to be tried and punished, and is owed care by the State.

GOOD TO REMEMBER

On the ward, the section means the police station is not the first stop for a survivor of an attempt. Frame the encounter as an emergency, treat and document accordingly, and remember that the presumption protects the patient and the abetment law protects against those who might have driven them there - the two are not in tension. Where a case genuinely looks unusual, the burden of displacing the presumption is not yours to discharge and not the patient's to answer.

10.6 Currency, controversy and the limits of the reform

The reform is real but partial, and the exam rewards seeing both. The controversy the section itself raises is the gap between decriminalisation and repeal. When it was enacted the section decriminalised the attempt without repealing Section **309** of the Indian Penal Code; the presumption operated notwithstanding that offence, so the older crime stayed on the book but inoperative for the survivor, and commentators noted that a fuller reform would have removed it outright rather than papering over it with a presumption. The words unless proved otherwise were read by some as a residual doorway, since a presumption that can in theory be rebutted is not the same as an offence that cannot be charged at all.

The second live question is enforceability of the duty. A mandatory obligation on the appropriate Government to provide care, treatment and rehabilitation is only as strong as the services that actually exist to discharge it, and a duty framed in a statute does not by itself build the crisis care and follow-up capacity a survivor needs; the reform's ambition on the care side outruns the machinery available to deliver it. The currency point that now settles cleanly is the fate of the older offence. The Indian Penal Code was repealed and replaced in its entirety by the Bharatiya Nyaya Sanhita, 2023, in force from **1 July 2024**, so the provision the section is drafted around is no longer live law for conduct occurring on or after that date; the section's own text still refers to it, but a textual cross-reference does not keep a repealed offence in force. That repeal is not absolute for what came before it: the Bharatiya Nyaya Sanhita carries its own repeal-and-savings clause, preserving the Penal Code's previous operation, any liability or punishment already incurred under it, and any investigation or proceeding begun under it, to be continued as if the Code had not been repealed, so an attempt committed before that commencement date remains governed by the saved older position read together with this section's presumption and bar, and the law is not silent for that period. The new code did not carry over a general offence of attempting suicide. For conduct on or after that same commencement date, the only criminal

provision that now reaches an attempt is the narrow Section **226** of the Bharatiya Nyaya Sanhita, confined to the person who attempts suicide with the intent to compel or restrain a public servant from discharging his official duty, punishable with simple imprisonment which may extend to one year, or fine, or both, or community service. For the ordinary survivor of an attempt nothing in that provision applies, and the section's presumption and Government duty of care stand as the operative law. What the section itself decides is unambiguous, and that is what the answer should assert without hedging: a presumption of severe stress, a bar on the trial and punishment of the person who attempted, and a mandatory Government duty of care.

11 · Prohibited and restricted procedures (ECT, psychosurgery, restraint, seclusion)

Why the marks are here. The Mental Healthcare Act does not only decide who may be admitted and treated; it draws a hard perimeter around HOW a person with mental illness may be treated, naming a small set of interventions that are either forbidden outright or permitted only through a defined statutory gate. Examiners return to this perimeter because it is where a single modal verb settles the law. A procedure that "shall not" be done is not the same thing as one that "may only" be done on conditions, and a candidate who blurs the two has misread the Act rather than merely forgotten a detail. The territory is narrow, and the marks reward precision rather than breadth.

The scheme lives in a short, consecutive run of provisions. One lists the procedures the Act prohibits, one restricts a single neurosurgical treatment, and one governs the everyday coercive measures of restraint and seclusion. The examinable point is almost always the BOUNDARY between the categories rather than the content of any one rule, so it pays to learn the categories first and hang the detail on them. Read this topic as a small system of law, not as a list of facts to be recited.

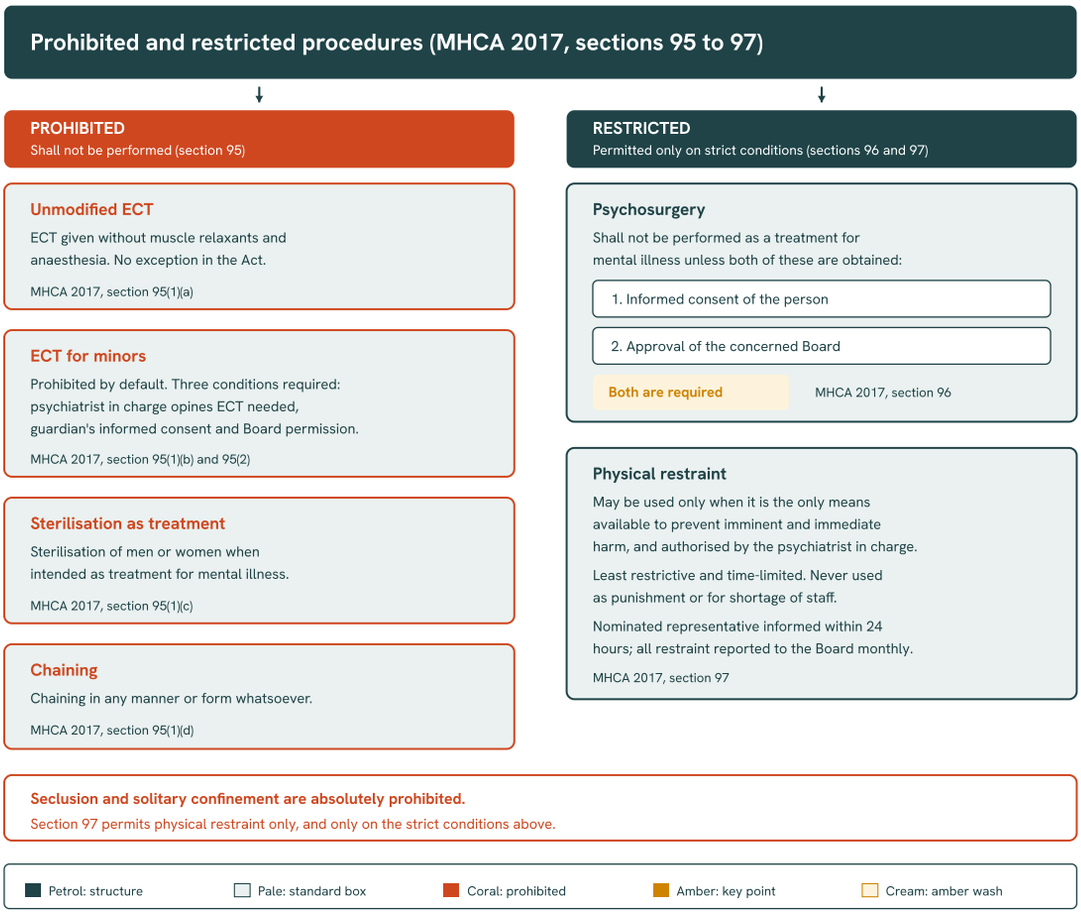


Fig 25.8. The Mental Healthcare Act 2017 separates absolutely prohibited procedures (section 95) from procedures permitted only on strict conditions (sections 96 and 97). Unmodified ECT has no exception, while ECT for minors, psychosurgery and physical restraint each pass only through a defined statutory gate, and seclusion stays barred outright.

11.1 Prohibited versus restricted: the architecture

The Act sorts controlled interventions into two families that must never be run together. A **prohibited procedure** is barred: the statute says it shall not be performed, and the only softening it permits is a single exception written into the statute itself. A **restricted procedure** is lawful, but conditionally: it shall not be performed UNLESS defined requirements of consent and authorisation have first been met. The difference is one of kind, not of degree. A prohibition is a closed door with, at most, one named key; a restriction is an open door with a lock on it, and the whole of the analysis is deciding which door you are standing at.

This architecture is not arbitrary drafting. It follows from the governing idea of the Act, that a person with mental illness keeps the ordinary rights of dignity and bodily integrity, and that any intrusion on those rights must be justified, minimised and supervised by someone outside the treating team. The interventions the Act singles out are procedures with recognised risks of coercion and misuse: given without anaesthesia, imposed on children, used to sterilise, or reached for when a ward is short of staff. Naming them in primary legislation, rather than leaving them to

professional custom, converts a matter of clinical etiquette into a matter of enforceable law that a statutory Board can review after the fact.

RULE **The category fixes the modal, and the modal fixes the law.** A prohibited procedure carries a "shall not": it is barred, and any relief comes only from an exception the statute writes for itself. A restricted procedure carries a "shall not … unless": it is permitted, but only once the conditions of consent and Board authorisation are satisfied. Deciding which category a procedure belongs to is therefore the whole task, because the operative rule falls straight out of the category.

The accompanying table maps each controlled intervention to its category, its operative modal and the lawful route, if any, that reopens it. Read down the modal column first, because it is the fastest way to see why the same word, ECT, can name both an absolute prohibition and a conditionally permitted treatment.

PROCEDURE	CATEGORY	OPERATIVE RULE AND MODAL	LAWFUL ROUTE, IF ANY
UNMODIFIED ECT, WITHOUT MUSCLE RELAXANTS AND ANAESTHESIA	Prohibited	Shall not be performed	None
ECT FOR A MINOR	Prohibited by default	Shall not be performed	Guardian's informed consent and the Board's prior permission
STERILISATION INTENDED AS TREATMENT FOR MENTAL ILLNESS	Prohibited	Shall not be performed	None, as a treatment for mental illness
CHAINING, IN ANY MANNER OR FORM	Prohibited	Shall not be performed	None
PSYCHOSURGERY	Restricted	Shall not be performed unless conditions met	Person's informed consent and the Board's approval
SECLUSION OR SOLITARY CONFINEMENT	Prohibited	Shall not be imposed	None
PHYSICAL RESTRAINT	Restricted, conditional	May only be used when necessary and authorised	Only means to prevent imminent, immediate harm, authorised by the psychiatrist in charge

11.2 The prohibited procedures

The prohibitions are gathered in section **95**, which opens with a non-obstante clause and then states that the listed treatments shall not be performed on any person with mental illness. The non-obstante wording is doing real work: it makes this rule prevail over everything else in the same Act, so no other machinery, not an emergency, not a substitute decision-maker, not an advance instruction, can be used to authorise what the section forbids. Four interventions sit on the list:

- **unmodified electroconvulsive therapy**, meaning ECT given without the use of muscle relaxants and anaesthesia;
- electroconvulsive therapy performed on a minor;
- **sterilisation** of a man or a woman, where it is intended as a treatment for mental illness;
- **chaining** in any manner or form whatsoever.

Two features of the drafting repay attention. The bar on the unmodified technique is the statutory root of the working rule that ECT may be given in modified form only; the Act does not merely discourage unmodified ECT, it forbids it, and, unlike the position for a minor, it attaches no exception of any kind. Sterilisation, by contrast, is caught specifically when it is intended as a treatment for the mental illness itself, which is the historical eugenic use the clause is written against; it says nothing about surgery undertaken for unrelated reasons, on ordinary consent, in a person who happens to have a mental illness. Reading that qualifier out of the clause is a common way to overstate it.

The technique of ECT itself, its electrode placement, stimulus dosing, seizure threshold and mechanism, belongs to **the ECT and neurostimulation notes**; here the Act speaks only to whether, and on whom, the procedure may lawfully be performed at all. The full consent procedure and eligibility rules for ECT, including the modified-only requirement as an operating standard, are developed where this chapter sets out the Act's ECT provisions. This section fixes only the placement of ECT within the prohibited-and-restricted scheme, and no more.

IN INDIA

The explicit bar on chaining a person in any manner or form is not a theoretical clause. It responds to documented reports of persons with mental illness being chained in Indian homes, custodial settings and faith-healing establishments; how widespread or prolonged the practice was is not itself something section **95** establishes. By naming the practice in primary legislation and placing it among the treatments that shall not be performed, the Act converts what had been tolerated as a family or community coping measure into an unlawful act, and hands inspecting authorities a bright line rather than a matter of degree to argue over.

MNEMONIC

The prohibition list: Unmodified ECT, Minor's ECT, Sterilisation, Chaining

These are the treatments the prohibited-procedures section forbids by default, in the order the Act lists them. The first admits no exception, and neither does the last; a minor's ECT alone reopens, through the proviso that follows, and sterilisation is caught only where it is meant as a treatment for the mental illness itself. If you can rebuild the list, you can rebuild the section.

11.3 The single conditional exception

One item on the prohibition list, and one only, is reopened by the Act. Electroconvulsive therapy for a minor is barred by default, but a proviso to the same section provides that, where the psychiatrist in charge of the minor's treatment is of the opinion that it is required, the treatment

shall be done with the informed consent of the guardian and the prior permission of the concerned Board. The consequence for the taxonomy is the point to carry away here: this is not a flat prohibition like the others but a prohibition with a single, fully conditioned gate, which is exactly why it must be read alongside its proviso and never quoted as an outright ban.

The mechanics of that gate, how the guardian's consent is taken, what the Board must weigh, and the requirement that its permission come before rather than after the treatment, are the province of this chapter's ECT-provisions material, which owns the consent-and-eligibility rules in full; they are named here only to place the exception inside the prohibited category. What this section contributes is the discrimination itself: an absolute bar admits no consent, a conditionally reopened bar admits a defined one, and the two ECT rules sit on opposite sides of that line even though they share a name. A candidate who carries "ECT is prohibited under the Act" as a single fact has flattened two different rules into one.

11.4 The restricted procedure: psychosurgery

Psychosurgery is handled separately, in section **96**, and it is the cleanest example the Act gives of a restricted procedure. **Psychosurgery** shall not be performed as a treatment for mental illness UNLESS two requirements have both been obtained: the informed consent of the person on whom the surgery is to be performed, AND the approval of the concerned Board. The conditions are conjunctive. The patient's consent does not stand in for the Board's approval, and the Board's approval does not stand in for the patient's consent; each is necessary and neither is sufficient alone. That is precisely what makes this a restriction and not a prohibition: the door is open, but it carries two locks and both must be turned.

The scope of the provision is a favourite trap, and it is worth stating flatly. The psychosurgery restriction governs psychosurgery, and psychosurgery only. It does not reach ECT, and there is no separate "ECT machinery" hiding inside it: every ECT rule lives in the prohibited-procedures section and its minor-treatment proviso, not here. A candidate who files ECT under the psychosurgery restriction, or who imports the psychosurgery consent conditions into the ECT analysis, has crossed a boundary the Act keeps deliberately sharp. The two provisions are neighbours in the statute and strangers in their content.

The contrast with the prohibited category is the deeper teaching point. Psychosurgery is not forbidden; a person who retains the capacity to consent may lawfully undergo it, provided the Board agrees. The informed consent the section demands is meaningful only in a person with the capacity to give it, a standard the Act defines where this chapter treats capacity to make treatment decisions, and which is presupposed rather than restated here. That is the whole logic of a restricted category: the Act judges the procedure too grave to leave to consent alone, but not so grave as to bar it outright, and so it inserts an independent gatekeeper between the clinician's proposal and the operating table.

11.5 Restraint and seclusion

The last provision, section **97**, governs the two coercive measures a ward reaches for in an emergency, and it treats them very differently. **Seclusion** and solitary confinement are prohibited

outright: a person with mental illness shall not be subjected to them, with no gate at all. **Physical restraint** is not banned but tightly restricted; it may only be used when it is the only means available to prevent imminent and immediate harm to the person or to others, AND when it is authorised by the psychiatrist in charge of that person's treatment. The modal split is the heart of the section, and it is asymmetric on purpose: seclusion attracts a flat "shall not", while restraint attracts a "may only ... when". Both conditions on restraint, the necessity test and the authorisation, are cumulative; neither alone will do.

Restraint, once permitted, is then hedged by a set of continuing duties that make it an accountable act rather than a clinical convenience:

- it shall not continue for any period longer than is absolutely necessary to prevent the immediate risk of significant harm, and it shall never be used as a punishment or a deterrent, nor reached for merely because the establishment is short of staff;
- the nominated representative shall be informed of every instance within **twenty-four hours**, and every instance shall be included in the establishment's report to the concerned Board on a monthly basis.

Read together, these duties describe restraint as something that must be necessary, proportionate, authorised in a named clinician's own judgement, time-limited to the actual risk, purpose-limited, disclosed promptly to the person's own safeguarder, and audited from outside. The nominated representative named in these duties is the person appointed under the Act to protect the patient's interests; that office is set out where this chapter treats the nominated representative, and is only invoked here rather than defined. The point that examiners press is that the duties survive the emergency: a restraint that was clinically defensible at the moment it began is still a breach of the section if it outlasts the risk, or goes unrecorded, or is never notified.

The clinical craft of managing the violent or highly aroused patient, the graded response of de-escalation, offered medication, rapid tranquillisation and the longer-term plan, is taken up where this chapter addresses the management of the high-risk patient. That clinical decision, however, is bounded at every step by this section. A restraint that is clinically reasonable but exceeds the statutory limits is still unlawful, and seclusion is not available as a de-escalation option at all, however tempting a quiet locked room may look on a stretched ward.

TRAP **Treating restraint and seclusion as one regime, or reversing which of them is barred.** The section does not restrict the two equally. Seclusion and solitary confinement are prohibited outright, while physical restraint is conditionally permitted. A candidate who writes that "restraint and seclusion may be used in an emergency" has merged a flat prohibition with a conditional permission and stated the law of neither correctly. Answer them apart: seclusion is out, restraint is in on conditions.

GOOD TO REMEMBER

For every episode of physical restraint, run the same discipline downstream. Authorise it in your own name as the psychiatrist in charge, stop it the moment the immediate risk has passed, tell the nominated representative within the statutory window, and enter it in the monthly return to the Board. Build these into a standing ward protocol rather than trusting memory in a crisis, because the commonest failures are not of judgement at the bedside but of the notification and reporting duties afterwards. A restraint that was defensible but undocumented is, on the section's own terms, still a breach.

PITFALL

The commonest ward-level error is to treat seclusion as a milder, more respectable step than restraint, a quiet side-room rather than hands on a patient, and to use it as routine behavioural management. The Act does the opposite: it permits physical restraint under tight conditions but prohibits seclusion and solitary confinement outright, with no gate at all. Reaching for a locked room to avoid "restraining" a patient is therefore not the safer choice but the unlawful one, and it is exactly the kind of practice a Board review is designed to surface.

11.6 Reading the perimeter: modal verbs, currency and scope

Where candidates lose the mark. Almost every error on this topic is one of three kinds, and all three come from reading the statute loosely rather than exactly. The first is a modal error: softening a "shall not" into a "may not", or hardening a "may only" into a flat permission. A discretionary power and a mandatory duty are different laws, and the Act chooses its verbs deliberately; the difference between seclusion's "shall not" and restraint's "may only" is the difference between a bar and a licence. The second is a category error: collapsing the prohibited and restricted families into one, so that psychosurgery is misremembered as banned or unmodified ECT as merely restricted. The third is a scope error: reading the psychosurgery restriction as though it covered ECT, or treating seclusion as a permitted lesser form of restraint.

A word on currency, because that is where the real-world pitfalls cluster. These are provisions of the current Act. Any comparison with how the earlier mental health legislation treated unmodified ECT and prolonged institutional restraint is not verified against primary-source grounding here, and should not be quoted as an established statutory contrast. When a viva turns to prohibited and restricted procedures, the safe posture is to name the current provision, state its modal verb exactly, and give any exception WITH its conditions rather than as a headline. A gate stated without its conditions earns no marks in the examination, and on a real ward it is a breach waiting to happen.

Prohibited	Restricted	Seclusion	Restraint
BARRED, WITH ONE NAMED EXCEPTION	LAWFUL ON CONSENT AND BOARD APPROVAL	FORBIDDEN OUTRIGHT	ONLY MEANS, THEN AUTHORISED

Prohibited means never, save the single statutory gate for a minor's ECT; restricted means only with the person's informed consent and the Board's authorisation; and seclusion, uniquely, is prohibited outright while physical restraint is merely restricted.

12 · ECT provisions under MHCA (consent, minors, modified ECT)

A short provision that examiners return to again and again. The Mental Healthcare Act does not leave electroconvulsive therapy to clinical judgement alone. It draws two firm lines around the treatment and places both inside its list of prohibited procedures at section **95**: electroconvulsive therapy given without anaesthesia and muscle relaxation shall not be performed at all, and electroconvulsive therapy in a minor shall not be performed either, save under a single, tightly conditioned exception. Almost everything a candidate is asked to say about ECT and the law follows from reading those two rules exactly, in the verbs the statute itself uses.

What this section governs is **consent and eligibility**: who may lawfully receive ECT, in what form, and on whose authority. It does not govern the technique of the treatment, and it does not lay out the full taxonomy of prohibited against restricted procedures, which this chapter treats in its own place. Hold both boundaries from the outset, because the two commonest ways to lose a mark here are to answer a consent question with a fact about how ECT is delivered, and to soften an outright prohibition into a mere restriction. The value of the topic is that it is small, self-contained and unforgiving of loose wording, which is exactly why it rewards precision.

12.1 The provision: two prohibitions and a proviso

The section is headed **prohibited procedures**, and it opens with a non-obstante clause: the treatments it names shall not be performed on any person with mental illness notwithstanding anything else contained in the Act. That opening does real work and is worth pausing on. A non-obstante clause makes the rule that follows prevail over every other provision of the same statute, so no other machinery in the Act - not emergency treatment, not consent given through a substitute decision-maker, not an advance instruction - can be used to authorise something this section forbids. When it says a treatment shall not be performed, it means the treatment cannot be reached by any other route the Act provides.

Two of the procedures it prohibits concern ECT: ECT given without muscle relaxants and anaesthesia, and ECT for minors. The provision lists other prohibited procedures beside these, among them sterilisation intended as a treatment for mental illness and restraint by chaining, but those belong to the wider classification of prohibited and restricted procedures set out elsewhere in this chapter and are named here only to show the company the ECT rules keep. What matters for this topic is the two-layer shape of the section: a first part that prohibits, and a second part that, opening with its own notwithstanding clause, carves a narrow exception for the minor. A candidate must read the two parts together, because the prohibition on ECT in minors is not the whole of the law; the exception in the second part is the other half, and quoting only the first half over-states the ban.

RULE **The Act permits only modified ECT, and prohibits ECT in a minor except under one fully conditioned exception.** Unmodified ECT shall not be performed at all; ECT in a minor shall not be performed either, unless the treating psychiatrist is of the opinion that it is required and it is done with the guardian's informed consent and the Board's prior permission. Everything else on this topic is an elaboration of those two sentences.

Modified	Minors	Guardian	Board
THE ONLY LAWFUL FORM OF ECT	ECT PROHIBITED BY DEFAULT	INFORMED CONSENT REQUIRED	PRIOR PERMISSION REQUIRED

12.2 Modified ECT only

The first ECT rule is the prohibition on **unmodified electroconvulsive therapy**, that is, ECT given without the use of muscle relaxants and anaesthesia. The verb is mandatory and absolute: such treatment shall not be performed. The immediate legal consequence is the point the examiner wants stated plainly. Because the unmodified form is barred, **modified electroconvulsive therapy** - ECT delivered under general anaesthesia with pharmacological muscle relaxation - becomes the only lawful form of the treatment. Reduced to the position it establishes, only modified ECT may be given.

The reason the legislature took this step is not hard to see, and stating it briefly shows the examiner you understand the rule rather than merely reciting it. Unmodified ECT produces a full motor convulsion, with the injury, indignity and fear that attend it; the modification markedly attenuates the motor convulsion and reduces musculoskeletal injury risk, addressing much of what historically made the treatment feared and misused. The Act converts what had been a standard of good practice into a rule of law with no discretion attached to it. There is, in particular, no emergency dispensation from it: however urgent the clinical situation, the section provides no lawful route to ECT without anaesthetic and relaxant cover. A clinician who cannot arrange modified ECT cannot lawfully substitute the unmodified form.

What this section does not cover. How modified ECT is actually delivered - electrode placement, bilateral against unilateral application, stimulus dosing, the seizure threshold and mechanism of action - is the clinical technique of the treatment, and it belongs to **the ECT and neurostimulation notes**, not here. This provision owns the law of consent and eligibility: it tells you that ECT must be modified and by whom it may be consented to, not how to prescribe or administer it. Keeping the consent question and the technique question apart is itself examinable, and conflating them is a common way to drift off the point.

IN INDIA

The Mental Healthcare Act settled the question nationally by making the modified form the only lawful one and the unmodified form a prohibited procedure. How widely unmodified ECT was practised beforehand, and how the Indian position compares with practice elsewhere today, are historical and comparative questions this note does not verify and leaves as a declared gap rather than an asserted fact. What is settled is the law itself: here the rule is not guidance but statute, and the everyday working version is simply that ECT in India means modified ECT.

PITFALL

Treating direct ECT as a permissible fallback when anaesthetic cover is hard to arrange. In resource-limited settings the temptation is to reason that some ECT is better than none and to give it unmodified in an emergency. The Act allows no such reasoning: the prohibition on unmodified ECT is absolute and carries no emergency exception. The lawful response to unavailable anaesthetic support is to arrange it or to defer the treatment, never to fall back on the prohibited form.

12.3 ECT in a minor: prohibited, then conditionally permitted

The second ECT rule is the one most often mis-stated. By default, ECT for a **minor** - a person who has not attained the age of majority, as the Act defines the term - shall not be performed; it sits in the prohibited list alongside unmodified ECT. But the section does not stop there. Its second part opens with its own notwithstanding clause and creates an exception: if, in the opinion of the psychiatrist in charge of the minor's treatment, ECT is required, then such treatment shall be done with the informed consent of the guardian and the prior permission of the concerned Board. The prohibition and the exception are two halves of one rule, and a precise answer states both.

The exception is **cumulative and conditional**: it is not enough to satisfy one of its requirements, and the requirements are not interchangeable. Three conditions must be met together before ECT in a minor becomes lawful:

- the psychiatrist in charge of the minor's treatment must be of the opinion that ECT is required - a clinical-necessity filter that turns on the treating psychiatrist's judgement, not on any clinician's view and not on the family's wish;
- the **guardian** must give **informed consent** - because a minor cannot give valid consent to the treatment, consent is exercised on the minor's behalf by the guardian, and it must be informed rather than merely obtained;
- the **concerned Board** - the Mental Health Review Board with jurisdiction over the case - must grant its permission, and that permission must be prior, sought and given before the treatment is administered rather than ratified afterwards.

Each condition carries a mandatory verb: the treatment shall be done with the guardian's consent and the Board's permission. The word that trips candidates is prior. The Board's role here is a genuine external check placed ahead of the treatment, not a paperwork step completed later, and an ECT course begun in a minor on the strength of guardian consent alone, with the Board approached afterwards or not at all, is unlawful however sound the clinical indication. The design is deliberate: ECT in a developmentally vulnerable minor is a high-stakes decision, so the law layers three different safeguards - a clinical judgement of necessity, a surrogate's informed consent, and an independent authority's prior sanction - and it requires all three to align before the treatment may proceed.

MNEMONIC

Opinion, Guardian, Board

The three cumulative gates for lawful ECT in a minor, in the order the section sets them. **Opinion** - the psychiatrist in charge is of the opinion that ECT is required; **Guardian** - the guardian gives informed consent on the minor's behalf; **Board** - the concerned Board grants prior permission before treatment begins. Miss any one of the three and the treatment is not lawful.

ECT SCENARIO	POSITION UNDER SECTION 95	STATUTORY FORCE
UNMODIFIED ECT, WITHOUT MUSCLE RELAXANTS AND ANAESTHESIA	Shall not be performed; only modified ECT is lawful	Absolute prohibition, no exception
ECT FOR A MINOR, BY DEFAULT	Shall not be performed	Prohibition
ECT FOR A MINOR, WHERE THE TREATING PSYCHIATRIST IS OF THE OPINION IT IS REQUIRED	Shall be done with the guardian's informed consent and the concerned Board's prior permission	Mandatory conditional exception, all conditions cumulative

TRAP **ECT is not absolutely banned in minors, and guardian consent alone does not make it lawful.** The classic error is to write that the Act forbids ECT in minors outright, forgetting the exception; the near-miss error is to remember the exception but to give only the guardian's consent, omitting the Board's permission. Both lose the mark. The lawful route needs the treating psychiatrist's opinion of necessity, the guardian's informed consent and the Board's prior permission, together and in advance.

12.4 Informed consent for ECT generally

Away from these two special rules, ECT is not a law unto itself; it is subject to the ordinary requirement of informed consent that governs any treatment under the Act. General informed consent applies to ECT as it applies to any other intervention, and the practical shape of the consent question follows the person's capacity and status rather than anything peculiar to ECT. For an adult who has the capacity to make the treatment decision, ECT requires that person's own informed consent, freely given on an adequate disclosure of what is proposed. Where the person's capacity is impaired, the Act's answer is support rather than automatic substitution: consent is worked out with the person through the nominated representative, not simply taken over from them.

The capacity standard itself, the ability to make a mental-healthcare treatment decision, is the Act's general test, and this chapter teaches it in its own place with the definition of mental illness and of capacity; ECT does not carry a special test of its own. Likewise the support-based routes the Act provides, the nominated representative and any valid advance directive, are treated elsewhere in this chapter and are named here only to complete the picture. The point to carry away is that the consent question forks by the person in front of you:

- a capacitous adult consents for themselves;

- an adult who lacks that capacity is supported by the nominated representative in reaching a decision rather than routinely bypassed by it: the representative gives consent on the person's behalf only in the narrow case where the person needs near-total support, and even then the person's capacity is kept under frequent review; a valid advance directive guides how the person is to be treated but does not itself supply the consent, and the making and operation of both are set out separately in this chapter;
- a minor is governed by the special exception in the prohibited-procedures section - the treating psychiatrist's opinion, the guardian's informed consent and the Board's prior permission.

Why the Board sits in the loop for a minor but not for an adult. The asymmetry is instructive. A capacitous adult's own consent is treated as sufficient authority for ECT; a minor cannot consent, the guardian's consent is a surrogate rather than the patient's own, and so the law adds an independent authority to check the decision before it is acted on. The Board's prior permission is the safeguard that compensates for the fact that the person receiving the treatment is not the person consenting to it.

> Only modified ECT may be given, because unmodified ECT shall not be performed; ECT in a minor shall not be performed either, unless the treating psychiatrist is of the opinion that it is required and it is done with the guardian's informed consent and the concerned Board's prior permission.

GOOD TO REMEMBER

Before booking ECT for a patient who is a minor, assemble three things and put each in the record: the treating psychiatrist's documented opinion that ECT is required, the guardian's informed consent (put it in writing as good practice, though the Act does not itself prescribe a written form for it), and the concerned Board's prior permission. Because the Board's permission must precede treatment, build the lead time into the plan; it is not a form to be completed after the first session. For an adult, confirm capacity first: where it is present the person consents for themselves, and where it is impaired the nominated representative's task is to support the person's own decision, giving consent on the person's behalf only where the person needs near-total support and with capacity kept under frequent review, guided by any valid advance directive rather than proceeding on the family's say-so alone.

12.5 Prohibited against restricted: keeping the categories apart

A recurring error on this topic is to blur the category the two ECT rules belong to. Both live among the Act's prohibited procedures, the strongest category, in which the treatment either may not be performed at all, as with unmodified ECT, or may not be performed on the class in question except under a defined exception, as with ECT in minors. That is a different and stronger thing than a restricted procedure, where a treatment is permitted but hedged with conditions. The full account of which procedures are prohibited and which are restricted, and the statutory limits on restraint and seclusion, is given elsewhere in this chapter; the reason to raise it

here at all is that the eligibility of ECT cannot be stated correctly without placing it in the prohibited category and not the restricted one.

The discrimination matters clinically as much as verbally. Calling the ECT rules a restriction implies a general permission subject to conditions, which invites the mistake of treating the conditions as procedural hurdles a determined clinician can work around. Calling them what they are, prohibitions - one absolute and one subject to a single narrow exception - keeps the emphasis where the statute puts it: on what may not be done, and on the exact and cumulative conditions under which the one exception opens.

12.6 Currency, controversy and the examination frame

The examinable heart of this topic is verb discipline. A statute is not a gist; it is an exact rule with an exact modal verb. Here the operative verbs are shall not be performed for the two prohibitions, and shall be done with for the conditions of the minor exception, and both are mandatory. Reading a discretionary may where the Act writes a mandatory shall changes the law: it would turn a prohibition into a matter of clinical choice and the minor's safeguards into optional courtesies. State the verbs as they stand and the answer is secure; soften them and it collapses.

Two honest limits belong in a complete answer. First, the age at which a person ceases to be a minor for the purposes of this section, and the separate provision that carries the Act's general requirement of informed consent to treatment, are matters of definition that this topic points to rather than fixes; where a figure or a cross-section is not certain, the disciplined move is to name the provision and not to invent its number. Second, the boundary with the technique of ECT is a boundary of scope, not of importance: electrode placement, dose and mechanism are as clinically weighty as the consent rules, but they are decided in the ECT and neurostimulation notes, and importing them here answers a different question. What this section decides is narrow and firm, and that is what an answer should assert without hedging: modified ECT only, ECT in minors prohibited save under the three cumulative conditions, and general informed consent for everything else.

13 · Comparison of MHCA 2017 with Mental Health Act 1987

Why the marks are here. A recurring short-note and viva task asks you to set the mental health statute a psychiatrist practises under today against the one it displaced. The examiner is not testing whether you can recite two indexes of provisions; the examiner is testing whether you grasp that Indian mental health law changed its philosophy. The **custodial** statute of **1987** existed to regulate institutions and to manage people the law treated as unable to decide for themselves; the statute of **2017** exists to presume capacity and to restore rights. Almost everything that separates the two Acts follows from that single reorientation, and an answer that names the reorientation earns the marks that a list of differences never will.

It helps to read the comparison as a question about what a mental health law is for. The older Act answered: to protect society and the patient by controlling where treatment happens and who may consent on the patient's behalf. The current Act answers: to protect the person's autonomy

and dignity, treating mental illness as a health condition and not as a legal status that strips the person of a voice. Hold those two purposes side by side and the specific provisions, on capacity, on the patient's forward wishes, on who represents them, on self-harm, on treatments of concern, and on who supervises the system, sort themselves into a single pattern rather than a heap of facts to be memorised.

1987	2017
MENTAL HEALTH ACT, REPEALED	MENTAL HEALTHCARE ACT, IN FORCE

13.1 The law that was replaced

To compare fairly you have to be honest about what the earlier Act was, rather than caricaturing it. The Mental Health Act of 1987 is generally described as itself a reform in its time, one that displaced a colonial lunacy law and added procedural safeguards around admission and discharge that its predecessor had lacked. Its organising idea, though, remained custodial: the statute was built around the licensed institution and around **guardianship** and the management of the patient's property. Mental illness, on this model, sat close to a legal status, a condition that removed the person from ordinary decision-making and put the State, the court and the family in the role of custodian.

Three features of that design, as the 1987 Act is generally described, are worth naming, because each is precisely what the later Act would invert. First, the centre of gravity was the establishment: the law's energy went into licensing and inspecting psychiatric hospitals and nursing homes, so that the regulation of places stood in for the empowerment of persons. Second, decisions were routed away from the patient, whether to a guardian appointed through a court-linked process or to the receiving institution. Third, admission and detention were the pivotal legal events, and the person's own account of what they wanted carried little formal weight. The criticism that gathered against this model was not that its safeguards were absent but that its premise was wrong:

- it equated a diagnosis with an inability to decide, instead of testing the decision itself;
- it gave the person no way to record, in advance, how they wished to be treated in a future episode;
- it left the choice of surrogate to law and family rather than to the patient;
- and it treated confinement as the natural mode of care rather than the exception.

Under the older regime an admission often turned on an order obtained through a magistrate, an institution-centred route that expressed the custodial premise. The detail of those procedures is now of historical interest only, because the Act that contained them has been taken off the statute book entirely, and it is that removal, not any single provision, which the comparison is really about. A caution belongs on the record here: the specific 1987 provisions set against the current Act in this note, including those in the table that follows, are the established historical account of the earlier statute and were not re-verified against the 1987 primary text in this pass, so read that

older column as the standard description rather than as freshly checked primary law; what is firmly grounded is the load-bearing point that the 2017 Act repealed and replaced the 1987 Act.

13.2 The paradigm shift: from custody to capacity

The current Act reorganises all of this around the person's decision-making capacity. Where the older law asked whether a person was mentally ill and, if so, who should decide for them, the newer law asks whether this person can make this particular decision and, if not, how they can be supported to. This is what is meant by calling it a **rights-based** and **capacity-based** framework: rights-based because it begins from the entitlements of the person rather than the powers of the institution, and capacity-based because the trigger for any substituted decision is a loss of capacity for a specific decision, not a diagnostic label. It is expressly aligned with the **UN Convention on the Rights of Persons with Disabilities**, the international standard for how the law should treat persons with disabilities, mental illness among them.

That alignment is the deepest of the differences, because it changes the default. In a custodial statute the default is intervention, and the person must be rescued from it by safeguards; in a rights-based statute the default is the person's own choice, and intervention is what must be justified. Every downstream contrast, the presumed capacity, the forward voice, the chosen representative, is an expression of that reversed default.

RULE **Read the two Acts as two models, not two indexes.** The Mental Healthcare Act 2017 is not the Mental Health Act 1987 with better sections; it is a different theory of what the law is for. Once you see the move from a custodial, institution-centred statute to a rights-based, capacity-based one, every specific difference becomes predictable rather than something to be recalled cold.

IN INDIA

The reform had a specific legal trigger. India is a party to that convention, and a state that ratifies one takes on a duty to bring its domestic law into conformity with it. A statute organised around custody and guardianship could not be squared with an instrument built on legal capacity and autonomy, so the real question was never whether to reform the 1987 Act but whether to amend or replace it, and only replacement could carry a change of premise. This treaty origin is why the current Act reads less like a hospitals-and-services law and more like a charter of rights for persons with mental illness.

13.3 A repeal, not an amendment

The mechanism by which the change was made carries its own teaching point. The 2017 Act does not tinker with the 1987 Act; it **repeals** it outright and puts a new statute in its place, the repeal being effected by an express repealing provision written into the 2017 Act itself. An amendment leaves the parent Act standing and edits it; a repeal-and-replace lifts the parent Act off the statute book completely and starts again. The examiner who asks for a comparison is implicitly asking you to notice this: the earlier Act is repealed for current substantive operation, subject to the extensive transitional savings the repealing provision itself carries.

Why does a repeal rather than an amendment fit a change of paradigm? Because when the organising premise of a law changes, editing individual provisions cannot carry the load. The definitions, the procedures, the bodies and the rights all have to be rebuilt around the new premise, and a patchwork of amendments to a custodial Act would leave the custodial scaffolding standing beneath them. Replacing the whole structure is the only way to make capacity, and not custody, the load-bearing idea. This is also why the answer should never present the two statutes as coexisting alternatives: one has wholly succeeded the other.

The Mental Healthcare Act 2017 did not amend the Mental Health Act 1987; it repealed and replaced it, exchanging a custodial licensing-and-guardianship regime for a rights-based, capacity-based one aligned with the UN disability convention.

PITFALL

Because the whole of the earlier Act went, a provision remembered from the 1987 framework is not a fallback when the 2017 machinery feels unfamiliar. Reaching for an institution-licensing route, or defaulting to a family guardian's consent because that is how one was taught, is to apply a law that no longer exists. When a current mechanism is unclear the answer is the correct 2017 provision, not the repealed predecessor, except for the narrow band of pre-commencement matters the repeal's own transitional savings keep alive; citing a superseded section as though it governs ordinary current practice is the way a presentation slip becomes a factual error.

13.4 The concrete markers of the shift

With the model clear, the specific novelties of the current Act become legible as instances of one move, and each is best learned as a contrast with the position it replaced rather than as a free-standing fact. The Act begins from a **presumption of capacity**, so that a person is taken to be able to make their own treatment decisions unless an assessment of the specific decision shows otherwise; the older law, by contrast, let the diagnosis do the work that a capacity assessment should do. It gives statutory standing to the **advance directive**, a person's recorded instruction about how they wish, or do not wish, to be treated in a future episode when they may be unable to say so, a forward voice the 1987 Act simply did not provide. It replaces the imposed guardian with the **nominated representative**, a person the patient may appoint themselves or, absent an appointment, one identified through the Act's own default order of representatives, to support them and, where needed, to speak for them.

The shift reaches into the treatment of self-harm and of treatments of concern as well. The current Act decriminalises the suicide attempt, directing a person who has attempted suicide towards care rather than prosecution and reversing the older exposure to the criminal law. It prohibits electroconvulsive therapy in its unmodified form, bringing a treatment the earlier statute did not specifically regulate under an explicit statutory bar; the clinical technique of that treatment is not the concern of this comparison and belongs to the ECT and neurostimulation notes. And where the older law licensed and inspected psychiatric hospitals and nursing homes through its licensing authorities, the registration and regulation of establishments now sits with

the Central and State Mental Health Authorities, so that regulatory function passes from one administrative body to its statutory successor rather than disappearing. Separately from that regulatory line, and not as a replacement for it, the current Act adds the **Mental Health Review Boards** as a quasi-judicial rights-review mechanism the 1987 framework had no equivalent of, so the genuinely new element here is the review of rights and not any transfer of the licensing function to a board. Each of these has its own detailed machinery, taught in this chapter where the Act's provisions are set out one by one; here they matter only as the visible edges of the single underlying move.

WHERE THEY DIFFER	MENTAL HEALTH ACT 1987	MENTAL HEALTHCARE ACT 2017
Governing idea	Custodial and institution-centred	Rights-based and capacity-based
Decision-making	Incapacity inferred from the illness	Capacity presumed until assessed otherwise
Patient's forward voice	None provided	Advance directive
Surrogate decision-maker	Guardian set by law and family	Patient-appointed, else statutory default order
Attempted suicide	Exposed to the criminal law	Decriminalised and directed to care
Unmodified ECT	Not specifically regulated	Prohibited
System oversight	Licensing authorities	Central and State Mental Health Authorities

MNEMONIC

DANCER - the six things the 2017 Act brought that the 1987 Act did not

Decriminalised suicide attempt, **A**dvance directive, **N**ominated representative, **C**apacity presumed, **E**CT in its unmodified form prohibited, **R**eview Boards as a new rights-review mechanism. The value of the mnemonic is that every letter is the same move seen once more, from custody towards capacity, so if you recall the theme the six recover themselves rather than having to be held as a list.

13.5 What did not change, and statute against reality

Where the contrast is easy to overstate. A good answer resists the temptation to make the two Acts opposites in every respect. The State's protective role did not vanish. The current Act still allows treatment and admission without the person's contemporaneous consent in defined circumstances, through its supported route, so the power to intervene for a person who cannot presently decide survives. What changed is that the power is now hedged with capacity assessments, a representative, review and time limits rather than exercised as custodial discretion. The continuity is deliberate: a purely libertarian statute that never permitted involuntary care would fail the very people the law exists to protect, and recognising this is what separates a mature answer from a slogan.

The harder continuity is between statute and service. A rights-based law presumes an infrastructure, review boards that actually sit, representatives who are available, directives that are honoured, community services that make non-custodial care real, and that infrastructure is uneven across the country. The most substantial criticism of the current Act is therefore not of its philosophy but of the distance between its promises and the resources on the ground, so that some of its rights remain aspirational in practice. For the exam this is the note to close on: the paradigm shift is real and is the correct headline, but its realisation is a work in progress. On currency, be unambiguous. The current Act is the operative mental health law; the 1987 Act is repealed for current substantive operation and survives only through its own narrow transitional savings, so any statement of the present general law must be drawn from the newer statute.

GOOD TO REMEMBER

The change is not academic at the bedside. A clinician trained under the older frame has to unlearn two reflexes: treating a diagnosis as automatic proof that the patient cannot decide, and treating a family member as the default consent-giver. Under the current Act the starting point is the patient's own presumed capacity, the patient's own advance instructions, and a representative the patient has chosen or, absent that, one identified through the Act's own default order, and the burden sits on the clinician to show why any of these should be displaced.

13.6 Framing the comparison in an answer

Because this topic is examined as a comparison, how you organise the answer matters almost as much as its content. Lead with the paradigm shift stated in a single sentence, then name the repeal-and-replacement so the reader knows the older Act is wholly gone, and only after that deploy the specific differences as evidence for the shift. A short contrast arranged by theme, governing idea, capacity, the patient's voice, the surrogate, self-harm, treatments of concern, oversight, earns its place because it shows understanding, whereas a table set out by section number shows only recall and invites the very error of citing a dead provision. Round off on two honest points: that the current Act is the law, and that its rights are further along on paper than in the services meant to deliver them. An answer built this way reads as an argument about a change of model, which is exactly what is being asked, and not as a memorised inventory of two statutes placed side by side.

TRAP **Answering the comparison as a section-by-section ledger.** Candidates line up provisions of one Act against provisions of the other and produce a table with no argument in it. The examiner wants the paradigm shift stated first and the provisions used as its evidence. A bare ledger also tempts you into citing a repealed provision as if it were current, which turns a presentation weakness into a factual mistake and forfeits marks twice over.

14 · Penalties and offences under MHCA

A right that cannot be enforced is only a wish, and this is the clause that puts teeth behind the whole Act. The Mental Healthcare Act spends most of its length conferring rights, prescribing procedures and constraining what may be done to a person with mental illness, and all of that architecture would be merely hortatory if a breach of it carried no consequence. The

penalties-and-offences machinery is what converts the Act's duties into enforceable law: it names the price of non-compliance and, in doing so, tells a practitioner and an establishment that the Act's procedures are not optional. The examinable core is a single provision, the **general penalty** at section **108**, and the marks are won or lost on stating it precisely, with its correct tiers and its correct verbs.

Two words are worth separating first, because candidates blur them. An **offence** is the prohibited conduct, the doing of what the Act forbids or the failing to do what it requires; the penalty is the consequence the law attaches to that conduct. The general penalty is not a list of forbidden acts but the residual consequence clause standing behind the Act's substantive duties, ready to price a breach wherever a specific penalty has not already been written. Read that way, the topic is small, exact and highly scorable.

14.1 The general penalty clause and what a contravention is

The provision is a general penalty because it is not tied to any one duty in the Act. Its trigger is a **contravention**, and a contravention here reaches three things, not one. A person who breaches any of the following falls within the clause:

- a provision of the Act itself;
- a rule made under the Act;
- a regulation made under the Act.

This breadth is deliberate. The Act operates not only through its own sections but through delegated legislation, the rules the appropriate Government frames and the regulations the Authorities issue, and a penalty confined to the bare text of the Act would leave that delegated layer unenforceable. By reaching provisions, rules and regulations alike, the clause makes the whole regulatory scheme, down to its subordinate instruments, carry the same enforceable weight. It is the safety net beneath the entire statute.

Because it is general, it is also residual. The Act singles out at least one breach for a penalty of its own: running a mental health establishment without **registration** is given a separate, specifically tiered administrative penalty in its own provision rather than being left to the general clause. The mental model is therefore two-layered. Where the Act has written a specific penalty for a specific offence, that specific provision governs; everywhere else, a contravention falls to the general penalty. A candidate who knows only that a penalty exists, without knowing that this one is the residual clause and not the whole penalty regime, has learned half the topic.

14.2 The two-tier ladder: first and subsequent contravention

The measure of the penalty is not flat. The clause escalates, distinguishing a **first contravention** from a **subsequent contravention** and treating the repeat offender more severely. It is best learned as a ladder with two rungs. For each rung the Act sets an imprisonment measure and a fine measure, and for each it leaves the court free to impose imprisonment, a fine, or both rather than forcing a single form of punishment. What changes between the rungs is not only how high

the ceilings sit but whether the fine carries a mandatory floor at all, and that asymmetry is where the marks hide. The accompanying table lays the two rungs side by side.

MEASURE	FIRST CONTRAVENTION	SUBSEQUENT CONTRAVENTION
IMPRISONMENT	up to **six months**	up to **two years**
FINE, MINIMUM	No floor stated; a ceiling only	Not less than **fifty thousand rupees**
FINE, MAXIMUM	up to **ten thousand rupees**	up to **five lakh rupees**
COURT'S OPTIONS	Imprisonment, or fine, or both	Imprisonment, or fine, or both

108	six months	two years	five lakh
ACT'S GENERAL-PENALTY SECTION	FIRST-CONTRAVENTION PRISON CEILING	SUBSEQUENT-CONTRAVENTION PRISON CEILING	SUBSEQUENT-CONTRAVENTION FINE CEILING

The pattern the table makes visible is the point. Moving from a first to a subsequent breach, the imprisonment ceiling rises, the fine ceiling rises steeply, and, uniquely, a mandatory minimum appears on the fine for the repeat offence where none existed before. A first contravention can attract a small fine, a short custodial term, or both, at the court's discretion up to the stated caps. A subsequent contravention cannot be met with a token fine, because the fine, if imposed, must clear the floor the Act sets. The escalation is thus qualitative as well as quantitative: the second time, the law removes some of the court's leniency on the fine.

RULE **The general penalty is residual, tiered and, in its measure, discretionary.** It reaches any contravention of the Act or of a rule or regulation made under it; the quantum escalates from a first to a subsequent contravention; and for each tier the court may impose imprisonment, a fine, or both. Only the subsequent-contravention fine carries a mandatory floor. Every other limit is a ceiling the court may rise to, not a fixed sentence it must pass.

14.3 Reading the verbs: ceilings, a floor and a choice

A statute is an exact rule with an exact verb, and this clause is a small masterclass in why the verb matters. The imprisonment and fine limits are almost all expressed as amounts the punishment may extend to. That phrasing sets a **ceiling**, a maximum the court may not exceed, while leaving it free to impose anything below that maximum, including a nominal penalty, according to the gravity of the breach. It does not fix the sentence. To read a ceiling as the tariff is to misstate the law by promoting a maximum into a mandate.

Against that background, one figure behaves differently, and the difference is the examinable subtlety. For the subsequent-contravention fine, the Act says the fine shall not be less than a stated amount but may extend to a higher one. That first half is a **mandatory minimum**, a floor the court must clear if it fines at all, and it is the single mandatory quantum in the whole provision. The second half is the familiar ceiling. So the repeat fine is bounded on both sides, a floor and a cap, while every other measure in the clause is bounded only above. Holding that one

asymmetry, a mandatory floor on the repeat fine and ceilings everywhere else, is what separates a precise answer from a vague recollection of large numbers.

The third verb worth naming is the connective one. Each tier offers imprisonment, or a fine, or both, a genuine disjunction with an inclusive tail. The court is not compelled to imprison; it may fine instead, and it may do both. This is why the clause is not, as it is often misremembered, a jail provision but a graduated sentencing power in which custody is one option among two.

TRAP **An amount the punishment "may extend to" is a maximum, not a mandatory sentence, and the general penalty is never automatic imprisonment.** Candidates read the imprisonment ceilings as fixed terms and state the penalty as a definite jail sentence, or forget that the court may impose a fine instead of, or in addition to, custody. The one mandatory quantum is the floor on the repeat-contravention fine; treat every other figure as an upper limit and you will not misquote the section.

14.4 A residual clause: general versus specific penalties, and what lies outside

Two boundaries keep this topic honest, and both are scope questions of the kind this chapter tests. The first is internal to the Act. The general penalty is residual: where the Act has written a specific penalty for a specific offence, that specific provision governs and the general clause stands behind it. Treating the residual clause as the whole penalty regime, and stretching it over breaches the Act has priced separately, flattens a two-layer scheme into one.

The second boundary is external, and candidates most often trip over it because the words sound adjacent. The general penalty punishes breaches of this Act. It is a wholly different question from whether a person with mental illness who commits a crime is criminally responsible for it, which the substantive criminal law decides and the criminal-responsibility material addresses. The penalty clause is a regulatory-enforcement provision aimed at those who flout the mental-health statute; the responsibility question is a doctrine of the general criminal law aimed at the mentally ill defendant. They share a chapter and little else, and conflating the enforcement of the Act with the exculpation of the accused is a category error worth guarding against.

The general penalty is also content-blind. It does not itself say which acts are prohibited or which procedures require consent; those substantive requirements live in the Act's other provisions and are taught with the items that own them, and the clinical technique, dosing and mechanism of electroconvulsive therapy belong to the ECT and neurostimulation notes. Its role sits downstream of all of that: once a substantive duty exists somewhere in the Act, whether a rule about admission, a requirement of consent, or a limit on a procedure, this is the clause that prices its breach when no more specific price has been set.

PITFALL

Applying the general penalty to an offence the Act has singled out for its own specific penalty. Running a mental health establishment without registration is not left to the general clause; the Act gives that breach a separate, specifically tiered administrative penalty of its own. Reaching for the general penalty to describe every breach, or quoting one tier's ceiling as though it were a fixed fine, is the scope error that both loses the mark and misstates the clinician's actual exposure.

14.5 In practice: triggering the penalty and how it is enforced

Why this matters at the bedside is quieter than the numbers suggest. What actually brings a clinician or an establishment within reach of the penalty is a concrete breach of the Act's duties, not an abstract one: proceeding without a consent the Act requires, admitting or detaining a person outside the admission procedure, carrying out a procedure the Act prohibits, or operating an establishment without registration. Each of these is a contravention, and the penalty clause does not ask whether harm resulted; it asks whether the Act was followed. That is a more demanding standard than a negligence test: a clinician who caused no injury can still have contravened a procedural requirement, which is why documented compliance, not good outcomes alone, is the real protection.

The reason not to overstate the clause is that its practical bite depends on machinery outside itself: a penalty means nothing until something invokes it. The clause is best understood as the backstop that gives the Act's supervisory bodies their ultimate leverage, not as a threat hovering over routine clinical work. Stated at the height the section itself supports, and no higher, the rule is clean, and that restraint is itself examinable.

IN INDIA

The Act is central law and its penalty clause applies nationally, but a penalty on paper is only as real as the machinery that invokes it. The establishment-registration penalty and the Board's own compliance powers are administrative sanctions, enforced through the State and Central Mental Health Authorities and the Review Boards, while the general penalty alone creates criminal, prosecutable punishment. The working protection for a practitioner is therefore procedural: register the establishment, follow the admission and consent procedures, respect the rights the Act confers, and keep the record that shows you did. The penalty is the backstop, not the daily instrument.

GOOD TO REMEMBER

When you are asked, in a viva or on a ward round, what happens if the Act is breached, resist the urge to name a jail term. The honest answer names the structure: a first contravention and a subsequent contravention are treated differently, the court may fine or imprison or do both, and only the repeat fine has a mandatory floor. If the breach is running an establishment without registration, that has its own specific penalty and is not this clause at all. Getting the shape right matters more than reciting a figure.

The Act's general penalty makes any contravention of the Act, a rule or a regulation punishable, more lightly for a first contravention and more heavily for a subsequent one, with the court free to order imprisonment, a fine, or both, and a mandatory minimum falling only on the fine for a repeat breach.

The Rights of Persons with Disabilities Act 2016

15 · Salient features of RPWD Act 2016

Why the marks are here. Disability law is the point at which psychiatry stops being purely clinical and becomes a matter of enforceable rights, because mental illness is a specified disability in Indian law, and a person with mental illness is a person with a disability once that functional, barriers-based definition is met, and the protections, benefits and certification that follow all rest on a single statute. A candidate is asked for the salient features of that statute because the examiner wants four things placed correctly: what the Act is, where it came from, when it took effect, and what it replaced. Those anchors are the whole of a short-note answer, and they are also the facts most often muddled, because the Act is easy to confuse with the welfare law it superseded and easy to date to the wrong year.

The Act is best read at its origin, meaning its number, its long title, its commencement clause and the legislation it repealed, because every later provision inherits its character from that origin. Read this way it is not a welfare scheme with a few rights attached; it is a rights statute from its first line, written to bring an international convention into Indian law, and grasping why that is so is the difference between a pass-level answer and a good one. The recognised categories of disability, the certification machinery, the benefits and the guardianship reform each have their own detailed treatment elsewhere in this chapter; here the object is the Act as a whole, seen from its foundations.

49 of 2016	27 Dec 2016	19 Apr 2017	1995
ACT NUMBER	PRESIDENTIAL ASSENT	BROUGHT INTO FORCE	ACT IT REPEALED

15.1 The Act, its number and its short title

The Rights of Persons with Disabilities Act reached the statute book as Act No. **49 of 2016**, receiving Presidential **assent** on **27 December 2016**. An Indian statute carries two identifiers a candidate should keep apart: the short title, which names the Act and gives its year, and the official Act number, which fixes it in that year's sequence of central legislation. Both point to the same statute, and quoting either correctly signals that the answer rests on the primary Act rather than on a textbook paraphrase of it.

Section **1** is where the Act names itself and states when it will begin. It gives the short title, the Rights of Persons with Disabilities Act, **2016**, and then sets out the commencement rule. Its **long title**, the formal recital that opens the Act, announces its purpose in a single sentence, and here that sentence does real work: the purpose it declares is not the welfare of the handicapped but giving effect to an international rights convention. The long title is therefore not decoration; it is the interpretive key to everything that follows, and an examiner who asks for salient features is partly asking whether the long title has been read.

15.2 Commencement: assent is not coming into force

The most examinable trap in the whole topic hides in one clause. An Act does not become operative law on the day it is passed, nor even on the day it receives assent; it becomes operative on its **commencement**. The short-title-and-commencement section provides that the Act "shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint." The two modal verbs are doing different jobs and both must survive intact. The coming-into-force is mandatory, because the Act shall come into force, while the choice of the actual date is discretionary, left to the Central Government to appoint. The statute is certain that it will begin; it is deliberately silent about when.

The appointed date arrived by notification: the Act was brought into force on **19 April 2017** through **S.O. 1215(E)**. Between assent and that notification the Act existed on paper but bound no one, a period of dormancy that catches the candidate who dates the Act's operation to the year of its assent. This is not pedantry. Rights become claimable, and duties become enforceable, only from commencement, so any question about when an entitlement first arose, or from when a duty could be enforced, turns on the notified date and not on the date of assent.

TRAP **Assent is not commencement.** The Act received Presidential assent in one year but was brought into force by a separate Gazette notification on a later date. Date the operation of the Act, and the moment any right became claimable or any duty enforceable, to the notified commencement, never to the year of assent. Quoting the assent year as the year the Act "came into force" is an easy mark lost.

15.3 A statute built to give effect to a treaty

The single fact that explains the Act's whole character is that it was written to implement a treaty. Its long title declares it an Act to give effect to the United Nations Convention on the Rights of Persons with Disabilities, the **UNCRPD**, and the Act's preamble records that India ratified that Convention on **1 October 2007**. India follows a dualist tradition, in which ratifying an international convention expresses the State's commitment but does not by itself make the Convention enforceable domestic law. For its guarantees to be claimable in an Indian court, Parliament must legislate, and this Act is that implementing legislation. The interval of several years between ratification and enactment is precisely that dualist step being worked through.

This treaty parentage is why the Act reads as it does. Because it exists to give effect to the Convention, its provisions are construed purposively and in harmony with the Convention's principles rather than read down as narrow welfare measures. Where a later section is ambiguous, the long title and the Convention it serves supply the direction of travel, towards autonomy, inclusion and equal recognition before the law. A candidate who says only that the Act "protects the disabled" has missed the point that it exists to confer rights already recognised in international law, and it is that framing, not the vocabulary of protection, that the salient-features question is testing.

RULE **The Act is treaty-driven and therefore rights-based.** It exists to give effect to the disability Convention, and every provision is read in that light: disability is approached as a question of rights and of the barriers society raises, not as a matter of welfare or charity. State that character first and the salient features fall into place beneath it, because each one is an application of it.

IN INDIA

India ratified the disability Convention several years before it legislated, and turning that ratification into enforceable domestic law is exactly what this Act performs. The practical consequence for the Indian clinician is substantial. The rights of a person with mental illness to non-discrimination, to reasonable adjustment and to the entitlements that follow certification now rest on a rights-based statute carrying the broader UNCRPD social-and-rights model, rather than the narrower, impairment-and-threshold-based regime it replaced. That is a firmer footing from which to advocate for a patient, and it is why the Act, and not merely its schedule of benefits, is worth knowing at the bedside as well as in the examination.

15.4 From welfare to rights: the earlier Act repealed

The Act did not enter an empty field. It **repealed and replaced** the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, **1995**, the country's earlier dedicated disability legislation. The change of name signals a change of philosophy. The earlier Act framed disability as a matter of equal opportunity and protection, a narrower, impairment-and-threshold-based regime, while the new Act frames it as a matter of rights, in which the person is a **rights-holder** owed non-discrimination and the adjustments that make participation possible. That is the move from a medical-and-charity view of disability to a rights-based, socially grounded one, in which disability is understood to arise from the barriers a society erects and not from an impairment considered alone.

Two ideas carry that model into the text and both are worth naming, though their machinery is developed elsewhere. The first is reasonable accommodation, the duty to make the specific adjustments a person needs to exercise rights on an equal basis, a refusal of which is itself treated as discrimination. The second is equal recognition before the law, the principle that a person with disability retains legal standing and decision-making status rather than being displaced by a guardian as a matter of course. The full reform of guardianship that this principle drives is taken up in this chapter's account of benefits, reservations and guardianship under the Act; what matters at the level of salient features is that the Act's paradigm, and not simply its list of benefits, is what changed.

POINT OF CONTRAST	PERSONS WITH DISABILITIES ACT, 1995	RPWD ACT 2016
UNDERLYING MODEL	Welfare and protection; a medical-and-charity view	Rights-based; a socially grounded understanding of disability
LEGAL IMPETUS	Domestic enactment implementing a regional proclamation, not a binding UN treaty	Domestic enactment giving effect to a ratified United Nations convention
STANDING OF THE PERSON	Beneficiary of State provision	Rights-holder owed non-discrimination and accommodation
STATUS TODAY	Repealed and replaced	The disability law now in force

Gathered up, the salient character of the Act is best expressed as the principles it embodies:

- respect for inherent dignity, individual autonomy and the freedom to make one's own choices;
- non-discrimination and equality of opportunity;
- full and effective participation and inclusion in society;
- accessibility, so that the physical and informational environment does not itself disable; and
- reasonable accommodation as an enforceable entitlement rather than a favour.

The RPWD Act is India's rights-based enactment of the UNCRPD, Act No. **49 of 2016**, in force from **19 April 2017**, and the successor to the narrower, impairment-and-threshold-based law of **1995**.

15.5 The architecture of the Act

Asked for the salient features of the RPWD Act **2016**, the strongest answer also maps the Act's structure and knows where the detail of each limb sits. The Act recognises a defined and considerably broadened set of disabilities, bringing within its scope conditions that the earlier law did not, mental illness among them. It establishes a statutory machinery for the assessment and certification of disability. It confers rights and entitlements, including in education, in public employment and in access to benefits. It reforms guardianship along the Convention's lines and connects with the National Trust framework for certain conditions. It designates authorities and commissioners to monitor implementation and to hear grievances, and it creates offences and penalties for contravention and for discrimination. Each of these is a salient feature in its own right, and this chapter takes the recognised categories of disability, the certification route, the benefits and reservations, and the guardianship reform in turn.

What holds the structure together is the origin already set out. Every limb, meaning who is recognised, how they are certified, and what they are owed, is an expression of the same UNCRPD-aligned rights-based commitment that the long title announces, which the narrower, impairment-and-threshold-based 1995 Act did not carry. That is why reading the Act at its origin is not a preliminary to the salient features but the most salient feature of all: the character of the statute determines the reach of every provision built upon it, and an answer that leads with the benefits before the character has quietly inverted the Act.

PITFALL

The commonest real-world error is to keep working within the framework the Act repealed, citing the older statute or advising a patient and family as though disability were still a matter of welfare provision rather than enforceable right. A new certificate, entitlement or complaint must be founded on the current Act; action already taken under the 1995 Act is not thereby erased, since the Act's own savings provision deems it done under the corresponding RPWD provision. Reaching for the superseded legislation is the disability-side equivalent of quoting a criminal provision that a later code has already replaced, and it is marked as an error of currency, not merely of loose citation.

15.6 Why the psychiatrist is examined on it

Where it touches practice. The reason this Act belongs in a psychiatry syllabus at all is that, under it, mental illness is a specified disability, and a person with mental illness is a person with a disability once the Act's functional, barriers-based definition is met. That inclusion pulls psychiatry into the Act's machinery. The recognition of disabilities and the place of mental illness among them, the certification through which that recognition is proved, and the benefits, reservations and guardianship reform that recognition unlocks are each taken up in the discussions that follow, and each rests on the rights-based foundation set out here. Alongside the Mental Healthcare Act, which governs care, treatment and the rights of the person within mental-health services, this Act governs the civil and social standing of the same patient, and in practice the two are read together.

Knowing the Act at origin is therefore not an academic flourish. It tells the clinician which statute is live, on what footing a patient's entitlements rest, and why an assessment of disability is an act with legal consequence and not merely a clinical note. The candidate who can state the Act's number, its treaty purpose, its commencement and the law it replaced has the spine of the topic; everything the later provisions add is flesh on that spine.

GOOD TO REMEMBER

When you assess a patient whose illness limits their functioning over the long term, remember that your clinical opinion can be the gateway to statutory rights and not only to treatment. Because mental illness is recognised as a disability, the psychiatric assessment carries a civil consequence, and framing it as a right the patient holds, rather than a benefit you are kindly recommending, is both more accurate in law and more useful to the family sitting in front of you.

16 · Recognized disabilities and inclusion of mental illness

Why the marks are here. The Rights of Persons with Disabilities Act is the statute that decides who counts as disabled in Indian law, and psychiatry has a direct stake in the answer because mental illness is one of the conditions it recognises. Two questions recur, in the examination and at the bedside. The first is which impairments the Act actually lists, and where mental illness falls among them. The second is what the much-quoted forty-per-cent figure governs, because it is routinely misattached. Both are settled by reading the Act's own definitions and its Schedule

rather than by memory of what a disability certificate looks like, and a candidate who can separate the definition of disability from the benchmark threshold, and place mental illness correctly within the recognised list, has the whole of this topic.

The Act carried Indian disability law from a narrow, medically framed list to a broad, socially framed one aligned with the United Nations Convention on the Rights of Persons with Disabilities. For the clinician this is not academic. Recognition under this statute is the gateway through which a person with a severe and enduring mental illness reaches statutory protections and entitlements, and the psychiatrist is very often the first professional to see that a patient is eligible at all. Knowing exactly what the Act recognises, and on what terms, is therefore part of doing right by the patient, not only part of passing the paper.

40%	21	5
BENCHMARK THRESHOLD	SPECIFIED DISABILITIES	HEADS IN THE SCHEDULE

16.1 Two definitions the Act keeps apart

The single most examinable feature of this Act is that it defines disability twice, and the two definitions do different work. A **person with disability**, at section **2(s)**, means a person with a long-term physical, mental, intellectual or sensory impairment which, in interaction with **barriers**, hinders full and effective participation in society on an equal basis with others. Notice what this definition does not contain: any number. It is deliberately the barriers model, in which disability arises from the meeting of an impairment and a disabling environment, not from the impairment considered on its own. The qualifier long-term is doing quiet work here too, because a transient or short-lived impairment, however severe while it lasts, does not by itself answer the definition.

The definition has three elements a candidate should be able to lift apart cleanly:

- a long-term physical, mental, intellectual or sensory impairment;
- an interaction between that impairment and environmental or attitudinal barriers; and
- a resulting hindrance to full and effective participation in society equally with others.

Against this stands the **person with benchmark disability**, at section **2(r)**, and here a threshold appears. A person with benchmark disability means a person with not less than **40** per cent of a specified disability, where that disability has not been defined in measurable terms; and, where the disability has been defined in measurable terms, a person with disability as certified by the certifying authority. This category is narrower, and it is the one to which the Act pins its heavier positive entitlements, the reservations and the schemes, whose detail is dealt with separately in this chapter's account of benefits, reservations and guardianship under the Act.

Why two definitions, and not one, is the reasoning worth showing rather than reciting. The Act does two different jobs. It protects a broad class of people from discrimination and guarantees them accessibility and equal participation, and for that purpose it wants the widest, most inclusive definition, one with no arithmetic gate at all. Separately, it distributes scarce positive goods, reserved seats, reserved posts and targeted schemes, and for that it needs a narrower,

sharply defined qualifying group. The benchmark definition is that narrower gate. Reading the two definitions as one, or importing the threshold into the general definition, collapses a deliberate two-tier design and is exactly the error the next box warns against.

TRAP **The threshold belongs to benchmark disability, not to disability.** Candidates read the headline figure and conclude that a person must reach it to be a person with disability at all. The general definition carries no percentage; the threshold is a second, higher gate for benchmark-linked entitlements only. A patient can be a person with disability under the Act, protected from discrimination and owed accessibility, and still fall short of benchmark status.

AXIS	PERSON WITH DISABILITY	PERSON WITH BENCHMARK DISABILITY
Threshold in the definition	None; no percentage stated	Not less than the benchmark proportion of a specified disability
Underlying model	Barriers model: impairment in interaction with barriers	Quantified extent of a specified disability
What it establishes	Status, equality and the anti-discrimination protections	The qualifying gate for reservation and benchmark-linked schemes
Role of certification	Not defined by a percentage certificate	Certified by the certifying authority where the disability is measurable

16.2 The Schedule of specified disabilities

What actually counts as a specified disability is not left to clinical opinion; it is fixed by a list. A **specified disability** means, at section **2(zc)**, the disabilities enumerated in the Schedule to the Act. This closed-list technique is deliberate. Certifying authorities, courts and government departments need a fixed, common reference for who is inside the specified-disability class and who is not, and an itemised Schedule supplies a legal certainty that a purely descriptive definition cannot. The Schedule fixes specified disabilities for this certification and benchmark-linked machinery; it does not confine the broader status of **person with disability**, which section **2(s)** defines on its own terms, independently of Schedule membership. The technique has a cost worth naming, however: a genuinely impairing condition the Schedule does not list falls outside the specified-disability machinery until the Schedule is revised to admit it, which is why the recognised list is written to be amendable rather than closed for good. The Schedule also widened the recognised conditions, from the **seven** categories of the earlier disability legislation to **21** specified disabilities, and it is this expansion that first brought several psychiatric and neurodevelopmental conditions squarely within disability law.

The itemised conditions are organised under **five** heads:

- physical disability, covering locomotor disability, visual impairment, hearing impairment and speech and language disability;

- intellectual disability, within which specific learning disabilities and autism spectrum disorder sit;
- mental behaviour, which is mental illness;
- disability caused by chronic neurological conditions and by blood disorders; and
- multiple disabilities, including deaf-blindness.

Two placements are worth holding, because both are tested by asking a candidate to file a condition correctly. Intellectual disability and mental illness sit under different heads, a separation the Act insists on and returns to in its own definition of mental illness. And autism spectrum disorder, together with specific learning disability, sits under intellectual disability rather than under mental illness, which is where an unwary answer tends to place them. The head names are not loose labels. Each condition has a fixed address in the Schedule, and the marks reward the candidate who knows the address and not merely the neighbourhood.

RULE **Recognition is by inclusion in the Schedule, not by severity.** A condition is a specified disability under this Act because it is listed in the Schedule; the broader status of person with disability under section 2(s) is not confined to the Schedule. Severity, expressed later as the benchmark proportion, is a separate question that fixes the level of entitlement, not whether the condition is a specified disability at all. First establish that the condition is scheduled; only then ask how much of it the person carries.

16.3 Mental illness within the Schedule

Where psychiatry enters the statute. Mental illness appears in the Schedule under the mental-behaviour head, and the Schedule gives it its own definition. **Mental illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgement, behaviour, capacity to recognise reality or the ability to meet the ordinary demands of life. The drafting is broad and functional. It turns on gross impairment of everyday functioning rather than on any named diagnosis, and that is precisely what lets a range of severe and enduring psychiatric conditions qualify without the statute having to list each of them. The test the Act sets is disability of function, not the presence of a particular label, which sits comfortably with the wider principle in these notes that a diagnosis is not named to a patient as the currency of their care.

The definition then carries an express carve-out that examiners like to probe. It does not include **retardation**, described as a condition of arrested or incomplete development of mind characterised by subnormality of intelligence. The Act is not denying that intellectual disability is a disability; it recognises it fully, but under the separate intellectual-disability head, not within mental illness. The two are kept apart on purpose, because they call for different assessment and different supports, and folding them under one heading would blur both. For the examination the discrimination to keep ready is short: intellectual disability is recognised, but as intellectual disability, never as mental illness.

IN INDIA

Mental illness was not first recognised as a disability by this statute. The Persons with Disabilities Act of 1995 that it replaced already listed mental illness among the disabilities it recognised; what the present Act does is broaden and reorganise the disability framework, adding conditions and building the benchmark structure onto it, rather than granting mental illness its first statutory footing. The practical significance for the clinician is unchanged: a person with a severe and enduring psychiatric illness is, in principle, eligible for the same order of statutory protection and entitlement as a person with a physical disability. In day-to-day practice the psychiatrist is usually the professional who first recognises that a patient's illness has reached a disabling level, and who sets the patient on the pathway toward a disability certificate. Recognising eligibility early, and saying so plainly, is itself part of good care.

16.4 Recognition, certification and the definition that is not this one

Three boundaries decide whether an answer has understood this topic or has merely memorised the figure. The first is recognition against certification. Being listed in the Schedule makes mental illness a specified disability, not an automatically recognised individual disability; an individual with mental illness becomes a person with disability, and so gains the general rights the Act owes every person with disability, the protection from discrimination and the claim to accessibility and equal participation, only when the section **2(s)** elements are also met, the long-term impairment interacting with barriers to hinder participation, not by diagnosis or Schedule placement alone, and none of which turns on any percentage. What recognition does not by itself confer are the benchmark-linked entitlements. Those, the reservations and the schemes, follow only from a certificate that the person meets the benchmark threshold, and the machinery for assessing and certifying mental illness as a benchmark disability, the instrument used and the certifying authority, is taken up separately in this chapter's account of disability certification and the assessment of mental illness. For those benchmark entitlements recognition is the door and certification is the key, and this topic owns the door.

The second boundary is the benchmark against the benefit. The threshold is the entrance to the benchmark-linked reservations and schemes; separate general schemes open to persons with disability as such, resting on section **2(s)** status rather than on the benchmark proportion, also exist and are not gated by the threshold. The content of the benchmark-linked entitlements, who reserves what and the guardianship provisions that travel with them, belongs to this chapter's account of benefits, reservations and guardianship under the Act. This topic owns the definition of the gate, not the goods that lie beyond it, and a candidate who pours reservation proportions into a recognition answer has quietly answered a different question.

PITFALL

The Rights of Persons with Disabilities Act carries its own definition of mental illness, and it is not the definition used in the Mental Healthcare Act. The two provisions read similarly but sit in different statutes and do different work: one decides recognition as a disability for entitlements, the other governs care, admission and rights under mental-health law. Quoting the disability Schedule's definition when the question is about mental-health-care law, or the reverse, is a common and avoidable error. The Mental Healthcare Act's definition of mental illness is taught with that Act's definitional provisions, and each should be cited to its own statute.

The third boundary is the quietest, and it is the one clinicians actually trip on. Recognition, certification and benefit are three steps, not one, and a patient can be standing at any of them. A patient whose illness is plainly disabling, so that the section **2(s)** elements, the long-term impairment, its interaction with barriers and the resulting hindrance to participation, are met, is a person with disability, and that status already owes the general protections the Act gives every person with disability; what it does not by itself deliver are the benchmark-linked benefits, which wait until a certificate is issued and the entitlement is claimed. Keeping the three steps apart is what lets a clinician be honest with a family about what a diagnosis does, and does not, by itself deliver.

GOOD TO REMEMBER

When a patient with a severe, persistent mental illness asks about disability benefits, the answer comes in two parts. Recognition is not in doubt, because an illness this severe and persistent satisfies the section **2(s)** elements, and mental illness is in any event a specified disability under the Act. What the patient needs is certification, first of the specified disability and then, if the benchmark proportion is met, at the benchmark level, each a separate assessment carried out under its own machinery. The clinician's task is to flag eligibility early and route the patient into the certification pathway, rather than to promise a particular benefit that only certification and the benefits framework can actually confer.

Mental illness is a specified disability recognised in its own right and kept distinct from intellectual disability; the benchmark proportion governs benchmark disability and its entitlements, never the definition of a person with disability.

17 · Disability certification and assessment of mental illness (IDEAS)

Why the marks are here. For a person living with severe mental illness, a disability certificate is the document that turns a clinical fact into a quantified legal entitlement. It is the gateway to the specified-disability status and, once the benchmark is crossed, to the stronger concessions, welfare schemes and reservations the disability statutes pin to that number; the Act's general equality and non-discrimination protections attach to a person with disability independently of any certificate and do not wait on it. The examiner is rarely satisfied by the clinical picture alone. The marks sit on the exact statutory machinery - which provision empowers the guidelines, who is competent to certify, what procedure the applicant passes through - and on the one instrument

by which disability in mental illness is actually measured in this country. Get the chain and the computation right and the answer writes itself; blur a mandatory duty into a discretionary power, or read the percentage off the wrong number, and the mark is gone.

This topic is deliberately self-contained. It is about the DISABILITY certificate and nothing else. It is not the certificate of fitness to resume a job, not the assessment that sits behind a compensation or pension claim, and not the report a psychiatrist prepares for a court. Each of those is a separate certification with a different purpose and a different instrument, and the commonest way to lose the mark is to let one bleed into another. Mental illness is one of the specified disabilities the Act recognises; the recognition and definition of that category are treated separately in these notes, and what follows begins once mental illness is already inside the schedule and asks only how its disability is certified.

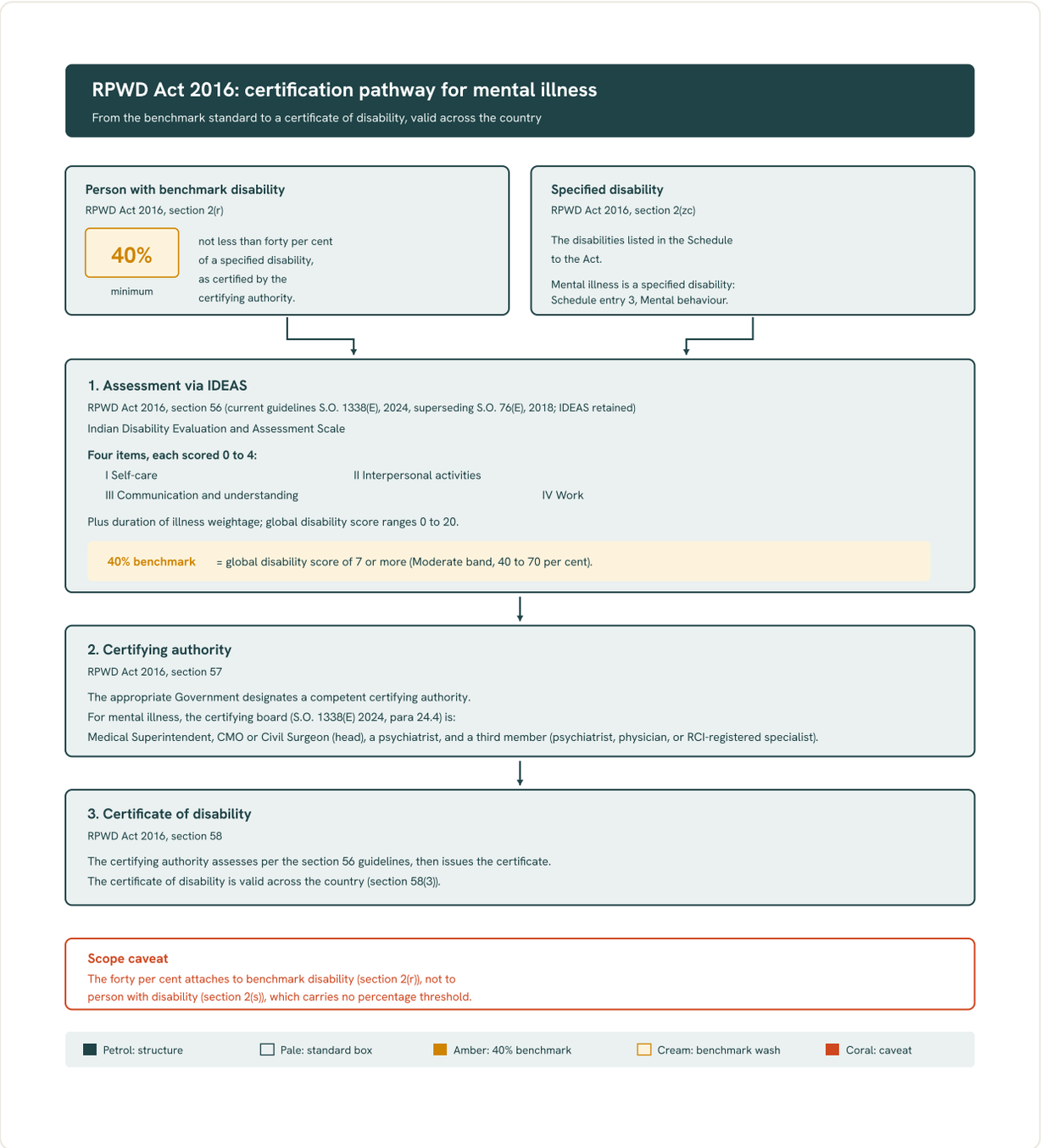


Fig 25.9. The RPWD Act 2016 route to a certificate of disability for mental illness: the benchmark standard of not less than forty per cent of a specified disability (section 2(r)) is measured with IDEAS under the section 56 guidelines, certified by the section 57 authority, and recorded on the section 58 certificate that is valid across the country.

17.1 The statutory chain: from the Act to a certificate

The Rights of Persons with Disabilities Act builds certification as a chain of three provisions, and each link carries an exact modal verb that must be reproduced. The first link is the enabling power at section **56**: the Central Government **shall** notify guidelines for the purpose of assessing the extent of a specified disability in a person. This is a mandatory duty, and it matters because nothing can be certified until those guidelines exist. They are the yardstick against which extent is measured, and a certificate issued against no notified guideline has no legal footing.

The second link, at section **57**, designates who may certify. The appropriate Government **shall** designate persons having the requisite qualifications and experience as **certifying authorities**,

competent to issue the certificate of disability, and shall also notify the jurisdiction within which, and the terms and conditions on which, they perform that function. Both duties are mandatory. A certificate issued by a person who has not been designated, or outside the notified jurisdiction, is not a valid certificate, which is why the identity of the certifying body is itself an examinable fact.

The third link, at section **58**, is the procedure the applicant actually passes through, and here the modal verbs switch deliberately. Any person with a specified disability **may** apply, in the manner prescribed by the Central Government, to a certifying authority having jurisdiction. The application is the citizen's option, never a compulsion. On receipt, the certifying authority **shall** assess the disability in accordance with the guidelines notified under the enabling power, and shall then either issue a certificate of disability in the prescribed form or inform the applicant in writing that he has no specified disability. The assessment is a mandatory duty and its two outcomes are the only two permitted: there is no lawful third option of leaving the application unanswered.

17.2 The assessment guidelines for mental illness

The guidelines the enabling power anticipates were notified by the Central Government in **2018** as gazette notification **S.O. 76(E)**, and they expressly superseded the older mental-illness guidelines of **2002**. For mental illness they lay down that assessment consists of a clinical assessment together with the IDEAS scale and, where it is relevant, an intelligence (IQ) assessment. Those 2018 guidelines also carried a discriminating rule that examiners used to return to: where both an IQ score and an IDEAS score were generated, the score indicating the more severe disability was taken, not an average and not whichever was measured first. That rule does not survive into the current 2024 notification, which instead directs that a person whose intellectual disability and mental-illness disability coexist is classified as having multiple disability and certified through the multiple-disability route, not by picking the worse of the two single-disability scores.

The same guidelines constitute the **certifying board** for mental illness. In outline the board is headed by a senior institutional officer, the Medical Superintendent, Chief Medical Officer or Civil Surgeon, or the equivalent officer a State notifies, and it includes a psychiatrist, who performs the clinical assessment, and a psychologist, who performs the IQ testing. This composition is worth holding, because it is the concrete answer to the section **57** question of who is competent to certify. The current notification is the 2024 **S.O. 1338(E)**, which superseded the 2018 **S.O. 76(E)**, and IDEAS is retained as the instrument, so the computation set out below is the tool a candidate must know. The 2018 notification is now historical. Its 2024 successor was not verbatim-verified for these notes, so the precise medical-board composition and the certificate-validity rules it sets are a declared gap: read the board as constituted per the current notification, but treat the exact 2024 designations, including that of the psychologist, as to be confirmed against the primary rather than settled here.

17.3 IDEAS: the instrument and its four domains

The Indian Disability Evaluation and Assessment Scale, **IDEAS**, is the instrument by which disability in mental illness is quantified for certification. It was developed by the Rehabilitation

Committee of the **Indian Psychiatric Society** and then adopted, with modifications, as the official tool. Its logic is important: it does not rate symptoms, it rates the disability that illness produces in everyday functioning. A florid mental state and a disabling one are not the same thing, and it is the second that the law compensates. IDEAS makes that judgement across **four** domains:

- **Self-care** - hygiene, grooming, bathing, toileting, dressing, eating and looking after one's own health.
- **Interpersonal activities (social relationships)** - initiating and maintaining interactions with others in a contextually and socially appropriate way.
- **Communication and understanding** - producing and comprehending spoken, written and non-verbal messages.
- **Work** - functioning in the domain of employment, housework or education.

Each domain is scored from **0 to 4**, the lowest step recording no disability in that area and the highest recording profound disability, a complete inability to perform. The rater's task is to convert clinical observation into these four graded judgements, which is why inter-rater consistency and a structured interview matter as much here as anywhere in the mental state examination.

MNEMONIC

Some Individuals Can Work

The four IDEAS domains in order: **S**elf-care, **I**nterpersonal activities, **C**ommunication and understanding, and **W**ork.

IN INDIA

Disability in mental illness is not certified on a free clinical impression but on a gazette-notified, home-grown instrument. IDEAS grew out of the Indian Psychiatric Society's own rehabilitation work and was then modified and notified by the Ministry of Social Justice and Empowerment, which is what makes it the official yardstick and also makes its items, scoring and computation government-open, free to reproduce with acknowledgement of the gazette notification. For an Indian candidate this is the answer that a Western disability scale would get wrong: the tool the law names is IDEAS.

17.4 Computing the score: total, duration weightage and global score

The four domain scores are added to give a total disability score, which therefore runs from **0 to 16**. IDEAS then does something distinctive that candidates routinely omit: it adds a weightage for the **duration of illness**. The reasoning is that chronicity compounds disability. The same symptom burden carried for a decade is more disabling than the same burden carried for a month, because it erodes the roles, skills, employment and social capital that do not quickly return once lost. The weightage is graded by how long the illness has run:

DURATION OF ILLNESS	WEIGHTAGE ADDED
under 2 years	**+1**
2 to 5 years	**+2**
6 to 10 years	**+3**
over 10 years	**+4**

The total disability score plus the duration weightage gives the **Global Disability Score**, which runs from **0 to 20**. It is this global figure, and not the raw four-item total, that is carried forward to the percentage. The distinction is small on the page and decisive in the exam and in the clinic, because the same four-domain profile can land in two different percentage bands depending only on how long the person has been ill.

4	0-16	0-20	40%
IDEAS DOMAINS	ITEM TOTAL	GLOBAL SCORE	BENCHMARK CUT-OFF

TRAP **Mapping the percentage from the four-item total.** The item total and the global score are different numbers, and only the global score carries the percentage band. Candidates score the four domains, read straight off to a percentage, and silently drop the duration-of-illness weightage. The weightage is added first, every time; the global disability score is what the percentage table responds to.

17.5 From global score to percentage and the benchmark

Where the number becomes an entitlement. The global disability score maps onto a severity band and a percentage of disability, and it is the percentage that the rest of the statutory world responds to. The banding is fixed by the notified guidelines, so it is read, not judged:

GLOBAL DISABILITY SCORE	SEVERITY	PERCENTAGE DISABILITY
0	No disability	**0%**
1 to 6	Mild	**below 40%**
7 to 13	Moderate	**40 to 70%**
14 to 19	Severe	**71 to 99%**
20	Profound	**100%**

The single figure to hold is the cut-off. The line that defines a **benchmark disability**, and that gates the Act's benchmark-linked reservations and schemes rather than every welfare measure, is **40%**, which is reached at the moderate band, that is at a global disability score of **7** or more. Below it, an applicant is still a person with disability who retains the Act's general rights, but does not cross the line to which the stronger, benchmark-linked concessions and reservations are pinned. The benchmark, in other words, is not merely a descriptor of severity; it is the switch that turns those entitlements on.

RULE **The percentage is a statutory computation, not a clinical impression.** The certificate rests on the IDEAS global disability score defined in the notified guidelines. A clinician's global sense that a patient is "severely ill" has no legal standing until it is expressed as that computed score and its percentage band, which is precisely why the instrument, the duration weightage and the banding must be applied as written rather than approximated.

PITFALL

Treating IDEAS as an intelligence test, or certifying from IDEAS alone when a coexisting intellectual disability is present. IDEAS is the instrument for mental illness; intellectual disability is assessed on IQ. Under the superseded 2018 guidelines a clinician who generated both scores took the more severe of the two; under the current 2024 notification, a person whose intellectual disability and mental-illness disability coexist is instead classified as having multiple disability and certified through the multiple-disability route. A clinician who still defaults to the old take-the-worse-score rule, or to IDEAS alone, is applying superseded guidance and under-certifies the very patient the safeguard was written for.

GOOD TO REMEMBER

Because the score is anchored to current functioning and to the duration of illness, it moves as the patient does. A certificate is a snapshot, not a life sentence. An applicant whose global score sits just under the benchmark today may cross it after a relapse and a longer illness course, and one certified during a severe episode may fall below the band after sustained recovery. Re-assessment when the clinical picture changes materially is part of using the instrument honestly, and it protects both the patient's genuine entitlements and the integrity of the certificate.

In mental illness the disability percentage is read off the IDEAS global disability score, and **40%** is the benchmark that opens the statutory entitlements reserved for benchmark disability.

17.6 The certificate: its reach, appeal and boundaries

Two features of the issued certificate are heavily tested. First, its reach: the certificate of disability **shall** be valid across the country. This pan-India validity is a deliberate reform of the unique-disability-identity era, replacing a patchwork of State-bound certificates with a single document a person can carry and use anywhere in the country. Second, its challengeability: the Act provides an appeal against the certifying authority's decision to an appellate authority the State designates, so a wrongly refused or wrongly graded applicant is not left without remedy. A candidate who names both the country-wide validity and the existence of an appeal shows the whole shape of the procedure, not just its front end.

Finally, the boundary that keeps this topic clean. The disability certificate is one of several psychiatric certifications and must not be confused with the others. It is not the certificate of fitness to resume a job, nor the assessment behind a workmen's compensation or disability-pension claim, nor the certificate or report a psychiatrist prepares for a court, which belongs to the Forensic ethics, consent and legal procedure notes. Each answers a different legal question

with a different instrument, and IDEAS and the benchmark threshold belong to this certification alone; they should not be borrowed to answer a fitness-to-work or a compensation question. Equally, the entitlements this certificate unlocks - the reservations, concessions, benefits and the guardianship framework of the disability statutes - are taken up in a separate section of these notes. Here the work ends at the certified percentage, which is exactly where the law means it to end and the next topic to begin.

18 · Benefits, reservations and guardianship under RPWD and National Trust Act

Why the marks are here. Guardianship is the point where disability law stops being about entitlements and starts being about a person's legal capacity to decide for themselves. Two Indian statutes govern it, and a candidate is expected to keep them apart. The Rights of Persons with Disabilities Act rebuilt guardianship around a rights-based, supported model; the National Trust Act built a separate, committee-appointed route for a defined group of developmental disabilities. Both create a machinery for a supporting or substitute decision-maker, both use the word guardianship, and by a quirk both place that machinery at the same-numbered section of their own Act, which is exactly why answers confuse them. The examiner is testing whether you know which statute reaches which person, and what kind of guardianship each actually confers.

The benefits-and-reservations half of this topic flows from the same rights-based logic. The Rights of Persons with Disabilities Act converts disability from a welfare category into a set of enforceable entitlements in education, employment and public schemes. The stronger of those entitlements attach to a person certified as having a benchmark disability, and how that certification is done, its instrument and its threshold, is taken up separately in this chapter's account of disability certification and is not reconstructed here. What follows is the guardianship framework in full, and the shape of the entitlements it exists to support.

> RPWD guardianship defaults to a limited, supported, decision-specific guardian appointed by a court or designated authority; the National Trust Act runs a separate, committee-appointed guardianship for its named developmental disabilities, and the two must never be merged.

Two	Limited	Committee	Support
PARALLEL STATUTES	THE RPWD DEFAULT	THE NATIONAL TRUST ROUTE	NOT SUBSTITUTION

18.1 From substituted to supported decision-making

The older Indian frameworks treated a person of unsound mind as globally incapable and installed a guardian to decide in their place. That is **substituted decision-making**, and its guardianship is **plenary guardianship**: a standing, all-purpose authority over the person and often their property. The Rights of Persons with Disabilities Act rejects this as the default. It begins from the presumption that capacity is retained, it offers support first, and it turns to a guardian only where a person, even after adequate and appropriate support, still cannot take legally binding decisions. This is **supported decision-making**, and the statute gives it a specific

legal form, **limited guardianship**, in which the guardian assists a decision rather than overriding it.

Why this shift matters clinically is easy to lose behind the vocabulary. A person's capacity to decide is rarely all-or-nothing: it is specific to a decision and it can change over time. A guardianship that removes decision-making wholesale, once and for all, mismatches that reality, disempowers the person, and invites abuse of the arrangement. A guardianship built to fit the decision that is actually in difficulty, and to expire when it is no longer needed, matches the clinical facts and keeps the person at the centre of their own life. That is the design intent the Act writes into law.

RULE **Guardianship under the RPWD Act is support, not substitution.** The default is a limited guardian who decides jointly with the person, for a defined decision and a defined period, in line with the person's own will; total support, subject to review, is the exception the court must specifically justify, never the starting point.

18.2 RPWD guardianship: the limited guardian

The reform is codified at section **14** of the Rights of Persons with Disabilities Act, headed Provision for guardianship. The trigger is deliberately narrow. Where a district court, or a **designated authority** notified by the State Government, finds that a person with disability who has already been given adequate and appropriate support is still unable to take legally binding decisions, that person may be provided the further support of a limited guardian to take legally binding decisions on their behalf, and to do so in consultation with the person. The modal verb matters: the court may provide this support, it is not bound to, and it enters only after ordinary support has already been tried and has not sufficed.

What limited means is defined inside the section, and it is the examinable core. Limited guardianship is a system of joint decision resting on mutual understanding and trust between the guardian and the person, and it carries these mandatory features:

- it shall be confined to a specific period, not granted as an open-ended status;
- it shall be confined to a specific decision or situation, not extended to the person's life at large; and
- it shall operate in accordance with the will of the person with disability, so the guardian gives effect to the person's own choice rather than displacing it.

The section also builds in an escape valve and a mandatory overlay. By its proviso, the court or designated authority may grant total support where the person genuinely requires it, or where limited guardianship would otherwise have to be granted repeatedly, subject to review, so the default is limited but total support, subject to review, remains available on the facts and under scrutiny. Separately, under **14(2)**, every guardian appointed for a person with disability under any other law is deemed to function as a limited guardian on and from commencement, an overlay that is not confined to appointments made before the Act and continues to catch guardians appointed under other laws afterward. Where the designated authority has appointed

the guardian, an appeal against that decision lies to an appellate authority notified by the State Government. Read together, these provisions make limited guardianship the rule, total support the justified exception, and the person's own will the standard the guardian is held to.

18.3 The National Trust Act route: the Local Level Committee

Running parallel to the RPWD scheme is the guardianship route under the National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, **1999**. This route is confined to the **four** conditions named in the Act's own title, and it is administered not by a court but by a **Local Level Committee** constituted under the Act. Its guardianship provision sits at section **14**, headed Appointment of guardianship, and its whole character is different from the RPWD instrument.

Two kinds of applicant may approach the committee. A parent of a person with disability, or a relative, may apply for the appointment of a person of their own choice to act as guardian. A **registered organisation** may also apply in the prescribed form, but here the Act adds a safeguard: no such application shall be entertained unless the consent of the person's existing guardian is also obtained. In deciding an application the committee shall consider two matters:

- whether the person with disability actually needs a guardian; and
- the purposes for which the guardianship is required.

The committee receives, processes and decides these applications and sends the particulars onward, and it also retains the power to remove a guardian it has appointed. The committee appoints the guardian for a defined group of developmental disabilities and orients the arrangement to the person's continuing care; but like every guardian appointed under a law other than the RPWD Act, that guardian is also deemed to function as a limited guardian under **14(2)** of the RPWD Act, so the committee supplies the appointing forum while the RPWD Act supplies the guardianship's limited, supported character. That is why families of children with autism or cerebral palsy are so often directed to the committee rather than to a court, and why the two statutes cover genuinely different ground even though the resulting guardian's authority is the same limited kind.

> **PITFALL**
>
> Do not route every guardianship request to the Local Level Committee. That door is open only for the conditions the National Trust Act names. A person whose disability is a mental illness lying outside those conditions falls under the Rights of Persons with Disabilities Act, before a court or a State-notified designated authority, and steering such a family to the wrong body costs them months they often cannot spare.

18.4 Two statutes, two guardianships, one confusion

Because the two Acts place guardianship at the same section number and use the same word for it, the commonest examination error is to describe one route with the features of the other. The way to protect the mark is to hold the axes apart and answer across all of them. The accompanying table sets out the discriminations an examiner tests.

AXIS	RPWD ACT, LIMITED GUARDIANSHIP	NATIONAL TRUST ACT ROUTE
Appointing body	District court, or a State-notified designated authority	Local Level Committee constituted under the Act
Default model	Limited, supported, joint decision-making	Committee-appointed for continuing care, but deemed a limited guardian under RPWD **14(2)**
Whom it reaches	Any person with disability under the Act's broad definition, not confined to the Schedule of specified disabilities	Only the developmental conditions the Act names
Who initiates	Follows a finding that support has not sufficed; done in consultation with the person	A parent, a relative, or a registered organisation applies
Scope and tenure	Confined to a specific decision and a specific period; total support only by justified exception	Appointment of a guardian for the person, removable by the committee
Underlying philosophy	Rights-based; capacity presumed; least restriction	Welfare and continuing care of a defined group

TRAP **Both provisions carry the same section number and the same label, yet they are different laws.** A candidate who memorises the guardianship section as one undivided fact loses the mark the instant the stem names a condition or an appointing body. The RPWD provision is limited and court-led and reaches any person with disability under the Act's broad definition, not merely the Schedule's specified disabilities; the National Trust provision is committee-led and confined to the conditions its Act names. Name the statute before you name the section, and the features fall into place.

GOOD TO REMEMBER

When a family asks you about guardianship, two questions settle the route before any form is filled: does the person's condition fall within the ones the National Trust Act names, and is a standing, total arrangement really needed, or would a limited guardian for a specific decision suffice? Reach for the least restrictive option that will work, and record why anything more was necessary, because both the statute and any later review will ask you exactly that.

18.5 Benefits and reservations, and where guardianship fits

Where the law bites in practice. The Rights of Persons with Disabilities Act does more than forbid discrimination; it creates positive entitlements. It reserves opportunities in higher education and in government employment for persons with benchmark disability, and it directs government to frame benefits and welfare schemes touching the education, health, livelihood and social security of persons with disability generally. The structural point the examiner wants is that the more substantial of these entitlements attach to a person recognised as having a **benchmark disability**, which is the qualifying category the Act uses to target its stronger

reservations and benefits. The precise proportions reserved, and the section numbers that carry them, belong to the salient-features treatment of this Act and are not asserted here.

How that recognition is assessed and certified, including the instrument used and the threshold that fixes a benchmark disability, is dealt with separately in this chapter's account of disability certification, and it should not be rebuilt in a guardianship answer. What matters for the present topic is the join between the two halves. A person may need a guardian precisely because a disability that affects decision-making is also what qualifies them for these entitlements, and a guardian, above all a limited guardian working in consultation with the person, is frequently the one who helps give those entitlements effect, from an educational place to a pension to enrolment in a scheme. The general civil-law machinery for managing the property and affairs of a person with mental illness sits outside both disability statutes and is taken up separately in these notes.

IN INDIA

Section **14(1)** gives the district court and any State-notified designated authority concurrent jurisdiction over a guardianship application, so a family may go to the district court whether or not an authority has been notified; in States that have not notified an authority, the district court remains the readily identifiable forum, so families meet very different waiting times from one State to another. The National Trust route, by contrast, is built to be reached locally through its committees, which is one reason it remains the practical first stop for parents of children with the developmental disabilities it covers, even though its guardianship is the less rights-forward of the two models. A psychiatrist who knows which door opens for which person, and can say so plainly to a family, saves them a great deal of avoidable delay.

In the examination this topic rewards the candidate who leads with the supported-decision reform, keeps the two guardianship routes cleanly apart, matches each modal duty to its correct statute, and treats benefits and reservations as entitlements gated by a certification taught elsewhere. Say those things in that order, name both Acts, and the answer reads as the work of someone who has understood the law rather than only memorised its headings.

Substance and narcotics law

19 · NDPS Act 1985 (salient provisions, classification of substances)

Why the classification carries the marks. The Narcotic Drugs and Psychotropic Substances Act, 1985, the NDPS Act, is India's principal criminal-control statute for drugs of abuse, and in an examination almost every mark it yields sits in two places: how the Act defines the substances it governs, and how it grades an offence by the quantity involved. This is not a pedantic point. How heavily an act is punished, and whether a route out of the criminal process toward treatment is open, follow substantially from which statutory class a substance occupies and in what amount it was held; but class and quantity alone do not decide whether the act is an offence at all, since the Act carries its own exception for medical or scientific dealing conducted within its rules, orders

and an applicable licence, permit or authorisation, and a treatment route further depends on addiction, voluntariness, a qualifying institution and the treatment being undergone. Get the class wrong and every conclusion built on top of it is wrong.

The discipline this topic really teaches is to read the Act as a lawyer reads it, from the primary text and by the Act's own definitions, rather than as a pharmacologist reads it. The statute does not ask what a molecule does in the brain; it asks where the law has placed that molecule. The clinical face of substance use, the dependence syndromes, withdrawal states and de-addiction pharmacology, sits outside this frame and is developed in the Substance use disorders notes; here the object is narrower and sharper, the law of classification itself.

Named	Listed	Notified	By statute
NARCOTIC DRUG, NAMED IN THE ACT AND EXTENDABLE BY NOTIFICATION	PSYCHOTROPIC SUBSTANCE, FIXED BY THE SCHEDULE	QUANTITY BANDS, SET BY THE CENTRAL GOVERNMENT	CLASS FOLLOWS THE LAW, NOT PHARMACOLOGY

19.1 Two classes, and a scheme graded by quantity

The Act builds its control in two central moves. It first names the things it governs, and for classification of controlled drugs the two principal statutory classes are narcotic drugs and psychotropic substances, distinct from the separate controls the Act carries elsewhere for precursor or controlled substances and for specified plants. It then criminalises the operations carried out around those two classes, the production, manufacture, possession, sale, purchase, transport and warehousing, together with the financing and harbouring that support them, subject to the Act's own exception for medical, scientific and otherwise licensed dealing conducted within its rules, orders and authorisations. On top of that prohibition it lays a graded scheme of punishment for many of its principal offences, in which the severity of the sentence tracks the quantity involved rather than the identity of the drug alone; several other offences under the Act carry offence-specific penalties independent of that quantity scheme. The examinable salient provisions are therefore not scattered across the Act; they gather at the front, in the definition clauses that fix the two classes, and in the quantity definitions that drive the sentence for the offences that turn on them.

Everything in the topic hangs off one organising idea, and it is worth stating before any single definition is opened: under this Act, what a substance is is a question answered by the statute, not by pharmacology. The Act works by naming and by listing, and a substance is controlled because the law has placed it in a controlled category, not because of what it does to the nervous system. This is the point a well-drilled candidate returns to whenever a definition looks counter-intuitive.

RULE **Classification under the NDPS Act is statutory, not pharmacological.** A substance falls within the Act because the Act's text names it or its Schedule lists it, not because of how the substance behaves in the body. Reason from the definition outward; reasoning inward from a drug's action is the single most reliable way to place a substance in the wrong class.

19.2 The narcotic drug: a means-and-includes definition

The Act's definition of a **narcotic drug** sits at section **2(xiv)**, and its drafting rewards close reading because the structure is itself examinable. The definition operates by **means and includes**: it first means a short, named set of substances, and then includes a further category on top. The named substances are:

- coca leaf;
- cannabis, in the sense the Act gives to hemp;
- opium; and
- poppy straw.

To that closed list the definition then adds its inclusion: it takes in all manufactured drugs as well. The means half is a fixed enumeration; the includes half opens the class to the category of manufactured drugs, which the Act defines separately on its own terms in another of its definition clauses. Read together, a narcotic drug is whichever of the named plant-derived substances the Act lists, together with the manufactured drugs the Act separately brings in, a closed list plus an inclusion, not an open description that a court is left to fill in.

Two features of that definition carry marks. First, the enumeration combines the closed list of four named source materials with a further inclusion for manufactured drugs, and a candidate should be able to recite the named heads rather than assume every manufactured drug is simply a derivative of one of them, since the Central Government can itself notify further substances into the manufactured-drug limb without touching the named list. Second, and more importantly, membership does not depend on pharmacology at all, and that is exactly where the classic error lives.

TRAP **Reading narcotic drug as a pharmacological category, and so excluding cannabis.** The everyday medical meaning of narcotic is a sedating opioid-type agent, and a candidate who imports that meaning reasons that cannabis, not being pharmacologically narcotic, must fall outside the definition. The statute says the opposite: cannabis is named in the enumeration and is a narcotic drug in law. Narcotic here is a legal label the text attaches, not a pharmacological description of the drug.

PITFALL

Trusting a secondary source for the exact words of the definition. The operative closing words of the narcotic-drug definition are all manufactured drugs. A widely used online case-law source reproduces the final word as manufactured goods, which is a transcription slip; the primary Gazette text of the Act reads drugs. When the precise word matters, and in a criminal statute it always does, verify the wording against the primary text of the Act rather than an aggregator, because one wrong noun quietly changes what the class contains.

19.3 The psychotropic substance: defined by the Schedule

The second class is built on a different mechanism, and the contrast between the two mechanisms is the heart of the topic. A **psychotropic substance** is defined at section **2(xxiii)**

not by naming particular drugs in the body of the Act, but by reference to a list. It means any substance, natural or synthetic, or any natural material, or any salt or preparation of such a substance or material, that is included in the list of psychotropic substances specified in the **Schedule** to the Act. Put plainly, a substance is psychotropic for the purposes of this Act if, and only if, it appears in that Schedule.

The definition is deliberately wide in one direction and narrow in another. It is wide in reach: it sweeps in natural and synthetic substances, raw natural materials, and any salt or preparation of them, so that a controlled substance cannot slip out of the class simply by being presented as a derivative or a formulation. It is narrow in gate: however broadly those words describe candidate substances, none of them is a psychotropic substance in law unless the Schedule actually lists it. The breadth describes what can be controlled; the Schedule decides what is.

This is the practical significance of a list-based definition. Because the controlled class is whatever the Schedule contains, the Act's reach over psychotropics can be extended by adding a substance to the Schedule, without reopening and rewriting the parent definition each time a new drug of abuse appears. The definition supplies the frame; the Schedule supplies the current contents. It is precisely this that separates the two classes in their primary mechanism: a narcotic drug's named list sits fixed in the Act's own enumeration, though its manufactured-drug limb can itself be widened by further Central Government notification, while a psychotropic substance is fixed entirely by the Schedule the Act carries with it.

19.4 Narcotic drug versus psychotropic substance

Because the two classes are defined by different machinery, a direct contrast is the examiner's favourite way into the topic. Setting them side by side on shared axes makes both the difference and its consequence easy to hold under pressure.

AXIS	NARCOTIC DRUG	PSYCHOTROPIC SUBSTANCE
WHERE THE CLASS IS FIXED	Enumerated in the body of the Act itself	Listed in the Schedule the Act carries
FORM OF THE DEFINITION	Means a named set and includes manufactured drugs, a closed list plus an inclusion	Means any substance, material, salt or preparation included in the Schedule, a gate by listing
WHAT IT TAKES IN	Coca leaf, cannabis, opium, poppy straw and manufactured drugs	Whatever the Schedule specifies, natural or synthetic, and their salts and preparations
RELATION TO PHARMACOLOGY	None: membership is by name, not by drug action	None: membership is by listing, not by drug action
HOW THE CLASS GROWS	By naming more in the Act itself, or by Central Government notification widening the manufactured-drug limb	By adding entries to the Schedule

MNEMONIC

Narcotics are Named; Psychotropics are Placed

Two words fix the whole contrast. A **Named** class: narcotic drugs are named in the Act's own enumeration. A **Placed** class: psychotropic substances are whatever has been placed in the Schedule. Hold which class is Named and which is Placed, and you can reconstruct both definitions and their key consequence, that a new psychotropic arrives by way of the Schedule while the named narcotic list sits in the Act itself. Qualify the mnemonic before relying on it: the manufactured-drug limb of the narcotic-drug definition can itself be widened by Central Government notification, so a narcotic drug is not confined only to what the Act names in so many words.

19.5 Classification by quantity: the graded scheme

The second axis of classification is amount, and it is what turns one prohibited act into a minor matter and another into a grave one. Once a substance is within either class, the Act does not punish every dealing with it identically: for many of its offences it grades the offence by the quantity involved, and it does so through two further definitions. A **commercial quantity**, at section **2(viia)**, is any quantity greater than the amount specified for that substance by the Central Government by notification in the Official Gazette. A **small quantity**, at section **2(xxiiia)**, is any quantity lesser than the amount similarly specified. Between the two lies an intermediate band, more than small but less than commercial, and the three bands attract punishment of ascending severity:

- a small quantity, drawing the lowest tier of punishment;
- an intermediate quantity, more than small but less than commercial, drawing the middle tier; and
- a commercial quantity, drawing the highest tier.

The structural point, and the one the exam rewards, is where the actual thresholds live. The Act does not fix the numbers. It defines the small and the commercial quantity by reference to amounts the Central Government specifies, substance by substance, in a Gazette notification, and the executive can revise those amounts without amending the Act. That is why an answer should state the scheme and its mechanism and should never attempt to recite thresholds from memory: the operative figures do not sit in the Act at all, they sit in delegated legislation, and they differ for every substance.

IN INDIA

The load-bearing feature of the Indian scheme is that the small-quantity and commercial-quantity thresholds are set by Central Government notification in the Official Gazette, not written into the Act. This keeps the classification responsive, because a threshold can be added or revised for a substance administratively, but it also means the operative numbers live outside the statute, in delegated legislation that a practitioner has to consult separately. The quantity seized, measured against the notified figure for that particular substance, is what fixes the band, and with the band the gravity of the charge.

The small-versus-commercial line does more than scale a sentence; for the individual relief provisions it also marks an outer limit, and that limit sits at small quantity itself, so an intermediate-quantity offence, more than small but below commercial, already falls outside that relief and not only a commercial-quantity offence does. The relief the Act extends to a qualifying addict is confined to the Act's consumption offence or to another offence involving a small quantity, not to offences sorted loosely into personal-consumption versus trafficking labels, and it does not reach an intermediate or commercial-quantity offence; a separate, systemic power the Act carries for the Government to establish treatment centres is not gated by offence-quantity at all. The full machinery of that individual relief, who qualifies, on what conditions, and how it sits against prosecution, is a distinct provision developed separately in these notes on the treatment and de-addiction side of the Act; what matters here is only that the quantity classification is part of the gate through which any such relief must pass.

GOOD TO REMEMBER

For the treating psychiatrist the quantity line is not an abstraction. Whether a dependent patient found with a substance faces the heaviest tier of the Act, or is instead eligible for the treatment-oriented route the Act reserves for consumption or small-quantity cases, turns on the class and the amount together. Knowing that the thresholds are notified rather than fixed in the Act, and that they differ by substance, is what keeps a clinician from either falsely reassuring a patient or overstating the jeopardy when the family asks what a seizure means.

Under the NDPS Act classification is a statutory question and not a pharmacological one: a narcotic drug is enumerated in the body of the Act, a psychotropic substance is whatever the Schedule lists, and for many of its offences the gravity is graded across small, intermediate and commercial quantities whose thresholds the Central Government fixes by notification rather than the Act.

20 · Treatment and de-addiction provisions, immunity for addicts under NDPS

Why the marks sit here. The Narcotic Drugs and Psychotropic Substances Act is remembered as a punitive statute, and for the trafficker it is exactly that. For the dependent user it also carries a reformative limb, and it is that limb the examiner probes, because answering well forces a candidate to separate three different powers that all point toward treatment yet operate at

different stages of the criminal process and under different modal verbs. One provision bars prosecution without requiring a finding of guilt. One lets a convicting court divert an offender into treatment instead of prison. One empowers the State to build the treatment system itself. Each is conditional, and reciting the headline without its conditions is how the mark is lost.

The idea that ties the limb together is that the law treats dependence as a condition to be treated rather than only an offence to be punished, but for the two individual routes below, that grace extends only to the consumption offence and to offences involving small quantity. The moment an offence involves more than small quantity, including the intermediate band below commercial, those two reformative routes fall away and the punitive machinery applies in full; the third, systemic provision carries no equivalent offence-quantity threshold, because it is a power to build the treatment system rather than an individual defence. Holding that boundary in mind keeps the two individual routes below in their correct scope, and the reader who wants the classification of quantities and substances that sets those bands will find it developed separately in these notes on the salient provisions of the Act. Here the object is narrower: the treatment, de-addiction and immunity provisions themselves.

Pre-conviction	Post-conviction	Systemic
IMMUNITY FOR THE ADDICT WHO VOLUNTEERS	RELEASE FOR TREATMENT IN PLACE OF SENTENCE	POWER TO ESTABLISH DE-ADDICTION CENTRES

20.1 Immunity from prosecution for the addict who volunteers

The reformative limb opens with a pre-conviction protection at Section **64A**, which grants **immunity from prosecution** to a dependent user who comes forward for treatment, without requiring a finding of guilt, and even while a prosecution against him is already pending. The provision reaches only a person who is an **addict**, which the Act defines as a person who is dependent on any narcotic drug or psychotropic substance. The immunity is not a pardon and it is not automatic; it is a conditional bar that attaches only when a defined set of facts is present, and the examiner rewards the candidate who can state those facts rather than the slogan.

The conditions must be read together, because the failure of any one of them dissolves the protection:

- the person is an addict within the meaning of the Act;
- he is charged with the offence of consumption of a narcotic drug or psychotropic substance, or with an offence involving only a **small quantity** of such substances, so that the bar does not extend to an offence involving more than small quantity, whatever that offence is labelled;
- he **voluntarily** seeks to undergo medical treatment for de-addiction;
- the treatment is at a hospital or institution **maintained or recognised** by the Government or a local authority; and
- he actually undergoes that treatment.

Where those conditions are satisfied the Act provides that he **shall not be liable to prosecution** for the consumption offence, or under any other section, for offences involving a small quantity.

The verb is mandatory. Once the addict has genuinely volunteered and undergone treatment at a qualifying institution, the bar operates as a matter of right, and the prosecuting agency has no discretion to insist that he nonetheless be tried. This is the design choice worth understanding: the State is prepared to forgo the prosecution of a consumption or small-quantity offence in exchange for the offender placing himself in treatment, because a treated dependent user serves the Act's purpose better than a punished one, while an offence involving more than small quantity, whatever it is called, is deliberately left outside; the boundary the Act draws is quantity, not the informal label of trafficking.

RULE **The bar on prosecution is mandatory; its withdrawal is discretionary.** The Act says the qualifying addict shall not be liable to prosecution, but the accompanying proviso says the immunity may be withdrawn if he does not undergo the complete treatment for de-addiction. The two halves of the same provision carry different modal verbs, and that split is the whole point. Protection is guaranteed to the one who completes; only the failure to complete reopens the door to prosecution, and even then the reopening is a discretion to be exercised, not an automatic consequence.

PITFALL

The provision is routinely recited as blanket immunity for a drug offence. It is nothing of the kind. It is confined to the consumption offence and to offences involving small quantity; a person whose offence involves more than small quantity, whatever it is labelled, gains nothing by volunteering for treatment. Equally, the immunity presupposes that the treatment was at a maintained or recognised institution and that it was actually undergone. Stating the immunity without its scope, or without those preconditions, is the commonest way the rule is misapplied at the bedside and in the exam alike.

20.2 Release for treatment in place of a sentence

Where the immunity route requires no finding of guilt, the second lever operates only after conviction. Section **39** gives the court a power of release on **probation** for treatment. When an addict is found guilty of the consumption offence, or of an offence relating to a small quantity, the court **may**, instead of sentencing him at once to any imprisonment, and **with his consent**, direct that he be released to undergo medical treatment for **de-toxification** or de-addiction. This is a judicial discretion, not an entitlement of the offender: the modal verb is permissive, and the offender's consent is a precondition, so the court may decline the course and the offender may refuse it.

The discretion is structured rather than open. The court exercises it having regard to the age, character, antecedents, or physical or mental condition of the offender, and only where it is of the opinion that it is expedient to do so. Release is then conditioned on the offender entering into a bond, with or without sureties, to appear and furnish a report on the result of his treatment within a period **not exceeding one year**, and meanwhile to abstain from any offence under the Act's substantive offences chapter. The treatment must be at a hospital or institution maintained or recognised by the Government; unlike the immunity provision, this route has no local-

authority alternative, so the two routes are close but not identical in the class of facility they accept.

The provision then looks past the treatment episode. After considering the report on the result of the treatment, the court **may** direct the release of the offender after due admonition, on his entering into a further bond to be of good behaviour and to abstain from the substantive offences for a period **not exceeding three years**. The structure is therefore a supervised pathway that runs from conviction, through a treatment episode reported back to the court, to a probationary discharge on good behaviour, the whole of it turning on the offender's consent and on the treatment report he furnishes to the court, rather than on incarceration.

GOOD TO REMEMBER

When an addict has been diverted under this power, the psychiatrist's report on the result of treatment is the very document the court acts on. Recording that the patient presented, engaged with treatment, and the outcome of that engagement is what the report conveys to the court; the further, good-behaviour release turns on that report being furnished and considered, not on a defined course being completed, though a report showing non-engagement leaves the court free to fall back on sentence. The clinical content of that de-addiction course, the pharmacology of detoxification and relapse prevention, belongs to the Substance use disorders notes; what the statute needs from the clinician is an accurate account of engagement and outcome.

20.3 Building the treatment system: establishing de-addiction centres

The first two provisions presuppose that a qualifying institution exists to treat the addict; the third supplies the power to create one. Section **71** empowers the Government to build the de-addiction infrastructure. In its current, amended form it provides that the Government **may** establish, recognise or approve as many centres as it thinks fit, and it names the purposes those centres serve:

- identification, treatment and management of addicts;
- education, after-care and rehabilitation;
- **social re-integration** of addicts; and
- supply of narcotic drugs and psychotropic substances to addicts registered with the Government, and to others where such supply is a **medical necessity**.

The verb is again permissive. This is an enabling power the Government may exercise, not a duty to place a centre in every district, and a second limb allows the Government to make rules for the establishment, maintenance, management and superintendence of such centres and for the supply of the controlled substances from them. It is that controlled-supply purpose that distinguishes the provision from an ordinary health-service enabling clause: the section enables the concerned Government, subject to such conditions and in such manner as may be prescribed, to supply narcotic drugs and psychotropic substances to registered addicts and where supply is a genuine medical necessity. It is not itself a licence, and it does not by itself legalise a centre's or clinician's own supply; compliance with the Act, its rules, orders and any applicable authorisation

remains necessary before supervised substitution or maintenance services can rest on firm ground.

One point of currency is examinable here. Older textbooks quote the original wording, under which the Government might, in its discretion, establish such centres; the current text broadened that to establish, recognise or approve, and expressly added management and social re-integration to the list of purposes. The modern provision should be cited in its amended form, and an answer that reproduces the older discretion-only wording as though it were the current law dates itself.

IN INDIA

The reformative limb only works if a qualifying institution is actually within reach, which is why this provision matters in Indian practice as much as the immunity itself. The two individual routes each require treatment at a qualifying institution, though the qualifying class differs slightly: the immunity route accepts recognition by the Government or a local authority, while the release-for-treatment route requires recognition by the Government alone. The crucial practical question for a clinician asked to support a claim of protection under either route is whether the treating facility carries the recognition that route requires. A course completed at an unrecognised facility does not answer the statute, however good the care. The centres provision is different in kind: it is the power by which Government establishes, recognises or approves such centres and, subject to prescribed conditions, supplies controlled substances through them; it is not itself an individual eligibility condition, and it does not licence a centre's or clinician's own supply. The clinical work delivered inside such a centre lies beyond the statute.

20.4 Reading the provisions correctly: stage, consent and the modal verbs

Where candidates come unstuck. The three provisions are easy to blur into a single sentence to the effect that the Act lets addicts get treatment instead of punishment, and that blur costs marks because it hides the very distinctions being tested. The two treatment routes for an individual differ in the stage at which they operate, in whose power they are, and in what triggers them; the third provision is not a route for an individual at all but a systemic enabling power. Setting the two individual routes side by side on shared axes makes the differences easy to hold under pressure.

AXIS	IMMUNITY ROUTE (PRE-CONVICTION)	RELEASE-FOR-TREATMENT ROUTE (POST-CONVICTION)
STAGE	Without a finding of guilt; can operate even while prosecution is pending	After a finding of guilt, in place of sentencing
WHOSE POWER	Operates for the addict as of right once the conditions are met	A discretion of the convicting court
STATUTORY VERB	Shall not be liable to prosecution, a mandatory bar	The court may direct release, a permissive power
CONSENT	Implicit in the act of volunteering for treatment	Express consent of the offender is required
ONGOING CONDITION	May be withdrawn if the complete treatment is not undergone	Bond to furnish a treatment report, then a good-behaviour bond
ELIGIBLE OFFENCES	Consumption and small-quantity offences only	Consumption and small-quantity offences only

The shared floor of the two routes is as instructive as their differences. Both are confined to the consumption and small-quantity end of the Act, both require the offender's willing participation, and both are conditioned on treatment at a recognised institution, though only the immunity route's proviso turns on that treatment being completed; the release-for-treatment route turns instead on a report on the treatment being furnished and considered. What separates them is only the moment at which the law intervenes and the identity of the actor whose choice controls the outcome: before any finding of guilt the choice and the benefit belong to the addict, while after conviction the choice belongs to the court and is exercised only with the offender's agreement.

TRAP **Collapsing the pre-conviction immunity and the post-conviction release into one provision.** They share a purpose and a scope, but one is a mandatory bar that prevents prosecution without requiring a finding of guilt, and can operate even while prosecution is pending, belonging to the addict once he qualifies, while the other is a permissive judicial power exercised only after conviction and only with the offender's consent. A candidate who describes the immunity as the court's discretion, or the release as an automatic entitlement of any addict, has swapped their essential features and forfeits the discrimination the question is testing.

The immunity provision bars prosecution of the addict who voluntarily undergoes complete de-addiction at an institution maintained or recognised by the Government or a local authority, for the consumption offence or an offence involving small quantity; the bar is mandatory, and only his failure to complete treatment may reopen it, and then at the authority's discretion.

Criminal responsibility and forensic assessment

21 · McNaughton rules and Section 84 IPC (insanity defence)

Where the criminal law admits a mind can be too disordered to blame. The insanity defence is the point at which the criminal law concedes that a person may perform the forbidden act and still not be a criminal, because the mind that produced the act was too disordered to carry responsibility for it. It is the oldest of the forensic questions and the most heavily examined, and in an Indian paper it now carries a second, sharper demand: the candidate must show that the substantive law has changed. The unsound-mind exception has moved out of the Indian Penal Code and into the Bharatiya Nyaya Sanhita (BNS), and the rule that fixes who must prove what has moved out of the old evidence law and into the Bharatiya Sakshya Adhiniyam (BSA). The two moves answer different questions: which insanity provision governs turns on the date of the alleged offence, while which evidence law governs turns separately on whether the proceeding was already pending when the Adhiniyam came into force. An answer that recites the old penal-code section as the live law forfeits the currency mark even when the doctrine it states is otherwise sound.

Behind the statute stands one common-law inheritance. Both the superseded Indian provision and the one that replaced it are codifications of the **McNaughton rules**, the answers the English judges gave when asked when madness should excuse. Everything examinable here is an unpacking of that lineage: what the rules require, how the Indian code recast them, what changed on the appointed date and what deliberately did not, and where the law places the burden of proof. It is also the criminal-responsibility face of a wider idea running through the chapter, that capacity is decision-specific and time-specific, one question seen from many legal angles, and its synthesis is drawn together elsewhere. The concern here is the one capacity a court asks about after a crime: whether the accused, at the instant of the act, could know what the law required him to know.

22	84	108	1 July 2024
CURRENT EXCEPTION, BHARATIYA NYAYA SANHITA	HISTORICAL EXCEPTION, PENAL CODE	BURDEN OF PROOF, SAKSHYA ADHINIYAM	RECODIFIED LAW IN FORCE



Fig 25.10. Criminal responsibility for the mentally ill offender in India: the two M'Naghten cognitive limbs are codified in BNS section 22 (current, effective 1 July 2024), which reproduces verbatim the wording of the now-historical IPC section 84, while BSA section 108 places the burden of proving the exception on the accused, to the balance of probabilities.

21.1 The McNaughton rules: the common-law origin

The rules take their name from Daniel M'Naghten, tried for a killing carried out under a paranoid delusion and acquitted on the ground of insanity. The acquittal caused enough public disquiet that the House of Lords put questions to the judges, and their replies, offered as an advisory statement of the law rather than as a decision in the case, became the formulation the common-law world has relied on ever since. The defendant's surname is spelled several ways across the reports, M'Naghten and McNaughton among them, and nothing of substance turns on the spelling; what matters is the test the judges set out in **1843**.

Two elements frame the rules before the test proper. The first is a starting position: every person is presumed sane, and to displace that **presumption of sanity** the defence must be clearly proved. The second is a threshold condition: the accused must have been labouring under a **defect of reason** arising from a **disease of the mind**. Ordinary confusion, ignorance or strong

emotion will not do; only a genuine failure of reasoning grounded in mental disease opens the door to the test.

The test itself has two limbs, set in the alternative so that either alone will suffice. At the time of the act, and as a consequence of the defect of reason, the accused either did not know the nature and quality of the act he was doing, or, if he did know that, he did not know that what he was doing was wrong. The whole enquiry is pitched at knowledge, which is why the rules are described as a purely **cognitive test**: they ask what the accused was able to know, not whether he could govern himself. A man who knew precisely what he was doing and knew it to be wrong, yet was driven to it by an urge he could not master, falls outside the rules as framed. That deliberate narrowness is the origin of every later objection to the test, and the alternative formulations devised in answer to it are examined elsewhere in this chapter; the Indian codes, as the following sections show, retained the McNaughton frame rather than discarding it.

21.2 Codification in India: the historical penal-code exception

When the general criminal law of the country was first codified, the McNaughton rules were written into the Penal Code as its general exception for the person of unsound mind, at section **84**. That provision was the Indian insanity defence for well over a century, and it governed the question until the recent recodification. It rendered the common-law test into a single sentence: nothing is an offence which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law.

Two features of that recasting repay attention, because both are examined. The drafters kept the legal phrase **unsoundness of mind** rather than any clinical term, holding the exception broad and legal rather than pinned to a diagnosis. And where the English rules spoke only of not knowing the act was wrong, the code opened that single limb into two, wrong or contrary to law, recognising a wider set of cognitive failures than the common-law wording named. Both points are taken up below.

The status of this section is the first thing to state and the easiest to get wrong. It applied before the general criminal law was recodified and it continues to govern offences committed while it was the law in force; it is not the current provision. Naming it as the source of the Indian test is correct; naming it as the live exception for a present-day offence is precisely the currency error this topic exists to catch.

21.3 The current provision, and the date that switched it on

The recodification replaced the Penal Code, and the insanity exception moved across to BNS Section **22**. The Sanhita states the rule in words identical to the historical section, down to the phrase unsoundness of mind and the same set of cognitive incapacities: it reproduced the old exception verbatim and did not modernise it. The doctrine did not change; only the statute book that carries it did.

The examinable pivot is the date. The Sanhita did not fix its own commencement; it left the appointed date to the Central Government, to be notified in the Official Gazette, and the date so

appointed was **1 July 2024**. From that date the Sanhita's exception is the governing substantive provision, and the historical penal-code section recedes to the offences committed before it. The two never compete: which applies is settled entirely by when the alleged act was done, so an opinion that has not first fixed that date may be reasoning under a statute that does not apply to the case.

Note the grammatical force of the provision, because it is not a discretion. It declares that nothing is an offence in the stated circumstances; where the exception is made out the act is simply not a crime, not an offence the court may excuse as a matter of leniency. That declaratory character is what makes the exception a true answer to liability rather than a plea in mitigation.

AXIS	HISTORICAL PROVISION (PENAL CODE)	CURRENT PROVISION (BHARATIYA NYAYA SANHITA)
STATUS	The pre-recodification insanity exception, now superseded	The substantive insanity exception in force
OFFENCES IT GOVERNS	Offences committed before the appointed date	Offences committed on or after the appointed date
WORDING OF THE TEST	Unsoundness of mind; incapable of knowing the nature of the act, or that it is wrong, or that it is contrary to law	Reproduced word for word, without amendment
PAIRED BURDEN STATUTE	Not fixed by this axis. The evidence statute, and so the burden provision, follows the pendency of the proceeding when the Adhiniyam commenced, not the date of the offence: a proceeding already pending continues under the former evidence law, and a proceeding not then pending takes the Bharatiya Sakshya Adhiniyam.	

21.4 Reading the exception: the incapacities, and legal versus medical insanity

The substance of the exception lies in what the accused must have been incapable of knowing, and there are three such incapacities. It is enough that, by reason of unsoundness of mind at the time of the act, the accused was incapable of any one of them:

- that he could not know the nature of the act, its physical character and immediate consequences;
- that he could not know the act was wrong, in the moral sense the law attaches to wrongdoing; or
- that he could not know the act was contrary to law, that it was forbidden by the legal order.

The relation between the second and the third is the fine point examiners reach for. The common-law rules spoke only of not knowing the act was wrong; the Indian code split that into wrongfulness and unlawfulness, so incapacity as to either suffices. The effect is an exception a little wider than the single English word would allow, and a candidate who folds the two back together has quietly narrowed the section its drafters opened.

MNEMONIC

Could not know: the Nature, the Wrong, the Law

The three cognitive incapacities the exception recognises: at the time of the act, and by reason of unsoundness of mind, the accused was incapable of knowing the **N**ature of the act, or that it was **W**rong, or that it was contrary to **L**aw. Any one of the three suffices, and every one of them is about knowing, never about being able to resist.

Legal insanity is the name the courts give to what the section demands, and it is not the same thing as a psychiatric diagnosis. A person may carry a severe mental illness and remain criminally responsible if, at the moment of the act, that illness did not deprive him of the capacity to know the nature of the act, or its wrongfulness, or its unlawfulness. What exempts is not the presence of disease but the specific cognitive incapacity the section describes, assessed at the instant of the act. This distinction between legal insanity and mere medical illness is the most productive discrimination in the topic, and it is why a bare diagnosis, however grave, never on its own makes out the defence.

RULE **Legal insanity, not medical illness, decides the defence, and the test is wholly cognitive.** The exception exempts only the accused who, by reason of unsoundness of mind at the time of the act, was incapable of knowing the nature of the act, or that it was wrong, or that it was contrary to law. It asks nothing about whether he could control his conduct, and it is not satisfied by the presence of a diagnosis, however severe.

AXIS	THE MCNAUGHTON RULES (ENGLISH COMMON LAW)	THE INDIAN CODIFIED TEST
THRESHOLD CONDITION	A defect of reason from disease of the mind	Unsoundness of mind
FIRST LIMB	Did not know the nature and quality of the act	Incapable of knowing the nature of the act
WRONGFULNESS LIMB	Did not know the act was wrong	Incapable of knowing it was wrong, or that it was contrary to law
CHARACTER OF THE TEST	Cognitive; about knowing, not controlling	Cognitive; no volitional limb was added

TRAP **Importing an irresistible-impulse limb the Indian law does not contain.** The exception exempts only the accused who could not know the nature of his act, or its wrongfulness, or its unlawfulness; it says nothing about an inability to resist a known and wrongful impulse. Candidates read a volitional test into the section, or treat any grave diagnosis as automatically exculpatory, and both misstate what is a narrow cognitive rule.

IN INDIA

Indian courts decide the defence on legal insanity, not medical insanity, and they give real weight to the conduct surrounding the act. Evidence of planning, of concealment or of flight after the act tends to show that the accused knew the nature and the wrongfulness of what he did; it may weigh against the exception, but does not by itself defeat it, however unwell he may be. The corollary for the psychiatrist is that the opinion must speak to the accused's capacity to know at the moment of the act, reconstructed from the whole record, and not merely to the diagnosis he carried before or after it.

21.5 Who must prove it: the burden and the presumption

Establishing the defence is not the same as raising it, and the difference is fixed by the law of evidence. The **burden of proof** for the insanity exception, as for every general exception, sits at section **108** of the Bharatiya Sakshya Adhiniyam. Its rule is that when a person is accused of an offence, the burden of proving the existence of circumstances that bring the case within a general exception is upon him, and the court shall presume the absence of such circumstances. The accused therefore does not merely raise the possibility of insanity; he must prove it, and the court begins from the presumption that he was sane.

The standard he must meet is lighter than the one the prosecution carries. The prosecution must still prove the offence beyond reasonable doubt, and that general burden is not displaced; but the accused establishes the exception on the balance of probabilities, the civil standard, which is why an insanity defence can succeed on evidence that would fall short of a conviction. Holding the two standards apart is the examinable core, and the presumption of sanity is what the accused must overcome to reach the exception.

This mirrors the common-law rules, which already required insanity to be clearly proved from a presumption of sanity; the modern evidence statute reproduces the burden rule of the law it replaced, so the allocation did not change with recodification, only the statute that houses it. A candidate must state without hedging that the burden lies on the accused, that the court shall presume its absence, and that the standard resting on him is the balance of probabilities.

For an act done on or after the appointed date the insanity exception is the Bharatiya Nyaya Sanhita provision, which reproduces the old penal-code section word for word; the test is purely cognitive, and the accused must establish it on the balance of probabilities while the court presumes his sanity.

21.6 The psychiatric assessment, and the questions that are not this one

What the psychiatrist decides, and what only the court decides. Because the exception turns on a mental state at one past moment, the assessment is retrospective and functional. The task is to reconstruct, from contemporaneous records, the accounts of the act, the person's own narrative and the known course of any disorder, whether at the time of the act the accused was capable of knowing the nature of the act and its wrongfulness or unlawfulness. The psychiatrist supplies a medical opinion on that capacity; the conclusion of law, that the accused was legally

insane and so not criminally responsible, belongs to the court alone, which reaches it on the whole case and never on the diagnosis alone.

Several neighbouring questions are constantly confused with this one, and each is answered by its own law rather than by the insanity exception:

- whether the accused can be tried at all turns on his mental state at the time of the trial, not the time of the act, so a person may be fit to be tried for an act committed while insane, or unfit to be tried although he was fully responsible when he acted; that trial-time capacity is taken up separately in this chapter;
- whether an abnormality that fell short of the exception can still lower the grade of a killing, and whether an act done without conscious control is answerable at all, are the questions of diminished responsibility and of automatism, treated in their own place in this chapter and not by restating this exception;
- the criminal responsibility of a child, exempted by reason of age rather than of unsoundness of mind, belongs to the Child psychiatry: assessment, treatment, services and protection notes, and not to the insanity defence at all.

The manner in which the opinion is finally put before the court, the form of the report, the certification of the expert to give evidence and the conduct of the testimony, is not part of this substantive law and belongs to the Forensic ethics, consent and legal procedure notes.

GOOD TO REMEMBER

Before writing a line of opinion, fix the date of the alleged act, because that date decides which insanity provision applies to the case; the burden statute is decided separately, by whether the proceeding was already pending when the Bharatiya Sakshya Adhiniyam commenced. Then anchor the opinion to the accused's capacity to know at the moment of the act rather than to the diagnosis he happens to carry, and say plainly where the record cannot support a firm view. The legal label is the court's to attach; your work is the mental state and its bearing on knowing.

PITFALL

Citing the superseded penal-code section as the live insanity provision in a real medico-legal report. For an offence on or after the appointed date the governing exception is the Bharatiya Nyaya Sanhita provision, and a report resting on the old section invites the other side to point out that it relied on a law no longer in force. The wording is identical, so the doctrine survives the slip, but the citation does not, and a discredited citation weakens the witness. Fix the date first, then cite the statute that the date makes applicable.

22 · Other tests of criminal responsibility (Durham, irresistible impulse, ALI)

The insanity defence is not one rule but a family of them. The M'Naghten test that governs the Indian courtroom asks a single, cognitive question: did the accused, by reason of unsoundness of mind, fail to know the nature of his act, that it was wrong, or that it was contrary to law? That narrowness is deliberate and it is taught in full under the McNaughton rules elsewhere in this

chapter, but it leaves two familiar figures outside the door. One is the defendant who knew perfectly well that his act was wrong and yet, driven by illness, could not stop himself. The other is the defendant whose crime seems to pour directly out of a disease process. Anglo-American courts spent a long stretch of the modern era building tests to catch those cases, and the three that recur in every forensic viva are the volitional supplement known as irresistible impulse, the causal Durham or product test, and the two-limbed test of the American Law Institute. The examiner wants three things: the exact formulation of each, where each sits against the M'Naghten baseline, and the point that decides most answers, which is that none of them is Indian law.

Understanding why these tests were built, and why they were then narrowed or abandoned, is worth more than memorising their words. Each was an attempt to fix a perceived defect in the cognitive test, each overcorrected in a different direction, and the arc of American doctrine over the last several decades is essentially the story of the courts finding the right width. India watched that experiment and kept its cognitive frame. A candidate who can narrate that arc, and place the Indian position at the end of it, has the whole topic.

22.1 The cognitive limit that produced the alternatives

Every alternative test is a reaction to the same feature of the M'Naghten rule: it is pitched wholly at knowledge. It asks what the accused was able to know at the moment of the act, and it asks nothing about whether he could govern his conduct once he knew. That leaves a real clinical population unaddressed, the patients whose illness spares cognition but wrecks control, and it was pressure from those cases that drove the reform. Each successor test loosens exactly one constraint and no more, which is why the comparison between them is so clean.

The first line of attack adds a faculty. If a man can know an act is wrong and still be unable to resist it, then a test confined to knowing is incomplete, and the volitional element must be admitted alongside it. The second line of attack abandons the enumerated faculties altogether and asks only about origin: never mind whether he knew or could resist, did the illness cause the act? The third line of attack keeps both faculties but attacks the threshold, replacing total incapacity with a partial one and replacing bare knowledge with a fuller grasp. These are the only three moves available, and the three examinable tests are one each.

RULE **Each alternative broadens the insanity defence along one axis and no more.** Irresistible impulse adds the volitional faculty to a test that had asked only about knowledge; the product test discards the faculties and substitutes causation; the American Law Institute test keeps both faculties but softens the threshold from total to partial incapacity. Identify which axis a test moves and you have understood it.

22.2 The irresistible impulse test

The earliest and most modest departure from the cognitive rule is the **irresistible impulse** test, which does not replace M'Naghten but supplements it. It concedes the cognitive question and then adds a volitional one: the accused may be excused even though he could tell right from wrong, if a diseased mental condition deprived him of the power to resist the impulse to act. Its

classic wording comes from **Smith v. United States**, a District of Columbia decision later quoted in full in the leading product-test judgment. An accused may be excused only where, although able to distinguish right from wrong, his reasoning powers were so far dethroned by a diseased mental condition as to deprive him of the will power to resist the insane impulse to commit the act, though he knew it to be wrong.

Several features of that formulation are worth fixing, because examiners test the discriminations rather than the slogan:

- It presupposes that the cognitive test has been failed on its own terms; the accused did know the act was wrong, so the excusing element is loss of control, not loss of knowledge.
- The impotence of will must be the product of a diseased mental condition, not of ordinary rage, jealousy or intoxication, which is what keeps the test from swallowing every crime of passion.
- It works only as a gloss on M'Naghten, a volitional limb bolted to a cognitive frame, never as a free-standing code of its own.

The objection to the test is evidential rather than logical. No examination distinguishes an impulse that genuinely could not be resisted from one that simply was not resisted, and a court is left accepting an expert's inference about a capacity that leaves no external trace. That difficulty is why the jurisdictions that adopted the test confined it to cases where the collapse of self-control was close to total, and why later reformers preferred a formulation that spoke of degrees of capacity rather than of a single, unprovable moment of surrender.

22.3 The Durham or product test

The boldest experiment swept both the cognitive and the volitional questions aside and asked one thing only. In **Durham** v. United States, decided by the District of Columbia Circuit in **1954**, the court held that an accused is not criminally responsible if his unlawful act was the **product** of mental disease or mental defect. This is the broadest of all the tests: it names no symptom, ties the jury to no particular faculty, and makes the whole enquiry one of causation. It was modelled on an older **New Hampshire rule** that had similarly refused to reduce insanity to a fixed legal formula and had left the question of mental disease to the jury as a matter of fact.

Its breadth was both its appeal and its undoing. By asking only whether the crime issued from illness, the product test allowed the full clinical picture to come before the court and freed psychiatry from having to force its findings through the narrow language of knowing and resisting. But the same breadth cut loose the legal question from any workable standard. With no definition of mental disease and no symptom for the jury to look for, the determination drifted toward whatever the expert witnesses asserted, and the phrase mental disease itself proved unstable as diagnostic fashions shifted. Critics charged that the test surrendered a question of moral and legal responsibility to clinical opinion. The verdict was delivered by the very court that had created the rule: in United States v. **Brawner** it abandoned the product test and adopted the American Law Institute formulation in its place. The product test survives in the examination

chiefly as the cautionary extreme, the demonstration of what happens when the insanity enquiry is made too wide.

22.4 The American Law Institute Model Penal Code test

Between the rigidity of M'Naghten and the formlessness of Durham sits the considered compromise, the test drafted for the **Model Penal Code** at section **4.01**. Its wording restores both faculties while lowering the bar for each. A person is not responsible for criminal conduct if, at the time of the conduct, as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality, or wrongfulness, of his conduct, or to conform his conduct to the requirements of law. The cognitive and the volitional questions are set in the alternative, joined by an "or", so that a failure of either capacity suffices.

Two changes of language carry the whole reform, and both are examined:

- The test asks whether the accused could **appreciate** the wrongfulness of the act, not merely whether he could know it. Appreciation implies an emotional and rational grasp of meaning, deeper than the bare intellectual awareness the older word demanded, and it admits the defendant who could recite that an act was forbidden without truly understanding what that meant.
- The test requires only that the accused lack **substantial capacity**, not that he be wholly incapable. This deliberately abandons the all-or-nothing quality of the older tests and lets the law recognise the partial impairments that clinical reality actually presents.

The drafters also closed the obvious loophole. The formulation expressly excludes an abnormality manifested only by repeated criminal or antisocial conduct, so that a diagnosis resting on the offending record itself cannot be used to bootstrap the defence; the habitual offender cannot convert his history of crime into evidence of the disease that excuses it. Taken together, the test spread across most of the American federal circuits as the settled middle path, until the volitional half of it fell out of favour after a notorious acquittal. The Insanity Defense Reform Act of **1984** removed the volitional prong from federal law, returning the federal test to an appreciation-of-wrongfulness standard and leaving the two-limbed version to those states that retained it.

TRAP **Presenting the product test or the Model Penal Code volitional prong as the current American standard.** The product test was abandoned by the same court that devised it, the District of Columbia Circuit, in Brawner, not by American courts generally, and the volitional limb was struck out of federal law by statute, though state rules still vary and some states retain a volitional element of their own. Write each as a landmark in a doctrinal arc, not as the rule in force everywhere, and never carry either into a statement of what every American court would apply today.

22.5 Reading the tests against one another

The examiner's favourite exercise is to set the tests side by side, and the discriminations are cleanest when each is measured against the M'Naghten baseline on two axes: the faculty it interrogates and the breadth it allows. The accompanying comparison arranges them so, from the narrowest cognitive rule to the widest causal one, with the compromise between.

MNEMONIC

Will, Cause, Both

The alternatives in one line: irresistible impulse tests the **will**, the product test tests **cause**, and the Model Penal Code test restores **both** faculties at a lower threshold. Set against M'Naghten, which tests knowledge alone, this fixes the whole family in memory and tells you at once what each one adds.

TEST	FACULTY IT INTERROGATES	CORE QUESTION	BREADTH AND CURRENT STANDING
M'NAGHTEN (THE BASELINE)	Cognition alone	Could he know the nature of the act, or that it was wrong?	Narrowest; the frame retained in India, taught in full elsewhere in this chapter
IRRESISTIBLE IMPULSE	Volition, added to cognition	Though he knew it was wrong, could he resist the impulse?	A gloss on the cognitive test, never free-standing; not accepted as such in India
DURHAM OR PRODUCT	Neither; causation only	Was the act the product of mental disease or defect?	Broadest; abandoned by the D.C. Circuit in Brawner, not nationwide
MODEL PENAL CODE	Cognition and volition	Did he lack substantial capacity to appreciate wrongfulness or to conform his conduct?	The middle path; the volitional half later dropped in federal law

1954	1962	1972	1984
DURHAM DECIDED	MODEL PENAL CODE TEST FRAMED	PRODUCT TEST ABANDONED	VOLITIONAL PRONG DROPPED, US FEDERAL

22.6 Why India keeps the M'Naghten frame

The alternatives are foreign-law history, not defences you can run here. The Indian insanity defence remains the cognitive right-and-wrong test. The current unsound-mind exception and the historical provision it replaced are set out in full under the McNaughton rules in this chapter, and what matters at this point is what they exclude. India never adopted the product test and never adopted the Model Penal Code standard, and its courts have generally not accepted irresistible impulse as a free-standing defence. Loss of control, by itself, does not answer the question the statute asks. It becomes relevant only where it can be shown to amount to an incapacity to know the nature of the act, that it was wrong, or that it was contrary to law, at which point it has stopped being a separate volitional test and has collapsed back into the cognitive one the Indian codes already contain.

The reasoning behind this conservatism is coherent rather than merely traditional. The cognitive test asks a question that can be reconstructed from evidence, whether the accused knew, and courts can weigh planning, concealment and flight against that claim. A volitional or causal test

asks a question that leaves no external trace and that the same reasoning cannot police, which is precisely the evidential objection that eventually narrowed the American tests too. India, in other words, reached the destination the American arc was travelling toward and simply never left it.

IN INDIA

An accused who knew his act was wrong but says he could not resist it does not, on that ground alone, satisfy the Indian test; a defence pitched purely on loss of control has no statutory footing here, and neither does one pitched on the act being a product of illness. The practical corollary is that an Indian forensic opinion is built around the accused's capacity to know the nature of the act, that it was wrong, or that it was contrary to law, at the material time, and the volitional and causal formulations enter, if at all, only as they bear on that cognitive question.

No alternative test is Indian law: India retains the M'Naghten cognitive frame, and its courts admit irresistible impulse only where it amounts to an incapacity to know the nature of the act, that it was wrong, or that it was contrary to law.

22.7 The alternatives in an Indian medico-legal opinion

The tests matter to the clinician chiefly as a discipline of drafting. A psychiatrist who has absorbed the Western literature naturally reaches for its vocabulary, and it is easy to write an opinion in language a foreign court would recognise but an Indian one cannot use. The examiner rewards the candidate who keeps the clinical description and the legal conclusion apart: describe the illness and its bearing on control and causation as fully as the record allows, then translate that description into the only question the Indian court is empowered to answer.

PITFALL

Offering, as the operative conclusion of a report for an Indian court, that the act was a "product" of the illness or that the accused acted on an "irresistible impulse". However accurate the clinical observation, the court has no test into which those words fit, and the opinion gives the judge nothing on which to decide. The error is one of scope rather than of assessment, and it is the counterpart on this topic of citing a superseded section as the live law.

GOOD TO REMEMBER

Describe volitional impairment and the illness-to-crime link freely in the clinical body of the report, because that is genuine and useful evidence, but anchor the conclusion to the question the law actually asks: at the material time, could the accused know the nature of the act and that it was wrong? Frame loss of control as bearing on that cognitive capacity, not as a test in its own right. The form of the report itself and the certification of the expert to give evidence belong to the Forensic ethics, consent and legal procedure notes.

23 · Fitness to stand trial (criteria, assessment)

A criminal trial is a contest the accused is meant to take part in. The adversarial process presumes a defendant who can hear the charge against him, follow the evidence as it unfolds, and

give his lawyer the instructions from which a defence is built. When mental disorder takes that ability away, to press on would be to try a person who cannot answer the case, which offends the most basic requirement of a fair hearing. So the law asks, before the trial begins and again if the question arises once it is under way, whether the accused can be tried at all. This is **fitness to stand trial**, the same idea the older courts called **fitness to plead**.

The marks gather here because the topic is small, self-contained, and constantly confused with a larger one. The words "unsound mind" appear and candidates reach at once for the insanity defence, answering a question no one asked. Fitness is about the present: can this person be tried now, and it is procedural. Criminal responsibility is about the past: what was his state of mind when he did the act, and it is substantive. Hold those two apart and the topic is clean; blur them and the whole answer slides off the point.

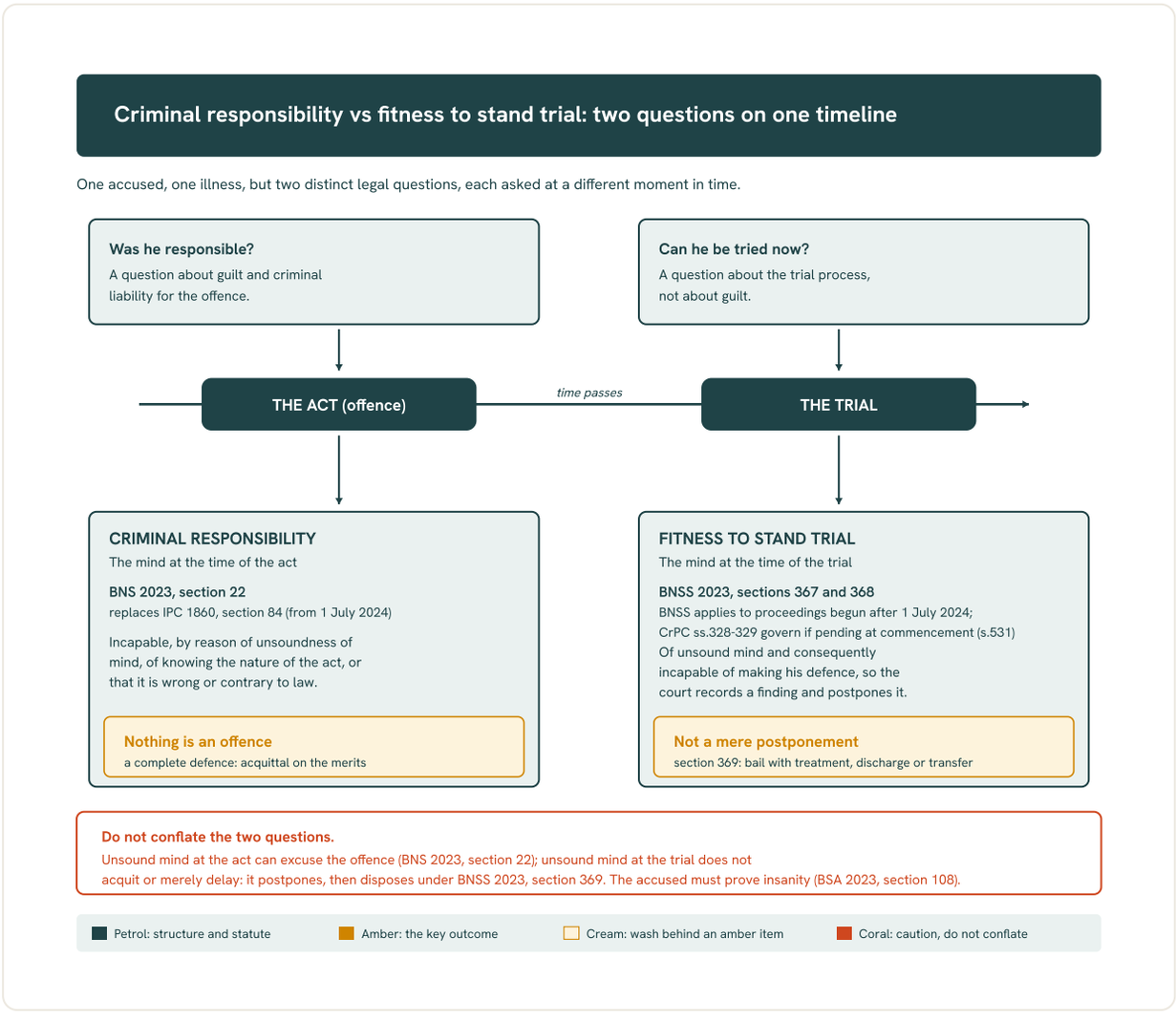


Fig 25.11. Criminal responsibility asks about the accused's mind at the time of the act (BNS 2023, section 22, replacing IPC 1860, section 84); fitness to stand trial asks about his mind at the time of the trial (BNSS 2023, sections 367 and 368). The first can excuse the offence. The second does not acquit and does not merely postpone the trial: on a finding of unfitness the court records the finding, postpones the proceedings, and then makes a disposal under BNSS 2023, section 369, which may release the accused on bail with out-patient treatment, order supervised treatment where bail is refused, discharge the accused on sufficient security, or transfer the accused to a residential facility.

23.1 What fitness to stand trial means

Fitness is the capacity to take part in one's own trial. It is not a measure of general mental health and it is not intelligence; it is a functional, task-specific competence, judged against what the trial actually asks a defendant to do. The statute does not grade the illness. It poses a consequence question: is the accused, by reason of **unsoundness of mind**, rendered **incapable of making his defence**. Two limbs have to be satisfied, and they are joined by the word "consequently": there must be a mental condition, and that condition must be the reason the accused cannot mount a defence. A severe diagnosis that leaves the defendant able to understand the charge, follow the proceedings and instruct counsel does not make him unfit; a less dramatic condition that dismantles those abilities does.

The reason the law insists on this threshold is not therapeutic but a matter of justice. A verdict reached against a defendant who could not understand the proceedings or contribute to his own defence is not a safe verdict, because the process that produced it was not one he could engage with. Fitness protects the integrity of the trial itself, which is why it is examined as a preliminary matter and can be raised at any stage the illness first shows itself, whether at the outset or midway through the hearing.

RULE **Unsoundness of mind bears on fitness only where it makes the accused incapable of making his defence.** The test has two limbs and the second decides it. Establish a mental condition and you have done the first half; what settles fitness is the functional bridge from that condition to the specific abilities a defence requires. A diagnosis, however grave, is not by itself a finding of unfitness, and the absence of florid symptoms is not by itself a finding of fitness.

23.2 Fitness set against criminal responsibility

This is the discrimination the topic is really testing, and it is worth stating in full because so many answers lose their footing on it. The two questions differ on their timeline, their purpose and what a finding does. Fitness looks at the accused as he is at the time of trial and asks whether he can participate; a finding of unfitness suspends the proceedings but says nothing about guilt. Criminal responsibility looks back to the time of the act and asks whether the accused should be held liable for what he did; it is a defence to the charge, decided at trial as part of the verdict. Whether unsoundness of mind at the moment of the offence exempts the accused from liability is governed by the substantive criminal law, now recast in the Bharatiya Nyaya Sanhita in place of the Indian Penal Code, and is taken up elsewhere in this chapter under the insanity defence. It is not restated here.

Because the two run on different axes, they can appear in any combination, and this is what makes them genuinely independent rather than two names for one idea. A defendant may be perfectly fit to stand trial and still argue that he was insane at the time of the act; another may have been fully responsible when he offended but become unfit, through illness arising afterwards, by the time the case reaches court. The first is tried and runs his defence, insanity included; the second cannot be tried at all until he is well enough, and the question of his responsibility simply waits for him. Confusing the two collapses this structure and produces an answer that assesses the wrong moment and the wrong issue.

TRAP **Describing the insanity defence when the question was about fitness.** The shared phrase "unsound mind" lures candidates into reciting the tests of criminal responsibility. But fitness is present-state and procedural and has nothing to do with the mental state at the time of the offence. If your answer is dating the accused's mind to when he acted, you have drifted into the wrong topic and will be marked on a question you were not asked.

Fitness to stand trial asks whether the accused can make his defence now and is decided by the court on medical and other evidence; criminal responsibility asks about his mind at the time of the act. They sit on different timelines and neither answers the other.

23.3 The criteria: what making a defence requires

The statute states the test as incapacity to make a defence and leaves the content of that phrase to be worked out in practice. Unpacked, making a defence calls for a cluster of abilities, each tied to a real demand the trial places on the defendant:

- to understand the charge he faces and what is being alleged against him;
- to understand the nature and object of the proceedings and their possible consequences;
- to follow the course of the evidence as it is given;
- to instruct and communicate rationally with his lawyer, giving the account from which a defence can be run;
- to make the decisions a defendant must make, including how to plead and whether to challenge the conduct of his trial.

These are abilities, not attainments: the law asks whether the accused can do these things, not whether he does them well or wisely. A defendant may make an unwise choice and remain fit, because unwisdom is not incapacity. Common-law systems have distilled the same cluster into named judicial standards, but those formulations are the property of other jurisdictions and are not set out here; what matters for the Indian answer is the functional content behind the statutory phrase, tested ability by ability against the disorder in front of you.

It helps to see how different conditions defeat fitness by different routes, because the assessment turns on the route, not the diagnosis. Acute psychosis may make it impossible to follow proceedings or to give a rational account; a severe mood or thought disorder may disorganise communication with counsel; intellectual disability or an acquired cognitive disorder may block understanding of the charge and its consequences; a profound disturbance of memory or attention may prevent the accused from tracking the evidence. The threshold itself, though, is participation rather than sophistication: the law wants a defendant who can engage with his trial, not one who could conduct it as a lawyer would. Setting the bar too high, so that only a mentally robust defendant counts as fit, misreads the standard as badly as setting it too low.

23.4 The statutory procedure: at inquiry and at trial

The code reaches the question both before and during trial, and gives each stage its own provision. At the inquiry stage, while a Magistrate is still examining whether a case should

proceed, section **367** governs. When the Magistrate has reason to believe the person before him is of unsound mind and consequently incapable of making his defence, he shall inquire into the fact of that unsoundness, and shall cause the person to be examined by the **civil surgeon** of the district or such other medical officer as the State Government may direct, examine that officer as a witness, and reduce the examination to writing. The provision continues an arrangement already present in the amended older law: where the civil surgeon finds unsoundness, the person is referred to a psychiatrist or clinical psychologist of a Government hospital or medical college for care, treatment and prognosis, with a right of appeal to a **Medical Board**.

Once the trial itself is under way, section **368** applies. If it appears to the Magistrate or Court of Session that the accused is of unsound mind and consequently incapable of making his defence, the court shall, in the first instance, try the fact of that unsoundness and incapacity; and if, after considering such medical and other evidence as is produced, it is satisfied of the fact, it shall record a finding to that effect and shall **postpone further proceedings**. Both provisions took effect on **1 July 2024**, replacing the corresponding sections of the former Code of Criminal Procedure.

The choice of verb is the whole of the duty. In both provisions it is expressed as "shall", not "may". The court is not given a discretion to try a defendant it suspects is unfit and settle the point later; the moment unfitness is genuinely in issue, it must be tried first, as a preliminary fact, on medical and other evidence, before the substantive trial can go any further. This ordering, the fact of unfitness decided ahead of the question of guilt, is the structural point candidates most often lose, and it is why an answer that reduces the duty to a discretionary power misstates the provision.

FEATURE	INQUIRY STAGE	TRIAL STAGE
When it operates	During the Magistrate's inquiry, before the trial proper	Once the trial is under way, before a Magistrate or Court of Session
What triggers it	The Magistrate has reason to believe the person is of unsound mind and incapable of making his defence	It appears to the court that the accused is of unsound mind and incapable of making his defence
Mandatory medical step	Shall cause examination by the civil surgeon or a directed medical officer, examine him as a witness and reduce it to writing, with onward referral to a psychiatrist or clinical psychologist and an appeal to a Medical Board	Shall first try the fact of unsoundness and incapacity on medical and other evidence
Effect of a positive finding	The fact is recorded and the person is directed to care, treatment and prognosis	Shall record a finding of unsoundness and incapacity and postpone further proceedings

367	368	1 Jul 2024
INQUIRY STAGE	TRIAL STAGE	SANHITA IN FORCE

IN INDIA

This topic runs on the Bharatiya Nagarik Suraksha Sanhita for proceedings instituted after the sanhita's commencement, and on the former Code of Criminal Procedure for any trial, inquiry or other proceeding pending immediately before that commencement, which the sanhita's own savings clause keeps alive as governing law. The machinery is distinctly Indian and the two stages take separate routes: at the inquiry stage the first medical opinion comes from the civil surgeon of the district or a medical officer the State Government names, with onward referral of a person found to be of unsound mind to a psychiatrist or clinical psychologist of a Government hospital or medical college for care, treatment and prognosis, and a route of appeal to a Medical Board; at the trial stage the court instead refers the accused directly to a psychiatrist or clinical psychologist, not through that same civil-surgeon-first sequence. Neither the referral to a psychiatrist or clinical psychologist nor the Medical Board appeal is a sanhita innovation: both continue an arrangement the amended older code already carried. A candidate who cites the old code's section numbers as the governing law is right where the proceeding was pending immediately before commencement, and wrong only where it was instituted afterward.

23.5 Assessing fitness: the psychiatrist's task

The referral you receive is narrower than it first looks. The court does not want a global opinion on the accused's mental health; it wants to know whether a mental condition is present and, if it is, whether it strips him of the particular abilities that making a defence requires. The assessment therefore runs on two tracks at once: a clinical evaluation to establish diagnosis and current mental state, and a functional evaluation that tests each defence ability against that state. Can he tell you what he is charged with. Can he follow what is happening in court and why. Can he give a coherent account to his lawyer and take part in decisions about his own case. The opinion is built from the answers, ability by ability, with the disorder linked explicitly to any incapacity found rather than assumed from the label.

Two features of the judgement are easy to forget. Fitness is present-state and can change: a person who is unfit in acute illness may become fit with treatment, so an opinion is a snapshot and may need revisiting as the condition moves. And the determination is ultimately the court's, not the clinician's. The statute has the court decide the fact on medical and other evidence, which places the psychiatrist as an expert witness supplying one input to a judicial finding, not as the person who makes it. Overstating the role, and writing an opinion as though it were the verdict, is a common way for a report to exceed its proper reach.

PITFALL

The commonest clinical error is to let the diagnosis do the work, certifying a psychotic or intellectually disabled accused unfit because he is unwell, without asking whether the illness actually disables the tasks of making a defence. Fitness is task-specific: a person with a serious disorder may still understand the charge, follow the evidence and instruct counsel, while another whose diagnosis looks milder may be unable to do any of these. Assess the abilities, not the label, and show the link between them.

GOOD TO REMEMBER

When you are asked to opine on fitness, build the report around the defence abilities themselves, understanding of the charge and the proceedings, the ability to follow evidence, and the ability to instruct counsel and decide on a plea, and state, for each, how the disorder does or does not impair it. Keep in view that you supply medical evidence and the finding is the court's to make. The form the report or certificate takes for the court, and the ethics of giving expert evidence, belong to the Forensic ethics, consent and legal procedure notes.

23.6 After a finding of unfitness

A finding of unfitness stops the trial; it does not end the case, and it is not a single order that merely freezes the clock. The court's first duty is to try the fact of incapacity itself, and once incapacity is found the disposal forks rather than defaulting to postponement. Where the evidence produced discloses no prima facie case for the accused to answer, he is discharged rather than held; where a prima facie case remains, the court records the finding of unsoundness and incapacity and postpones further proceedings so that treatment can begin. Postponement is therefore one branch of the disposal, not the whole of it, and the accused who is postponed stands neither acquitted nor convicted, the trial suspended and waiting for him. The sanhita's orientation is treatment and restoration rather than indefinite removal: at the inquiry stage the person is routed to care, treatment and prognosis, and the object is to restore fitness so that the trial can resume and the substantive questions, including responsibility for the act, can finally be answered by a defendant able to meet them.

What becomes of the accused once he is found incapable is set out separately. Where a person is found under section **367** or section **368** to be incapable of making his defence, section **369** governs his disposal, and it offers a graded set of outcomes rather than bare custody. On medical opinion the court may release him on bail where his condition does not require in-patient treatment and a relative or friend undertakes to secure regular out-patient psychiatric treatment and to prevent harm; where bail cannot be granted or no such undertaking is given, it orders him kept in a place where regular psychiatric treatment can be provided. Weighing the nature of the act committed and the extent of the unsoundness of mind or intellectual disability, the court then determines whether release can be ordered at all: it may discharge him on sufficient security, or, where discharge cannot be ordered, transfer him to a residential facility for care and training. Release on bail with an out-patient undertaking, supervised treatment where bail is refused, discharge on sufficient security and transfer to a residential facility are the real branches after a

finding of unfitness; the topic is not, as candidates too often write it, a single order that only postpones the proceedings.

The harder cases are those where fitness may never return. Postponement assumes restoration, but a defendant with a progressive dementia or a fixed cognitive deficit may remain permanently unable to be tried, and the law must then balance the public interest in a trial and the protection of others against the injustice of holding an untried person indefinitely. How the system resolves that tension turns on the disposal choices just described, weighed against the nature of the act and the extent of the disorder, but the clinician should recognise the problem, because a prognosis on the likelihood and timescale of restored fitness is often the most useful thing the psychiatric opinion can offer the court.

The one matter left open here is the mechanism by which proceedings are taken up again once fitness returns, which is set out in further provisions of the sanhita not detailed in these notes. One route in particular should not be confused with fitness at all: the preliminary assessment of a child in conflict with the law, which decides whether a juvenile is dealt with as an adult, is a different determination under a different statute and belongs to the Child psychiatry: assessment, treatment, services and protection notes, not to the law of fitness to stand trial.

24 · Diminished responsibility and automatism

Why the marks are here. Once a court accepts that a defendant performed the physical act, it can still be asked whether the mind behind that act was whole enough to carry the full weight of the charge. Two doctrines press exactly at that seam. **Diminished responsibility** is the claim that a mental abnormality, without excusing the killing, was serious enough to lower its grade; **automatism** is the stronger claim that the act was performed with no conscious control at all. An Indian paper examines the two together because the Indian answer to each is not the English textbook one: a candidate who reaches for the familiar Western framework describes a defence that does not exist here and misses the one that does.

The disciplined way to hold this whole topic is to see that Indian criminal law keeps no separate compartment for either idea. It does not grade criminal responsibility on a sliding scale, and it does not name automatism as a defence in its own right. Instead it feeds each question into a category it already possesses: the grade of a homicide can be softened on a mental ground through provocation, and an act said to be involuntary is answered through the unsound-mind exception where that exception's cognitive-incapacity test is actually met, though that exception is not the sole route by which an alleged involuntary act is examined. This routing, provocation for the grade of a killing and the unsound-mind exception for an involuntary act, is the long-established position of Indian criminal law, and these notes state it on that footing; the precise section of the recodified penal code, the Bharatiya Nyaya Sanhita, that now carries the grave-and-sudden-provocation exception has not been reconfirmed against the primary statute in preparing these notes, so it is named here without its number. Everything that follows is an unpacking of that single structural fact.

India has no diminished-responsibility defence; grave and sudden provocation is the partial defence nearest in effect to it, reducing murder to culpable homicide not amounting to murder, and automatism is answered through the unsound-mind exception when it arises from a disease of the mind.

1957	three	two
ENGLISH HOMICIDE ACT	AUTOMATISM STATES	INSANE OR SANE

24.1 Diminished responsibility: the partial defence India did not adopt

Diminished responsibility originated in Scots law and was introduced into England and Wales by the English Homicide Act of **1957**; there, it is a partial defence to murder alone. It concedes that the accused killed unlawfully, but argues that an abnormality of mental functioning, arising from a recognised medical condition, substantially impaired the capacity to understand the conduct, to form a rational judgement, or to exercise self-control, and provides an explanation for the killing, and so reduces the conviction from murder to the lesser homicide offence with its wider sentencing range. This current test followed the Coroners and Justice Act 2009 amendment to the 1957 device, and its defining feature is that it works on the grade of the offence rather than on guilt: the defendant is neither acquitted nor treated as fully responsible, but left in an intermediate position.

Indian law contains no equivalent. Its general exception for unsoundness of mind operates as a complete defence or as none at all, so there is no statutory instrument that recognises impaired-but-not-abolished capacity and lowers the charge on that account. A defendant whose disorder clouded but did not extinguish the relevant mental capacity falls outside the mental exception altogether, because that exception, whose test and current penal-code provision are set out elsewhere in this chapter where the insanity defence and the McNaughton rules are discussed, is written in all-or-nothing terms. Such a disorder may still weigh in mitigation when the judge fixes sentence, but that is judicial discretion applied after conviction, not a defence that alters the verdict. The absence of the intermediate rung is deliberate, and it is examined precisely because candidates assume the English ladder is present.

24.2 Grave and sudden provocation: the nearest partial defence to murder

The one place where Indian law does soften a killing on something like a mental ground is provocation. Where the accused is deprived of the power of self-control by provocation that is both grave and sudden, and in that state causes the death of the person who gave the provocation, or of another person by mistake or accident, the offence is brought down from murder to **culpable homicide not amounting to murder**. The exception is lost on any of three provisos: where the accused sought or voluntarily provoked the provocation as an excuse for killing or causing harm, where the provocation was given by something done in obedience to the law or by a public servant acting lawfully within the powers of that office, or where the provocation was given by something done in the lawful exercise of the right of private defence. Whether the provocation was in fact grave and sudden, and whether the accused acted while actually deprived of self-control, is a question of fact for the court on the circumstances of each

case. This is the true counterpart to diminished responsibility in the Indian scheme, because it is a genuine partial defence: it does not acquit, it re-grades. The comparison the examiner wants is that both doctrines lower a murder charge without excusing it, but they rest on entirely different foundations.

Grave and sudden provocation is not a defence of mental incapacity. The accused is treated as responsible, and the law makes a limited concession to ordinary human frailty rather than to illness. Its logic carries both an objective and a subjective element: the provocation must be grave enough that it could deprive a reasonable person of self-control, and it must in fact have deprived this accused of self-control at the moment of the act. The requirement that it be sudden weighs heavily against the exception where a real interval allowed the passions to cool, but the point is not automatic: whether the exception is made out remains a question of fact, and if it fails, on this or any other ground, the remaining ingredients of murder and any other applicable exception must still be established before a murder conviction follows. The psychiatrist's role here is narrow and easily overstated: an opinion on temperament or a co-existing condition may be sought, but the defence itself is a legal construct the court applies, not a psychiatric plea.

FEATURE	DIMINISHED RESPONSIBILITY (THE ENGLISH PARTIAL DEFENCE)	GRAVE AND SUDDEN PROVOCATION (THE INDIAN PARTIAL DEFENCE)
What it rests on	An abnormality of mental functioning that substantially impaired a relevant capacity	Loss of self-control caused by provocation, in a person treated as responsible
Effect on the charge	Reduces murder to the lesser homicide offence	Reduces murder to culpable homicide not amounting to murder
Nature of the concession	To mental illness or abnormality	To human frailty, not to illness
Available in Indian law	No such free-standing defence exists	Yes, as a recognised exception to murder

24.3 Automatism: the concept and the states behind it

Automatism is the assertion that the body acted while the mind was not consciously directing it, so that the movement, though it caused harm, was not a willed act of the person at all. It bites deeper than any partial defence because it attacks the voluntariness a criminal act presupposes: if the conduct was truly involuntary, the guilty act and guilty mind the law requires, analysed elsewhere in this chapter where mens rea and actus reus are set out, are simply not made out. The plea is therefore about absence of conscious, voluntary control at the material time rather than about impaired judgement.

Clinically it is raised by a small set of transient states in which awareness and volition are genuinely suspended:

- the post-ictal state that can follow a seizure, with confused, automatic behaviour;
- a hypoglycaemic state, in which falling glucose disorganises conscious control;

- a somnambulistic state, in which complex acts are carried out during **somnambulism** without waking awareness.

The trap for the clinician is to think the diagnosis settles the law. It does not. The legal category is not the medical label but the answer to two prior questions: was conscious voluntary control actually absent when the act was done, and what caused its absence. A further variant, automatism attributed to voluntary intoxication, is governed by the separate law on intoxication rather than treated as automatism proper, and the clinical management of substance use itself belongs to the Substance use disorders notes.

24.4 Insane versus sane automatism: the internal and external divide

English common law sorts automatism not by its clinical name but by its cause: this internal/external classification is the comparator, not enacted Indian law. Where the involuntary act springs from a **disease of the mind**, an internal cause, English law classes it as **insane automatism** and deals with it as insanity is dealt with; where the involuntary act springs from a purely external cause, English law classes it as **sane automatism**, which if accepted there points toward an ordinary acquittal. India has no separately codified automatism defence carrying either label. A disease-linked involuntary act reaches the unsound-mind exception only where that exception's cognitive-incapacity test is actually met; where it is not, or where the alleged cause is external, the Indian court must assess voluntariness, the ingredients of the charged offence and any applicable statutory exception directly, without a promised codified acquittal.

The pivot, disease of the mind, is a legal construct and not a psychiatric one, and English courts have read it broadly, turning on whether the cause is internal to the person and liable to recur. The reason English law works so hard at this line is that its two branches lead to opposite destinations there: insane automatism, treated as unsoundness of mind, leads not to freedom but to the disposal that follows a successful mental exception, with its provision for detention and treatment; sane automatism, if made out, ends in a clean acquittal. India draws no equivalent guarantee for either branch: an Indian court reaches the insanity disposal only where the unsound-mind exception's own test is met, and has no codified route promising sane automatism an acquittal, so it works from voluntariness, the offence's ingredients and any applicable exception rather than from the common-law label. Because releasing a person whose brain may repeat the act carries a public-protection cost, English courts are cautious about the external-cause branch and readier to route a recurring internal condition through the insanity route.

MNEMONIC

Inside the mind, insane; outside the mind, sane

An internal cause, a disease of the mind, makes the automatism the insanity question and sends it into the unsound-mind exception; an external cause makes it sane automatism, a common-law route to acquittal that Indian statute does not separately codify. Sort by where the cause sits, not by the diagnosis on the chart.

AXIS	AUTOMATISM FROM A DISEASE OF THE MIND	AUTOMATISM FROM AN EXTERNAL CAUSE
Common-law label	Insane automatism	Sane automatism
Where the cause lies	Internal to the person, liable to recur	External to the person
Route in Indian law	Answered through the unsound-mind exception, only where its cognitive-incapacity test is met	Not a separately codified Indian route; the court assesses voluntariness, offence ingredients and any applicable exception directly
Direction of outcome	Toward the insanity disposal, with detention and treatment, where the exception is made out	Under the common-law comparator, toward an ordinary acquittal; Indian law promises no codified route to that outcome

RULE **Neither doctrine is a free-standing Indian defence; each is routed into a category the law already holds.** A killing is down-graded on a mental ground through grave and sudden provocation, the nearest analogue to diminished responsibility rather than the only exception that reduces murder to the lesser offence, and an act said to be involuntary that stems from a disease of the mind is justiciable through the unsound-mind exception where its test is met, though that exception is not the sole route by which an alleged involuntary act is examined. Automatism from an external cause survives as a common-law idea that Indian statute does not separately name, and an Indian court assesses such a case directly on voluntariness, the offence's ingredients and any applicable exception.

24.5 The forensic assessment, and the errors it invites

What the psychiatrist actually supplies. Because both questions turn on a mental state at a past instant, the assessment is functional and almost always retrospective. The task is to reconstruct, from contemporaneous records, witness accounts of the act itself, the person's own account and the known pattern of the condition, whether conscious voluntary control was present or absent at the material time, and to form a view on the likely cause and whether it amounts to a disease of the mind. What the psychiatrist supplies is a medical opinion; the legal category, whether the automatism is insane or sane, and whether responsibility stands, is the court's to decide. An honest report says where the contemporaneous evidence is thin and frames its conclusion as an inference, because a bare diagnosis neither proves nor disproves that the act was involuntary. The conventions for putting that opinion before a court, and the certification of an expert to testify, are not part of this substantive law and belong to the Forensic ethics, consent and legal procedure notes.

GOOD TO REMEMBER

Anchor the opinion to the moment of the act and its cause, not to the label. Ask whether conscious voluntary control was present when the act occurred and whether the cause is internal and recurrent, because that placement, not the name of the condition, decides which legal route the automatism takes. Where the records will not support a firm view, say the evidence is insufficient rather than fill the gap with an impression.

IN INDIA

In practice a referral labelled as automatism is, more often than not, the insanity question in another dress, because the internal-cause states that reach a court, such as post-ictal or somnambulistic behaviour, are the ones the law treats through the unsound-mind exception. The useful Indian report translates the clinical picture into terms the law can act on, points the recurring internal condition toward that exception, and does not offer a diminished-responsibility verdict Indian law cannot receive.

TRAP **Answering as though India had a diminished-responsibility defence, or treating automatism as a distinct Indian plea.** The marks come from knowing that India routes both questions through existing categories: provocation for the grade of a homicide, and the unsound-mind exception for automatism that arises from a disease of the mind. Importing the English partial defence, or presenting sane automatism as a codified Indian defence, is the classic way to lose an answer that structure would have secured.

PITFALL

Writing the wrong law into a real medico-legal report. Offering "diminished responsibility" as an available Indian plea, or citing the superseded penal code as the live provision, does not merely lose an examination mark; it discredits the report and the witness, because the opposing side need only point out that the doctrine or section relied upon is not the law in force. Frame the opinion in the categories Indian law actually uses, and leave the legal conclusion to the court.

25 · Mens rea, actus reus and legal concepts of intent

Where forensic psychiatry enters the criminal law. When a court asks whether a mentally ill person can be convicted of a crime, it is really asking about two building blocks the law has used for centuries: was there a prohibited act, and was there a guilty mind behind it. Almost every forensic-psychiatric opinion in a criminal matter, whether it concerns the insanity defence, diminished responsibility, automatism or fitness to plead, is in the end an argument about one of these two blocks, and most often about the second. Grasping **actus reus** and **mens rea** is therefore not abstract jurisprudence for the candidate; it is the grammar in which the psychiatrist's evidence has to be written if it is to be admissible and useful.

The marks reward the candidate who keeps the legal categories and the clinical ones apart: a diagnosis is not a defence, and a symptom is not the absence of intent. The disciplined witness translates a psychiatric finding into the language of the mental element and stops there, leaving the verdict to the court.

25.1 The two elements of a criminal offence

An ordinary criminal offence is built from **two** elements that the prosecution must establish together: a prohibited act and the guilty mind that accompanies it. The external element is the *actus reus*, the conduct the law forbids; the internal element is the *mens rea*, the blameworthy state of mind with which that conduct is done. Neither is sufficient on its own. A person who forms a murderous wish but does nothing has no act and commits no offence; a person who

causes harm by pure accident, without any of the mental states the law demands, has done the act but without the guilty mind. Only where both are present, proved to the criminal standard, can a conviction follow.

MNEMONIC

Actus non facit reum nisi mens sit rea

"An act does not make a person guilty unless the mind is also guilty." The single line encodes the whole topic: the forbidden **act**, the guilty **mind**, and the requirement that the two belong to the same event. Every criminal-responsibility defence works by attacking one half of it.

AXIS	ACTUS REUS	MENS REA
What it is	The external, prohibited element: conduct, its surrounding circumstances and, for result crimes, its consequence	The internal, blameworthy element: the state of mind accompanying the act
What the law asks	Did the accused do the forbidden thing, and do it voluntarily?	With what intention, knowledge or awareness of risk was it done?
How it can be missing	An involuntary movement, or conduct the law does not in fact prohibit	Accident, mistake, or a mind the law treats as incapable
Where psychiatry usually bears	Rarely, automatism being the exception	Commonly, the psychiatric opinion speaking to the capacity for the required mental state

RULE **The act and the guilty mind must coincide.** It is not enough that each existed at some point; they must meet in the same transaction, the mental element present at the moment the prohibited act is done. This concurrence principle is why timing dominates a forensic opinion: the evidence must fix the mental state to the material time, not to the assessment carried out months later, because a disturbance that arose only afterwards leaves the offence intact.

A crime needs both a forbidden act and the particular guilty mind the law specifies for it, present together at the same moment; prove one without the other and there is no offence.

2
ACT AND GUILTY MIND

both
MUST CONCUR

25.2 The actus reus: the external element

The actus reus is more than a bodily movement. It is usually analysed as up to three things the prosecution may have to prove: the conduct itself, the surrounding circumstances that make that conduct criminal, and, for offences defined by their outcome, the proscribed consequence. In a homicide the conduct is the assault, the circumstance is that the victim was a living person, and the consequence is the death.

- **Conduct** - the act, or in defined cases a failure to act.

- **Circumstances** - the facts that give the conduct its criminal character.
- **Consequence** - the proscribed result, for those offences defined by their outcome.

Two further ideas complete the external element. First, the conduct must be **voluntary**: the law attributes an act to a person only when it was a willed movement of the body. A reflex, a convulsion or a movement during a state of clouded consciousness may be legally involuntary, and this is the doorway through which automatism enters, a plea set out elsewhere in this chapter where diminished responsibility and automatism are discussed. Second, liability can arise from an **omission**, but only where the law imposes a duty to act, as a parent owes a child, so that the failure to discharge that duty becomes the forbidden conduct. For result crimes the prosecution must also prove **causation**, that the accused's act was in fact and in law the cause of the proscribed consequence; an intervening cause may break that chain. The psychiatrist is seldom the witness on causation, but should place it on the act side rather than the mental one.

25.3 The mens rea and the ladder of fault

Mens rea is not a single state but a graded ladder of culpability. The law recognises several mental states, and each offence specifies which one it requires; broadly, the graver the offence, the higher the fault demanded. Running from the most to the least blameworthy, the familiar forms are intention, knowledge, recklessness and negligence. **Intention** is the aim or purpose to bring about the prohibited result. Knowledge is awareness that a circumstance exists or that a consequence is practically certain to follow. **Recklessness** is the conscious taking of an unjustified risk, the accused having foreseen the possibility of harm and gone on regardless. Negligence is a failure to meet the standard of care a reasonable person would show; it is inadvertent, and it is judged against an external standard rather than against what the accused actually foresaw. In Indian usage, a rash act is not a synonym for a negligent one but a distinct alternative: rashness carries awareness of the risk, the accused proceeding in the hope or belief that the harmful consequence will not occur, so it sits closer to conscious risk-taking than to negligence's inadvertence.

FAULT STATE	WHAT THE ACCUSED'S MIND IS DOING	HOW IT IS TESTED
Intention	Aims at the result, or acts in order to bring it about	Subjective: what this accused meant
Knowledge	Is aware the result is practically certain, or that the circumstance exists	Subjective: what this accused knew
Recklessness	Foresees the risk and unreasonably runs it	Subjective foresight of the risk
Rashness	Foresees the risk and proceeds, hoping or believing the harm will not occur	Subjective: the accused's own awareness of the risk
Negligence	Fails to advert to a risk a reasonable person would have seen	Objective: the reasonable-person standard

Why the ladder matters to the witness. A mental illness does not act uniformly on every rung. A disorder may leave a person able to intend an act at the level of bare purpose while destroying the higher-order appreciation that it was wrong, or leave intention untouched and bear only on the judgement of risk. Mapping the clinical picture onto the specific fault state the charge requires, not onto culpability in general, is the discipline that turns a diagnosis into evidence a court can use.

25.4 Legal concepts of intent

Intent in law is narrower and more technical than in ordinary speech, and several distinctions earn marks. Direct intention is the straightforward case, where the consequence is exactly what the accused wanted. Courts also recognise a form sometimes called oblique or indirect intention, where the accused did not desire the result but foresaw it as a virtually certain side effect of what they did set out to do, and from such foresight a court may infer intention. A second concept, **transferred intent**, applies where the accused directs a criminal intent at one target but the harm falls on another: the intent is carried across to the actual victim, so that aiming at one person and killing a bystander is still an intentional killing. And because intention is a fact about a person's mind, it is almost never proved directly. It is inferred from conduct and circumstance, on the common-sense premise that a person ordinarily intends the natural consequences of their acts, which is a presumption of evidence and not a rule that fixes the mind against contrary proof.

TRAP **Confusing motive with intention.** **Motive** is the reason behind the act, such as jealousy, gain or revenge; intention is the decision to do the prohibited act itself. Motive is generally irrelevant to guilt: a mercy killing and a killing for money share the same intention to cause death, and a benign motive does not erase mens rea. Candidates lose marks by arguing that a sympathetic motive negates intent. Motive can help to prove or disprove intention as a piece of evidence, but it is not itself the mental element.

25.5 When the guilty mind is dispensed with, or treated as absent

The requirement of a guilty mind is displaced in two very different ways, and the candidate should not run them together. At one end sit **strict-liability** offences, where the law dispenses with proof of mens rea for some or all elements of the act; the prosecution need only show that the accused did the prohibited thing. These are typically regulatory or public-welfare offences, where the social interest in deterrence is thought to justify convicting without an inquiry into fault. They are the exception, not the rule, and the graver the offence and its penalty, the more strongly the courts resist reading the mental element out of it. At the other end sits the **insanity exception**, and here the candidate should resist collapsing it into a mens-rea-negating device. The current Indian provision is a complete statutory General Exception in its own right, analytically distinct from the prosecution's separate obligation to prove the offence-specific mental element, not a rule that simply deems mens rea absent. An accused can form the intention to perform the physical act and still fall within the exception, because it asks a different question: whether unsoundness of mind removed the capacity to know the act's nature, or that it was wrong or contrary to law. Insanity evidence can also, independently of the exception, raise a reasonable doubt about an offence's own mental element; the two routes carry different burdens

and are not to be run together. That overlap without identity, not a straightforward negation of the mental element, is the conceptual bridge from psychiatry to the criminal law. Its full statement, the governing test, the current Indian substantive provision and the burden of proof, is developed elsewhere in this chapter where the insanity defence is set out; what matters here is that the exception may overlap with, but is not the same thing as, an absence of mens rea.

IN INDIA

Indian penal law does not leave the guilty mind to a single overarching doctrine. It writes the fault element into each offence through defined mental-state words, such as voluntarily, dishonestly, fraudulently, with intent, knowingly, rashly or negligently, and the statutory definitions of those words do much of the work the common law leaves to the maxim. The courts read a presumption of mens rea into an offence unless the statute clearly excludes it, while accepting genuine strict-liability offences in regulatory fields. The forensic implication is practical: identify the exact fault word the charge uses, because the opinion must speak to that mental state and no other.

25.6 The forensic psychiatrist and the mental element

For the psychiatrist, the framework defines both the question and its limits. The court does not want a diagnosis; it wants to know whether, at the material time, the accused had the capacity for the mental state the charge requires. The opinion should reconstruct that mental state as it was when the act was done, from history, contemporaneous records and the phenomenology, and relate it to intention, knowledge, awareness of risk or knowledge of wrongfulness, as the charge demands.

GOOD TO REMEMBER

Frame the report around the mental element, not around the verdict. Say what the illness did to the accused's capacity to intend, to know or to appreciate wrongfulness at the time of the act, and let the court draw the legal conclusion. Anchoring every statement to the material time, and separating what the illness explains from what it might excuse, is what makes the evidence admissible and hard to shake under cross-examination. The manner of putting that opinion before a court, and the certification of an expert to testify, belong to the Forensic ethics, consent and legal procedure notes.

PITFALL

Treating a diagnosis as though it were the absence of mens rea. A person can carry a serious mental illness and still have formed the intention, or possessed the knowledge, the offence requires; illness and an intact fault element routinely coexist. The clinical error is to reason from "the accused was psychotic" straight to "the accused had no guilty mind", skipping the step the law actually cares about, which is what the specific illness did to the specific mental capacity at the specific moment of the act. The report that names the disorder and stops has answered a medical question the court did not ask.

26 · Narcoanalysis, brain mapping and polygraph (deception detection, legal status)

Why the marks are here. Every so often an investigating agency, faced with a suspect who will not confess, reaches for a technique that claims to read the truth directly from the body or the brain. Three such techniques recur in the forensic setting - **narcoanalysis**, the **polygraph** and **brain mapping** - and together they make up the field of **deception detection**. The examiner is not testing the wiring of the machines. The marks are for three separate things a candidate must keep apart: what each technique actually measures, why its scientific standing is disputed, and, decisive for a court, whether the law permits it to be used at all and on what conditions. A candidate who can hold the technique and its admissibility apart answers the whole question; one who fuses them loses it.

These are investigative aids, not clinical tests. None of them makes a diagnosis, and none delivers a verdict of truthful or lying that a judge can simply adopt. Two neighbouring topics must be held off at the outset. The clinical detection of feigned or exaggerated illness, malingering, is a distinct skill and is set out elsewhere in this chapter; it borrows these instruments but does not own their legal status. And the professional-ethics questions the tests raise - consent for a purpose that is not the subject's own treatment, the psychiatrist acting for the investigator rather than the patient, and the report eventually placed before a court - belong to the Forensic ethics, consent and legal procedure notes. What this section owns is the trio of techniques and, above all, their legal position in India, which is settled and frequently examined.

26.1 The three techniques and what each claims to do

Narcoanalysis rests on a pharmacological idea. A sedative-hypnotic drug is given slowly into a vein and titrated to a drowsy, disinhibited, half-hypnotic state, on the theory that a person whose higher control is loosened can no longer sustain the effort of a deliberate lie and will let the truth slip out. The clinical reality is close to the opposite. The same disinhibition that is meant to release the truth also makes the subject highly suggestible and prone to confabulation, so that what emerges is an unstable mixture of memory, suggestion and invention. The account a subject gives under the drug is therefore not a faithful record of fact, and its value, where it has any, is as a lead to be independently verified rather than as evidence in itself.

The polygraph works on a physiological idea rather than a pharmacological one. It records several channels of autonomic arousal continuously while the subject answers a structured sequence of relevant and comparison questions, and the examiner infers deception from the pattern of reactivity, not from the words of the answer. The channels typically recorded are:

- respiration, its rate and depth;
- electrodermal activity, the sweat-gland or galvanic skin response;
- cardiovascular activity, the blood pressure and pulse.

The inference is only as strong as its central assumption, that lying reliably raises arousal more than truthful answering does, and that assumption is where the method is most exposed. Brain mapping, in the Indian forensic setting, refers specifically to the **Brain Electrical Activation**

Profile, an electroencephalographic method that presents the subject with crime-related probe stimuli and looks for the electrical brain response that signals recognition. Its logic differs from both the others: it does not claim to catch a lie but to detect experiential knowledge, that is, whether the brain treats a specific detail of the offence as already familiar, as it would be to a person who was present and not to an innocent stranger.

TECHNIQUE	WHAT IS RECORDED	INFERENCE DRAWN	PRINCIPAL WEAKNESS
Narcoanalysis	Speech produced in a drug-induced disinhibited state	That a disinhibited subject discloses withheld truth	Suggestibility and confabulation; the content is not reliable fact
Polygraph	Autonomic arousal across respiratory, electrodermal and cardiovascular channels	That deception raises arousal on the relevant questions	Arousal is non-specific; open to anxiety, countermeasures and examiner bias
Brain mapping	Electrical brain responses to crime-related stimuli	That the brain recognises a familiar detail of the offence	Detects recognition, not guilt; reliability disputed

26.2 Why the scientific standing is disputed

The reason all three are described as techniques of contested scientific validity is the same in each case: none of them measures deception itself. Each measures a proxy and then reasons backward from that proxy to a conclusion about truthfulness, and every step of the backward reasoning can fail. It is worth setting the criticisms out on principle, because the examiner rewards a candidate who can say why the methods are weak rather than merely assert that they are.

- the signal is indirect - pharmacological disinhibition, autonomic arousal, or stimulus recognition - and none of these is unique to lying, so an innocent explanation is always available for the same reading;
- the reading is examiner-dependent and defeatable: an anxious but honest subject can generate exactly the arousal that is scored as deception, a prepared subject can defeat the test with deliberate countermeasures, and interpretation is hard to standardise or replicate;
- there is no agreed, validated error rate for any of them that a court could weigh against the strength of the other evidence.

Narcoanalysis carries an additional and specific hazard, that its central mechanism is also a mechanism of false memory: the disinhibition that is supposed to lower the guard on the truth simultaneously lowers the guard on suggestion, so a leading question can plant an answer the subject then reports with conviction. The polygraph and brain mapping avoid that particular trap but share the deeper one, that a physiological or electrical correlate of arousal or familiarity is not the same thing as a lie. The distance between the correlate and the conclusion is precisely where an innocent person can be caught and a guilty one can slip through, and no amount of instrumental precision closes it, because the gap is one of logic and not of measurement.

26.3 The constitutional bar on compulsion

Where the examinable law sits. The Constitution guarantees, in Article **20(3)**, the **right against self-incrimination**: no person accused of an offence shall be compelled to be a witness against himself. The settled reading of that guarantee turns on a distinction between two kinds of evidence. A person may be compelled to furnish physical or material evidence - a fingerprint, a specimen, a handwriting sample - because giving it does not require the accused to speak from their own mind. A person may not be compelled to give testimonial or communicative evidence, evidence whose source is the content of the accused's own mind, because that is precisely to make them a witness against themselves.

The results of narcoanalysis, the polygraph and brain mapping fall, on this analysis, on the protected side of the line. Each extracts a communication from the subject's own mental processes - a spoken account, an autonomic reaction to a question, an electrical sign of recognition - so compelling the subject to undergo the test is compelling them to become a witness against themselves. In **Selvi v State of Karnataka (2010) 7 SCC 263** the Supreme Court held that the compulsory, involuntary administration of these techniques violates that right, and also the right to life and personal liberty under Article **21**, and that it amounts to cruel, inhuman or degrading treatment. The bar is thus doubly grounded: in the specific protection against self-incrimination and in the broader protection of personal liberty and dignity.

RULE **Compulsory administration is unconstitutional.** Forcing a subject to undergo narcoanalysis, the polygraph or brain mapping violates the right against self-incrimination and the right to life and personal liberty, and amounts to cruel, inhuman or degrading treatment. The prohibition attaches to the compulsion, not to the technique: what the Constitution forbids is extracting the mind's contents against the subject's will, whatever the instrument used to do it.

26.4 Consent, and the safeguards on a voluntary test

The consequence of the constitutional bar is a rule that is easy to state and easy to get subtly wrong: no such test may be conducted without the subject's **consent**. But consent is necessary, not sufficient. Compulsory testing is prohibited outright, and a voluntary request remains subject to judicial consideration and authorisation and the prescribed safeguards; consent alone creates no right to testing. In Amlesh Kumar v State of Bihar, the Supreme Court held that an accused has no indefeasible right to narcoanalysis, and that the court must weigh voluntariness, the safeguards and the totality of circumstances before authorising it. A subject who genuinely and freely agrees is not being made a witness against themselves, but that agreement does not by itself entitle them to the test; a subject who is pressured, tricked or ordered is being made one.

Consent, however, does not turn the product of the test into free evidence. Even a result obtained voluntarily, and any information later discovered by following up on that result, are governed by the National Human Rights Commission Guidelines of **2000**. Two things follow. First, a voluntary result is not automatically admissible as substantive proof of guilt merely because the subject agreed to the test; its use is constrained by the safeguards that framework imposes. Second, and less obviously, the protection does not reach the derivative material. A fact or physical object subsequently discovered with the help of a voluntary test may be proved under

section 27 of the Evidence Act, the discovery rule, so that although the voluntary result is not itself admissible against the subject, the physical evidence or fresh lead it throws up can be admitted against them. Stating the consent rule without this second half is the commonest way it is misremembered.

20(3)	21	2000
SELF-INCRIMINATION BAR	LIFE AND DIGNITY	NHRC GUIDELINES

TRAP **Reading the leading judgment as a total ban on these techniques.** It is not. What was struck down is the compulsory, involuntary administration of narcoanalysis, the polygraph and brain mapping; the voluntary, consented route survives, subject to the National Human Rights Commission safeguards. A candidate who writes that the tests are simply "banned in India" has stated the law too widely and thrown away the distinction the question is built to test. The accurate sentence names compulsion as the thing prohibited, and consent as necessary but not by itself sufficient: a voluntary request still needs judicial consideration and authorisation before it may proceed.

PITFALL

Conducting or lending clinical cover to one of these tests without valid, documented consent, on the assumption that an investigator's request or a court's involvement supplies the authority. It does not. What the law requires is the subject's own free consent, and its absence makes the administration unconstitutional however the request was routed. A psychiatrist asked to perform or supervise such a test should confirm consent independently, record it, and decline where consent is absent or coerced.

26.5 The psychiatrist's role and its limits

The clinician drawn into this area, whether asked to administer a test, to be present during one, or to interpret its result, works within tight boundaries. The first is scientific: the result is not a diagnosis and not a determination of truth, and it must never be presented to an investigator or a court as if it settled whether the subject is lying. At most it is one indirect and disputed datum. The second is legal: the psychiatrist cannot supply the consent the subject has not given, and no institutional request substitutes for it. The third is a matter of role, because the psychiatrist here is acting for the justice system rather than treating a patient, and the duties that flow from that shift - disclosure, the limits of confidentiality, the form of the eventual report - are the province of the Forensic ethics, consent and legal procedure notes and are not resolved by clinical instinct.

Kept in its place, the topic is straightforward. The examiner wants a candidate who separates three questions and answers each on its own terms: does the technique measure what it claims, which is doubtful; is its output reliable enough to act on, which it is not without independent corroboration; and may it lawfully be used, which it may, but only with consent and within the National Human Rights Commission framework. Confusing the three - treating a legal permission as a scientific endorsement, or a scientific criticism as a legal prohibition - is the very error the whole topic is constructed to expose.

GOOD TO REMEMBER

Before going near any of these tests, confirm and document the subject's own consent, and treat its absence as a bar rather than an obstacle to be worked around. Never present the output as a diagnosis or as proof that the subject is truthful or lying; confine any report to what was observed and defer the truth-question to the court. If asked to rely on a result, say plainly that it corroborates nothing on its own and would need independent verification to carry any weight.

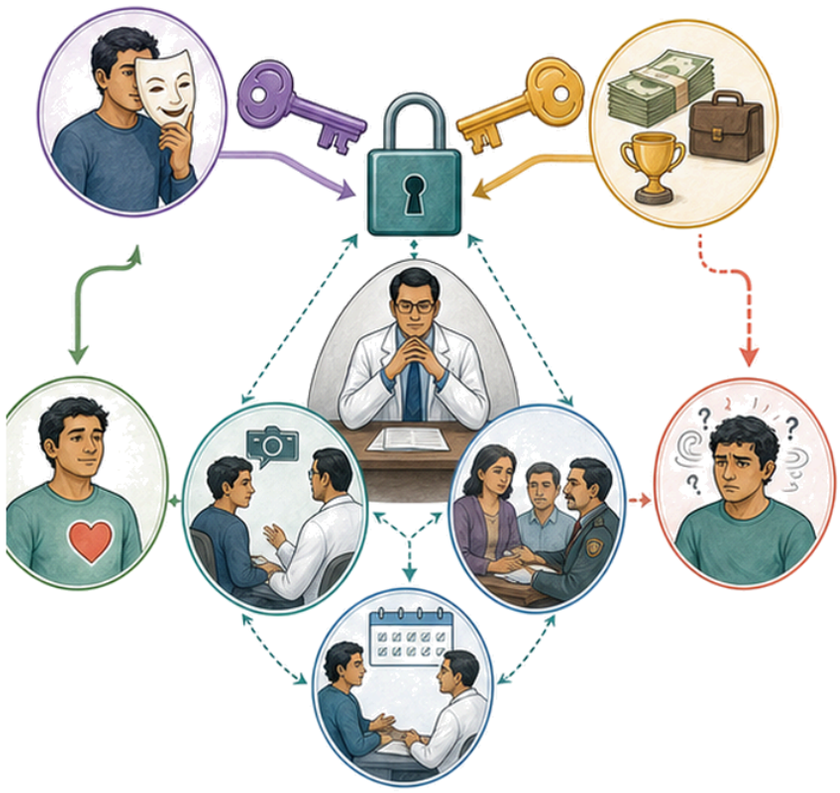
IN INDIA

The Indian position is settled and practical. Brain mapping in its Brain Electrical Activation Profile form, together with narcoanalysis and the polygraph, is still sought at the investigation stage, but none of the three has independent evidentiary value, and consent alone creates no right to testing: a voluntary request remains subject to judicial consideration and authorisation, and for an accused seeking the test the appropriate stage is ordinarily when defence evidence is led at trial, not an automatic consent-based investigation-stage route (Amlesh Kumar v State of Bihar). Voluntary results and anything derived from them are handled under the National Human Rights Commission Guidelines, so a psychiatrist asked to conduct or interpret a test should treat consent as the threshold question and the guidelines as the operating limit, and should resist any suggestion that a test result can stand in for evidence a court would otherwise require.

No deception-detection test may be conducted without the subject's consent; compelling narcoanalysis, the polygraph or brain mapping violates the right against self-incrimination and amounts to cruel, inhuman or degrading treatment.

27 · Malingering and detection in forensic settings

Why the marks are here. A forensic opinion is only as good as the honesty of the person being examined, and in exactly the settings where a psychiatric report carries the most weight - a criminal charge, a compensation claim, a plea that the accused is too unwell to be tried - the examinee has the clearest possible reason to shape what the examiner sees. **Malingering** is the deliberate manufacture of illness for a payoff that lies outside the illness itself, and the psychiatrist who cannot recognise it is left in one of two failing positions: deceived into a false opinion, or, having learned to distrust, so quick to see feigning that the genuinely ill are disbelieved. The topic is examined because it sits at the precise point where clinical skill meets medico-legal consequence, and because the discriminations it demands - conscious from unconscious, external reward from internal need - are the ones candidates most often blur.



- Intentional production
- External incentive
- Look for inconsistency
- Use collateral evidence
- Do not diagnose from suspicion alone

Fig 25.12 Malingering requires both intentional production or gross exaggeration of symptoms and an external incentive. Detection integrates observed inconsistencies, collateral records and structured assessment; suspicion alone is not a diagnosis.

The single organising idea is that malingering is defined by two things at once: the symptom is produced or grossly amplified on purpose, and the reason for producing it lies outside the person, in some tangible gain the illness is meant to secure. Take away either half and it is no longer malingering. That double test is what separates it from every neighbouring presentation, and it is also what tells the examiner where to look, because a motive that is external and instrumental tends to leave external and instrumental traces.

> Malingering is the intentional production or gross exaggeration of symptoms for an external incentive; it is not a mental disorder but a condition warranting clinical attention, and it is established by positive, converging evidence of feigning, never inferred from an unwelcome diagnosis alone.

27.1 What malingering is, and why it is not a diagnosis

To malinger is to feign. The examinee either produces a symptom that is not there or takes a real complaint and pushes it into **gross exaggeration**, and does so knowingly, in the service of a goal that the sickness is only a means to reach. The goals are worldly and specific: escaping a criminal trial or its punishment, evading a duty such as work or service, or securing money through a compensation or disability claim. This is what is meant by an **external incentive**. The reward is a change in the person's outward circumstances, not anything internal to their psychology, and it is the externality of the motive that gives the concept its shape and its detectability.

It follows from this that malingering is classified not as an illness but as a **condition warranting clinical attention**, something that may become the focus of an assessment without itself being a disorder with its own psychopathology, course and treatment. The distinction is not pedantry. A disorder is something the patient has and the clinician treats; malingering is something a person does and the clinician must detect and describe. Recording it in a report is therefore an assertion about conduct and motive, not about pathology, and it must be justified by evidence of the same order that any serious accusation demands. The examiner who forgets this drifts into using the word as a term of disbelief rather than as a finding, which is where reports go wrong.

27.2 The three-way differential: two questions that sort it

The heart of the topic is a differential across three presentations, and it resolves cleanly if two questions are asked in order. First, is the symptom produced deliberately, or does it arise outside the person's conscious control. Second, if it is deliberate, what is the incentive - something tangible in the outside world, or the internal satisfaction of occupying the role of a patient. The three presentations answer these two questions in three different combinations, and the combination is the diagnosis.

Malingering answers both: deliberate, for an external reward. **Factitious disorder** shares the first answer but not the second - the symptoms are produced deliberately, yet the motive is internal, the psychological need to be seen and treated as sick, what is classically called **the sick role**, with no external payoff in view. **Conversion** and the other unconsciously produced presentations answer the first question differently altogether: the symptom is genuine to the person and not deliberately made, so no question of incentive in the malingering sense even arises. The examiner who collapses these three - who calls a factitious patient a malingerer, or treats a conversion symptom as feigned - has made the single commonest error in the area, and it is an error about the two questions, not about the symptoms themselves.

AXIS	MALINGERING	FACTITIOUS DISORDER	CONVERSION AND OTHER UNCONSCIOUS PRESENTATIONS
How the symptom is produced	Deliberately produced or grossly exaggerated	Deliberately produced	Not deliberate; outside conscious control
The incentive behind it	External and tangible: escape trial or duty, gain compensation	Internal: to occupy the sick role	No conscious incentive; the symptom is experienced as real
Standing as a disorder	Not a disorder; a condition warranting clinical attention	A recognised mental disorder	A recognised mental disorder
The clinician's task	Detect the feigning and describe the evidence	Diagnose and manage the disorder	Diagnose and treat the disorder

MNEMONIC

Conscious for a prize, malinger; conscious for the role, factitious; not conscious at all, conversion

The two hinge questions compressed into one line. Deliberate production plus an external, tangible reward is malingering; deliberate production for the internal reward of the sick role is factitious disorder; a symptom that is not deliberately produced at all is conversion or another unconsciously generated presentation. Fix the awareness and the incentive, and the label follows.

TRAP **Equating malingering with factitious disorder because both involve deliberate symptoms.** The two part on the incentive, and its direction is the whole point: malingering runs on an external, tangible gain, factitious disorder on the internal need to be a patient. A candidate who defines malingering as "producing symptoms deliberately" and stops there has described both conditions and distinguished neither. The examiner is testing whether you can name the external incentive as the discriminator, so make that the sentence you write first.

27.3 Detecting malingering: converging evidence, not a single sign

Because the motive is external, the feigning tends to leave marks that honest illness does not, and detection is the disciplined business of looking for them and requiring several to point the same way before any conclusion is drawn. No single finding is proof, and the strength of the method lies entirely in convergence: one anomaly raises a question, several independent anomalies pointing at the same feigned presentation begin to answer it. Four families of evidence carry most of the weight, and it helps to understand why each one works and where each one fails.

- **Inconsistency between reported and observed function.** The examinee describes a level of impairment that their spontaneous behaviour, when they are not being formally tested, does not support: a memory said to be gone that works when the person is distracted, a weakness that eases when attention moves elsewhere, a distress that lifts in the waiting room. It works because sustaining a fabricated deficit across every unguarded moment is hard; it fails when the genuine condition itself fluctuates, so the gap must be marked, not fleeting.

- **Symptom patterns that are atypical or over-endorsed.** The feigned picture tends not to follow the natural shape of the disorder it imitates. Symptoms are affirmed too readily and too broadly, rare and improbable complaints are endorsed, and the presentation is often a lay caricature of illness rather than its true form. It works because a person mimicking a disorder cannot know its fine internal grammar; it fails where the examinee has real clinical knowledge or genuine partial illness that lends the account authenticity.
- **Poor effort on validity testing.** Structured tasks can be built so that even a severely impaired but honest person performs well, so that failure below that floor points away from illness and toward withheld effort. It works because it separates capacity from cooperation; it fails when it is over-read, since a single poor score in a distressed or poorly engaged examinee is a question, not a verdict.
- **Corroboration from collateral sources.** Records, informants and observation across time and across settings test the self-report against something the examinee does not control. It works because the story a person tells and the record others keep are hard to align if the story is invented; it fails only when collateral is thin, which is precisely when the examiner must say so rather than fill the gap.

RULE **Malingering is established by positive, converging evidence of feigning, never by exclusion and never from one sign.** A single failed test, an unlikeable examinee, or a diagnosis the person happens to want are not grounds; what is required is several independent lines - inconsistency, atypicality, poor effort and collateral - agreeing that the presentation is manufactured for a gain. Treating malingering as a diagnosis of exclusion, reached when nothing else seems to fit, inverts the logic and is how the genuinely ill come to be wrongly disbelieved.

27.4 Validity testing and the instrumental methods

Two kinds of structured testing formalise the effort question, and the exam rewards knowing that they ask different things. One asks whether the person is over-reporting symptoms, endorsing more, and more improbable, complaints than any real syndrome generates; this is the logic of **validity testing** applied to what the examinee says. The other asks whether the person is genuinely trying on a cognitive task, typically through forced-choice formats where even severe honest impairment leaves performance near the level that chance alone would give. Performing consistently below that level is a powerful single indicator, because doing worse than random guessing implies the examinee knew the correct answer and steered away from it, an effort that only a person controlling their own responses could produce.

AXIS	SYMPTOM VALIDITY: OVER-REPORTING	PERFORMANCE VALIDITY: POOR EFFORT
What it asks	Is the person reporting more, and more improbable, symptoms than a real syndrome produces	Is the person genuinely trying on the task
What flags feigning	Atypical, rare and over-endorsed symptoms	Effort below what severe genuine impairment or chance would give
What genuine illness looks like	A coherent pattern that fits the disorder's natural shape	Impairment that still shows real, sustained effort

Beyond the interview and these tests lie the instrumental methods of deception detection - narcoanalysis, brain mapping and the polygraph. They belong to the malingering conversation because they too claim to separate truthful from feigned or concealed report, but their reliability and, above all, their legal admissibility are contested, and that question is set out elsewhere in this chapter, where narcoanalysis, brain mapping and the polygraph are discussed. The malingering examiner should know these methods exist, should treat a positive instrumental result as neither necessary nor sufficient to establish feigning, and should defer the question of when they may lawfully be used to that discussion. The distinct ethical problem of subjecting an unwilling examinee to a procedure designed to catch them out belongs to the Forensic ethics, consent and legal procedure notes and is not settled here.

IN INDIA

The Indian settings that generate external incentives are the ones that generate malingering: criminal referrals in which an accused may feign illness to claim the unsound-mind exception or to be found unfit to plead, both of which are taken up elsewhere in this chapter, and compensation, disability and fitness-to-work assessments in which a certificate carries money or a livelihood. Well-standardised symptom and performance measures are often not to hand in routine practice, so the Indian assessment leans hardest on the two tools that are always available - careful documentation of observed against reported function, and collateral gathered from records and informants. The instrumental methods sometimes pressed for by investigating agencies sit under a contested legal position covered elsewhere in this chapter, and a psychiatrist asked to rely on them should keep that limit clearly in view.

27.5 The forensic assessment and its dangers

How the examination is actually conducted. Because the whole question is whether a self-report can be trusted, the assessment is built to test consistency rather than to take the account at face value. The examiner moves from open, unstructured enquiry to specific probing, re-examines the same ground at different times to see whether the story holds, and observes the examinee outside the formal interview where the effort of maintaining a fabricated deficit relaxes. Collateral is gathered before the interview, not after, so that the account can be checked against something independent while the person is still in the room. Throughout, the stance is neutral: malingering

is detected and documented, not confronted, because an accusation across the desk yields defensiveness and loses the observational advantage without adding evidence.

The hardest discipline is to hold two truths together. A person can be both malingering and genuinely ill, so a finding that some symptoms are exaggerated does not establish that the person is well, and detecting feigning never closes the separate question of real illness underneath it. Feigning is also a matter of degree rather than a switch, ranging from mild embellishment of a real complaint to wholesale fabrication, and the report should say where on that range the evidence places the presentation. What the psychiatrist supplies is a description of the evidence and the reasoning from it to a conclusion, framed as an inference of a stated strength; the report certifies findings, not a motive it cannot evidence, and the conventions for putting such an opinion before a court belong to the Forensic ethics, consent and legal procedure notes.

GOOD TO REMEMBER

Gather the collateral before you interview, not after, so the account can be tested against something independent while the person is in front of you. Keep the stance neutral, because malingering is detected rather than confronted, and hold on to the fact that feigning and genuine illness coexist, so exaggeration in part never proves wellness in whole. Describe the observed against the reported, let the convergence carry the weight, and where the evidence supports only doubt, write doubt and name what further information would settle it.

PITFALL

Committing the word "malingerer" to a medical record or a court report on an impression rather than on convergent evidence. The label is an accusation of deliberate fraud; asserted without the positive findings to support it, it is clinically wrong, because it forecloses a genuine illness that may coexist, and medico-legally reckless, because the opposing side needs only to show that the conclusion rested on suspicion for the whole report to fall. If the evidence supports only doubt, record doubt; a defensible report never reaches further than its findings allow.

28 · Psychiatric aspects of homicide and filicide

Why the marks are here. Killing is the point at which psychiatry and the criminal law meet most sharply, and the questions a court then puts to the psychiatrist - was this person responsible, what drove the act, could it have been foreseen and prevented - all turn on the mental state at the moment of the offence. **Filicide**, the killing of a child by a parent, concentrates these questions further, because it forces the assessor to hold together parental psychopathology, the safety of any surviving children and a society that finds the act almost unthinkable. This topic is examined less for its epidemiology than for two things a candidate must produce cleanly: the recognised classification of these killings, and the specific clinical contexts in which the risk is real.

The foundation is a base-rate fact that must be stated with care, because getting it wrong in either direction is a failure of both scholarship and fairness. Homicide committed by a person with mental illness is uncommon, and the great majority of people with even severe mental illness are never violent. What raises the risk is not the diagnostic label but the active symptomatic state:

lethal violence is over-represented in florid psychosis carrying persecutory or command features, and in acute substance intoxication. Holding both halves of that sentence together - the rarity and the specific high-risk state - is what separates a defensible answer from a stigmatising one.

Homicide by a person with mental illness is uncommon but is over-represented in active psychosis with persecutory or command features and in substance intoxication; filicide is classified by the parent's motive, neonaticide is a separate category tied to concealed pregnancy in a young mother, and postpartum psychosis is a recognised high-risk context for infanticide.

5	first day
RESNICK FILICIDE MOTIVES	NEONATICIDE WINDOW

28.1 Homicide in the context of major mental illness

The link between psychosis and homicide is real but narrow, and understanding its shape prevents both complacency and over-prediction. Risk rises when psychotic symptoms directly engage a potential victim: a **persecutory** delusional system that casts a specific person as a lethal threat, or hallucinations that **command** the patient to act, convert a private illness into a danger to others. The mechanism is one of subjective self-defence or of felt compulsion: the patient acts not on ordinary motive but within a delusional reality in which the act feels necessary or unavoidable. Substance intoxication is the second and independent amplifier - it disinhibits, distorts perception, and in combination with psychosis is a far stronger driver than either state alone.

The features that should raise concern in an acutely psychotic patient are worth holding as a short set:

- persecutory delusions that name or locate a specific persecutor, rather than a diffuse sense of threat;
- command hallucinations to harm, particularly where the patient shows early compliance or feels unable to resist them;
- delusions of passivity or control, in which the patient experiences their own actions as imposed from outside;
- comorbid substance intoxication, which lowers the threshold for acting on any of the above.

These are state markers, not a general risk formulation. The systematic taxonomy of static and dynamic risk factors, and the structured tools that weigh them, are developed elsewhere in this chapter; the point here is narrower - that lethal violence in mental illness is bound to the active symptomatic state, which is why it is often reversible with treatment and why the assessment of any homicide case begins with a disciplined reconstruction of the mental state at the time of the act. Where that reconstruction establishes that the act arose from an illness meeting the legal threshold, the matter becomes one of criminal responsibility, the insanity defence, taken up in full elsewhere in this chapter; short of that threshold, India has no diminished-responsibility

defence, so the mental abnormality may instead bear on proof of an offence-specific mental element or on sentence, or engage the grave-and-sudden-provocation exception where its own conditions are independently established, matters taken up in full elsewhere in this chapter.

28.2 Filicide and its classification by motive

Filicide is the killing of a child by a parent, and the single most examinable fact about it is that it is classified by the parent's motive, not by the method or the age of the child. The most widely used scheme is **Resnick**'s, which separates the killings into motivational groups. Learning them as motives rather than as a bare list is what makes them clinically useful, because the motive is what predicts the mental state behind the act and the way the law is likely to treat it.

In **altruistic** filicide the parent kills out of a distorted belief that death spares the child suffering - the severely depressed mother who can see no future for herself or her child, or the psychotic parent convinced the child is doomed. It is the category most strongly associated with serious affective or psychotic illness and with maternal suicide, the killing forming part of an extended suicide. **Acutely psychotic** filicide is killing driven directly by psychosis, by command hallucinations or delusions, without the coherent if deluded protective logic of the altruistic type; here the act may be bizarre and, in any ordinary sense, unmotivated. The **unwanted-child** type is the killing of a child the parent regards as an obstacle or a burden, classically where the child is genuinely unwanted and the parent unsupported. **Fatal maltreatment**, sometimes called accidental filicide, is death resulting from cumulative abuse or neglect rather than from an intention to kill, and it is the category that sits at the interface with child protection. The **spouse-revenge** type, the rarest, is the killing of a child in order to inflict suffering on the other parent.

RULE **Filicide is classified by the parent's motive, not by the act.** The same outcome, a dead child, can arise from profound depressive illness, from florid psychosis, from an unwanted pregnancy or from cumulative neglect, and it is the motive that fixes the likely mental state, the risk to any surviving children and the legal disposal. An answer that catalogues methods or injuries has missed the axis the examiner is testing.

RESNICK CATEGORY	CORE MOTIVE	TYPICAL MENTAL STATE	FORENSIC AND CLINICAL EMPHASIS
Altruistic	To spare the child suffering	Severe depression or psychosis; risk of extended suicide	Strongest link to major mental illness; assess the parent's own suicidality
Acutely psychotic	No rational motive; act driven by symptoms	Active psychosis, command hallucinations, delusions	Reconstruct the symptoms operating at the time of the act
Unwanted child	Child experienced as a burden or obstacle	Often no major mental illness; situational	Social adversity, support, and safeguarding of future children
Fatal maltreatment	No intent to kill; death from abuse or neglect	Variable; personality, substance use, stress	Interface with child protection and surviving siblings
Spouse revenge	To make the other parent suffer	Often personality pathology rather than psychosis	Rarest; focus on the parental relationship

28.3 Neonaticide as a distinct category

Neonaticide, the killing of a newborn within **the first day of life**, is commonly treated as a special, age-defined subtype of filicide, analysed separately because its perpetrator profile is different. It is classically committed by a young mother who has denied or concealed the pregnancy, often frightened, unsupported and without antenatal care, who delivers alone and disposes of the newborn in a state of panic or dissociation. Major mental illness is usually absent; what dominates is denial, immaturity and social desperation rather than psychosis or depression. Because both the psychopathology and the social setting differ so completely from the filicide motives, neonaticide is analysed on its own terms, and folding it into the motive list for older children is a standard and costly error.

TRAP **Neonaticide is a special, age-defined subtype of filicide, and it is not usually a mental-illness case.** Candidates absorb the first-day killing into the motive classification and reach for psychosis or depression to explain it. The prototypical picture is the opposite: a concealed pregnancy in a young, unsupported woman, a solitary delivery, and a dissociative or panic-driven act, with no major mental illness at all. The discriminator the examiner wants is the perpetrator profile, not a motive.

28.4 Postpartum psychosis and the risk of infanticide

Standing apart from both the situational neonaticide and the diverse filicide motives is the killing that arises out of **postpartum psychosis**, a recognised high-risk context for infanticide. Puerperal psychosis is a psychiatric emergency: it can arise abruptly in the early period after delivery, it is frequently affective in colour, and it can carry delusions concerning the infant - that the baby is defective, evil, or better off dead - together with command phenomena. The lethal danger is that these beliefs generate exactly the altruistic and acutely psychotic mechanisms described above, now directed at a wholly dependent newborn who cannot protect itself. This is

why the condition is treated as an emergency regardless of how settled the mother appears in the intervals between disturbance.

GOOD TO REMEMBER

A mother with postpartum psychosis should never be assumed safe to be the sole carer of her infant on the strength of a calm interview. Ask directly about intrusive or command-driven thoughts of harming the baby, arrange urgent review and admission, and keep mother and infant together only under supervision. The decision to admit jointly or to separate is a safeguarding decision as much as a treatment one.

Treatment is urgent, and where the illness is severe or life is at risk it may include physical treatments whose clinical technique and consent framework belong with the ECT and neurostimulation notes; the forensic point here is only that recognition and containment of the risk must come first.

28.5 The psychiatric assessment of the parent or perpetrator

What the psychiatrist actually does. The psychiatric contribution to a homicide or filicide case is a careful reconstruction of the mental state at the time of the act and a formulation of the motive, because these determine everything that follows: the availability of the insanity defence or a partial defence, the risk to any surviving children, and the treatment the perpetrator needs. The assessment gathers the person's account of the act, the pre-offence history and mental state, collateral and documentary evidence, and screens specifically for the depressive, psychotic and intoxication states that carry the risk. In a parent, it must always extend to the safety of other children in the household.

PITFALL

The dangerous clinical error is to hear a depressed mother say her children would be better off without her, or better off coming with her, as if it were ordinary depressive worthlessness. In a parent, the thought that a child would be better off dead is altruistic-filicide ideation until proven otherwise, and it must be asked about as directly and as specifically as suicidal ideation, with the same threshold for protective action. Missing it because it was heard as routine rumination is how a preventable death is not prevented.

IN INDIA

In Indian practice the evaluation of a mother who has killed her infant or newborn usually turns on reconstructing the perinatal mental state and screening for postpartum psychosis and severe depression, because the legal disposal runs through the general criminal law and the defences taken up elsewhere in this chapter. The classic neonaticide setting, a concealed pregnancy in a young and unsupported woman, is a recurring feature of casework, and it calls for a social and safeguarding response as much as a psychiatric one.

Two boundaries frame the work and should be named rather than absorbed. The formal examination for the court, the expert report, and the ethics of acting where treatment meets

evidence belong with the Forensic ethics, consent and legal procedure notes. Where fatal maltreatment or the safety of surviving children brings child-protection law into play, the governing statutes are set out in the Child psychiatry: assessment, treatment, services and protection notes. The forensic psychiatrist names these frames and works within them, but the assessment itself remains what it has always been: a disciplined reconstruction of a mind at the moment it did something almost unbearable to contemplate.

Civil law, capacity and family law

29 · Testamentary capacity (criteria and assessment)

Why the marks are here. A will speaks only after its maker is dead, at the one moment when the person who could explain it can no longer be asked, so the law insists that the mind behind it was sound when the document was made. Disputes about that soundness are common - a late will that cuts out one child, a large gift made in the shadow of dementia, a bequest a family says was the product of illness - and the court that must resolve them turns to the psychiatrist for an opinion on capacity. The examiner rewards the candidate who treats **testamentary capacity** as what it is: a functional, decision-specific and time-specific test, governed by a statute that says who may make a will and by a classic common-law authority that says what a sound mind for that particular purpose actually involves. A bare diagnosis is not the answer to any of it.

Two sources hold this topic together, and the disciplined answer keeps both in view at once. The Indian Succession Act supplies the statutory frame: it names who is competent to make a will and, through a short set of Explanations, tells us what soundness of mind means for this act and when it is measured. The common law supplies the anatomy of that soundness through the case every examiner expects by name, which breaks the "sound mind" of the statute into the concrete faculties a testator must actually exercise. Learn the two together and the wrong-statute traps that cluster around this topic fall away.

59	1925	1870	4
MAKING A WILL	INDIAN SUCCESSION ACT	BANKS V GOODFELLOW	LIMBS OF SOUNDNESS

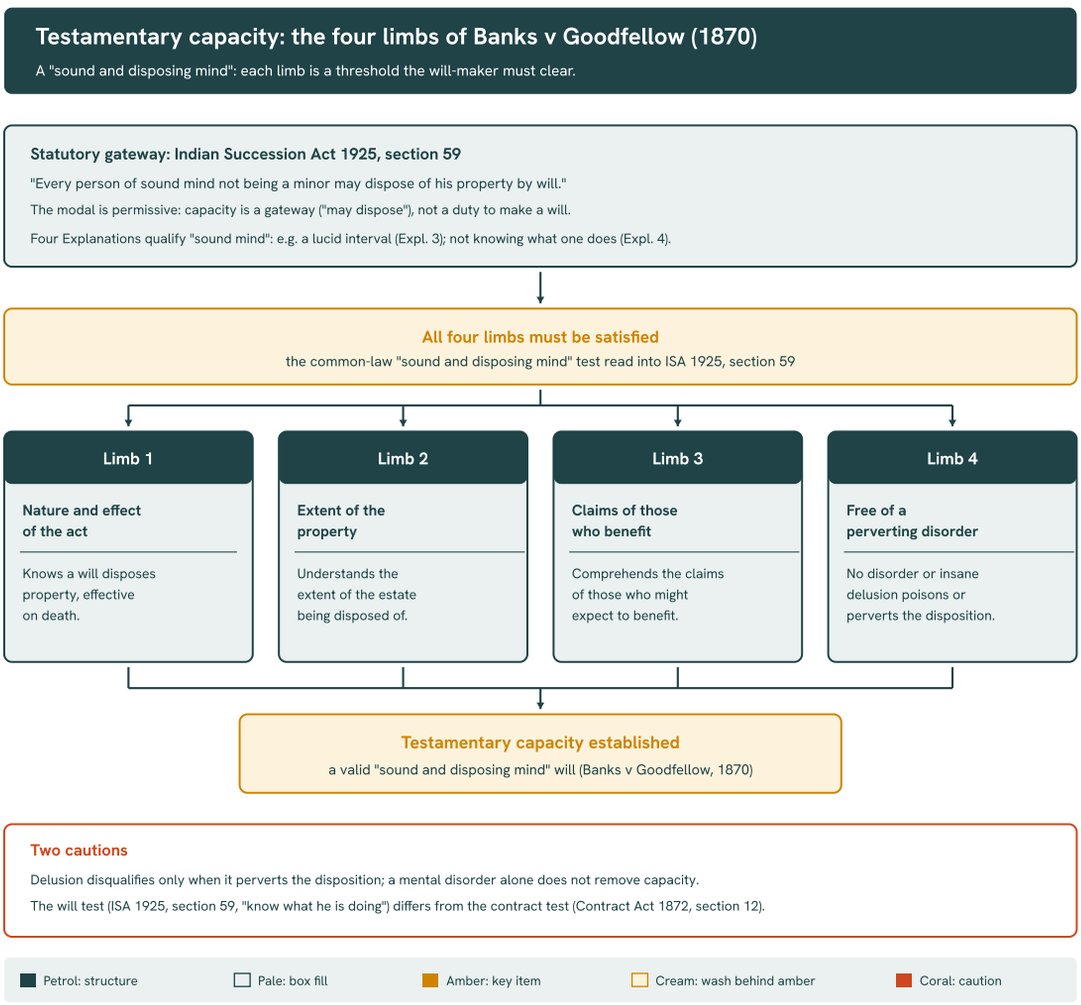


Fig 25.13. The four limbs of testamentary capacity from Banks v Goodfellow (1870), read into the permissive gateway of Indian Succession Act 1925, section 59. All four thresholds must be cleared for a "sound and disposing mind"; a mental disorder or delusion disqualifies only when it perverts the disposition.

29.1 Who may make a will

The starting provision sits in the Indian Succession Act of **1925**, at section **59**, and its opening words set both the standard and its character: every person of **sound mind** not being a minor may dispose of property by will. Two features of that sentence repay slowing down on. The first is that the operative verb is permissive - the section says such a person may make a will, conferring a power rather than imposing a duty. It is an enabling provision, naming who is free to dispose of their estate rather than commanding that anyone must. The second feature is that competence is stated as the pairing of two requirements, soundness of mind and majority, joined so that a sound-minded child cannot make a valid will and neither can an adult whose mind is not sound at the material time.

For the psychiatrist the majority limb is not our concern - age is a matter of record the court establishes for itself - and the whole clinical enquiry lives in the words "sound mind." That phrase is the hinge of the topic. It is not used in its loose everyday sense; the Act gives it content through

the Explanations that follow the main provision, and it is those Explanations, not a diagnostic label, that the examiner wants reproduced and applied.

29.2 What soundness of mind means for a will

The provision qualifies "sound mind" through **four** Explanations, and together they convert a vague adjective into a set of workable rules. The first preserves the will-making power of a married woman over any property she could dispose of by her own act during her life; it is a rule about legal personality rather than about psychiatry, and it does not turn on any mental state. The remaining Explanations are the ones that matter clinically, because each fixes a relationship between a mental state and the power to make a will.

The second Explanation is a caution against equating a sensory or communication impairment with incapacity: persons who are deaf or dumb or blind are not, on that account, incapacitated from making a will, provided they are able to know what they do by it. The condition attached is the whole of the rule: the impairment does not disqualify so long as the person can understand what the act of making the will achieves. The third Explanation is the one candidates most often reach for: a person who is ordinarily insane may make a valid will during an interval in which he is of sound mind, the **lucid interval** in which the standing illness has, for the time being, lifted. The rule is permissive and it is real: an established diagnosis of chronic mental illness does not bar a will made in a genuine window of clarity.

The fourth Explanation states the outer bound in the negative and in absolute terms: no person can make a will while he is in such a state of mind, whether arising from intoxication or from illness or from any other cause, that he does not know what he is doing. The modal force here is worth marking, because it is the mirror of the third: this is not a "may not" that admits of exception but a flat "cannot," and it is deliberately cause-neutral, reaching any state, however it is arrived at, that robs the person of knowing what the act of willing is. The through-line of those clinical Explanations is a single test seen in different situations - the will stands or falls on whether, at the moment of making it, the person knew what they were doing by it.

Held as a single picture, the four Explanations read as follows.

THE SITUATION	WHAT THE WILL-MAKING PROVISION SAYS
A married woman	May dispose by will of any property she could alienate by her own act during her life
A person who is deaf, dumb or blind	Is not thereby incapacitated, provided able to know what they do by the will
A person who is ordinarily insane	May make a will during an interval in which he is of sound mind - a lucid interval
Any person whose mind is disordered by intoxication, illness or any other cause	Cannot make a will while in a state in which he does not know what he is doing

29.3 The common-law test: a sound and disposing mind

The statute tells us that soundness is required and, through the third and fourth Explanations, that it is judged at the moment of making the will, but it does not itself spell out the faculties that soundness comprises. That anatomy comes from the common law, from **Banks v Goodfellow** of **1870**, in which Cockburn CJ set out the test of the **sound and disposing mind** that Indian courts continue to apply. The judgment identifies **four** things a testator must be able to do. The testator must understand the nature of the act of making a will and its effects - that this document directs who will take the estate after death. The testator must understand the extent of the property being disposed of, in broad terms rather than to the last rupee. The testator must be able to comprehend and appreciate the claims of those who might expect to benefit, the persons who have a natural call on the testator's bounty, whether or not the testator chooses in the end to provide for them. And, negatively, no disorder of the mind must poison the affections or pervert the sense of what is right so as to distort the disposition itself.

The understanding limbs are cognitive and specific to the act of testation: they ask what the person can grasp and weigh about this will, this estate and these potential beneficiaries. The final limb is different in kind. It is not a further thing to understand but a negative condition, a requirement that no mental disorder reach into and distort the very choices those limbs describe. That structure is why the test can be satisfied by a person who is far from mentally well, and can fail in one whose cognition on formal testing looks intact: the four limbs ask not whether the mind is healthy but whether it was, for this act, sound and disposing.

MNEMONIC

Deed, Extent, Claims, Delusion

The four limbs of the sound and disposing mind, in order: understand the **Deed** - the nature of making a will and its effect; grasp the **Extent** of the property being given; comprehend and appreciate the **Claims** of those who might expect to benefit; and be free of any disorder or delusion that perverts the disposition. The understanding limbs are faculties the testator must have; the delusion limb is a distortion they must not have.

RULE **A valid will needs a sound and disposing mind at the moment of execution.** The statute sets the standard - soundness of mind together with majority - and the common-law test unpacks soundness into the four faculties the testator must exercise: understanding the act and its effect, the extent of the estate, and the claims of those who might benefit, with no disorder of the mind perverting the disposition. It is a capacity for this decision at this time, not a global verdict on the person or a certificate of mental health.

29.4 Disorder, delusion and the survival of capacity

Capacity survives a diagnosis. The single most discriminating feature of the test lives in its fourth limb, and it runs against intuition. A testator may carry a serious mental disorder, and may even hold frank delusions, and still have testamentary capacity; the presence of illness does not, by itself, defeat the will. What defeats it is narrower and more specific: an **insane delusion** counts only when it is one that influences the disposition, poisoning the testator's natural affections or

their sense of who has a claim, and so bringing about a gift that a sound mind would not have made.

The distinction is best held with a pair of examples. A testator who harbours a fixed, unfounded belief about some matter wholly unconnected with the estate - a delusion about a neighbour, or about events long past - may still make a perfectly valid will, because that belief plays no part in how the property is divided. Contrast the testator who believes, against all reason and evidence, that a devoted child is an enemy conspiring against them, and who disinherits that child precisely for that reason: here the delusion has reached into the disposition and perverted it, and capacity fails. The question the assessor must answer is therefore not "is this person deluded" but "did a delusion shape this will," and only the second defeats it. This is why testamentary capacity can be partial and disposition-specific rather than all-or-nothing.

None of this is a historical curiosity. The sound-and-disposing-mind test remains the governing common-law standard for testamentary capacity, applied and reaffirmed in modern probate litigation, including the recent English authority of **Hughes v Pritchard** - the live framework the assessment must be built around, not a nineteenth-century relic to be recited and set aside.

TRAP **Assuming that a mental disorder, or a delusion, automatically destroys testamentary capacity.** It does not. A testator may have a diagnosis, or even hold delusions, and still make a valid will; capacity fails only where a delusion actually influences the disposition. Writing that the testator "was psychotic and therefore lacked capacity" answers the wrong question and loses the mark, because the examiner is looking for the causal link between the delusion and the terms of the gift, not the mere co-existence of illness and a will.

Testamentary capacity is decision-specific and time-specific: a valid will needs a sound and disposing mind at the moment of execution - the testator understanding the act, the extent of the estate and the claims upon it - and a mental disorder defeats it only when a delusion actually perverts the disposition.

29.5 Assessing and recording testamentary capacity

Because the test is functional and fixed to a moment, the assessment must be functional and, very often, retrospective. Two quite different referrals arise. In the contemporaneous referral the psychiatrist assesses a living testator - typically elderly or seriously ill - at or near the time the will is made, so that a record of capacity exists should it later be contested. In the retrospective referral, the commoner one, the testator has died and the mental state at execution must be reconstructed from whatever survives: the clinical record, the notes of the person who took instructions and prepared the will, informant accounts of the testator's conduct at the time, and the terms of the will itself. In neither case is the task to certify a diagnosis or to pronounce the person globally capable or incapable; it is to map the limbs of the test onto this particular will.

In practice the enquiry tracks the limbs of the test:

- Does the testator understand that they are making a will, and what a will does - that it directs who receives their property after death?

- Do they have a realistic grasp of the nature and extent of the property they are disposing of?
- Can they identify and weigh the claims of those who might expect to benefit, family and dependants, even where they choose in the end to exclude them?
- Is there a mental disorder present, and if so, is any delusion influencing the disposition, or is the illness irrelevant to the choices actually made?

Two habits separate a useful opinion from a dangerous one. The first is to record the testator's actual reasoning - the words in which they described the estate, named the family, and explained the exclusions - rather than a bare conclusion, so that the court can see how each limb was met or failed. The second is candour about the evidence: where the contemporaneous record is thin the psychiatrist should say so and frame the view as an inference, because an overstated report both misleads the court and destroys the witness's credibility under challenge. Good practice, though not a statutory command, is to arrange a capacity assessment whenever an aged or gravely ill person makes a will. The form in which the opinion is finally put before a court, the expert report and the certificate for the court, is not testamentary law and is treated in the Forensic ethics, consent and legal procedure notes.

GOOD TO REMEMBER

Assess and record the testator's grasp of three things against the actual will - the act of making it, the extent of the estate, and the claims of those with a call on their bounty - and ask specifically whether any delusion is shaping the gift. Where a testator is elderly or seriously ill, a capacity assessment made at the time the will is executed is worth far more than any reconstruction attempted after death, once memory has hardened into partisanship.

IN INDIA

Wills are governed by the Indian Succession Act, and its provision on who may make a will supplies the statutory soundness standard that the courts read together with the Banks v Goodfellow limbs. The psychiatrist advises and the court decides, since testamentary capacity is ultimately a finding of fact for the judge. In everyday practice the referral is civil and usually retrospective, arising from a contested will, and the useful report is the one that tracks the limbs of the test against the particular will and testator rather than offering a diagnosis or a blanket judgement on the deceased.

29.6 Keeping the will test apart from its neighbours

Testamentary capacity is one of a family of legal capacities, each with its own standard and its own governing text, and the examiner's favourite move is to run them together. The capacity to make a binding agreement - contractual capacity - is governed by its own provision in the Indian Contract Act, with its own definition of soundness of mind, and it is taken up as its own topic in this chapter; its test is not the will test and must not be borrowed for one. The capacity to make a mental-healthcare or treatment decision has its own statutory test under the Mental Healthcare Act and is likewise treated elsewhere in this chapter. What these capacities share is a common structure, not a common test: each is decision-specific and time-specific, so the assessor must first

identify which decision the law has actually raised, reach for the right standard, and apply that standard's own limbs.

India retains these as distinct, separately worded tests rather than a single all-purpose capacity, and for the careful examinee that is a help rather than a burden. The discipline is simply to pair the decision with its own test - a will with the sound and disposing mind, a contract with the contract-law definition of soundness, a treatment decision with the mental-health-law test - and never to answer one capacity question with another's wording or another's statute. The candidate who keeps the acts, the standards and the limbs paired loses nothing to the confusion the paper is built to induce.

PITFALL

Answering a will question with the wrong statutory test. Soundness of mind for a contract has its own definition in the Indian Contract Act, and it is not the standard for a will; a testator's capacity is measured against the Indian Succession Act's soundness requirement and the Banks v Goodfellow limbs, at the moment of execution. Lifting the contract-law soundness test - or a standing "of unsound mind" label from the case notes - across to a disputed will is a scope error that produces the wrong answer even when every clinical fact in the report is correct.

30 · Contractual capacity and competence

Why the marks are here. A psychiatrist is pulled into contract law the moment a family disputes a gift, a sale, a loan or an agreement signed by a relative who was, or is said to have been, mentally unwell. The court does not ask whether the person carried a diagnosis; it asks a narrower and far more answerable question - was this particular person, at the particular moment of the transaction, able to understand what they were doing and to judge its effect on their own interests. Contractual capacity is therefore a functional and time-bound test, and the examiner rewards the candidate who can name the governing sections precisely, reproduce their exact wording, and keep this test cleanly apart from the neighbouring tests of testamentary capacity and of capacity to make a treatment decision.

The whole topic sits in two short sections of one old statute, and the discipline the examiner is testing is statutory rather than clinical: can you say who the law treats as competent, what it means by soundness of mind, and at what instant that soundness is measured. Each of those is a separate provision with its own wording, and the difference between a discretionary "may" and a mandatory rule is exactly the kind of detail the paper is built to find. A candidate who paraphrases the gist loses marks a candidate who quotes the limbs keeps.

11	3	12	2
COMPETENCE	CUMULATIVE CONDITIONS	SOUND MIND	SOUNDNESS LIMBS

30.1 Who is competent to contract

The law of who may enter a binding agreement is set out in the Indian Contract Act of **1872**, at section **11**. It treats a person as **competent to contract** only when **three** conditions hold together, joined in the text by "and" and therefore strictly cumulative: the person is of the **age of**

majority according to the law to which they are subject; is of sound mind; and is not disqualified from contracting by any law to which they are subject. Because the conditions are cumulative, the failure of any single one defeats competence. A mentally sound adult who happens to be disqualified by some other statute is not competent, and neither is a mentally sound person who is below the age of majority.

The age limb is why a minor cannot bind themselves. An agreement made by a minor is not merely unenforceable against them; it is **void ab initio**, void from the very beginning, the position long settled in the **Mohori Bibee** line of authority. This void-from-the-outset position is settled for a minor's agreement specifically, and it should not be read across to the other two limbs as though incompetence from any source produced the identical result. The consequence of an agreement made by a person who was not of sound mind is left to the statutory provisions taken up below and is not asserted here.

The third limb, that the person is not disqualified by any other law, is a reminder that soundness of mind is only one of the doors that must be open. Various statutes disqualify particular persons or particular kinds of transaction, and where they bite, competence fails regardless of how lucid the person was. For the psychiatrist this is a useful boundary: the remit is the sound-mind limb, and it is neither necessary nor appropriate to opine on age or on legal disqualifications, which the court establishes for itself. The clinical question is confined to the one limb the law actually refers to a mental state.

MNEMONIC

Age, Mind, No-bar

The three cumulative requirements of the competence section, in order: **Age** of majority, sound **Mind**, and **No** legal **bar** - not disqualified from contracting by any law to which the person is subject. All three must hold at once; the failure of any one defeats competence.

30.2 What "sound mind" means for a contract

Soundness of mind is not left to ordinary usage; it is given its own definition, for this purpose alone, at section **12**, and this is the provision the psychiatrist is really being asked about. A person is of **sound mind** for the purpose of making a contract if, at the time of making it, they are capable of two things together: understanding the contract, and forming a **rational judgement** as to its effect upon their interests. The test therefore has **two** limbs - comprehension of the transaction, and rational appraisal of what it will do to one's own position - and both must be present for the mind to count as sound.

The two limbs are worth pulling apart, because they fail in different ways. The first is cognitive and specific to the deal: does the person grasp the nature and the terms of this transaction, what is being given and what is being received. The second is evaluative and self-referential: can the person weigh the consequences of the bargain against their own interests, seeing that a sale below value depletes their estate, or that standing surety exposes them to another's debt. A person may

understand the mechanics of a contract in the abstract and still be unable, through illness, to appraise its effect on themselves; it is the pairing of the two capacities that the section demands.

A functional test, not a diagnostic one. Nothing in this definition turns on a label. A person may carry a serious psychiatric diagnosis and still satisfy both limbs for a given transaction, and a person with no diagnosis at all may fail them in a state of acute confusion. The statute asks what the mind could do at the moment, not what condition it bears. This is why a bare certificate that the person "suffers from a mental illness" answers the wrong question: the court needs to know whether, for this transaction, the person could understand it and reason about its effect on their own interests, which a diagnosis alone can neither establish nor exclude.

RULE **A contract needs a competent mind at the moment it is made.** Competence is the cumulative package of the competence section - majority, sound mind, and no disqualification - and soundness of mind for this purpose is the capacity, at the time of contracting, to understand the agreement and to form a rational judgement of its effect on one's own interests. Both the standard and the timing are set by statute, not by the assessor's general impression of the person.

30.3 Soundness is judged at the moment of contracting

The most examined feature of the definition is its timing. Soundness is assessed at the instant the contract is made, not as a standing trait, and the statute spells out what that means through two situational rules that cut in opposite directions. A person who is usually of unsound mind, but occasionally of sound mind, may make a contract when they are of sound mind: the recognised illustration is the **lucid interval**, in which an otherwise incapacitated person contracts validly during a genuine window of clarity. The mirror rule is stricter and is the one candidates forget: a person who is usually of sound mind, but occasionally of unsound mind, may not make a contract while they are of unsound mind, so the ordinarily capable person who signs while delirious or intoxicated is, for that transaction, outside the section's protection.

The reason the section is built this way is evidential as much as conceptual. If capacity can flicker, then what governs a disputed deal is the mental state at the material time, and contemporaneous evidence of that state - the notes of the day, the observations of those present, the person's own conduct around the transaction - becomes decisive. Conditions that wax and wane, such as delirium or intoxication, make the timing the whole question, because the same person may be within the section one hour and outside it the next. The two rules together say that neither a usual incapacity nor a usual capacity settles the matter; only the state at the moment does.

The two situational rules are best held as a single picture, since a candidate who remembers one half routinely forgets that it works both ways.

USUAL BASELINE	STATE AT THE MOMENT OF CONTRACTING	EFFECT ON THIS CONTRACT
Usually of unsound mind, occasionally sound	Sound - a genuine lucid interval	May make the contract
Usually of sound mind, occasionally unsound	Unsound - for example delirium or intoxication	May not make the contract

Contractual capacity is transaction-specific and time-specific: the only question is whether, at the moment of the deal, the person could understand it and form a rational judgement of its effect on their own interests.

30.4 Assessing and reporting contractual soundness

Because the statutory test is functional and tied to a moment, the assessment must be functional and, very often, retrospective. By the time a dispute reaches a psychiatrist the transaction is usually months or years past, so the opinion is reconstructed from contemporaneous records, the person's own account, informant histories, and any independent evidence of the mental state around the material time. The psychiatrist is not certifying a diagnosis and is not declaring the person globally capable or incapable; the task is to map the two statutory limbs onto the specific agreement in question, and to say, as far as the evidence allows, whether they were met when it was signed.

In practice the enquiry follows the section's own structure:

- Did the person understand the nature of this transaction - what was being given, received or promised, and on what terms?
- Could they form a rational judgement as to its effect on their own interests, weighing the benefit against the cost or the risk?
- Was that capacity present at the time the contract was made, allowing for fluctuation and for genuine lucid intervals?
- Is the opinion documented with the person's actual reasoning, rather than a bare conclusion, so that a court can see how each limb was met or failed?

The honest retrospective opinion is careful about its own limits. Where the contemporaneous record is thin, the psychiatrist should say so and frame the view as an inference rather than a certainty, because the burden of persuading the court sits with the party challenging the transaction and an overstated report does that party's work while damaging the witness's credibility. The manner in which the opinion is finally put before a court - the form of the report, the psychiatrist's duties as an expert, and the certificate for the court - is not contract law and is treated in the Forensic ethics, consent and legal procedure notes; here the point is only that the clinical content of the opinion is dictated by the two statutory limbs and by the moment at which they must be shown.

GOOD TO REMEMBER

Assess and record the person's understanding of the particular deal and their reasoning about its effect on their own interests, at the material time. A global label - "of unsound mind" - is not what the court can act on; the demonstrated grasp of this transaction is. Where the records will not support a firm view, say the evidence is insufficient rather than filling the gap with an impression.

IN INDIA

The governing standard is statutory: the Indian Contract Act fixes the definition of soundness, and the psychiatrist advises rather than decides, since competence is ultimately a finding for the court. In everyday practice the referral is civil and retrospective, arising from a contested gift, property transfer, sale or agreement, and the useful report is the one that tracks the two statutory limbs against the specific transaction rather than offering a diagnosis or a blanket verdict on the person.

30.5 Keeping the contracting test apart from its neighbours

Contractual soundness is one of a family of legal capacities, each with its own test, and the examiner's favourite error is to run them together. The capacity to make a valid will - testamentary capacity - is governed by a different provision, in the Indian Succession Act, and by a different standard; it is taken up as its own topic in this chapter and must not be answered with the contracting definition. The capacity to make a mental-healthcare or treatment decision has its own statutory test under the Mental Healthcare Act and is likewise treated elsewhere in this chapter. What these capacities share is a boundary rather than a common test: because each has its own statutory standard, the contracting definition cannot be lent to a will dispute or to a treatment-refusal question, and the psychiatrist must answer the exact capacity the court has actually raised.

India retains these as distinct, separately worded tests rather than a single all-purpose capacity, and that is a strength for the careful examinee: the discipline is simply to identify which act is in issue, reach for the right statute, and apply its limbs. The contracting test measures understanding and rational judgement of a bargain's effect on the maker's interests; a will and a treatment decision each ask something with its own wording and its own moment. The candidate who keeps the acts, the statutes and the limbs paired loses nothing to the confusion the paper is trying to induce.

TRAP **Answering a will or a treatment-refusal question with the contracting test.** The soundness-of-mind definition for contracting is a distinct statutory test. Testamentary capacity lives in the Indian Succession Act under its own standard, and treatment-decision capacity under the Mental Healthcare Act; quoting the contract definition for all three, or naming the wrong statute, is the classic way to lose an otherwise easy mark.

PITFALL

Treating a diagnosis as though it settled the matter. A standing diagnosis of mental illness, dementia or intellectual disability does not by itself void a contract, and a person may hold a serious diagnosis yet retain soundness for a particular deal, or regain it in a lucid interval. Reading soundness as a global, once-and-for-all status rather than a transaction-specific and time-specific finding is how a clinician's report overreaches what the statute actually asks - and it cuts the other way too, since an ordinarily well person can lose soundness for a transaction signed while acutely confused.

31 · Marriage, nullity and mental illness (Hindu Marriage Act, Special Marriage Act)

Where the marks sit. Mental capacity at the time of the marriage decides whether a ground for nullity exists, not whether the parties are married at all: a defect present at the wedding leaves the marriage standing until a court acts on it, and the governing Act decides whether that route is annulment of a voidable marriage or a declaration that the marriage was void. When mental illness is said to have been present at the moment the marriage was contracted, the question the court is really asking is one of formation - was this a good marriage in the first place - and the answer is nullity, not divorce. The psychiatrist is drawn in to speak to the state of a party's mind at the wedding, not at some later crisis, and the marks reward the candidate who keeps a formation defect apart from a dissolution ground and who can reproduce the exact statutory wording rather than gesture at its gist.

Two statutes carry this in the personal law a candidate must know. The Hindu Marriage Act governs marriages between Hindus, and the Special Marriage Act governs a civil, secular form of marriage irrespective of religion, subject to the section **4** conditions and the current law; each sets a mental-capacity condition for a valid marriage in near-identical words, but the two Acts part company on what a breach of it does to the marriage. Under the Hindu Marriage Act a breach makes the marriage voidable and open to annulment by a decree of nullity; under the Special Marriage Act the same breach makes the marriage void. The discipline the paper tests is statutory: the right section, the right limb, the right modal verb, and the clean line between void and voidable, which here runs between the two Acts themselves.

5	12	4	24
HINDU CONDITIONS	HINDU VOIDABLE	CIVIL CONDITIONS	CIVIL VOID

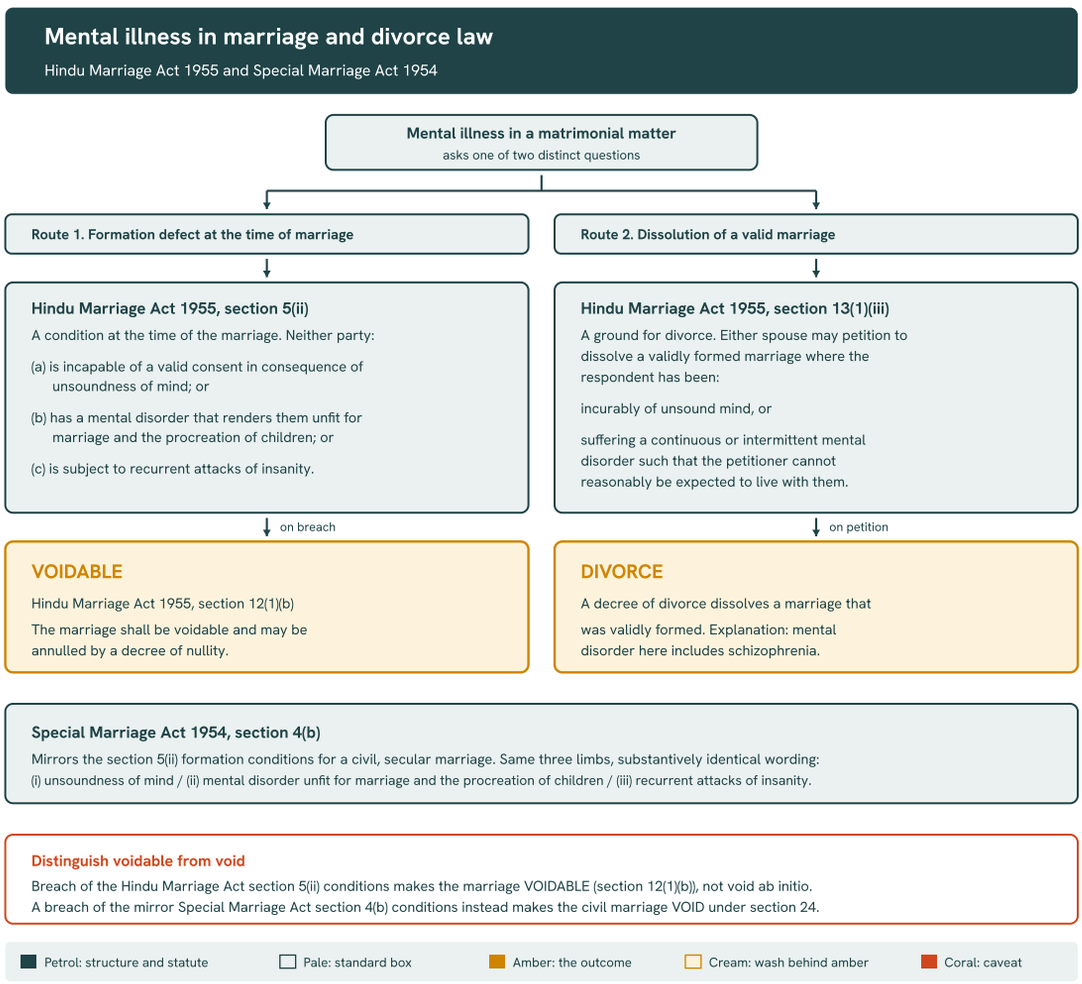


Fig 25.14. Mental illness reaches a marriage by two distinct routes. A formation defect under Hindu Marriage Act 1955 section 5(ii) makes the marriage voidable (section 12(1)(b), annulled by a decree of nullity), while section 13(1)(iii) is a ground to dissolve a validly formed marriage by divorce; the Special Marriage Act 1954 section 4(b) mirrors the formation conditions, but a breach of them makes a civil marriage void under section 24, not voidable.

31.1 The mental-capacity condition for a valid Hindu marriage

The conditions for a valid Hindu marriage are set out in the Hindu Marriage Act of **1955**, and the mental-capacity condition among them is clause (ii) of section **5(ii)**. The Act permits a Hindu marriage to be solemnised only where the conditions in that section are fulfilled, so this is a **formation condition**: it looks at the parties as they were at the time of the marriage and asks whether the marriage was well made, and it is indifferent to anything that befalls either of them afterwards. That temporal anchor is the whole of the topic. A condition that speaks to the moment of formation cannot be satisfied or defeated by a later illness, and a later illness cannot be crammed into it; that is what separates this ground from the neighbouring divorce ground and is where most candidates lose the mark.

The condition is breached if, at the time of the marriage, either party falls within any one of three alternative situations:

- is incapable of giving a valid consent to the marriage in consequence of unsoundness of mind;

- though capable of giving a valid consent, has been suffering from mental disorder of such a kind or to such an extent as to be unfit for marriage and the procreation of children; or
- has been subject to recurrent attacks of insanity.

The clause in its present form is not original to the Act as first enacted. It was substituted by **Act 68 of 1976**, the reform that recast the mental-capacity requirement into the three-limbed shape now examined. Reading the current text as though it were the Act as first enacted is a small but common error, and the wording the paper tests is the substituted wording, not what stood before it.

31.2 Reading the three limbs apart

The three situations are alternatives, not a cumulative test: any one of them, present at the time of the marriage, breaches the condition, and they are worth separating because they weigh quite different things. The first turns on consent. Here the disturbance is grave enough that the person is **unsoundness of mind** incapable of giving a valid consent to the marriage at all; the defect is in the very act of agreeing, so the marriage rests on a consent the law does not recognise. The second limb assumes the opposite starting point. The person can give a valid consent, and does, but carries a mental disorder of such a kind or to such an extent as to render them **unfit for marriage and the procreation of children**. This is a fitness test rather than a consent test, and its threshold is one of gravity: a diagnosis is not enough, the disorder must reach the kind or the extent the clause names. The third limb is the person **recurrent attacks of insanity**, and it captures a relapsing course rather than a settled state, using the archaic statutory word that the substituted clause retained.

The middle limb is the one that repays care, both because its threshold is a matter of degree and because its procreation-linked wording sits awkwardly with the modern rights-based understanding of mental illness and disability; a candidate should reproduce the clause as it stands while recognising that the phrase has drawn sustained criticism. Note too that the clause speaks of "mental disorder", a term the Act defines for the purpose of its divorce ground; that definition belongs to the topic on dissolution and is not restated here, and it should not be read across uncritically to the formation condition. What the formation limbs share is the moment they examine: each asks about the mind at the time of the marriage, and none is concerned with what the illness does to the marriage years later.

MNEMONIC

Consent, Fitness, Freedom

The three alternative situations of the mental-capacity condition, in order: incapacity of **Consent** through unsoundness of mind; a mental disorder that defeats **Fitness** for marriage and the procreation of children despite valid consent; and the absence of **Freedom** from recurrent attacks of insanity. Any one, present at the time of the marriage, breaches the condition.

31.3 The Hindu Marriage Act consequence: voidable, not void

The consequence of breaching the mental-capacity condition is the second half of the topic, and it is stated precisely at section **12(1)(b)**. A marriage in contravention of the condition in clause (ii) of the conditions section shall be **voidable** and may be annulled by a **decree of nullity**. The two modal verbs are doing exact work and must be preserved. The marriage *shall be* voidable, which fixes the category the defect falls into; a party *may* then seek annulment, which is discretionary in the sense that it depends on a party bringing the petition and on the court granting a decree. A voidable marriage is not the same thing as no marriage. It is valid and fully effective for every purpose until a party obtains a decree, and if no one ever petitions it stands. That is the opposite of a **void ab initio** union, which the law treats as never having been a marriage at all and which needs no decree to be a nullity.

Why the distinction bites. It is not academic. It decides who can act, when the marriage ends, and from what point. Because a Hindu Marriage Act mental-capacity breach yields a voidable marriage, the union survives until it is set aside at the instance of a party, and children and property questions are answered against a marriage that existed in law up to the decree.

AXIS	VOID MARRIAGE	VOIDABLE MARRIAGE
What the law treats it as	never a valid marriage at all	a valid marriage until it is annulled
Status before any decree	a nullity from the outset	valid and fully effective
Who ends it, and how	no decree is needed to treat it as a nullity, though one may be sought	only a party may petition, and the court may annul by a decree of nullity
Where a Hindu Marriage Act mental-capacity breach sits	not here	here - contravention of the clause (ii) condition

RULE **Under the Hindu Marriage Act, a mental-capacity defect at the wedding makes the marriage voidable, not void.** Breach of the formation condition renders the marriage liable to be set aside on a party's petition; until a decree of nullity is granted the marriage is valid for all purposes. The Hindu Marriage Act says the marriage shall be voidable and may be annulled, and the candidate must keep both verbs and must not upgrade this ground to a void marriage. The Special Marriage Act runs the other way: there the same breach is void, so the void-or-voidable answer turns on which Act governs.

31.4 The Special Marriage Act: same condition, void not voidable

The civil, secular route to marriage is the Special Marriage Act of **1954**, a form of civil marriage open irrespective of religion, which the parties may solemnise in whatever form they choose since the Act does not require a religious ceremony, subject to the Act's conditions and to the current law. This is the Act's solemnisation chapter, and it is this chapter, not the Act's separate provision for registering a marriage already performed in some other form, that carries the mental-capacity condition examined here. Its mental-capacity condition is clause (b) of section **4(b)**, and its three limbs are substantively identical to the Hindu Act's: incapacity of valid consent through unsoundness of mind; a mental disorder of such a kind or extent as to be unfit for

marriage and the procreation of children despite capacity to consent; and recurrent attacks of insanity. The same clinical test therefore serves both statutes, so the psychiatric opinion does not change with the Act. What changes, and this is the discrimination the paper rewards, is the consequence of a breach. Under the Hindu Marriage Act a breach of the mental-capacity condition renders the marriage voidable under section **12(1)(b)**, valid until a party has it annulled; under the Special Marriage Act a marriage solemnised under that chapter with the same breach is **null and void** under section **24**, a nullity from the outset that a party may have declared by a decree of nullity. A civil marriage solemnised under this chapter that fails the mental-capacity clause is therefore void, not merely voidable, and this void-versus-voidable split between the two Acts, on identical clinical facts, is the examined point. Registration of a marriage already performed in some other form is a separate current route under the Act, carrying its own condition on the parties' mental state at registration and its own, milder consequence for breach, namely that the registration rather than the marriage may be declared of no effect; that registration route is not restated here. The practical work is to cite the Act that governs the marriage in front of you and the consequence that Act attaches to a breach. That section also sets the Act's other conditions for a valid civil marriage, including that neither party already has a living spouse and that each has reached the minimum age the Act fixes for a bride and a groom; those are named here only to place the mental-capacity clause within its section, and are not the psychiatric ground.

IN INDIA

The clinical opinion is identical across the two statutes; what changes is the governing Act, and with it the section cited and the void-or-voidable consequence a breach carries. A marriage solemnised under Hindu personal law is tested against the Hindu Marriage Act, while a civil or inter-faith marriage is tested against the Special Marriage Act, and comparable mental-capacity conditions run through the other personal-law statutes with wording of their own. Match the governing Act to the parties before framing the report, because quoting the wrong statute for the right facts is an avoidable and much-penalised slip in a viva.

31.5 Nullity is a formation defect, not a divorce ground

The title of this topic pairs marriage with nullity, and the trap the paper sets is the line between nullity and divorce. Nullity, the route owned here, rests on a defect present when the marriage was formed: the mind was not fit to marry at the wedding, so the marriage was defective at its formation and may be unravelled by a decree. Divorce is the opposite premise. It is the **dissolution** of a marriage that was validly formed and subsisting, brought to an end for a reason that matters now, and where mental illness is the reason it operates as a ground of divorce with its own threshold. That dissolution ground is taken up as its own topic elsewhere in this chapter and is not restated here; what this section owns is the formation defect and the nullity that follows from it.

The reason the distinction earns marks is not that a single variable, the timing of the illness, sorts the same facts into one route or the other. Nullity and divorce ask different questions of those facts. Nullity asks whether the mental-capacity condition in section **5(ii)** stood breached at the

time of the marriage; if it did, the marriage is voidable under section **12(1)(b)** and may be annulled, whatever course the illness took afterwards. Divorce under section **13(1)(iii)** asks a different question: it presupposes a validly formed and still subsisting marriage and turns on whether the illness now meets the statutory severity threshold that ground sets, irrespective of when the disorder first began. Timing is therefore decisive for one question only, whether the section **5(ii)** condition was breached at solemnisation, and it does not by itself fix which remedy the facts will support: a disorder that predated the wedding can found a nullity petition if it breached the condition then, and can equally found a divorce if the marriage was validly made and the dissolution threshold is now met. This is why the psychiatric history should still fix onset against the date of the marriage as precisely as the records allow, but as evidence going to the formation condition, not as a switch that routes the whole case.

TRAP **Reading a formation defect as a divorce ground, or the reverse.** Facts that show incapacity or unfitness at the time of the marriage answer the nullity question; facts that show a grave illness arising within a valid marriage answer the divorce question. Citing the dissolution ground for a defect present at the wedding, or the formation condition for an illness that developed later, answers the wrong question and forfeits the mark.

PITFALL

Two currency-and-scope errors recur in practice. The first is treating a voidable marriage as if it were void from the outset, and advising a family that "there is no marriage" when in law the marriage stands until a party obtains a decree. The second is conflating the formation ground with the divorce ground, so that a clinician frames an opinion about a spouse's current illness as though it bore on the validity of the wedding years earlier. Both overstate what the statute allows and mislead the very people who have come for guidance.

31.6 The psychiatrist in nullity proceedings

Because the condition is anchored to the moment of the marriage, the assessment is almost always retrospective and is functional rather than diagnostic. By the time a nullity petition reaches a psychiatrist the wedding may be long past, so the opinion is reconstructed from contemporaneous records, informant accounts and any independent evidence of the party's mental state around the date of the marriage. The task is not to certify a diagnosis or to pronounce the person globally sound or unsound, but to map the statutory limbs onto that moment, and the enquiry follows the section's own structure:

- the diagnosis, and how securely it can be made for the relevant period;
- the mental state at the time of the marriage, reconstructed as far as the evidence allows;
- whether, on the first limb, the person could give a valid consent to the marriage;
- whether, on the second limb, a disorder reached the kind or extent that makes for unfitness for marriage and the procreation of children;
- the course of the illness, and whether it ran in the recurrent pattern the third limb describes.

The burden of establishing the ground rests on the party seeking nullity, and the ground must be proved on the whole admissible evidence; medical evidence is ordinarily important, especially where available, but is not an invariable statutory prerequisite, so the quality of the reconstruction frequently decides the case. That makes candour about the limits of a retrospective opinion a professional duty rather than a weakness: where the contemporaneous record is thin, the honest report says so and frames the view as an inference, since an overstated opinion does the petitioner's work while damaging the witness. How the opinion is finally put before a court, the form of the expert report and the duties of the expert witness, is not family law and is treated in the Forensic ethics, consent and legal procedure notes; here the content of the opinion is dictated entirely by the limbs and by the moment at which they must be shown.

GOOD TO REMEMBER

Pitch the opinion to the wedding, not to the clinic today. Set out the diagnosis, the mental state at the time of the marriage, and whether the person could consent or was rendered unfit, and tie each finding to the limb it bears on. Resist a global "of unsound mind" verdict, which is not what the court can act on, and where the historical evidence will not support a firm view, say the evidence is insufficient rather than filling the gap with an impression.

The mental-capacity condition for a valid marriage is judged at the time of the marriage, and its breach is a defect of formation, never a ground of divorce; under the Hindu Marriage Act that breach makes the marriage voidable and annullable by a decree of nullity, while under the Special Marriage Act the same breach makes the marriage void from the outset.

32 · Divorce and annulment on grounds of mental illness

Where the marks sit. A marriage can end in law in more than one way, and the psychiatrist is drawn in whenever mental illness is said to be the reason. The route addressed here is divorce - the dissolution of a marriage that was validly contracted and subsisting - on the ground that the other spouse is mentally ill. Under the Hindu Marriage Act of **1955** this ground lives at section **13(1)(iii)**, and it is worded with a precision the examiner rewards: it is not enough that a spouse carries a psychiatric diagnosis. The section asks a question about severity, endurance and curability, and it leaves the final decision to the court.

Most of the marks turn on keeping divorce apart from nullity, and a diagnosis apart from a legal ground: dissolving a valid marriage is a different legal act from declaring one void or voidable for a defect present when it was formed, and naming a disorder is not the same as satisfying the statutory threshold. Keep those distinctions clear and the topic is secure.

32.1 A dissolution ground, and its pedigree

Divorce is the **dissolution** of a subsisting, validly formed marriage: the union existed in law and is now brought to an end by a **decree of divorce**. Holding that firmly is the key to placing this ground correctly, because the same clinical facts can be argued along a quite different legal route. Under the Act a marriage "may ... be dissolved" on the mental-illness ground, and the verb is

doing real work: dissolution is discretionary and judicial, so even where the clinical picture is made out the court is asked to grant a decree, not compelled to. The petition may be presented by either the husband or the wife, and the ground looks throughout to the other party's condition, so a petitioner cannot found the case on their own illness. The mental-illness ground sits among the Act's other grounds of divorce, but it is the one that turns squarely on psychiatric evidence, which is why the clinical case the section needs falls to the psychiatrist to build rather than to the lawyer.

The clause in its present form is not original to the Act as first enacted. It was substituted by **Act 68 of 1976**, the reform that recast several of the fault grounds and, importantly, attached a statutory Explanation defining what "mental disorder" means for this purpose. Reading the current wording as though it were the original provision is a common slip; the definitions that make the ground workable were a later addition, and it is those definitions the examiner most often tests.

1955	13(1)(iii)	1976
HINDU MARRIAGE ACT	MENTAL-ILLNESS GROUND	EXPLANATION ADDED

32.2 The alternative limbs of the ground

The section gives the petitioner alternative ways of making out the same ground, set down as one or the other and not as a single combined test. The first is that the respondent has been **incurably of unsound mind**. Here the operative words are unsoundness and, decisively, its incurability: a disturbance that can be cured, however severe while it lasts, does not answer this limb. The second is that the respondent has been suffering, continuously or intermittently, from **mental disorder** of such a kind and to such an extent that the petitioner cannot reasonably be expected to live with the respondent. This limb says nothing about cure; its test is one of gravity and of the effect of that gravity on married life.

The phrase "continuously or intermittently" in the second limb is deliberate and clinically apt. A relapsing and remitting illness that returns in episodes is not taken outside the ground merely because the respondent is well between them; what the limb asks is whether the disorder, taken as it actually runs, reaches the kind and extent that makes cohabitation unreasonable. The limbs are worth pulling apart because they weigh different things: the first asks whether the condition can be cured, the second asks whether, cure or no cure, the disorder is grave enough that continued life together cannot reasonably be expected of the petitioner. In clinical terms the hard work usually lies in the first limb, because incurability is a strong and unforgiving word - a prognosis of persistent, treatment-refractory illness is a very different assertion from a diagnosis, and it should be offered only where the course genuinely supports it. A candidate who runs the limbs together, importing incurability into the second or dropping the cohabitation test from it, has misread the clause.

AXIS	FIRST LIMB: INCURABLE UNSOUNDNESS	SECOND LIMB: GRAVE MENTAL DISORDER
Statutory core	the respondent "has been incurably of unsound mind"	a "mental disorder ... of such a kind and to such an extent" that cohabitation cannot reasonably be expected
What must be shown	unsoundness of mind, and that it is incurable	a qualifying mental disorder of sufficient kind and extent
Does curability decide it	yes - incurability is itself the threshold	no - severity and its effect on married life are
Course of the illness	a settled, enduring unsoundness	may be continuous or intermittent
The question for the court	can the condition be cured	can the petitioner reasonably be expected to live with the respondent

32.3 What the Act means by "mental disorder"

The reason this ground is examinable, and not merely a gesture at illness, is that the Act refuses to leave "mental disorder" to ordinary usage. The Explanation to the clause defines it, and defines it broadly. For this purpose "mental disorder" is stated to mean:

- mental illness;
- arrested or incomplete development of mind;
- **psychopathic disorder**; or
- any other disorder or disability of mind;
- and it is expressly stated to include **schizophrenia**.

Two features of the definition repay attention. It is a broad means-and-includes definition: the defined categories are exhaustive at category level, but one category, "any other disorder or disability of mind", is itself a wide catch-all, and "arrested or incomplete development of mind" brings intellectual disability within the term rather than confining it to psychotic illness. The express naming of schizophrenia is the detail candidates remember, and it is a real feature of the provision - the most litigated diagnosis was put beyond argument as to whether it can, in principle, count.

The Explanation also defines psychopathic disorder in its own right: a persistent disorder or disability of mind, whether or not it includes sub-normality of intelligence, that results in abnormally aggressive or seriously irresponsible conduct on the part of the respondent, and it holds whether or not the condition requires or is susceptible to medical treatment. That last clause is easily missed and worth stressing: a psychopathic disorder can found the ground even if it is untreatable or needs no treatment, because the definition turns on the resulting conduct, not on treatability. The breadth of the definition has a practical consequence worth carrying into the witness box: a psychiatric label will rarely take a genuine condition outside "mental disorder", so

the real contest in almost every case is not whether the condition counts but whether it reaches the threshold the limbs set.

32.4 A threshold, not a diagnosis

The crux of the topic. Because the Act names disorders and even singles out schizophrenia, it is tempting to read the ground as satisfied the moment a diagnosis is made. It is not. The definition of "mental disorder" tells you which conditions are capable of founding the ground; it does not tell you that every instance of them does. Each limb imposes a further test that is about degree rather than label - incurability on the first, and a kind and extent that makes cohabitation unreasonable on the second. A stable, treated illness, or a diagnosis that leaves the person able to sustain married life, meets neither.

Consider a respondent whose illness is well controlled between relapses and who functions in the marriage for long stretches. The diagnosis is not in doubt, yet neither limb may be made out: the first is defeated by treatability, and the second by the absence of the required gravity. The section's questions are answered by the course and the consequences of the illness, not by its name in the case notes. This is where the clinical and the legal part company - the diagnosis is a clinical fact the psychiatrist can supply, but whether it reaches the statutory threshold is a mixed question the court decides on the whole of the evidence.

RULE **The ground is a threshold, not a diagnosis.** The Act asks how grave the condition is and, on the first limb, whether it is incurable, not merely what it is called. Naming a disorder, schizophrenia included, establishes only that it is capable of founding the ground; the petitioner must still prove the incurability, or the kind and extent, that the section actually demands.

PITFALL

Asked whether a spouse's illness "is a ground for divorce", a clinician may answer yes on the strength of the diagnosis alone, encouraged by the Act expressly listing schizophrenia. The express inclusion only makes a disorder capable of founding the ground. Treating the diagnosis as though it settled the legal question overstates what the clinical evidence can carry and steps into the court's role of applying the statutory test.

32.5 Divorce is dissolution, not nullity

The title of this topic pairs divorce with annulment, and that pairing is exactly where candidates come to grief. Divorce dissolves a marriage that was validly formed and subsisting, and it operates from the date of the decree forward. **Nullity**, or annulment, rests on the opposite premise: it is a finding that the marriage was void, or voidable and then set aside, because something was wrong at its very formation. Mental illness can feature in both routes, but it enters through different doors. As a divorce ground it speaks to a condition that makes the continued marriage unsustainable; as a nullity ground it speaks to a defect of capacity or consent that was present when the marriage was contracted.

The consequences differ, which is why the distinction is not merely formal. A decree of divorce accepts that a marriage existed and brings it to an end; a decree of nullity treats the marriage as

never having been valid, or unravels it from the outset. In practice the same clinical picture can be pleaded along either route, but what selects the route is whether the marriage was validly formed, not when the illness began: the divorce ground presupposes a valid, subsisting marriage and asks only whether the condition reaches the threshold, so an illness that predated the wedding can still found a divorce where the marriage was validly contracted and the severity test is met. Onset relative to the marriage bears on the nullity question alone, whether a disqualifying condition existed at solemnisation and so vitiated the formation, so the psychiatrist should record onset for that inquiry without treating a pre-marital start as evidence against divorce. The formation conditions, the void and voidable categories and the nullity procedure are taken up as their own topic, in the account of marriage and nullity elsewhere in this chapter, and are not restated here; what this section owns is the dissolution ground and its threshold.

TRAP **Reading a formation defect as a divorce ground, or the reverse.** Facts that show unsoundness or want of capacity at the time of the marriage point to nullity, because they go to how the marriage was formed. Divorce, by contrast, dissolves a validly formed and subsisting marriage whenever the respondent's condition meets the statutory threshold, whether or not the illness began after the wedding. Citing the dissolution ground for a genuine formation defect is one error; treating a pre-marital onset as by itself a bar to divorce, when the marriage was validly contracted and the threshold is met, is the other.

32.6 The psychiatrist in matrimonial proceedings

In practice the psychiatrist is brought in to examine the respondent, or to comment on the records, and to give the court an opinion pitched to the statutory limbs. The burden of proving the ground rests on the petitioner, and the mental-illness ground is proved on the whole of the legally admissible evidence, medical evidence being ordinarily important, especially where available, but not an invariable statutory prerequisite, so the quality of the psychiatric opinion frequently decides the case. What the examination should capture follows the section's own structure:

- the diagnosis, and how securely it can be made;
- the current mental state and its severity;
- the course, whether continuous or intermittent;
- the prognosis, and specifically whether the condition is curable;
- the functional impact on the capacity for married life.

The opinion is then framed to the section: address curability squarely where the first limb is in play, and kind and extent where the second is, and leave the ultimate question of whether the marriage should end to the court. That opinion is often retrospective and always partial, since the examiner may be meeting the respondent long after the events pleaded, so it should be pitched with candour about its limits, because an overstated report does the petitioner's work while weakening the witness. How the psychiatrist actually gives that evidence - the form of the expert report, the duties of the expert witness and the conduct of testimony - is not family law and is

treated in the Forensic ethics, consent and legal procedure notes; here the point is only that the clinical content is dictated by the limbs and by the thresholds each of them sets.

IN INDIA

Indian courts have read the qualifying threshold strictly: neither a bare diagnosis nor a spell of psychiatric treatment establishes the ground by itself, and the petitioner must show on the evidence that the statutory test, incurability or a disorder of the required kind and extent, is actually met. Comparable mental-illness grounds run through the other personal-law statutes and the secular marriage law, though their wording and their thresholds differ, so the governing provision must be matched to the parties before the clinical opinion is shaped.

GOOD TO REMEMBER

When you examine a spouse for matrimonial proceedings, keep the opinion clinical: set out the diagnosis, severity, course, prognosis and curability, and the impact on the capacity for married life, and map each to the limb it bears on. Resist being drawn into whether the marriage should be dissolved, which is the court's question and not the clinician's, and where the evidence is thin, say so rather than filling the gap with an impression.

The divorce ground for mental illness dissolves a valid marriage only where the petitioner proves incurable unsoundness of mind, or a mental disorder so grave that cohabitation cannot reasonably be expected; a diagnosis alone, schizophrenia included, is never enough.

33 · Child custody and psychiatric evaluation

Why the marks are here. A custody question reaches the psychiatrist because a court has to decide something it cannot observe for itself: which arrangement will let a particular child grow up safe, stable and well. When one parent has, or is alleged to have, a mental illness, the court needs someone to translate that illness into what it actually means for the day to day care of the child. The examiner is testing three things at once - that you lead with the principle the whole area turns on, that you will not mistake a diagnosis for the answer, and that you understand the limits of your own role. Get those three right and the rest of the answer writes itself.

State the governing idea before anything else, because every later step serves it. In an Indian custody matter the **welfare of the child** is the paramount consideration, standing above the claims of either parent. The **Guardians and Wards Act 1890**, which applies across communities, and the **Hindu Minority and Guardianship Act 1956**, which applies to Hindus, both make the child's welfare the decisive test. The psychiatric evaluation exists to inform that test, and nothing more.

In an Indian custody dispute the child's welfare is the paramount test; a parent's mental illness counts only through its effect on parenting capacity and on the child, and the psychiatrist informs the decision without making it.

Welfare	Function	Informs	Both
THE PARAMOUNT TEST	NOT THE DIAGNOSIS	THE COURT STILL DECIDES	PARENTS AND CHILD ASSESSED

33.1 The welfare principle and the statutory frame

Custody is decided by the court acting as **parens patriae**, the guardian of those who cannot protect their own interests. This is why the parents' wishes, their relative wealth, and even the ordinary preferences written into personal law are all subordinate to a single question: what does this child need. It helps to separate two ideas that candidates routinely blur. Custody is the day to day care and control of the child; guardianship is the wider legal authority over the child's person and property. A parent may hold custody while the framework of guardianship sits elsewhere, and the welfare test governs both.

Both governing statutes point the same way. Where a personal law names one parent as the preferred natural guardian, that preference *yields* the moment it collides with the child's welfare, because welfare, not lineage and not gender, is the criterion the court is bound to apply. In practice the court weighs the age and sex of the child, the continuity and stability of the child's existing environment, the character and capacity of each parent, the child's own ascertainable wishes, and any threat to safety. None of these is applied mechanically; they are balanced against one another, and the psychiatric evaluation feeds several of them at once.

RULE **Custody turns on the child's welfare, not on a parent's label.** The statutes make welfare the decisive test, so the evaluation exists to translate any parental illness into its concrete effect on care and on the child, and to stop precisely there. An opinion that says more than that has stepped outside the psychiatrist's remit and into the court's.

33.2 From status to function: why a diagnosis does not decide

The single most important clinical and legal move in this area is the shift from status to function. A diagnosis is a status; parenting is a set of functions. A parent's mental illness is not, by itself, disqualifying. What the law asks is whether, and how, the illness affects the parent's capacity to care for this child and the welfare of the child, never the name of the condition on the certificate. This is also the posture the modern rights-based framework of disability law expects: a person is not defined, and must not be written off, by a diagnostic label.

Worked through, the discrimination is straightforward. A parent whose illness is well treated, who has insight, who adheres to treatment and who has a supportive network may parent perfectly well, and a diagnosis alone neither proves nor disproves that. An illness becomes relevant only through its functional consequence: active psychosis with command phenomena that concern the child, a manic episode with reckless endangerment, a depression so severe that a young child is left unfed or unsupervised, or disorganisation that removes basic protection. In each of those the concern is what the parent cannot currently do for the child, not the diagnostic heading under which it falls. The evaluator's job is to make that functional link explicit, or to say clearly that no such link exists.

TRAP **Treating a diagnosis as automatic unfitness.** Candidates write that a parent with schizophrenia or bipolar disorder should lose custody. The law asks for the effect of the illness on parenting and on welfare, not for the diagnosis; a well-treated, insightful, supported parent may care for a child perfectly, and a label on its own decides nothing. Answer with function, and the mark follows.

33.3 Parenting capacity: what the evaluation actually assesses

The core of the psychiatric evaluation is an assessment of **parenting capacity**: not whether a parent is ill, but whether the parent can meet this particular child's needs, now and in the foreseeable future. It is a functional, here-and-now and forward-looking judgement, and it is best broken into domains that can each be observed, described and, where necessary, defended under cross-examination:

- basic care and physical safety - feeding, supervision, medical needs, and protection from harm;
- emotional availability and warmth - the capacity to attune to the child and to respond to distress;
- consistency, structure and boundaries - predictable routines and reliable containment;
- a realistic understanding of the child's developmental and emotional needs;
- the capacity to place the child's needs above one's own, including during adult conflict;
- willingness to support the child's relationship with the other parent rather than obstruct it.

The last domain matters more than trainees expect. A parent who actively works to poison the child's bond with the other parent is displaying a parenting deficit, whatever their diagnostic status, and a parent with an illness who nonetheless protects that bond is showing real capacity. Capacity is established not by assertion but by method: an interview and mental state examination of each parent, a developmental and psychiatric history, and, above all, direct observation of each parent interacting with the child. What a parent describes and what a parent does with the child in the room are different data, and the evaluation needs both.

MNEMONIC

Parent, Child, Fit, Risk

A custody evaluation moves through the **parent** (the parenting capacity of each caregiver), the **child** (developmental needs, attachments and age-weighted wishes), the **fit** between them (how well each parent meets this particular child's needs), and the **risk** to the child's safety. The four run in the order a careful assessment actually follows, and none of them is the diagnosis.

33.4 The child's side: attachment, needs and age-weighted wishes

An evaluation that examines only the parents has done half the work. The child is assessed in their own right. The quality and security of the child's **attachment** to each caregiver, and the continuity of care the child has actually experienced, carry real weight, because welfare is a matter of relationships and stability rather than an idealised parent chosen in the abstract.

Developmental needs shift with age, and an arrangement that serves an infant well may fail an adolescent; the evaluation is always about this child at this stage, not a generic child.

The child's own voice. The child's wishes are ascertained and given weight according to age and maturity - the more developmentally mature the child, the more their stated preference counts, without it ever becoming the sole determinant. Here the evaluator must tread carefully. A child's stated preference can be authentic, or it can be coached, or it can reflect a wish to placate the more frightening parent or to protect the more fragile one. Eliciting the child's voice sensitively and alone, and interpreting it against the whole picture rather than taking it at face value, is a skill the examiner expects you to name explicitly. The child is heard; the child is not asked to choose.

33.5 Risk to the child within the evaluation

Safety is the threshold that sits inside welfare: no arrangement can be in a child's interest if it exposes the child to harm. The evaluation therefore screens actively for risk - domestic violence, substance misuse, neglect, and physical, sexual or emotional abuse - as well as for danger arising directly from untreated parental psychopathology. **Parental alienation**, in which one parent systematically corrodes the child's relationship with the other, is itself a form of emotional harm to the child and belongs squarely in the risk formulation rather than being dismissed as ordinary post-separation hostility.

Where abuse of a child is alleged or suspected, the matter stops being a purely private custody dispute and engages the statutory child-protection machinery. The child-protection statutes, and the systems that assess and safeguard children at risk, are set out in the Child psychiatry: assessment, treatment, services and protection notes; the custody evaluator's task is to recognise the threshold, document the concern accurately, and route it into that machinery, not to adjudicate the abuse allegation itself. Confusing the two - trying to prove or disprove abuse within a custody opinion - is how an evaluator exceeds both competence and remit.

33.6 Method and the limits of the psychiatrist's role

A defensible custody opinion rests on more than one voice. The evaluator interviews and examines each parent, observes each parent together with the child, sees the child sensitively and alone, and gathers **collateral information** from school, treating clinicians, and documentary records. Triangulating these sources is precisely what protects the opinion from a single parent's partisan account, and it is the difference between an assessment and an endorsement.

The most important boundary is the one written into the nature of the task: the psychiatric evaluation informs the court's welfare determination, it does not make it. The evaluator describes parenting capacity, the child's needs and attachments, and any risk, and shows the reasoning that connects them; the choice of custody arrangement remains the court's alone. Staying inside that boundary is not diffidence, it is the correct forensic posture, and it is what keeps the opinion admissible and useful. The wider ethics of acting as an expert - confidentiality in the forensic setting, the avoidance of a mixed treating and evaluating role, and the certification of a report or

opinion for the court - are the subject of the Forensic ethics, consent and legal procedure notes, and are named here rather than taught.

PITFALL

Forming a view from one parent's account without ever observing the child, seeing each parent together with the child, or gathering independent collateral. A custody opinion built on a single, interested informant is unsafe, it tends to import that informant's bias unexamined, and it rarely survives cross-examination.

GOOD TO REMEMBER

Write your opinion as parenting capacity and welfare, never as a verdict on the parent. Say what each parent can and cannot do for this particular child and why, flag any risk plainly, and leave the arrangement itself to the court. An opinion framed this way is both more useful to the judge and far harder to discredit.

33.7 The components at a glance, and how it is examined

Set out side by side, the evaluation separates cleanly on what each part examines and how each part goes wrong. The accompanying table lays out the axes an examiner tests; commit the structure, because a viva question almost always asks you to reason across the whole assessment rather than recite one piece of it.

AXIS	WHAT IT EXAMINES	WHY IT MATTERS	COMMON ERROR
The parent	Parenting capacity: safety, warmth, consistency, insight, the ability to prioritise the child, support for the other parent's contact	Determines whether care will be adequate and stable	Reading the diagnosis instead of the function
The child	Age, developmental needs, attachments, and age-weighted wishes	Anchors the decision in this child's actual needs	Ignoring the child's voice, or over-weighting a coached wish
The fit	How well each parent meets this particular child; continuity of care and environment	Welfare is about a relationship, not a parent in isolation	Assessing parents in the abstract
The risk	Violence, substance misuse, neglect, abuse, alienation, illness-driven danger	Safety is the threshold within welfare	Missing risk by focusing only on capacity

IN INDIA

Indian courts decide custody as guardians of the child, and the welfare test cuts across community and personal law: even where personal law names a preferred natural guardian, that preference gives way to the child's welfare. Custody of a child of **tender years** is often, though never automatically, entrusted to the mother on a welfare rationale rather than by a fixed rule. Because custody usually arises within divorce or judicial-separation proceedings, the psychiatrist is generally asked for an opinion in a matrimonial context in which feelings run high and each side may try to recruit the evaluation to its own case. The welfare test, however, is distinct from and outlives the question of whether the marriage itself survives, and the evaluation should be framed to serve the child even when the adults are framing it to serve themselves.

In the examination this topic rewards the candidate who leads with the welfare principle, refuses to be drawn into equating a diagnosis with unfitness, describes a structured multi-source evaluation, and states plainly that the psychiatrist informs but does not decide. Say those four things clearly, name the two governing statutes, and the answer reads as the work of someone who has actually stood in the witness box rather than only read about it.

34 · Guardianship and management of property of mentally ill

Why the marks are here. When mental illness erodes a person's ability to look after money, land and everyday affairs, the law is asked to do two things at once: shield the person and the estate from loss and from exploitation, while intruding on their autonomy no more than the situation demands. The mechanism it reaches for is the guardianship of property and the appointment of someone to manage the estate. For the examiner this is less a topic than a discrimination. Mental illness can trigger several distinct legal offices, and candidates routinely fold them into one. The task is to hold the property-management route apart from the healthcare-facing office and from treatment-decision capacity, and to know that the framework a psychiatrist works inside today is not the custodial one the older textbooks were built around.

34.1 From custody of the estate to management of it

The oldest Indian machinery for the property of the mentally ill treated the ill person as a ward to be taken in charge. Under the colonial lunacy law the emphasis was custodial: the state, through the court, assumed control of the estate of a person found to be of unsound mind and installed someone to hold it. That **custodial guardianship** of the estate has been superseded. The modern posture begins from the presumption that legal capacity is retained, treats impairment as specific to particular decisions rather than a global forfeiture of legal personhood, and asks for the least intrusion that will protect the person and the property. The rights-based reworking of guardianship for the disabilities it covers, under the disability-rights statute and the National Trust legislation, is set out with the account of benefits, reservations and guardianship elsewhere in these notes. What remains here is the ordinary statutory route, the residual position where no statute fits, and how property management differs from the healthcare offices around it.

PITFALL

The commonest real-world error is to describe property guardianship in the vocabulary of the repealed lunacy law, as though a finding of unsoundness still stripped a person of legal personhood wholesale and handed a relative standing, all-purpose control. It does not. An opinion or an application written on that assumption over-reaches the patient's rights and invites the court to reject it. Anchor the reasoning to the current, least-restrictive frame, not the custodial one it replaced.

34.2 The ordinary statutory route, and the residual jurisdiction

The ordinary route today runs through statute. Because mental illness is itself a specified disability, a person whose illness erodes decision-making is reached by the **disability-rights statute's limited guardianship**, a supported, joint model named and taught with the reform statutes elsewhere in these notes; where its covered conditions apply, the National Trust legislation runs its own committee-appointed guardianship. What there no longer is, is a free-standing, nationwide civil-court power to appoint a guardian of the person and a manager of the estate at large. The property-management machinery of the old Mental Health Act 1987, the judicial inquisition and management of the estate through the district court, was repealed with that Act and not re-enacted by the present mental-health legislation. Beyond the disability statutes, then, the position is a legislative vacuum: where no statutory route fits, the only residual power is the exceptional parens patriae jurisdiction of the chartered High Courts, derived from Clause XVII of their Letters Patent and recognised in recent Bombay High Court authority. That jurisdiction is territorially and institutionally limited, confined to those courts and their territory, and is not a general civil court supplying property management to all. These notes therefore do not assert a nationwide civil-court manager route, because none is grounded; what precisely fills the vacuum for a person outside the disability statutes and outside a chartered High Court's reach is unsettled, and is flagged here as a gap rather than invented. The psychiatrist's contribution is the same throughout: the medical evidence, a reasoned opinion framed to the particular affairs at issue, that the person's illness presently deprives them of the capacity to manage them.

Because a guardian's or manager's authority is tied to the person's incapacity, a restoration of soundness or an increase in capacity is a ground to review, reduce, dismantle or terminate the arrangement through the applicable statutory or judicial mechanism, not a universal automatic discharge. Guardianship of property is therefore a contingent trust, not a permanent status conferred by the diagnosis, and it is administered for the benefit of the ill person under the appointing forum's continuing supervision rather than handed over as ownership.

RULE **Guardianship of property is a protective trust, not a transfer of ownership or a global loss of legal personhood.** The manager administers the estate for the ward's benefit under the appointing statutory or judicial forum's supervision, which is continuing judicial oversight only where a court has made and retained that supervision; recovery or increased capacity is a ground to review, reduce, dismantle or terminate the arrangement through the applicable statutory or judicial mechanism, not a ground for automatic surrender.

34.3 Where the reform statutes take over

These statutory routes are where the ordinary work is done. For the disabilities they cover, two rights-based statutes supply the guardianship, and a candidate must be able to name them and say which person each reaches, even though their machinery is taught elsewhere in these notes. The disability-rights legislation offers a **limited guardianship** built on joint and **supported decision-making**, in which the guardian shares decisions with the person instead of displacing them. The National Trust legislation runs a separate, committee-appointed guardianship for the developmental and intellectual disabilities named in it. Both express the same instinct that runs through the modern law: support before substitution, and no more control than the person's situation needs. The practical question a psychiatrist answers is which of these doors a given patient goes through, and what medical evidence the chosen forum will want.

34.4 Property guardian versus the healthcare nominated representative

The discrimination that carries the marks separates the office that governs property from the office that supports healthcare decisions. The mental-health legislation appoints a **nominated representative** to help a person exercise and protect their rights within the mental-healthcare system. That representative is emphatically not a property guardian: they do not manage the estate, cannot deal with the person's land or money, and take no authority over civil affairs from the role. The traffic does not run the other way automatically either. A guardian or manager appointed to handle property acquires property powers, and that property appointment alone carries no power to consent to or refuse psychiatric treatment, which belongs to the separate machinery of treatment-decision capacity and its supports, discussed with the mental-health statute's capacity test elsewhere in these notes. The same person can nonetheless separately hold treatment-related authority through that statute's own nominated-representative office, most concretely for a minor, whose legal guardian is that statute's default nominated representative unless directed otherwise; that authority comes from the nominated-representative role, never from the property appointment itself. Keeping the two offices conceptually apart, while checking in a given case whether they have in fact come to be held by the same person, is both the examiner's favourite trap and a genuine clinical safeguard.

OFFICE	WHAT IT GOVERNS	WHO APPOINTS	DECISION MODEL
Limited guardian (disability-rights and National Trust routes; the ordinary statutory route)	Defined affairs of a person with the covered disability	A court or designated authority, or the National Trust committee	Supported and joint, least-restrictive
Parens patriae of the chartered High Courts (residual, exceptional)	Property and affairs where no statute fits	The chartered High Courts only, under Clause XVII of the Letters Patent	Managed for the person, court-supervised; territorially and institutionally limited
Nominated representative (mental-health legislation)	Healthcare and mental-healthcare rights only	As the mental-health law provides	Supports the person's own treatment decisions

TRAP **Treating the nominated representative as a property guardian.** Because both are triggered by mental illness and both sound protective, candidates merge them. They are different offices with different appointers, domains and decision models: the nominated representative supports healthcare choices and touches neither land nor money, while the property guardian or manager controls property but has no say over consent to treatment.

Property and money are run by a guardian or manager of the estate; healthcare is supported by the nominated representative - two separate offices, and neither reaches into the other's domain.

IN INDIA

The Indian answer is layered rather than single. The disability-rights and National Trust statutes supply the ordinary route, a modern supported guardianship for the disabilities they cover, which include mental illness; the old Mental Health Act 1987 property-management mechanism was repealed and not re-enacted, so beyond those statutes only the chartered High Courts hold a residual, exceptional parens patriae jurisdiction rather than any general civil court; and the mental-health legislation supplies the healthcare-facing nominated representative. A psychiatrist asked to help is really being asked which of these frames fits this patient, and what medical evidence the chosen forum needs to see.

34.5 Assessing capacity to manage property and affairs

What the psychiatrist actually assesses. The clinical task is a functional capacity assessment, not the pinning of a diagnosis. **Capacity to manage property and affairs** asks whether, at the relevant time, the person can understand what property they have and its broad extent, appreciate the claims of those who depend on them, weigh the choices involved in keeping or disposing of it, and communicate a decision. It is decision-specific and time-specific. A person may lack capacity for a complex commercial transaction yet retain it for ordinary spending, and capacity lost in an acute episode may return with remission. This is why the office is contingent and why recovery is a ground to review or discharge it. It also means the test is about the quality of the decision-making, not the wisdom of the outcome: a person who retains capacity is entitled to make an unwise or eccentric use of their money, and an imprudent choice on its own is no ground to displace them. What justifies intervention is an inability to carry out the reasoning, traced to the illness, and not merely a decision the family would have made differently. The same functional logic underlies the capacity to make a will and the capacity to enter a contract, each taken up on its own terms elsewhere in these notes; but they are judged against different tasks, and none of them is settled by the psychiatric label alone.

GOOD TO REMEMBER

Write the opinion as decision-specific and time-specific, tie it to the particular affairs in question, and record the prospect of recovery. State plainly that being under a property-management order does not by itself authorise anyone to consent to the patient's treatment, and that a return of capacity should trigger review of whether the management is still needed. That is what keeps the report useful to the court and protective of the patient.

35 · Fitness for job and certification of mental fitness

Why the marks are here. A psychiatrist is asked to certify fitness for a job far more often than to give evidence in any court, and it is quiet, everyday medicolegal work that the examiner likes precisely because candidates underprepare it. An employer wants to know whether a person can start a post, or return to one after illness, and turns to the treating or an assessing psychiatrist for a signed opinion. The task looks administrative, but it sits on a genuine question of capacity - can this person, in their current mental state, do this particular job safely and effectively - and it is bounded by employment law that has changed in the person's favour. The marks reward the candidate who can say exactly what such a certificate asserts, what it does not, and how it differs from the two documents it is most often confused with.

The whole difficulty of the topic is discrimination between look-alikes. A one-line signature that a person is "fit" or "unfit" can, depending on which document it belongs to, decide an appointment, unlock a statutory benefit, or sway a legal case, and the same clinician may be asked for all three about the same patient. Keeping them apart is the intellectual content the paper is testing, so it is worth taking the three certifications one at a time before turning to what a fitness opinion should actually contain.

3	3
CERTIFICATIONS TO SEPARATE	DEFINING FEATURES

35.1 Three certifications that must not be conflated

The commonest error in this area is to treat every request for a "mental fitness certificate" as one thing. It is not. The first is the **fitness-for-duty certificate**, an occupational opinion that states whether a person's current mental state permits safe and effective performance of a specified role, with any accommodations or restrictions that make that possible. It answers a forward-looking, work-focused question, and it is the document this topic owns. The second is the **disability certificate**, which does something entirely different: it quantifies impairment so that a person can access certification-linked entitlements, reservations and schemes, and its instrument, its certifying authority and its benchmark threshold are taught with the disability-certification topic in this chapter and are not to be borrowed here. The third is an **expert report or certificate for a court**, prepared as expert testimony to assist legal proceedings; that document, and the psychiatrist's duties in producing it, belong to the Forensic ethics, consent and legal procedure notes.

What separates the three is not the clinical examination, which may be similar, but the question each answers and the legal machinery each feeds. A fitness certificate is about a job; a disability certificate is about entitlement; a court report is about a legal decision. Reaching for the wrong instrument - answering a fitness-to-work request with a disability threshold, or dressing a treatment opinion as a fitness certificate - is how a clinician gives an authoritative-sounding answer to a question nobody asked.

CERTIFICATION	THE QUESTION IT ANSWERS	WHAT IT IS FOR	WHERE ITS DETAIL BELONGS
Fitness-for-duty certificate	Can this person safely and effectively do this role now?	Occupational fitness for a specified job, with accommodations or restrictions	This topic
Disability certificate	How much impairment, for statutory entitlement?	Quantifying impairment for certification-linked entitlements, reservations and schemes	The disability-certification topic in this chapter
Expert report or certificate for a court	What is the clinical opinion for these proceedings?	Assisting a legal decision as expert evidence	The Forensic ethics, consent and legal procedure notes

A fitness-for-duty certificate answers one narrow, current, role-specific question - can this person safely and effectively do this job now, and with what adjustments - and it is neither a disability certificate nor a report for a court.

35.2 What a fitness-for-duty certificate actually asserts

A sound occupational-fitness opinion has three defining features, and each is a guard against a way the certificate is misused. It is role-specific: it speaks to the demands of one named job, not to the person's general worth or employability, so a person may be fit for a desk-based role and not for one that requires night driving or the carriage of a firearm, and the certificate must say which. It is time-limited: it certifies a current state, valid for a stated review period, because a mental state is not a fixed attribute and a fitness opinion given today cannot vouch for the person indefinitely. It is evidence-based: it rests on an actual assessment of the present mental state and the specific occupational demands, not on a diagnostic label carried in the notes.

These three features are why a bare "fit" or "unfit" is a poor certificate. "Unfit", without a role, without a time frame and without a basis, tells the employer nothing they can act on lawfully or safely, and it invites them to read a temporary limitation as a permanent exclusion. The useful document names the role, states the period, and gives enough of the reasoning that the employer can see what the restriction is protecting against.

MNEMONIC

Which role, until when, on what evidence

The three features of a defensible fitness-for-duty certificate: it is **role**-specific (fit for which job, with what accommodations), **time**-limited (a current opinion with a review date, not a standing verdict), and **evidence**-based (grounded in an assessment of the present mental state against the actual demands of the post, not in a diagnosis on the file).

RULE **Fitness is a judgement about a role at a moment, not a verdict on a person.** The certificate certifies that a specified individual can, as they are now, meet the demands of a specified job safely and effectively, with any stated accommodations or restrictions, for a stated period. Every one of those qualifiers - the person, the job, the moment, the adjustments, the review date - is part of what is being certified, and dropping any of them turns a lawful, useful opinion into an over-broad label.

35.3 The functional assessment: matching the person to the role

Because fitness is defined by the job, the assessment begins with the job. The psychiatrist has to understand the actual demands of the role - its cognitive load, its interpersonal and supervisory content, its safety-critical elements, its shift pattern, its access to hazards or to vulnerable people - and then ask whether the person's current mental state allows those demands to be met. This is a **functional assessment**, not a diagnostic one: the question is what the person can do in this post, not what condition they carry, and the two do not map onto each other neatly, since a person with a serious diagnosis may be entirely fit for many roles and a person with none may be temporarily unfit for a demanding one.

Where a limitation exists, the opinion should reach for adjustment before exclusion. A **reasonable accommodation** - a modified duty, a graded return, an altered shift, a temporary reassignment away from a safety-critical task - often converts an "unfit for the role as it stands" into a "fit with these adjustments", and that is usually the more accurate as well as the more humane answer. Restrictions are the mirror image: the specific tasks the person should not perform for now, named narrowly so that everything not restricted remains open. A defensible certificate therefore records several things together rather than a single word:

- the specific role and its demands the opinion is addressed to;
- whether the person's current mental state meets those demands, and where it does not;
- the accommodations that would make the role workable, and the restrictions that should apply meanwhile;
- the period for which the opinion holds and the point at which it should be reviewed.

GOOD TO REMEMBER

Start from the job description, not the diagnosis. Ask what this post actually requires and whether the person can meet it now, then default to graded return and specific accommodations rather than a blanket "unfit". Name the restrictions narrowly and time-limit the whole opinion, so the employer knows precisely what is being protected against and for how long.

35.4 The employment-rights frame the certificate sits inside

A fitness opinion is no longer written in a vacuum in which an employer may do as they please with it. Disability, including mental illness where it amounts to a disability, is a protected ground in employment, and the certificate operates inside that protection rather than around it. This changes the clinician's posture: the default is inclusion with support, and a limitation has to be genuine, job-specific and no wider than the evidence requires, because a loosely worded exclusion can become an unlawful act when the employer relies on it.

The Indian frame. The reform is statutory, and the psychiatrist should know which way it cuts.

IN INDIA

The **Rights of Persons with Disabilities Act** protects against discrimination in employment on the ground of disability, so a psychiatric diagnosis is not a lawful reason to refuse or remove a person from a post by itself. Fitness certification therefore runs alongside a duty of non-discrimination and an expectation of reasonable accommodation, and the useful certificate is the one that supports a person into work with the right adjustments rather than one that hands an employer a broad "unfit" to exclude on. The separate disability certificate that unlocks statutory benefits, with its instrument and threshold, is a different document dealt with elsewhere in this chapter, and the two should never be run together.

PITFALL

Issuing a global or open-ended "unfit for duty" instead of a role-specific, time-limited opinion. A sweeping certificate misinforms the employer, forecloses accommodation, and can convert a temporary or partial limitation into an unlawful exclusion on the ground of disability. The clinical error is treating fitness as a standing property of the person rather than a current judgement about a particular role, and it does real harm in both directions - it can shut a capable person out of work, and it can wave through a person into a safety-critical task the evidence did not actually support.

35.5 Scenarios, boundaries and the limits of the task

The request reaches the psychiatrist in a few recurring shapes. Pre-employment screening asks whether a person can take up a post; **fitness to resume duty** asks whether a person can return after a period of illness or treatment, often the commonest referral and the one where a graded plan is most useful; and periodic re-certification arises in posts, especially **safety-critical roles**, where a standing requirement of demonstrated fitness applies. Each is the same functional question against a different backdrop, and each is answered role by role and moment by moment rather than once and for all.

Two boundaries keep the task honest. The first is confidentiality: the certificate should convey only the conclusion and the work-relevant restrictions and accommodations, not the clinical detail behind them, because the employer has no freestanding entitlement to a person's mental-health information; disclosure needs the person's informed consent or another lawful basis, and only the minimum necessary detail should be released, never a transcript of the consultation. The second is scope: the fitness certificate is an occupational document, and the moment the same clinical picture is wanted as evidence for a court, the exercise becomes expert testimony governed by different duties and treated in the Forensic ethics, consent and legal procedure notes. Likewise, questions of compensation or a disability pension for a work-related psychiatric condition are a distinct assessment with their own purpose and are taken up separately in this chapter; a fitness opinion neither answers them nor should be stretched to.

The honest fitness opinion is modest about what it can promise. It certifies a present capacity for a defined role, hedged by the accommodations that make it workable and by a review date, and it declines to guarantee the future or to pronounce on the person's worth. That restraint is not weakness; it is the whole discipline of the certificate, and it is what keeps a routine signature from doing more legal work than the assessment behind it can bear.

TRAP **Answering a fitness-to-work question with a disability instrument, or vice versa.** The occupational-fitness certificate, the disability certificate that quantifies impairment for benefits, and the expert report for a court are three separate documents with three separate purposes. Borrowing the disability assessment's instrument or threshold to answer whether a person can do a job, or offering a fitness opinion where a court report is wanted, is the classic way to lose an easy mark by producing an authoritative answer to the wrong question.

36 · Workmen compensation and disability pension (psychiatric)

Why the marks are here. A psychiatrist is drawn into compensation and pension work because the law asks a question medicine cannot answer on its own. It does not want to know what the diagnosis is; it wants to know how far the ability to earn has been reduced, and by an injury or illness that some employer or the State is answerable for. This is where clinical description has to be re-expressed in the vocabulary of a statute, and candidates lose marks by answering the medical question when the legal one was asked. The workplace-injury route in India now runs through Chapter VII of the Code on Social Security, which since November 2025 has repealed the Employee's Compensation Act, **1923**, originally the Workmen's Compensation Act and the source of this topic's older name; rights and proceedings that had already accrued under the repealed Act continue under the Code's repeal-and-savings provisions. A disability pension runs through the various service and pension frameworks instead. Employee's compensation centrally uses the statutory concepts of disablement and **loss of earning capacity**; a disability pension uses whatever metric the applicable service or pension scheme prescribes and cannot be assumed to turn on the same idea.

The examinable content is a discipline of translation. The same florid diagnosis can attract a large award or a negligible one depending only on what it does to the person's capacity to work, and

the same clinical picture is weighed differently under a compensation statute, a benefits statute and a pension scheme, because each defines the loss it is buying in different terms. The candidate who can carry a symptom into the language of earning capacity, and keep the three assessments apart, has the marks; the candidate who signs a diagnosis and stops has not.

36.1 The compensable question is loss of earning capacity

The Act does not compensate injury as such. It compensates the economic consequence of injury, the reduction in what the worker can earn, and a diagnosis is only the raw material from which that reduction is worked out. Two employees with the same illness may attract very different awards if one returns to full earning and the other cannot; conversely a modest-looking condition that removes one specific vocational capacity can be economically catastrophic, as when a locomotive driver develops a psychotic illness or a surgeon a disabling tremor. The psychiatric opinion therefore has to end in a statement about the capacity to earn, not in a list of symptoms, and the reasoning that connects the two is the substance of the work.

RULE **Compensation follows the loss of earning capacity, not the diagnosis.** The statute buys the economic consequence of the condition, measured against the work the person could do at the time of the accident. A florid label with preserved earning power attracts little; a contained condition that destroys a particular earning capacity may attract a great deal. The clinician's task is to value the loss, not to name the illness.

36.2 Partial and total disablement under the Act

What follows is now historical law: it describes the repealed Employee's Compensation Act, 1923, retained here because claims and rights that had already accrued before the repeal continue to be decided under it. The repealed Act framed the injury as **disablement** and graded it in two dimensions at once: by how much of the person's working life it removes, and by whether it is temporary or permanent. **Partial disablement**, defined at section **2(1)(g)**, is disablement that, where it is temporary, reduces earning capacity in the employment the person was engaged in at the time of the accident, and, where it is permanent, reduces earning capacity in every employment the person was capable of undertaking at that time. **Total disablement**, defined at section **2(1)(l)**, is disablement, whether temporary or permanent, that incapacitates the person for all work he was capable of performing at the time of the accident. The pivot between the two is the breadth of employment affected, not the visible severity of the injury.

Two deeming provisions convert scheduled injuries into a grade without a fresh enquiry into earning capacity. An injury specified in the second part of the Act's Schedule of injuries shall be deemed to result in permanent partial disablement. Permanent total disablement shall be deemed to result from an injury in the first part of that Schedule, or from a combination of the listed injuries whose loss of earning capacity totals **100%** or more. Outside those deemed cases the grade must be assessed on the facts, and it is precisely there, where no Schedule entry decides the matter, that the psychiatric opinion does its work.

1923	Part I
EMPLOYEE'S COMPENSATION ACT, REPEALED	SCHEDULE I INJURIES, DEEMED PERMANENT TOTAL

The table below sets out the repealed Act's grading structure, retained for historical and pre-commencement reference:

GRADE AND NATURE (REPEALED ACT)	EARNING CAPACITY THAT IS LOST	HOW THE GRADE ARISES
PARTIAL, TEMPORARY	Reduced in the employment the person was engaged in at the time of the accident	Assessed on the facts
PARTIAL, PERMANENT	Reduced in every employment the person was then capable of undertaking	Assessed on the facts, or deemed for an injury in the Schedule's second part
TOTAL, TEMPORARY	Incapacitated for all work the person was then capable of performing	Assessed on the facts
TOTAL, PERMANENT	Incapacitated for all such work on a lasting basis	Assessed on the facts, or deemed for the Schedule's first part or a qualifying listed combination

TRAP **Partial and total are not grades of severity.** They describe the breadth of employment the incapacity spans, not how bad the injury looks. Partial disablement reduces earning capacity in the employment engaged in, or in every employment the person could undertake; total disablement incapacitates for all work the person could then perform. A total disablement can be temporary, and a severe-looking condition can still be only partial. The candidate who reads total as meaning permanent and catastrophic has misread the definition.

The current law replaces this two-by-two structure. Under the Code on Social Security, permanent partial disablement and permanent total disablement are each separately defined and graded, with temporary disablement as its own distinct category rather than a temporary/permanent split within partial and total. The deeming machinery for scheduled injuries and occupational diseases now sits in the Code's own Schedules rather than in the repealed Act's Schedule I, and disputes are decided by a competent authority appointed under the Code rather than by the Commissioner for Employees' Compensation named under the repealed Act. The exact provision numbers are not reproduced here; see the note at the end of this fragment.

36.3 Fitting a psychiatric condition into the framework

The difficulty here is structural rather than clinical. The Act's Schedule was built around visible, measurable physical injury and a list of occupational diseases; it does not enumerate psychiatric conditions or assign them a deemed percentage. A psychiatric sequela, whether a depressive or post-traumatic disorder after a workplace accident, an organic syndrome after a head injury, or an illness said to be occupationally precipitated, therefore almost always falls to be assessed on the general earning-capacity test rather than read off the Schedule. That throws the whole weight of the question onto the clinical opinion and onto its translation into economic terms, which is why this is genuinely psychiatric work and not a clerical signature.

IN INDIA

Because the Schedules assign no deemed figure to a mental illness, a psychiatric claim is decided on the general earning-capacity test, and the dispute over grade and quantum is adjudicated by the competent authority appointed under the Code on Social Security (historically, for claims decided under the repealed Act, the Commissioner for Employees' Compensation). The clinician's report is evidence before that authority, so it has to speak the statute's language, grade of disablement and effect on earning capacity, and not stop at a diagnostic label. A report that names a condition but never reaches earning capacity leaves the adjudicating authority with nothing to convert into an award.

What the report must actually do. A usable opinion carries the reasoning from symptom to earning capacity in steps the adjudicating authority can follow:

- the diagnosis and its expected course, stated plainly and without jargon;
- the specific functional deficits the condition produces, in attention, stamina, reliability, judgement and interpersonal capacity;
- how those deficits bear on the work the person actually did, and on other work they were capable of doing;
- whether the disablement is temporary or permanent, and partial or total, in the statute's sense;
- the causal link between the workplace event and the condition, on which entitlement ultimately depends.

36.4 Impairment, earning capacity and keeping certificates apart

The recurring clinical error is to answer with an **impairment** figure. Impairment measures the loss of function of the person as a whole; loss of earning capacity measures what that impairment does to the ability to work and earn. They are related but not the same, and the Act asks for the second. A hand injury that is a small whole-person impairment is a large loss of earning capacity for a pianist; a psychiatric condition that looks impairing may leave earning capacity in the person's actual field largely intact. The psychiatrist is asked to bridge from the first to the second, using knowledge of the person's occupation, not to hand over a bare percentage of impairment and let the authority guess at its economic meaning.

PITFALL

Certifying a whole-person impairment percentage, or importing the benchmark meant for the disability-rights benefits certificate, when the Act wants an opinion on loss of earning capacity. The two figures are not interchangeable: a benefits threshold answers a different statutory question, and lifting it into a compensation report both overstates and understates the wrong thing. The honest report reasons its way to an earning-capacity opinion rather than borrowing a number designed for another purpose.

Three quite different certificates are commonly conflated, and keeping them separate is half the topic. The statutory disability certificate issued for benefits, reservations and welfare entitlements

under the disability-rights law uses its own instrument and its own benchmark, and certifies disability, not earning loss. The certificate of fitness to resume duty answers whether the person can safely and competently do a job, a forward-looking occupational question. The compensation assessment values a loss of earning capacity already suffered, and a pension assessment values whatever metric, often disablement or impairment attributed to service rather than earning capacity, the applicable scheme prescribes. Each is owned by a different statute and none can be substituted for the others; and where the same clinical picture is wanted as expert evidence for a court or tribunal, that report and the ethics of giving it belong with the Forensic ethics, consent and legal procedure notes.

GOOD TO REMEMBER

Before writing, decide which statutory question you are answering, benefits, fitness to work, or compensation and pension, and use that framework's language throughout. The commonest reason a psychiatric report is sent back is that it answers a different question from the one the form was designed for, and no amount of clinical detail rescues a report aimed at the wrong target.

36.5 Disability pension: a different metric

A **disability pension** is the periodic counterpart to the largely lump-sum compensation of the Act: a recurring benefit for a person whose capacity has been reduced by disability, paid under government service rules, armed-forces rules and various organised-sector schemes rather than under the compensation statute. It raises two psychiatric questions. The first is **attributability**, whether the mental illness is attributable to, or aggravated by, the conditions of service, as opposed to a constitutional illness that would have arisen anyway. The second is the degree of disablement to be recognised. Here the metric often shifts away from loss of earning capacity toward a percentage of disablement or impairment attributed to service, which is why a pension assessment and a compensation assessment of the same patient can reach different figures for entirely defensible reasons.

The precise eligibility thresholds, the rounding conventions, the rules governing attributability and aggravation, and the scheme-specific percentages are fixed by each individual pension framework and are not reproduced here. What the candidate must hold is that these schemes exist, that they turn on a different metric from the compensation statute, and that a compensation percentage must never be carried across into a pension answer, or the reverse. Naming the metric correctly, and refusing to import a figure from the wrong scheme, is what a careful assessment looks like when the exact numbers are set elsewhere.

In any compensation or pension question, translate the psychiatric condition into how far it reduces the capacity to earn, or, for a pension, the degree of disablement attributable to service, and state the grade of disablement, not the label of the illness.

37 · Adoption law and psychiatric fitness of adoptive parents

Why the marks sit here. Adoption pulls the psychiatrist into family law to answer one narrow, statutorily framed question: whether a person proposing to adopt is fit, in mind and in function, to raise a child. Indian law does not leave that fitness to sentiment. It writes it into the eligibility conditions a prospective parent must satisfy, so an examiner can ask for the exact standard, the instrument that sets it, and the clinician's part in evidencing it. The topic belongs with civil and family capacity because adoptive fitness is assessed like any other decision-specific capacity: functionally, at the point of placement, as the ability to take on and sustain the parenting of a particular child, and not as a global verdict on the person's worth.

India runs two parallel routes into a lawful adoption, and what follows covers only one of them in full. Under the Juvenile Justice route, two texts carry the whole of the assessable law. The primary statute is the Juvenile Justice (Care and Protection of Children) Act 2015, whose adoption chapter fixes the fitness conditions for prospective adoptive parents; the working detail is supplied by the Adoption Regulations 2022, framed by the Central Adoption Resource Authority (**CARA**), which turn that standard into concrete eligibility criteria. The Act's own savings clause preserves the second route: an adoption may still proceed under the Hindu Adoptions and Maintenance Act 1956 for a Hindu adopter, and that Act sets its own capacity condition, that the adopter be of sound mind and not a minor, on terms this section does not reproduce. The wider machinery of the Juvenile Justice Act, its care-and-protection provisions, children in conflict with law and the juvenile board, is the province of the Child psychiatry: assessment, treatment, services and protection notes and is not taught here. What belongs to family-capacity law, and to this section, is the fitness of the adopting adult under the JJ Act/CARA route, with the Hindu-law route's own conditions flagged where they diverge from it.

37.1 The statutory architecture: one Act, one delegated code

The reason there are two texts, and the reason examiners test the relationship between them, is that Indian adoption law is built as primary legislation resting on delegated legislation. The Act lays down the mandatory fitness standard for adoptive parents and then, in the very provision that permits a single or divorced person to adopt, defers the operational detail to the adoption regulations framed by the Authority. That Authority is CARA, and those regulations are the Adoption Regulations 2022. The two must therefore be read together: the Act sets the standard and the enabling frame, and the Regulations supply the eligibility gate that a placing agency actually applies. A candidate who quotes one without the other has read only half the law.

IN INDIA

Adoption of a child in need of care and protection runs through the Central Adoption Resource Authority and its recognised specialised adoption agencies, so the fitness standard a psychiatrist may be asked to support is the working gate of that system rather than an abstract test. It is applied in practice through a social investigation and home-study of the prospective parents before a placement is proposed. A psychiatric opinion therefore enters an established administrative process and should be framed to serve it, addressing the statutory conditions directly rather than offering a free-standing character assessment.

37.2 The fitness threshold for adoptive parents (section 57)

The Act's eligibility provision states the core standard in four limbs. A **prospective adoptive parent** *shall* be physically fit, financially sound, **mentally alert** and **highly motivated** to adopt a child for providing a good upbringing. Read the modal verb with the care the examiner will apply. The provision does not say a prospective parent should preferably be mentally alert; it says they *shall* be. This is a mandatory threshold condition of eligibility, not a desirable attribute a placing agency may weigh and waive, and mistaking it for advisory guidance is the fastest way to misstate the law.

Of the four limbs, the psychiatrically load-bearing one is mental alertness, and it is the peg on which a psychiatric opinion is usually hung. The Act deliberately frames it as an active, functional attribute rather than as the absence of any diagnosis. Physical fitness and financial soundness are matters for other assessors; the psychiatrist speaks to whether the person is mentally alert and highly motivated in the sense the statute intends, which is a capacity to engage with and sustain the task of parenting.

MNEMONIC

Fit, Solvent, Alert, Motivated

The four limbs of the eligibility threshold in order: physically **fit**, financially sound (**solvent**), mentally **alert**, and highly **motivated** to give the child a good upbringing. All four are joined by a mandatory "shall", so none is optional.

37.3 The operational eligibility criteria (Regulation 5)

The Regulations sharpen the Act's four adjectives into criteria a placing agency can test. A prospective adoptive parent *shall* be physically, **mentally, emotionally and financially capable**, and two further conditions attach, each carrying its own modal force:

- they *shall* be physically, mentally, emotionally and financially capable of raising a child, which restates the Act's standard as an affirmative capability;
- they *shall not* have any **life-threatening medical condition**, the Regulation's own mandatory wording, read subject to CARA's operational qualification below; and
- they *should not* have been convicted of any criminal act of any nature, nor stand accused in any case of child rights violation.

Note that the modal is not uniform across the three, and the discrimination is examinable. Capability is a mandatory "shall" and the life-threatening-condition clause is a mandatory "shall not", but the conviction-and-accusation clause is worded as a "should not". Reproduce each as the Regulations do rather than levelling them all to a single verb. Read the "shall not" alongside CARA's own standing instructions before calling it an unconditional individual bar: in a couple's application, the Adoption Committee is directed to reject on this ground only where both applicants are affected, weighing medical advice and the other applicant's willingness and capacity to parent, and a controlled lifestyle condition is not on its own a rejection ground; a single applicant's position is assessed on the same functional footing rather than as an automatic exclusion.

RULE **Adoptive-parent fitness is a mandatory statutory condition, not a clinical preference.** Both the Act and the Regulations use the language of duty: the prospective parent must clear the fitness bar for a placement to be lawful. The standard is functional capability to parent, evidenced across the physical, mental, emotional and financial domains, together with the absence of a life-threatening condition, rather than the mere presence or absence of a psychiatric label. The psychiatrist's role is to speak to that functional standard, not to certify normality.

37.4 Who may adopt: consent, couples and the single applicant

Eligibility is not confined to married couples, and the rules on marital status are a favourite of the viva. Where a married couple adopts, the consent of both spouses *shall* be required, so a placement on the wish of one spouse alone is not lawful. A couple is further held to a minimum of relationship stability: no child *shall* be given in adoption to a couple unless they have at least **two years** of **stable marital relationship**, except in the case of relative or step-parent adoption. State that condition with its exception, because the exception is the part candidates drop.

Single applicants are eligible on defined terms. A single or divorced person *may* also adopt, subject to the adoption regulations, and here the enabling verb matters: the law permits it, it does not compel any placement. Within that, a single female *may* adopt a child of any gender, whereas a single male *shall not* be eligible to adopt a girl child. The accompanying table sets the applicants against the rule and its statutory force so the pattern, rather than any isolated phrase, is what is committed.

APPLICANT	ELIGIBILITY RULE	STATUTORY FORCE
Married couple	Consent of both spouses; a minimum period of stable marriage, except in relative or step-parent adoption	Mandatory (*shall*)
Single or divorced person	Permitted to adopt, subject to the adoption regulations	Enabling (*may*)
Single female	May adopt a child of any gender	Enabling (*may*)
Single male	Not eligible to adopt a girl child	Prohibition (*shall not*)

TRAP **Adoption is not restricted to married couples, and a single person is not barred, though the single-male bar is not universal.** Candidates routinely write that only a couple may adopt, or that single applicants are excluded. Under the JJ/CARA route, the law permits a single or divorced person to adopt, and a single female to adopt a child of any gender; the only categorical bar on a single applicant under that route is that a single male shall not adopt a girl child. That bar does not hold across all of Indian adoption law: under the Hindu Adoptions and Maintenance Act, a male may adopt a female child, subject, among the Act's other conditions, to an age gap of at least twenty-one years between them. Flatten either route into "single people cannot adopt", or the JJ/CARA bar into a universal one, and the mark is gone.

37.5 The psychiatric fitness assessment in practice

When a psychiatrist is asked to speak to whether a prospective parent is mentally alert, or mentally and emotionally capable, the question is functional rather than nosological. The statute is not asking for a certificate that the person has never had a mental illness; it is asking whether the person can, in a sustained way, meet the demands of raising the particular child proposed. A stable, treated condition that does not impair parenting is not a statutory disqualifier. The real concern is an untreated or unstable condition that would foreseeably interrupt the safety and continuity of a child's care, which is exactly what the life-threatening-condition exclusion is reaching towards on the physical side.

A useful opinion therefore addresses function and stability, not a label, and covers:

- the applicant's current mental state and its stability over time, rather than a diagnosis considered in isolation;
- the capacity to understand and sustain the demands of parenting the specific child proposed;
- insight, treatment adherence and the support system that maintains stability; and
- any condition that would foreseeably interrupt safe, continuous care.

GOOD TO REMEMBER

A diagnosis is not a verdict. An applicant with a well-controlled mood or anxiety disorder who is stable, adherent and well supported can meet the statutory fitness standard, and writing "unfit" on the strength of a label alone is both poor practice and poor law. Say what the person can do and how reliably, tie it to the mental, emotional and functional criteria the statute names, and reserve an adverse opinion for an impairment that genuinely threatens the child's care.

37.6 Currency, scope and the interface with the court

Two boundaries keep an opinion safe. The first is currency: for the JJ/CARA route, the live framework is the Juvenile Justice Act and the Adoption Regulations 2022 operating through CARA, and Indian adoption regulation has been revised more than once, so an assessment resting on an older adoption guideline is resting on superseded law. The second is scope: the fitness of the adopting adult is the family-capacity question this section owns, while the broader child-protection and juvenile-justice provisions of the same Act, together with the child-protection statutes generally, are taught in the Child psychiatry: assessment, treatment, services and protection notes and should not be folded into the fitness opinion. In the JJ/CARA route,

that opinion feeds an administrative process, not a courtroom one: the adoption order itself is passed by the District Magistrate, not by a court. Court-facing reports arise only where separate litigation, or the parallel Hindu-law route, brings the matter before a judge; the craft of a certificate or report for that setting, its form, duties and confidentiality, belongs to the Forensic ethics, consent and legal procedure notes. Here the psychiatrist supplies the fitness content, not the procedure of whichever forum eventually receives it.

PITFALL

The commonest real-world error is anchoring an opinion to a superseded adoption code, or letting it drift outside the fitness question into the wider child-protection and juvenile-justice provisions that are governed elsewhere. Both make the opinion unsafe. Tie the assessment to the current Act and its Regulations, keep it to the fitness of the adult, and hand the courtroom-certification craft to the notes that own it.

57	5	Two years
JJ ACT: PARENTS' FITNESS	CARA: ELIGIBILITY CRITERIA	COUPLE'S MINIMUM MARRIAGE

Adoptive-parent fitness is a mandatory statutory "shall", set as functional capability to parent and operationalised through CARA's eligibility criteria; the psychiatrist evidences function and stability at the time of placement, never converting a diagnosis into a disqualification.

Violence risk and dangerousness assessment

38 · Concepts of dangerousness and violence risk in psychiatry

Why the marks are here. Few forensic questions reach the psychiatrist as often as the risk of violence. It is asked when a court seeks an opinion before sentence or release, when a review board weighs continued detention, when a ward team decides whether a patient may take leave, and, in ordinary inpatient work, whenever an involuntary admission turns on the harm a person might do to himself or to others. The examiner builds a whole band of questions around it because this is where candidates slip: they answer as though the task were to label a person, when the discipline has spent decades learning that it is not. This section teaches that conceptual footing. It sets out what the older idea of **dangerousness** claimed, why it was abandoned, and what replaced it.

Keep the boundaries of the section in view. The structured instruments that operationalise the modern model, the actuarial tools set beside them, the taxonomy of factors they weigh, and the management of a patient once risk is judged high are each taken up separately in these forensic notes. Here the work is only to get the idea right, because every one of those downstream tasks inherits its logic from the shift described below. A candidate who understands the shift can reconstruct the rest; one who does not will misuse even a good instrument.

38.1 What "dangerousness" meant

The older construct treated the propensity to harm as a fixed personal trait, a stable disposition carried inside the individual and revealed, rather than created, by circumstance. On this view a person either was or was not dangerous, much as he might be tall or short; the environment merely gave the trait its opportunity to show. The idea was legally attractive precisely because it delivered a binary status a court could act on. If dangerousness were a settled attribute of the person, then detaining or releasing him followed cleanly from a single categorical finding, and the psychiatrist could be asked to supply that finding as a matter of expertise.

The construct rested on features that each, in turn, became a reason it fell. It was *dichotomous*: the output was a verdict, dangerous or not, with nothing in between. It was *decontextualised*: because the trait lived in the person, the situation the person was in was treated as incidental. And it was *enduring*: a trait, once present, was assumed to persist, so a finding made today was taken to speak to conduct far into the future. Under this model the clinical task was framed as prediction. The clinician was to forecast whether the individual would be violent, as though violence were an attribute waiting to express itself and the only question were whether the expert could read it in advance. That framing is the one the modern field rejects, and knowing why is the substance of the marks.

38.2 Why the construct failed

The empirical case against dangerousness was blunt. When clinicians predicted it, they were wrong far more often than right, and wrong in a consistent direction: they over-predicted. Cohorts detained as dangerous who were later released by order of a court, and then followed up, went on to serious violence in only a minority of cases, so that most of those held on a dangerousness finding would never have caused the harm the finding forecast. The error was not random noise but a systematic bias toward seeing danger that was not there.

The reason is structural and worth being able to state, because it recurs whenever any rare event is predicted. Serious violence has a low **base rate** in almost any population a clinician assesses. When the event to be predicted is uncommon, even a rule that is accurate most of the time generates a large number of **false positives**, because the handful of people who will truly act are swamped by the many who share the same warning features and will not. A test can look impressive on its hit rate and still, applied to a low-base-rate outcome, flag mostly people who pose no real threat. This is arithmetic, not pessimism, and it does not improve with clinical confidence.

The false positives were not costless. Each was a person detained, stigmatised or denied liberty for a harm he would not have caused, and over-prediction became a respectable-looking route to indefinite preventive detention. There was a second, quieter failure that mattered just as much for practice. Because the danger was located inside the person, the model looked past the circumstances that actually shape conduct, and because it named a fixed trait it offered nothing to do: assessing an unchangeable attribute yields a label and no lever, and gives the clinician no purchase on reducing the very outcome it claims to foresee. The construct thus failed at once

empirically, in its over-prediction; ethically, in the liberty that over-prediction cost; and practically, in the levers a fixed trait denies.

38.3 The reframing: from a trait to a risk

Modern practice replaced the trait with **violence risk**. The change is not merely terminological. Instead of asking whether a person is dangerous, the clinician asks how likely a particular harm is, to whom, how soon, and under what conditions. The newer construct differs from the old in its very form. Risk is *probabilistic*: it is a likelihood, never a certainty, and is properly expressed as a matter of degree rather than a yes or no. It is *contextual*: it is a judgement about a person in a situation, so the same individual may pose a high risk in one set of circumstances and a low one in another. And it is *dynamic*: it rises and falls with time, symptoms and circumstance, so it is a state that fluctuates rather than a settled feature of the person. This single move, from a fixed attribute to a variable, conditional judgement, is the conceptual pivot on which the whole band rests.

RULE **Risk is a state, not a trait.** Violence risk is a probabilistic, contextual and dynamic judgement about a behaviour occurring in a situation, not a fixed property of the person; and because it is a state, the clinical task becomes to assess and manage it, not to predict a status. Every downstream tool and every management plan is an attempt to do that assessment and management well, which is why getting the concept right is prior to getting any instrument right.

The two models can be laid side by side on the axes the examiner tests. Learn the pattern rather than any one row, because viva questions turn on moving from the left column to the right, or on catching an answer that has quietly slid back into the language of the left.

AXIS	DANGEROUSNESS (THE OLDER IDEA)	VIOLENCE RISK (MODERN PRACTICE)
Nature of the construct	A fixed personal trait	A probabilistic, contextual state
Form of the judgement	Dichotomous: dangerous or not	Continuous: a likelihood, along dimensions
Locus	Within the person	The person within a situation
Time course	Static and enduring	Dynamic, varying with time and circumstance
Clinical task	Prediction of a status	Assessment and management of a probability
What it yields	A label or verdict	A formulation with conditions and a plan
Stance to modifiable factors	Nothing to act on	Identifies targets that lower risk

38.4 The anatomy of a risk judgement

Because risk is a probability rather than a verdict, it has structure, and a competent statement makes that structure explicit. A risk judgement is described along **four** dimensions: its nature, meaning the kind of harm feared; its magnitude, meaning how serious that harm would be; its

imminence, meaning how soon it might occur; and its frequency, meaning how often or how repeatedly it is likely to arise. A single global adjective collapses them all into one word and loses the information a decision actually needs, which is why "he is dangerous" tells a court almost nothing while a statement that specifies each dimension tells it a great deal.

What	How bad	How soon	How often
NATURE OF HARM	MAGNITUDE	IMMINENCE	FREQUENCY

The missing element is the condition. Those dimensions describe the harm, but risk is conditional, and the conditions are where the clinical value lies. The same person may carry a high risk under one set of circumstances and a low one under another, so a formulation that omits the circumstances has described only part of the judgement. This is why the modern output is a **risk formulation** rather than a score: it ties the estimated harm to the situations that raise it and the situations that lower it, and it names what follows. A usable risk statement therefore sets out, together:

- the specific behaviour feared, not violence in the abstract;
- the likely target or victim, where one can be identified;
- the circumstances under which the risk rises;
- the circumstances under which it falls; and
- the interventions that follow from the two.

38.5 From prediction to assessment and management

The reframing does more than sharpen language; it changes the job. When risk is understood as a dynamic state, some of what drives it can change over time, and what can change can be targeted. This is why the newer model treats the clinical task as **risk assessment and management** rather than the prediction of a fixed attribute. The point of assessing risk is not to file a forecast but to find the levers, and a construct that admits levers is one a clinician can act on.

The distinction that makes this possible is between the **static** and the **dynamic** drivers of risk. Static considerations are historical and settled, and they anchor the baseline level; dynamic considerations are current and modifiable, and they are what a treatment plan works on. It is the dynamic component that turns a dead-end prediction into a live management task: assess the level and the pattern, identify the modifiable drivers, intervene on them, and reassess, because the estimate is expected to move. The full taxonomy of these factors, static and dynamic, and how they are grouped, is developed separately in these notes and is not rebuilt here; the conceptual point is only that a state, unlike a trait, contains things that can be changed.

The shift also reframes method. The old dangerousness judgement was in practice an unstructured clinical guess, a single expert's global impression, and its poor accuracy was inseparable from its lack of structure. Modern practice replaced that guess with structured approaches, whether the **actuarial** instruments that combine fixed predictors by rule or the **structured professional judgement** that guides the clinician through a defined set of considerations without reducing the decision to a formula. Those methods, and the debate

between them, belong to the separate treatment of risk instruments in these notes; naming them here matters only because they are the machinery through which the reframing is carried out. The management of the violent and high-risk patient, the acute and longer-term plan that acts on the dynamic drivers, is likewise its own section.

38.6 Communicating and acting on risk

A risk opinion is a communication, and its usefulness depends as much on how it is expressed as on how it was reached. The form the modern model demands is conditional and time-limited: it states the assumptions it rests on, ties the estimate to circumstances, gives it a horizon rather than treating it as permanent, and says what would change it. An opinion written that way can be acted on and revisited; a bald categorical label cannot, and it invites exactly the over-detention that discredited the older construct.

GOOD TO REMEMBER

Write a risk opinion the way you would want to read one. Name the specific harm and the circumstances that drive it, put a time horizon on the estimate, and state what would raise or lower it and what you are doing about the modifiable part. "Risk of serious assault is high in the days around contact with his estranged partner and low while that contact is prevented" is a working opinion; "he is dangerous" is a dead end that a court can only over-read or ignore.

IN INDIA

Indian mental health law frames its thresholds in the language of risk of harm to self or to others, not in the older language of dangerousness, and it makes the presence of such a risk a condition for the involuntary route into inpatient care, whose provisions are set out separately in this chapter. The practising psychiatrist meets the concept in two everyday places: in supporting or resisting an involuntary admission, and in medico-legal opinions where a court or authority asks about risk. In both, the reframing is the safeguard, because it obliges the clinician to state a conditional, time-bound judgement rather than to pronounce a person permanently dangerous.

PITFALL

The commonest real-world error is to give a court or a board a categorical verdict, "he is dangerous" or "he is not dangerous", instead of a conditional risk formulation. The first over-detains, because a permanent-sounding label resists any later release; the second falsely reassures, because it strips away the circumstances under which the risk is in fact high. Either way the opinion has smuggled the discredited trait model back in under a modern heading, and it does so most easily when the clinician is asked a yes-or-no question and answers it in kind.

TRAP **Treating "dangerousness" and "violence risk" as interchangeable synonyms.** Candidates use the two words as though they named the same thing and lose the mark the question is testing. They name two different models: one predicts a fixed attribute of the person, the other assesses a probabilistic, contextual and changeable state. An answer that predicts the person rather than the risk-in-context, or that offers a yes-or-no verdict where a conditional judgement is wanted, has answered the older question and earns nothing.

The ethical weight of all this sits just outside the section and should be named, not taught here. A risk opinion can justify preventive detention, and a clinician who learns of a specific, credible threat to an identifiable person may owe a duty that reaches beyond the consulting room; those questions of ethics, confidentiality and the limits of the expert's role belong to the Forensic ethics, consent and legal procedure notes. What this section fixes is the concept those duties operate on.

> Dangerousness asks whether a person is dangerous; violence risk asks how likely which harm is, to whom, how soon and under what conditions, and what changes it. Modern practice, and the examiner, want the second question.

39 · Structured violence risk assessment (HCR-20)

What the marks reward here. Structured violence risk assessment is the discipline of enquiring into the risk of future violence in a fixed, evidence-guided way rather than by global impression, and the examiner who sets this topic almost never wants the internal scoring of any single instrument. What earns the mark is understanding how such an instrument is built, what it is for, and how you would defend the way you used it. The most frequently examined member of the family is the **HCR-20**, and it is the worked example this section is built around. The conceptual groundwork of why a probabilistic, contextual notion of risk replaced the older idea of dangerousness is set out with the account of dangerousness and violence risk in this chapter, and is only leaned on here.

The family is built on a shared shape. First, the assessment is anchored to a fixed list of empirically supported factors, so the clinician cannot simply attend to whatever is salient in the room and quietly overlook a predictor the literature has established. Second, and this is where the methods divide, there is the question of how those listed factors become a conclusion: an actuarial instrument combines them by a fixed statistical rule, while the approach this instrument belongs to keeps the clinician's judgement in charge. Everything that follows turns on that second choice.

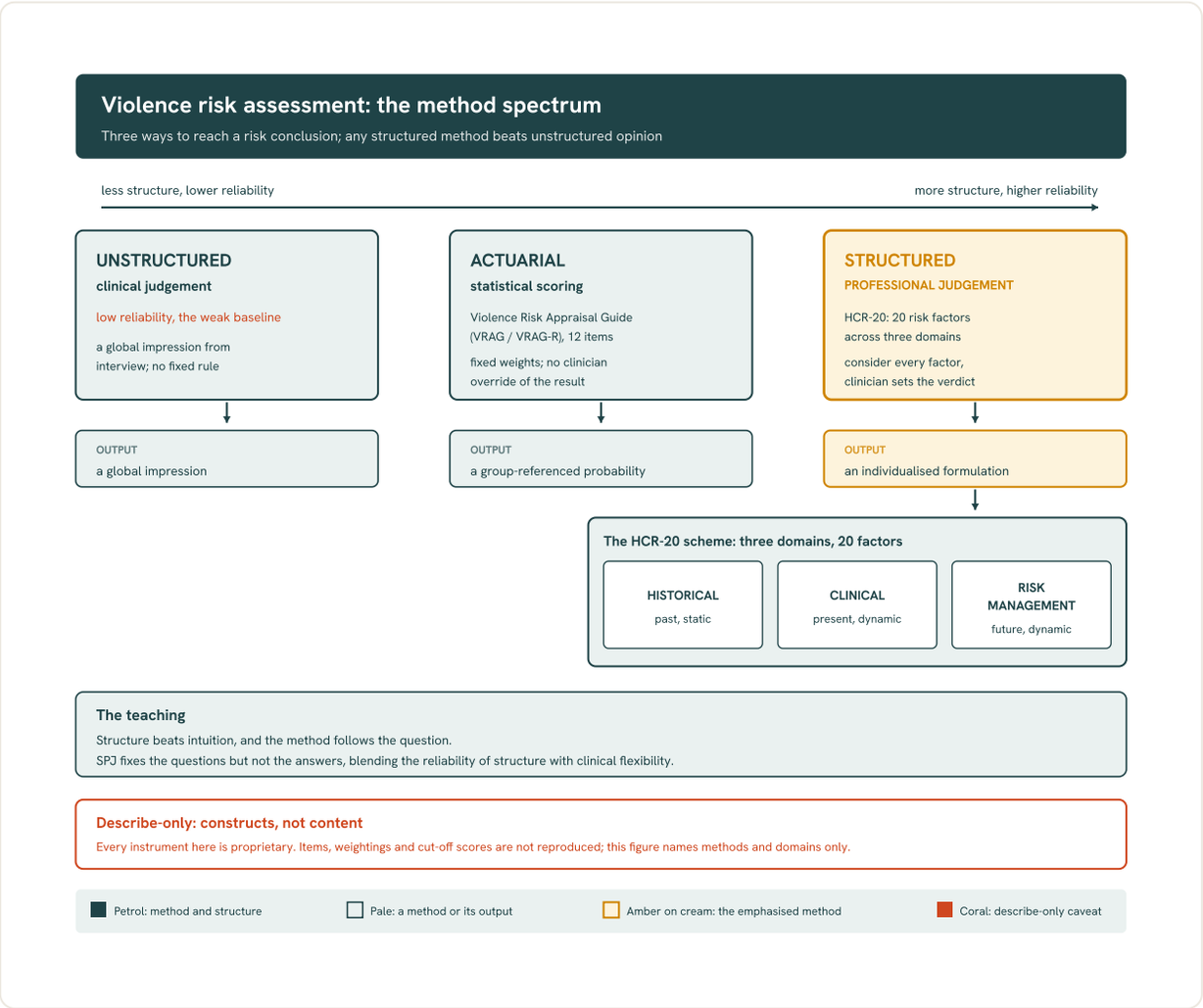


Fig 25.15. Violence risk assessment runs on a method spectrum. Unstructured clinical judgement is the discredited, low-reliability baseline; the actuarial Violence Risk Appraisal Guide (VRAG / VRAG-R) scores fixed weighted items to a group-referenced probability; and structured professional judgement, exemplified by the HCR-20 across its Historical, Clinical and Risk-management domains, fixes the factors that must be considered without pre-weighting them, so it blends the reliability of structure with the flexibility of clinical judgement. Instrument items and cut-off scores are proprietary and are not reproduced.

39.1 Structured professional judgement, and where this instrument sits

Structured professional judgement occupies the middle of a spectrum. At one pole is unstructured clinical opinion, which fixes neither the factors nor the method and predicts weakly; at the other is the actuarial method, which fixes both, combining predetermined and weighted items by a mechanical algorithm and leaving the clinician no licence to depart from the result. Structured professional judgement fixes the questions but not the answer. The instrument specifies the factors that must each be rated and considered, which is its central safeguard against the omission of a known predictor, but the integration of those factors into a risk statement, and the formulation that carries it, remain the clinician's own. The actuarial method itself and the long argument between the two approaches are developed with the account of the other risk tools in this chapter and are only placed here.

The HCR-20 is the exemplar of this method in violence risk work, now in its current third edition. It was developed by **Douglas, Hart, Webster and Belfrage**, and it is a set of professional guidelines rather than a test in the narrow psychometric sense: it directs the assessment without

dictating the verdict. Because it is a copyright-held, proprietary instrument, its manual must be purchased and its item content is not free to reproduce, so a teaching text describes its architecture and purpose and does not print its items. That constraint is returned to below, and it is itself examinable.

RULE **It structures the questions, not the answer.** The instrument ensures systematic consideration of its **20** specified factors, across the whole span of past, present and future, and prompts case-specific formulation; it does not exhaust every possible empirically supported predictor, and it does not convert them into a score. The safeguard is the fixed list; the judgement, the formulation and the final risk category remain the clinician's, which is exactly what makes the method structured and professional rather than actuarial or intuitive.

39.2 The shape of the instrument: the factors and the three domains

The instrument organises violence risk assessment around **20** key risk factors, and it groups them into **three** domains whose initials give the instrument its name: the **Historical** domain, the **Clinical** domain, and the **Risk management** domain. The grouping is not cosmetic. Each domain corresponds to a different tense of the patient's life - what has already happened, how the patient is now, and what is anticipated - so the three together oblige the assessor to look backward, at the present, and forward in one disciplined sweep. An assessment that attends only to a florid mental state, or only to a violent history, has examined one domain and mistaken it for the whole.

MNEMONIC

H, C, R - history, here-and-now, hereafter

The three domains are the three tenses of the assessment. The **H**istorical domain is the settled past, the **C**linical domain is the present state, and the **R**isk management domain is the anticipated future. The name of the instrument is its own contents list.

20	3	SPJ
KEY RISK FACTORS	TEMPORAL DOMAINS	STRUCTURED, NOT ACTUARIAL

Beyond the factors and their grouping, the item content, the coding criteria and the rating anchors are proprietary and are not set out here. The teaching point a candidate must carry away is the architecture - a fixed, comprehensive factor set, arranged by time - and the discipline it imposes, not a reproduction of the coding sheet.

39.3 The three domains and the logic of past, present and future

The value of the domain structure becomes clear when each domain is read for what it contributes to the final judgement. The historical domain gathers the relatively settled features of a life, the record of past behaviour and the long-standing characteristics that shape it, and its function is to anchor the baseline level of concern; being largely fixed, it moves little with treatment and changes slowly if at all. The clinical domain captures the here-and-now, the current state that can shift from week to week, and it is where an assessment registers that a person's risk has risen with a relapse or fallen with recovery. The risk management domain is

prospective: it asks what the future holds for this person, the plans, supports, stresses and supervision that lie ahead, and whether the arrangements around them will contain the risk or inflame it. Read together, a settled baseline, a current state and an anticipated trajectory give a far richer picture than any single snapshot.

This is also where the instrument operationalises the raw material of risk. The historical domain is built largely from static considerations, and the clinical and risk-management domains largely from changeable ones, which is how a fixed factor set nonetheless leaves room for risk to move over time. The full taxonomy of static and dynamic risk factors, and how they are grouped, is developed with the account of the risk factors for violence in mental illness in this chapter and is only named here; the instrument's job is to make sure they are all considered, not to define them.

DOMAIN	TENSE	WHAT IT GATHERS	ITS FUNCTION IN THE JUDGEMENT
Historical	The past	Settled features of the person and the record of past behaviour	Anchors the baseline; largely fixed, so it moves little with treatment
Clinical	The present	The current state and presentation, which can shift over short periods	Registers whether risk is rising or falling now
Risk management	The future	The anticipated situation - plans, supports, stresses and supervision ahead	Asks whether what lies ahead will contain the risk or inflame it

39.4 How an assessment is actually conducted

Structured professional judgement is a method as much as a list, and knowing the sequence is what separates a candidate who can name the instrument from one who could use it. The assessor does not fill in a form but works through a defined order of tasks, and two of those tasks are what give the method its character. One is the weighing of relevance: establishing that a factor is present is only the start, because a factor may be present yet peripheral in one case and decisive in another, and it is the judgement of what it means for this person that an actuarial tool has no equivalent for. The other is the building of a **risk formulation**, an account of what drives this person's risk and how, from which the assessor generates plausible **risk scenarios** - concrete stories of how, when and towards whom violence might occur - before arriving at a summary risk judgement and a plan. Set out in order, the sequence runs:

- establish the presence of each factor from interview, records and collateral information;
- weigh the relevance of each present factor to this individual, not merely its presence;
- integrate the relevant factors into a formulation of what drives the risk;
- generate specific scenarios of how, when and towards whom harm might occur;
- reach a categorical summary judgement and translate it into a management plan.

Why relevance and formulation carry the method. The steps that distinguish this approach from a checklist are the weighing of relevance and the building of a formulation. A checklist stops at presence and tallies it; structured professional judgement insists that presence is only the raw material and that the clinical work lies in deciding what each present factor means for this person and how the factors combine. The output is therefore an individualised, defensible account rather than a number, and the management plan that follows from it, the acting on the changeable drivers the formulation exposes, is taken up with the account of the management of the violent and high-risk patient in this chapter.

39.5 What the method buys, and what it does not

Set against both the unstructured opinion it replaces and the actuarial rule it sits beside, structured professional judgement has a characteristic profile of strengths. Its fixed factor set gives it comprehensiveness, making it hard to forget an established predictor. Because the basis of the opinion is explicit and open to review, it is transparent and defensible. It attends to the changeable and protective features of a case, not only to the fixed historical ones, so the assessment points at what can actually be done. And its output is built for management and communication, a formulation and its scenarios, rather than for prediction alone.

The costs are the other face of these strengths. The method leans on the competence of the assessor: because the judgement is retained, a poorly trained or careless rater can misuse a good instrument, and the reliability an actuarial algorithm delivers mechanically must here be earned by disciplined practice. It is more demanding of time and information than ticking a short actuarial list. And it deliberately declines to produce a probability, yielding a reasoned category and a formulation, not a percentage against a reference group. That structured methods in general outperform unstructured opinion is not in dispute; the finer comparison of accuracy between the actuarial and structured-judgement approaches, and the evidence for each, belongs to the account of the other risk tools in this chapter.

TRAP **Calling this an actuarial instrument, or expecting it to yield a probability.** Candidates group every risk tool together and describe the instrument as though it summed items into a predictive score. It does the opposite: it is a structured professional judgement scheme, and its output is a clinically reasoned category set in a formulation, not a group-referenced probability. An answer that reports a percentage risk, or an actuarial cut-off, from this instrument has misclassified the very method the question is testing.

39.6 A proprietary and restricted instrument

An unusual amount of what a candidate should know about this instrument concerns not its clinical content but its status as intellectual property, and the examiner does test it. The instrument is copyright-held and proprietary. Its manual, the user's guide, must be purchased; it is not a public-domain checklist, and its individual items are not available for licensing, so this resource follows a describe-only editorial policy and does not extract or print them. That the publisher declines to licence items does not by itself settle what Indian copyright law permits for every educational use; applicability turns on the specific use, audience, amount and context, and no categorical legal conclusion is drawn here. Access to the tool is pitched at a restricted

qualification level, on the assumption that a user has the professional training needed to code and interpret it responsibly. These facts explain why every responsible textbook, this one included, names the domains and describes the method but does not reproduce the items or their anchors.

The restriction is not mere legal housekeeping; it guards the instrument against exactly the misuse its structure invites. Because the factors are laid out as a list, an untrained reader is tempted to treat them as a questionnaire to be added up. But the coding of the factors is not a scoring system in the actuarial sense, and the discipline the manual and its training exist to instil is precisely that the number of factors present is not the risk level.

PITFALL

The characteristic misuse is to treat the factor list as a tally and to read a high count of present factors as automatically high risk. That is to smuggle an actuarial habit into a method built to resist it. In structured professional judgement the summary risk category is a clinical integration, what the present and relevant factors mean, taken together, for this person, and not the arithmetic of how many boxes are ticked. A patient with many present factors that are, on formulation, of little current relevance may warrant less concern than one with a few highly relevant ones. Counting the items is not assessing the risk.

39.7 Using the instrument in Indian forensic practice

Two practical realities frame the use of this instrument in India. The first is access: a proprietary, restricted, purchasable instrument is not uniformly available across public forensic services, and its use presupposes training that is not yet widespread, so a candidate should be honest that structured tools of this kind are used unevenly in Indian practice. The second is transfer: unlike an actuarial tool, whose probabilities are only as portable as the sample they were derived on, a structured professional judgement scheme travels comparatively well, because its product is a reasoned, individualised formulation rather than a number tied to a foreign reference group. The structure disciplines the assessment wherever it is used; what does not automatically transfer is any assumption that a given profile carries the same likelihood here as elsewhere.

IN INDIA

Indian courts and authorities tend to ask a categorical question, whether a person poses a risk and whether it can be managed, rather than to ask for a percentage, and that suits a method which yields a reasoned category and a formulation better than one which yields a normed probability. The workable position for the Indian forensic psychiatrist is to use a structured instrument as an aid that disciplines the assessment and makes the reasoning explicit and defensible, to keep its proprietary item content out of any document a lay reader will see, and to treat the categorical, formulated opinion, rather than a borrowed number, as the deliverable. The standards for the report itself and for giving evidence as an expert are set out in the Forensic ethics, consent and legal procedure notes.

GOOD TO REMEMBER

The completed structured assessment is, above everything else, your defensible record. When an opinion on violence risk is challenged, and in forensic work it will be, the worth of having worked through a fixed, recognised factor set is that you can show you systematically considered its **20** specified factors and can point to the formulation that led to your category. Present the domain your concern sits in and the scenario you fear, give a categorical judgement tied to a management plan, and let the structure carry the defence. The acute and longer-term management that plan sets in motion is taken up with the account of the management of the violent and high-risk patient in this chapter.

This is a structured professional judgement scheme, not an actuarial one: it fixes the factors you must weigh across a historical, a clinical and a risk-management domain - past, present and future - then leaves the conclusion, a reasoned risk category set in a formulation, to the clinician. The list is fixed; the judgement is yours.

40 · Other risk tools (VRAG, PCL-R, actuarial versus structured clinical judgment)

What the marks reward here. Structured violence risk assessment is a family of methods, not a single instrument, and the examiner almost never wants the internal scoring of any one tool. What earns the mark is understanding how a tool is built and how you would defend the one you chose. This section sits beside the best-known structured checklist and takes up the other instruments a candidate is expected to name and place: the **actuarial Violence Risk Appraisal Guide**, the clinician-rated psychopathy measure on which so many risk schemes lean, the **Psychopathy Checklist-Revised**, and a dynamic **Short-Term Assessment of Risk and Treatability**. The idea that binds them, and the one the marks are really testing, is the contrast between the actuarial method and structured clinical judgement.

Two questions sit under every risk instrument. The first is how the risk factors are combined into a conclusion: by a fixed arithmetic rule, or by a clinician's disciplined judgement. The second is what that conclusion is for: estimating the probability of a future event, or managing a particular person over time. The actuarial versus structured clinical judgement debate is an argument about the first question, and its modern resolution turns on the second.

40.1 Three ways to reach a risk conclusion

Historically, clinicians judged violence by unstructured opinion: a global impression formed from the interview, with no fixed set of factors and no rule for weighing them. This reads fluently in a report but performs poorly, with weak agreement between assessors and modest predictive validity, and it is the discredited baseline against which every structured method is measured. The actuarial method answered it with the opposite discipline. A fixed set of empirically derived items, each carrying a predetermined weight, is combined by a mechanical algorithm to yield an estimate of risk against a reference sample; the clinician who scores a pure actuarial tool has no licence to override the result. Between these poles sits **structured professional judgement**, which fixes the questions but not the answer: the instrument names the factors that must be

rated and considered, guarding against the omission of a known predictor, while the final risk statement and its formulation remain the clinician's.

The empirical backbone of the actuarial case is older than any of these instruments. Across many fields of prediction it has been found that the mechanical combination of a set of data points tends to equal or exceed the same clinician combining the same information in his head. The lesson carried into forensic work was not that clinicians are useless but that the unaided integration of many weighted cues is a task the human mind does unreliably, while a formula does it the same way every time. That is the argument an actuarial tool cashes out, and it is why a bare clinical impression is no longer a defensible method on its own.

The finding that organises the whole field is remarkably stable across decades of research: any structured method, actuarial or professional judgement, outperforms unstructured clinical opinion. The genuinely open question is therefore not whether to structure the assessment, but which structured method suits the task in front of you.

RULE **Structure beats intuition, and the method follows the question.** Unstructured clinical opinion is the weak comparator that both structured approaches defeat. The choice between actuarial scoring and structured professional judgement is not, then, a contest of accuracy; it is a choice of purpose - a group-referenced probability, or an individualised and manageable formulation.

40.2 The actuarial approach and the Violence Risk Appraisal Guide

An actuarial instrument works the way an insurer prices a policy. Predetermined items are scored from history and records, summed by a fixed formula, and read against tables that link the total to the observed rate of the outcome in the sample the tool was built on. The judgement has, in effect, already been done, by the researchers who derived and validated the weights, and frozen into the scoring. The exemplar in forensic psychiatry is the Violence Risk Appraisal Guide, built by **Quinsey, Harris, Rice and Cormier** from a forensic offender sample. Its current form is a **12**-item actuarial tool, revised in **2013** by **Rice, Harris and Lang** to be simpler to score. Its items and its score-to-probability bands are proprietary and are not reproduced here; what a candidate must carry away is the method, not the grid.

The strengths are the strengths of any mechanical rule: high reliability, transparency, and resistance to the impressionistic biases that sink unstructured judgement. The weaknesses are structural, and worth being able to list, because each is a discussion point:

- the group-to-individual problem, since the output is the rate observed in a reference group and no single person is a rate;
- a reliance on fixed, historical items that do not move with treatment, so the tool is nearly blind to change;
- sample specificity, since the probabilities hold only to the extent that the person resembles the population the tool was derived on;
- silence on protective factors, which are not part of the equation; and

- a design built for prediction, not for the management decisions a clinical team actually has to take.

The taxonomy of static and dynamic factors these tools weigh is developed with the account of violence risk factors in this chapter, and is only named here.

PITFALL

An actuarial probability is a property of a group, not a verdict on a person. Reporting a percentage risk as though the figure described the individual in the chair is the commonest misuse, and it compounds when a probability derived from a Western forensic sample is applied unmodified to a patient the tool was never normed on. State the estimate for what it is - the rate seen in similar cases, one input to a clinical opinion - and not as this person's settled destiny.

40.3 Structured professional judgement and the START

Structured professional judgement keeps the clinician in the loop by design. The instrument supplies an evidence-based list of factors that must each be rated and considered, which is its central safeguard: it stops an assessor forgetting a factor the literature says matters. It does not then dictate the conclusion. The clinician integrates the ratings, adds case-specific considerations, and produces a categorical judgement, usually low, moderate or high, embedded in a formulation and a set of plausible future scenarios. The best-known instrument of this type is the Historical Clinical Risk Management scheme, whose structure is taken up with the account of structured violence risk assessment in this chapter and is only named here.

A useful contrast within the same family is the Short-Term Assessment of Risk and Treatability, published by **Webster, Martin, Brink, Nicholls and Desmarais** in **2009**. It is explicitly dynamic: its **20** items are the changeable, treatment-relevant features of a case rather than settled history, which suits it to inpatient and rehabilitation work, where the live question is whether risk is rising or falling. Its signature feature is dual coding: every item is rated twice, once as a strength or protective factor and once as a vulnerability or risk factor, so the same domain can be read as an asset or a liability depending on the person. And it is deliberately broad in the outcomes it addresses, spanning not only violence towards others but suicide, self-harm and victimisation as well, so a single rating informs several risk questions at once.

As with the actuarial guide, the manual and its item content are proprietary; the teaching point is the design - dynamic, coded for both strengths and vulnerabilities, and treatability-focused - not the item list.

40.4 The Psychopathy Checklist-Revised and the place of psychopathy

The Psychopathy Checklist-Revised is routinely grouped with the risk instruments, but it is not, in itself, an actuarial predictor of violence. It is a clinician-rated measure of a personality construct, psychopathy, developed by **Robert D. Hare** and published by **Multi-Health Systems**. It is scored from a semi-structured interview together with a careful review of collateral and file information, which is why it cannot be completed from a single consultation and why thin records degrade it. Its items are organised into factors, but the item and factor content, and the

scores at which interpretive labels attach, are proprietary; it is a restricted-user tool that its publisher releases only to assessors holding an advanced degree with specific forensic training. That access restriction is itself an exam-relevant fact, and the reason these contents are named rather than printed in any teaching text.

Why the measure earns a place in a violence chapter is empirical: psychopathy is among the more robust individual correlates of violence and of reoffending, so a psychopathy rating frequently feeds a risk formulation, and several structured and actuarial schemes incorporate it as a component. The discipline to hold onto is that the score measures a construct. It is neither a psychiatric diagnosis nor, by itself, a risk score; it informs the risk judgement and does not constitute it. The three tools map onto the method spectrum as follows.

INSTRUMENT	METHOD CLASS	WHAT IT INDEXES	RATING SOURCE	OUTPUT
VRAG-R	Actuarial	Violence risk	Coded from history and records	Probability against a reference group
PCL-R	Clinician-rated construct measure	Psychopathy	Interview plus collateral and file review	Factor-structured score (proprietary)
START	Dynamic structured professional judgement	Short-term risk and treatability across outcomes	Clinician rating of strengths and vulnerabilities	Categorical risk plus formulation

40.5 Actuarial versus structured clinical judgement

Why the distinction earns marks. A candidate who can only recite instrument names has missed the question; the assessable skill is placing any tool on the actuarial-to-judgement spectrum and saying what that placement buys and what it costs. The contrast is cleanest laid out on shared axes.

AXIS	ACTUARIAL METHOD	STRUCTURED PROFESSIONAL JUDGEMENT
Item selection	Fixed, empirically derived and weighted	Fixed list that must be considered, not weighted
How factors combine	Mechanical algorithm	Clinical formulation
Clinical override	None in the pure form	Judgement is retained
Dominant factor type	Mainly fixed and historical	Historical, changeable and protective
What it yields	Probability against a norm group	Categorical risk plus a formulation
Primary purpose	Prediction and screening	Risk management and scenario planning
Worked example here	The VRAG	The START, and the Historical Clinical Risk Management scheme

The old "clinical versus actuarial" war, fought as though one side had to win outright, is largely settled, and in a way that dissolves the question. Structured methods beat unstructured judgement; that much is not in dispute. Between the two structured methods there is no single victor, because they answer different questions. An actuarial tool is efficient for screening and for anchoring a baseline against a known group rate. Structured professional judgement is built for what happens next: an individualised formulation, attention to changeable and protective factors, and the scenario planning a treating team needs in order to act. Mature practice uses them as complements, and the management of the high-risk patient, which works on the dynamic factors these tools expose, is taken up separately in this chapter.

In everyday forensic work the two methods are less often rivals than layers. A common pattern is to let an actuarial estimate set the baseline, the anchor against a known group rate, and then to adjust that anchor with structured judgement of the changeable and case-specific factors the formula cannot see; this is the so-called adjusted-actuarial approach. What structured professional judgement adds on top of an actuarial floor is incremental: the individualising detail, the modifiable drivers, the protective factors, and the account of the circumstances under which this person's risk rises or falls. Neither layer makes the other redundant, which is exactly why the modern answer to "actuarial or clinical" is "structured, and matched to the decision in front of you".

TRAP **Structured clinical judgement is not clinical intuition.** Candidates see the word clinical inside structured professional judgement, lump it with the discredited unstructured opinion, and then rank the actuarial method as automatically superior. The opposite is the case: structured professional judgement is a rigorous, evidence-guided method, and the weak comparator that both structured approaches beat is unstructured judgement, not each other.

Structure beats unstructured judgement; the actuarial method estimates a group-referenced probability while structured professional judgement builds an individualised, manageable formulation - so you choose between them by the question, prediction or management.

40.6 Using these instruments in Indian practice

Everything above was developed abroad, and that is the practical catch for an Indian forensic psychiatrist. An instrument's validity is not portable by default: it holds only to the extent that the person and the setting resemble the sample the tool was derived and validated on, and the base rates of violence, the completeness of recorded history, and the very questions the law asks all differ here from that context. The tools remain useful, but as structured aids to reasoning rather than as machines that hand down a verdict.

12	20	2009
VRAG-R ACTUARIAL ITEMS	START DYNAMIC ITEMS	START INTRODUCED

IN INDIA

These instruments were derived and normed on Western forensic populations, and none has an established Indian normative base, so their probabilities and interpretive bands cannot be assumed to transfer. Indian courts also tend to ask a categorical question, whether a person is dangerous or fit, rather than for a percentage, and the psychiatrist's reasoned opinion remains central. The workable position is to use these tools as structured aids that discipline the assessment and make the reasoning explicit, not as generators of a number, and to remember that no widely validated indigenous actuarial instrument is in routine use.

GOOD TO REMEMBER

In a forensic report, name the instrument and its method, state plainly that a structured tool informs but does not determine your opinion, and anchor the conclusion in an individualised formulation. Keep the proprietary contents of restricted instruments out of any document a lay reader will see. The standards for the report itself and for expert testimony are set out in the Forensic ethics, consent and legal procedure notes.

41 · Risk factors for violence in mental illness

Risk is read from factors, not from a diagnosis. When a court, a review board or a ward team asks how likely a patient is to be violent, the answer does not turn on the diagnostic label but on a set of identifiable features that raise or lower the probability of harm. Those features are the risk factors, and organising them is the substance of this topic. The reframing that made this the right question - the move from judging a person dangerous to estimating a risk that is probabilistic, contextual and changeable - is set out separately in these notes and is assumed here; the work now is to name the factors that a risk judgement weighs, to sort them in a way that guides action, and to be precise about which of them carry the excess risk seen in mental illness. Examiners return to this ground because it is where careless answers cluster. A candidate who reaches for "mental illness causes violence" has already lost the mark, while one who can separate the fixed markers from the modifiable ones, and can say where the real excess risk sits, has shown exactly the discipline the question is testing.

The factors themselves are the durable content of the field. The instruments that combine them into a structured assessment, the actuarial tools set beside those, and the plan that acts on them once risk is judged high are each taken up in their own right elsewhere in this chapter; here the task is to know the factors, to sort them in a way that leads to action, and to say precisely which of them carry the excess risk that attaches to mental illness. Get the factors right and the downstream machinery has something worth combining; get them wrong and no instrument will rescue the assessment.

41.1 The organising cut: static against dynamic

The single most useful way to hold the risk factors in mind is to ask, of each, whether it can change. On that test they fall into **two** classes. **Static** factors are historical and settled: they belong to what has already happened to a person, or to fixed features of who they are, and no

treatment will alter them. **Dynamic** factors are current and changeable: they are features of the present clinical state and social situation that can rise, fall, or be treated. The classes are grouped this way for a reason that is practical rather than tidy. The static factors tell you how much baseline concern a case warrants; the dynamic factors tell you what you can actually do about it.

Because this cut turns on modifiability, it maps straight onto the clinical task: it separates the part of the assessment that anchors a long-run estimate from the part that a management plan works on and then rechecks. A second, looser way of grouping the same factors is by domain - the person's history, their present mental state, and the circumstances around them. That domain lens is a descriptive convenience, and it is roughly how several structured instruments lay their items out, but it cuts across the static and dynamic division rather than replacing it, and it is the modifiability cut that carries the clinical and the examination weight.

Static	Dynamic	Combined
FIXED HISTORY; SETS THE BASELINE LEVEL OF CONCERN	CURRENT STATE; THE MODIFIABLE TREATMENT TARGETS	ACTIVE PSYCHOSIS WITH SUBSTANCE USE, WHERE RISK CONCENTRATES

41.2 Static (historical) risk factors

Static factors are the fixed history a risk assessment starts from. The most important of them, and the one every scheme places first, is **previous violence**: a documented history of violent behaviour is the strongest single anchor a clinician has for judging future violence. The others in this class share the quality of being settled facts about the person or their past. A young age at the first violent act marks an early-onset, more entrenched pattern rather than a late and situational one. Male sex carries a higher base rate of serious physical violence. And childhood maladjustment - conduct disturbance, abuse, instability and disrupted development in the early years - marks a developmental trajectory that raises the adult baseline. None of these can be shifted by treatment, which is precisely what makes them static: they set the floor of concern, and they do not move.

RULE **Past violence is the best single predictor of future violence.** Of all the factors weighed, a documented history of violent behaviour predicts future violence more strongly than any other, because past behaviour is the most reliable guide to behaviour under similar conditions and because it integrates, in one observable fact, the many influences that a list of separate predictors only approximates. This is why a careful, specific history of any previous violence - its context, its target, its severity and its pattern - is the core of every risk assessment, and why its omission is the most damaging single gap an assessment can carry.

The clinical value of the static factors is exactly their stability. They give a defensible baseline that does not swing with a good phase or a bad one, and they discipline an assessor against being falsely reassured by a calm interview in someone whose history says otherwise. Their limitation is the mirror image of that strength. Because they cannot change, they name no target and offer no lever; an assessment built on static factors alone can estimate risk but can do nothing to reduce it. That is the work the dynamic factors do.

41.3 Dynamic (changeable) risk factors

Dynamic factors are the current, modifiable features that raise or lower risk from week to week, and they are where the clinical yield of the whole assessment lies. The first group is the patient's active symptoms, and not all symptoms carry risk equally. The ones that matter are those that make violence feel, to the patient, necessary or externally driven. **Threat or control-override symptoms** - the belief that one is under threat from others, or that an outside force is overriding one's own control, as in delusions of passivity or of thought and behaviour being imposed - are the psychotic experiences most consistently linked to violence, because they recast an assault as self-defence or as something one is compelled to do. **Command hallucinations**, especially those instructing harm in a voice the patient feels unable to resist, work in the same way. It is the content and the felt compulsion of the symptom, not the diagnosis it sits within, that raises the risk.

Beyond the symptoms, several further dynamic factors recur. **Substance misuse** is among the most powerful of all, and its particular role in mental illness is considered further when the excess risk is discussed below; the clinical management of a substance use disorder itself belongs to the Substance use disorders notes. **Treatment non-adherence** - stopping medication, disengaging from services, missing the very contact through which deterioration would be caught - both reflects and drives rising risk. And social instability, meaning the loss of housing, occupation, supervision and supportive relationships, strips away the external structure that contains behaviour and amplifies the effect of everything else. Each of these can be targeted, which is why they, and not the settled history, are the material a management plan actually works on.

41.4 Setting the two classes side by side

The distinction is worth laying out on shared axes, because the examiner tests movement across the columns and because the two classes differ in almost everything except that both predict. Learn the pattern rather than any single row, and notice that the difference in modifiability is what drives every other difference below it.

AXIS	STATIC (HISTORICAL)	DYNAMIC (CHANGEABLE)
Nature	Settled facts of history and person	Current clinical state and circumstance
Modifiability	Fixed; unchanged by treatment	Modifiable; the targets of treatment
Typical members	Prior violence, early age at first violence, male sex, childhood maladjustment	Threat and control-override symptoms, command hallucinations, substance misuse, non-adherence, social instability
What they anchor	The long-run baseline level of concern	The current, near-term direction of risk
Clinical use	Screening and baseline estimation	Intervention, monitoring and reassessment
Limitation	Name no target to act on	Fluctuate, so demand repeated review

A closing word on the domain lens keeps it from becoming a third scheme to memorise. Grouping factors as historical, clinical and contextual describes where a factor comes from, not whether it can change, so a single domain holds both kinds: the historical domain is largely static, while the clinical and the contextual domains are where the dynamic, movable factors sit. Used together, the domain lens makes sure no source of information is overlooked, and the static and dynamic cut keeps sight of what can actually be done about what is found.

41.5 Where the excess risk sits in mental illness

The label is not the risk factor. The single most examined point in this topic is also the most misunderstood in public life: a psychiatric diagnosis, taken by itself, is a poor guide to violence. The excess risk that genuinely attaches to mental illness is not spread evenly across all patients or all conditions. It is concentrated in active psychosis complicated by co-occurring substance use, and it is carried by particular symptoms rather than by the diagnostic category. A person with a stable, treated illness and no substance use stands in a wholly different place from one in an untreated psychotic relapse who is also drinking or using, even under the same diagnostic heading.

The concentration comes from the active psychotic state and from substance use, acting together. Within the psychotic state the risk is carried by the specific symptoms already named: the sense of being threatened or of having one's control overridden, and commands that feel impossible to resist. These are features of a current relapse, not of the diagnosis in remission, which is why risk tracks the state and falls when the state is treated. Substance use raises risk by several routes at once - disinhibition and intoxication, the destabilising of an underlying illness, worsened adherence, and the social chaos that surrounds dependence - and its effect is more than additive when it sits on top of an active psychosis. It is the meeting of the two, far more than either alone and far more than the label, that accounts for most of the elevated risk clinicians actually meet.

TRAP **Naming the diagnosis as the risk factor.** Asked for the risk factors for violence in mental illness, candidates write "schizophrenia" or "psychosis" as though the diagnostic label were itself the factor. It is not. The risk is carried by an active symptomatic state - threat and control-override symptoms, commands that feel irresistible - and, above all, by co-occurring substance use, not by the diagnosis in the abstract. An answer that indicts the category rather than the state has lost the mark and repeated the very stigma the evidence corrects.

PITFALL

The mirror-image clinical error is to build the whole assessment on the static history - previous violence, sex, early onset - because it feels objective and countable, and to record the current state only in passing. Such an assessment can produce a plausible baseline and still be useless, because it names nothing that can be changed and so leads to no plan. The static factors tell you how worried to be; only the dynamic factors tell you what to do, and an assessment that neglects them predicts without managing.

In mental illness the excess risk of violence sits in active psychosis with co-occurring substance use, not in the diagnostic label; and across all cases previous violence remains the single strongest predictor.

41.6 From factors to formulation, and to practice

Risk factors are inputs, not conclusions. Counting them does not yield a risk level; they are weighed and combined, either by a fixed actuarial rule or through structured clinical judgement, into a formulation that ties the estimated harm to the circumstances that raise and lower it. The structured instruments that carry out that combining, such as the **HCR-20** and the **VRAG-R**, operationalise the very factors set out here, by structured clinical judgement and actuarial method respectively; their internal structure, and the actuarial-versus-judgement debate, are taken up in their own right elsewhere in this chapter and are only named here. The **PCL-R** measures psychopathy rather than combining this taxonomy into a violence-risk conclusion; it may inform a formulation or appear as a component within another instrument, but it is not itself a combining violence-risk tool. A full formulation also weighs protective factors - the supports, engagement and stability that lower risk - which a bare factor count leaves out; these too are named here and are developed with the instruments that code them.

Turning the taxonomy into an actual assessment means eliciting each class deliberately rather than hoping it surfaces. In practice that means covering, for every case:

- a detailed history of any past violence, including its context, target, severity and pattern, as the strongest single anchor;
- the current mental state for threat and control-override symptoms and for commands the patient feels unable to resist;
- current substance use, screened in every case and never assumed to be absent;
- engagement and adherence with treatment and services; and

- the stability of housing, occupation, supervision and close relationships.

The static items anchor the baseline; the dynamic items, being the modifiable ones, become the targets of the plan whose acute and longer-term forms are set out separately in this chapter. The point of sorting factors this way is never the sorting itself. It is that a formulation which ends with a set of dynamic targets can be acted on and revisited, while one that ends with a static score can only be filed.

IN INDIA

The factor taxonomy itself travels well - previous violence, active psychosis, substance use and social instability raise risk everywhere - but the instruments that weigh these factors were derived and normed on Western forensic populations and have no established Indian base, so their probabilities and cut-offs cannot be assumed to transfer. Indian practice therefore leans on the factors themselves, appraised through structured clinical judgement, more than on any actuarial score. Local realities shape the dynamic factors in particular. The family remains the main structure of supervision and the main route back into treatment, so involving it is often the most powerful modifiable protective factor available; and gaps in access and continuity of care make treatment non-adherence a live and common driver of relapse and of rising risk.

GOOD TO REMEMBER

A risk assessment that records the diagnosis and the past history but not the current dynamic state has captured the least changeable part of the picture and missed the part you can treat. Make it routine, in every case, to document the active symptoms that carry risk, to screen for co-occurring substance use rather than assume it, and to check adherence and social supports - and then, for each dynamic factor you find, to name what you intend to do about it. That is what turns a list of factors into a plan.

42 · Management of the violent and high-risk patient

Why the marks are here. The acutely violent or agitated patient is one of the few situations in psychiatry where a clinical decision and a legal act are the same act. Every step taken to make a ward safe, from a word to an offered tablet to an injection given without consent to a hand laid on a patient, runs from ordinary care toward the deprivation of another person's liberty, and the law watches the far end of that line closely. The examiner builds a whole question here because candidates who can recite risk factors and name instruments often come apart on what actually matters at the bedside: what to do, and in what order. This section teaches that answer, the graded response to acute disturbance and the longer-term work that follows once the emergency has passed.

Two ideas hold the topic together. The first is that management is *graded*: interventions are ranked by how far they override the patient's own choices, and you exhaust the less coercive before reaching for the more coercive, escalating only as far as safety requires and stepping back as soon as it allows. The second is that management runs across *two horizons* at once: the acute horizon of the next several minutes, where the task is to contain disturbance and prevent

immediate harm, and the longer horizon of weeks and months, where the task is to lower the risk that produced the episode. Answer only the first and you have described a scuffle; answer only the second and you have left a dangerous situation unmanaged.

RULE **Use the least coercive measure that will keep people safe, and no more.** Acute management climbs a ladder: environmental and verbal measures first, then medication offered and taken by choice, and only where safety demands it and the law permits, coercive sedation and physical control. Each rung is justified by the failure of the one below it, never by disruption or convenience, and you climb down the moment the danger falls.

MNEMONIC

Talk, offer, tranquillise, restrain

The four rungs of acute management, in order. **Talk** the situation down; **offer** medication the patient can accept by choice; **tranquillise** by injection only if talking and offering have failed and danger remains; **restrain** physically, only as a lawful last resort to prevent imminent harm. Seclusion and solitary confinement are prohibited outright in India and are never a rung on this ladder.

42.1 The graded ladder of acute intervention

The options are arranged as a ladder because coercion is a harm in itself: the burden of justifying each step rises as the step takes more of the patient's autonomy, so the least restrictive measure that will work is always the right place to start. The examiner tests movement between the rungs and the reasoning that carries you from one to the next, which the table lays out.

RUNG	WHEN YOU REACH FOR IT	WHAT IT AIMS AT	THE SAFEGUARD IT DEMANDS
Environmental and verbal de-escalation	First, in every case of acute disturbance, and continued throughout	Lowering arousal so the patient regains control and coercion becomes unnecessary	None beyond good practice, because it overrides no choice
Offered oral medication	When talking alone is not settling the patient	Relief of distress and agitation, taken by the patient's own consent	A genuine choice, since it is help offered and not force applied
Rapid tranquillisation	When de-escalation and offered medication have failed and danger persists	Calming enough to reduce risk and permit care, not sedation into unconsciousness	Given under necessity, with physical monitoring afterwards
Physical restraint	The last resort, when less restrictive measures cannot contain a risk of harm	The immediate physical safety of the patient and of others	Lawful only within the statutory limits set out elsewhere in this chapter, which permit physical restraint but ban seclusion outright

Reading down the last column shows the logic: each higher rung takes more of the patient's liberty and demands more justification.

42.2 De-escalation: the mandatory first line

De-escalation is the coordinated use of environmental and interpersonal measures to bring down a patient's arousal and help them recover their own control, so that no more coercive measure becomes necessary. It is not a soft preliminary to the real work; it is the first line of treatment for acute disturbance, attempted in every case and continued even while more coercive options are prepared in case it fails.

Its two arms are worth separating, because a candidate who names only the talking has described half of it. The **environmental** arm reshapes the situation the disturbance is happening in: reduce the stimulation and noise, remove the audience a frightened patient may be performing to, take away objects that could become weapons, and ensure there is space, a clear exit for patient and staff, and enough staff nearby that no one is trapped. A visible but unthreatening staff presence signals that the situation is contained without becoming a confrontation. The **interpersonal** arm is the manner of the person who engages: one clinician leads so the patient is not surrounded by competing voices, keeping a calm posture and tone, respecting personal space, and avoiding threats, ultimatums and any display that reads as a challenge. The aim is not to win an argument but to lower the temperature.

Much of what settles an agitated patient is the acknowledgement of a real grievance and the meeting of an unmet need. A patient may be agitated because they are in pain, frightened, thirsty, needing the toilet, or waiting without information, and a clinician who listens, names the distress and offers realistic choices restores a sense of agency. Practical verbal measures that repay learning include:

- letting the patient speak and signalling that their distress has been heard;
- speaking simply and slowly, in short sentences, without jargon or threats;
- offering realistic choices so the patient keeps some control of what happens.

42.3 Offered medication: the collaborative step

When talking alone is not settling the patient but the situation is not yet an emergency of imminent harm, the next rung is medication offered and taken by consent. The distinction between medication a patient accepts and medication imposed on them is not a technicality; it is the whole difference between collaboration and coercion. A patient who takes an oral medication offered as relief from distress has not been overridden at all, and their autonomy is left intact. Offering the choice, explaining that it is there to help rather than to control, and where possible giving some say in the form, keeps the encounter therapeutic rather than adversarial.

The specific agents and doses at this step are clinical-protocol matters this section does not fix; the reasoning the examiner wants is the principle. Where a patient will accept oral medication, that acceptance is preferable to any imposed alternative even when the imposed alternative would act faster.

42.4 Rapid tranquillisation: calming under necessity

When de-escalation and offered medication have failed and the patient remains an immediate danger to themselves or others, this does not by itself authorise treatment without consent:

where the Mental Healthcare Act's emergency-treatment provision is satisfied, necessary parenteral medication may be given under that provision to bring the disturbance under control, subject to its professional, consent, seriousness, purpose and duration limits, and otherwise the applicable treatment-consent provisions continue to govern. This is **rapid tranquillisation**, and its purpose is precise and easily misstated. The aim is to calm the patient enough to reduce the risk and allow assessment and treatment to proceed; it is not to sedate them into unconsciousness. An answer that describes the goal as knocking the patient out has misunderstood the intervention and the standard it is held to.

Because it is a treatment imposed without consent, rapid tranquillisation carries the same requirement of justification as any coercive act: it is used only where it is necessary for safety and the less restrictive rungs have not sufficed. It also carries genuine physical risk, and a sedated patient cannot simply be left, because over-sedation must be caught early. In broad terms the responsible clinician attends to:

- the level of consciousness and the depth of sedation against what was intended;
- the airway, breathing and circulation, which sedation can compromise;
- the patient's basic physical observations until they have recovered.

The exact agents, doses, observation intervals and escalation thresholds are protocol specifics this section does not assert. The frame it does assert is a calming aim not an obliterating one, a necessity justification not a convenience one, and mandatory physical monitoring of a chemically sedated patient.

TRAP **Jumping to rapid tranquillisation or restraint as the first move.** Under the pressure of a violence scenario candidates skip straight to the injection or the restraint team, and the examiner reads that as not knowing the graded approach. De-escalation is the first line in every case and is what a correct answer opens with; medication offered by consent precedes medication imposed; and coercive measures are justified only by the failure of the less coercive ones and by a genuine risk of harm. Naming the top of the ladder first, or omitting the rungs below it, loses the marks the question is built around.

42.5 Physical restraint, and the outright ban on seclusion

Physical restraint, the manual or mechanical holding of a patient, is the most restrictive measure the law still allows and therefore the last rung on the ladder. It is used only when the measures below it have failed or are inadequate and a risk of harm cannot otherwise be contained. **Seclusion**, the supervised confinement of a patient alone in a room they may not leave, is a different matter: in India it is not a bounded last resort at all but is prohibited outright, so it never appears on this ladder. Physical restraint, by contrast, is not merely a clinical decision; it is bounded by statute, where the clinical answer and the legal answer meet.

IN INDIA

The Mental Healthcare Act **2017** governs restraint and seclusion, and it draws a hard line between them. Its section **97**, set out in full with the prohibited and restricted procedures elsewhere in this chapter, prohibits seclusion and solitary confinement of a person with mental illness altogether. Physical restraint alone is conditionally permitted, and only where it is the sole means available to prevent imminent and immediate harm to the person or to others, only when authorised by the psychiatrist in charge, kept time-limited and recorded, and never used as a punishment or for the convenience of staff. The clinical decision to restrain therefore lives inside a statutory frame; to seclude a patient at all, however well meant, is unlawful, and restraint that steps outside those bounds is unlawful as well as poor practice.

Translated into practice, those bounds mean physical restraint is chosen only when nothing less will do, kept to the shortest duration the danger requires, held under continuous review, and ended the moment the risk has fallen. The patient is not abandoned to the measure: their physical safety is observed throughout, and the episode, its justification, duration and review, is documented contemporaneously. Its justification lasts exactly as long as the harm is imminent, and no longer.

PITFALL

The characteristic real-world failure is physical restraint used for the ward's convenience rather than the patient's safety: to manage staffing, to quieten a disruptive but not dangerous patient, or as an unspoken sanction for difficult behaviour, then left in place longer than any imminent risk warrants and poorly recorded. Each of these steps outside the statutory limits, which permit physical restraint only to prevent imminent harm, only as the sole means available, and only time-limited and recorded. Reaching for seclusion is a failure of a blunter kind, because seclusion is banned outright and is never a lawful option to begin with. Using restraint where there is no imminent risk, or continuing it past the point of danger, converts a lawful safety measure into an unlawful one.

One further boundary should be named and not taught here. When the assessment of a violent patient turns up a specific and credible threat to an identifiable other person, the duties that may then follow, the questions of confidentiality and of any duty to protect a third party, belong to the Forensic ethics, consent and legal procedure notes.

42.6 The longer horizon: targeting the modifiable drivers

Why the second horizon carries the marks. Containing an acute episode does nothing about the reasons it happened; a patient calmed today who returns to the same drivers will be back tomorrow. Longer-term management is therefore a change of task, from containing disturbance to lowering the probability of recurrence. The lever is the distinction between the drivers of risk that cannot be changed and those that can: the historical, static factors anchor a patient's baseline, while the modifiable, dynamic factors are what a treatment plan works on. The full taxonomy of these factors is developed in the separate treatment of the risk factors for violence

in mental illness in these notes rather than rebuilt here, and longer-term management is in essence the systematic pursuit of the **modifiable risk factors**.

Treat	Address	Support	Structure
THE UNDERLYING ILLNESS	SUBSTANCE USE	ADHERENCE	THE FOLLOW-UP

Each of these targets a driver that can actually move. **Treating the underlying illness** comes first, because active symptoms are themselves dynamic drivers of risk, and the effective treatment of a relapsing psychosis or a manic episode removes one of the strongest levers on the patient's dangerousness. **Addressing substance use** matters because intoxication and dependence are among the most powerful modifiable contributors to violence; the clinical treatment of substance use disorders and the pharmacology of de-addiction are covered in the Substance use disorders notes, and a violence-reduction plan which ignores a patient's substance use has left its most tractable driver untouched.

Supporting adherence follows directly, because the treatment that lowers risk only does so while the patient is actually receiving it, and disengagement or covert non-adherence is often the first step back toward relapse and the risk that comes with it. Attending to the therapeutic alliance, to side effects that drive patients away from their medication, and to the practical barriers to staying in treatment is part of managing risk, not separate from it. **Structured follow-up** ties the rest together: assertive engagement, a clear care plan, the monitoring of the dynamic factors, and a crisis plan for the situations known to raise this patient's risk. Because the modifiable drivers change with time, the plan is reviewed rather than written once, and the structured risk assessment covered separately in these notes is the instrument through which that review is kept honest.

42.7 The record and the review

Two practices run through the whole of management and are examined as competence, not paperwork. The first is **documentation**: a coercive decision that is not recorded cannot be shown to have been justified, proportionate, time-limited or reviewed, and where each step overrides a patient's liberty the record is the evidence that the law's conditions were met. The second is the **post-incident review**. After a serious episode, the event is reviewed for the patient, whose experience of being restrained or sedated needs understanding and whose care plan may need revising, and for the staff, whose safety and learning bear on the next episode. A ward that manages violence well de-escalates first, coerces only within the law when it must, and learns from each event.

GOOD TO REMEMBER

Two habits separate safe management from lucky management. In the acute phase, your manner and the environment are the first instrument, not the prescription pad, and if you do sedate, keep watching the patient's breathing rather than assuming the job is done. The work does not end when the patient settles: review the episode with patient and staff, then turn the care plan to the drivers that can be changed, because that is where the next incident is prevented.

Manage the violent patient by climbing the least-coercive ladder first, de-escalation, then medication offered by consent, then rapid tranquillisation only to calm and not to sedate into unconsciousness, and physical restraint only as a lawful last resort to prevent imminent harm, seclusion being prohibited outright in India; then lower future risk by treating the illness, addressing substance use, supporting adherence and structuring the follow-up.

Cross-cutting synthesis

43 · Cross-cutting synthesis

Why this synthesis earns its own place. Every other section in this chapter teaches one rule and then closes; this one shows how those rules interlock. Read alone, the Mental Healthcare Act, the disability legislation, the narcotics law, the tests of criminal responsibility, the civil and family capacities and the assessment of violence risk look like a list of unrelated statutes a candidate must memorise in parallel. They are not unrelated. The chapter has two spines - the legislation a psychiatrist practises inside, and the questions a court puts from the outside - and a single construct runs the length of both and holds them together. That construct is **capacity**, and learning to see it is what turns a dozen separate topics into one subject.

The reason it matters for the marks, and for the ward, is that capacity is almost never the global, once-settled attribute that everyday language implies. It is asked of a particular decision, and it is asked at a particular time. The same patient, on the same afternoon, can have the capacity the law requires for one decision and lack it for another; and a person who lacked it a month ago may have it today. Miss either property and the whole architecture collapses into the error the examiner is watching for - reading one capacity off another, or fixing a person's capacity as a permanent fact of who they are. This section re-teaches no single test. It names each in a clause, cross-refers it to the topic that owns it, and then does the one thing no other section can: it lays the tests side by side so the shared logic shows.

Which decision?	Which moment?	Which forum?
CAPACITY IS DECISION-SPECIFIC	CAPACITY IS TIME-SPECIFIC	COURT, BOARD OR WARD

43.1 One construct beneath two spines

Set the chapter out as its architects did and the shape becomes easy to hold. The first spine is the mental health legislation a psychiatrist works within: the Mental Healthcare Act with its definition of illness and its consent, admission and review machinery; the Rights of Persons with Disabilities Act with its certification and guardianship; and the narcotics law. The second spine is the run of forensic questions a court asks from the bench: was the accused responsible for the act, is a person competent to make a will, a contract or a marriage, is the accused fit to be tried, and does this patient pose a risk the law must weigh. The two spines are usually taught, and examined, apart. What binds them is that every question on either spine is, when you reach its base, a question about whether a specified person could make a specified decision. The legislation asks it

in order to protect and to empower; the court asks it in order to attribute or to withhold responsibility. The asking is the same act.

Because the seam is a single construct, the sections interlock rather than merely sit next to one another. A treatment refusal on the ward and a disputed will in a civil court are the same question - can this person make this decision - wearing different robes. Once that is seen, the statutes stop competing for memory and begin to reinforce it: recall the seam, and each provision hangs off it in its proper place. The rest of this section develops the two properties that make the seam behave the way it does, lays the capacities on a common grid, walks a single case across the handoffs it must cross, and shows how one judgement is read differently depending on who receives it.

43.2 The same patient, several decisions

The first property is that capacity is **decision-specific**. It is not a global competence a person carries about with them; it attaches to the decision in front of them, and it can be present for one and absent for another at the very same moment. The Mental Healthcare Act's treatment-decision capacity asks only whether the patient can make the mental-healthcare choice at hand; it says nothing about whether the same patient can make a will. **Testamentary capacity** asks whether the person grasps the nature of the act of making a will and the claims they ought to weigh, a standard taught in full in this chapter's topic on will-making capacity. **Contractual capacity** asks whether, at the point of contracting, the person was of sound enough mind to understand the bargain and judge its effect on their interests, which is a different topic again. **Criminal responsibility** asks whether unsoundness of mind at the time of an act should excuse it. Each is its own test, owned and set out in its own place in this chapter; none is a proxy for the others.

That they can diverge in the same person is not arbitrary but structural, because each decision makes a different demand. A will requires a person to hold in mind the extent of their property and the people with a claim on it; a consent to treatment requires them to weigh a foreseeable benefit against a foreseeable harm over a shorter horizon; a contract requires them to appraise an exchange and its consequences for their own interests. A delusion that fixes on the natural beneficiaries of an estate may destroy the capacity to make a valid will while leaving the capacity to consent to an injection wholly intact, and a fluctuating confusional state may remove the capacity to weigh a complex financial bargain while leaving a simple, well-rehearsed treatment choice within reach. So the answer for one decision genuinely does not settle another, and an opinion that a person "lacks capacity", full stop, is not an opinion at all until it names the decision it is about.

43.3 The same decision, a specified moment

The second property is that capacity is **time-specific**. It is judged as at a moment, not for a lifetime, and the moment the law fixes on differs for different questions - which is the single most consequential distinction in the whole chapter. Treatment-decision capacity is assessed when the decision must actually be made, and reassessed as the patient's state changes, because a person too disturbed to decide on admission this week may be well able to decide on discharge the next.

The capacity to make a valid will is judged as at the time the will is executed; the capacity to contract as at the time of contracting. And the forensic pair pulls furthest apart on precisely this axis: criminal responsibility is judged as at the time of the act, while **fitness to stand trial** is judged as at the time of the trial, which may fall months or years later and in a quite different mental state.

That gap is where careful candidates separate themselves from careless ones. A man may have been floridly psychotic when he killed and have recovered entirely by the time he is arraigned: responsible-or-not is answered by his mind at the act, fitness by his mind in the dock, and the two answers can point in opposite directions without any contradiction between them. The mirror case is just as real - a person sane at the time of an act may become unfit to be tried through an intervening illness. Because capacity moves in time, every forensic and civil opinion is anchored to a date and to a decision, and an assessment reported without its moment is incomplete in exactly the way an assessment reported without its decision is.

43.4 The capacities on one grid

Laying the capacities on shared axes is the payoff of treating them as one subject rather than five. The grid below restates no test - each is taught where it is owned - but sets each against the same three columns: the decision it governs, the moment at which it is judged, and who puts the question and answers it. Read down any column and the family resemblance is plain; read across any row and the test's own distinctness is preserved.

CAPACITY IN ISSUE	THE DECISION IT GOVERNS	WHEN IT IS JUDGED	WHO PUTS AND ANSWERS THE QUESTION
Treatment-decision capacity	Consent to, or refusal of, mental-healthcare and treatment	When the decision must be made, and again as the state changes	The treating clinician under the Mental Healthcare Act, open to the Review Board
Testamentary capacity	Making a valid will	As at the time the will is made	A civil court, on the will-making standard
Contractual capacity	Entering a binding contract	As at the time of contracting	A civil court, on the soundness-of-mind standard
Criminal responsibility	Whether unsoundness of mind excuses the act	As at the time of the act	The criminal court
Fitness to stand trial	Whether the accused can take part in the trial	As at the time of the trial	The criminal court

The grid makes one lesson unavoidable, and it is the rule to carry out of this section.

RULE **Capacity is decision-specific and time-specific - it is asked of one decision at one moment, never of the person in general.** A finding for one decision does not carry to another, and a finding at one time does not carry to another. So an assessment is complete only when it names both coordinates: which decision it is about, and as at which moment it speaks. Anything shorter - "the patient has capacity", or "the patient lacks capacity" - is not yet an opinion the law can use.

43.5 The handoffs a single case crosses

A real case does not stay in one box; it hands the same person from one capacity question to the next, and often from one forum to another. Watching a single patient move through the chapter is the surest way to feel how the sections interlock in practice rather than only on a grid.

- An admission decision turns first on treatment-decision capacity: whether the patient can make the admission and treatment choice themselves decides whether they are admitted on their own request or through the supported route, a determination the Mental Healthcare Act governs and the Review Board can later be asked to examine.
- A capacity question can become a **guardianship** question: where the inability to manage one's affairs is enduring rather than momentary, the issue shifts from a single bedside decision to the appointment of someone to decide across a domain of life, under the disability legislation's limited-guardianship route or the general property-management machinery, each taught in its own place here.
- A criminal act raises two capacity questions at once: responsibility, fixed as at the time of the act, and fitness, fixed as at the time of the trial - the same accused, two separate inquiries that must not be run together.
- A consent-to-treatment moment can recur inside the forensic pathway: a patient found unfit, or detained after a verdict, still has treatment decisions to be made, and a treatment such as electroconvulsive therapy re-poses the consent-and-capacity question the Act governs, while the clinical technique of that treatment belongs to the ECT and neurostimulation notes.

TRAP **Answering the responsibility question with evidence of the trial-time state, or the fitness question with evidence of the state at the act.** The two inquiries share an accused and a diagnosis, so a candidate under pressure fuses them and describes the mental state at the one moment they can most easily picture. But responsibility looks back to the act and fitness looks to the courtroom now, and the states at those two moments can be wholly different. Keep the clock, not the person, at the centre: name which moment the question fixes on before you describe any mental state.

Two boundaries are worth marking as the case crosses them. When the forensic frame touches a child - a custody dispute, or a juvenile whose case raises a preliminary assessment - the governing child-protection statutes are named here and taught in the Child psychiatry: assessment, treatment, services and protection notes, and are not reworked as though they were insanity assessments. And when the criminal inquiry reaches the substantive law, currency is everything: the insanity provision candidates first learned in the Indian Penal Code has been recodified into the Bharatiya Nyaya Sanhita, and the older provision is historical wording for an act committed after the recodification took effect. It is not automatically superseded for an act committed before

that date, because the recodifying statute's own transition clause keeps the older provision live as the operative law for offences from before commencement. The synthesis does not restate either provision - it is owned by this chapter's topic on criminal responsibility - but it insists that the offence date, not the date of writing, is what decides which version is named.

GOOD TO REMEMBER

When a patient is about to cross from one of these questions to the next, write the opinion to the decision and the moment actually in issue, and resist the pull to answer the broader question you can see coming. A capacity opinion for consent to admission is not a fitness opinion and not a testamentary opinion; date it, name its decision, and let the next question be assessed on its own facts when it arrives.

43.6 One judgement, three readers

The seam runs through risk as well as through capacity. A single clinical judgement that a patient carries some degree of **violence risk** does not hold one fixed meaning; it is read differently by each forum that receives it, because each brings a different question and does a different thing with the answer. The risk factors and the structured and actuarial instruments that generate the judgement are taught in this chapter's risk-assessment topics; what the synthesis adds is that the same judgement is not the same fact to a court, to a Review Board and to a ward.

WHO READS THE RISK JUDGEMENT	THE QUESTION THEY BRING TO IT	WHAT THEY DO WITH IT
The criminal or civil court	Is this person a risk the law must act on	Disposal, detention or conditions on liberty
The Mental Health Review Board	For a supported admission, should the admission or readmission be permitted, or should discharge be ordered; for a restraint episode, has the establishment persistently and wilfully ignored the restraint limits	Permit the admission or readmission, or order discharge, on the specific admission-review route; or, for restraint, issue the separate desist order the Act provides. There is no free-standing power to vary a detention or restriction outside these named routes
The ward team	How are this patient and others to be kept safe now	The clinical management plan, bounded by the statutory limits on restraint and seclusion

The practical corollary is that a risk opinion must be written for the reader who asked for it. A formulation built to guide a ward's management plan is answering "what do we do now", and it is not, without more, an answer to the court's question of whether detention is justified or to the Board's question of whether a restriction remains proportionate. The judgement can be the same and its use quite different.

IN INDIA

Every capacity and risk question in this chapter is answered under an Indian statute and before an Indian forum, and the examiner marks the Indian provision, not the Western test it descends from. Treatment-decision capacity and the review of detention sit with the Mental Healthcare Act and its Review Board; guardianship with the disability legislation and its committee route or the general civil machinery; criminal responsibility and fitness with the recodified criminal law before the trial court. A technically correct English or American answer to an Indian question still loses the mark here, because the question is written to test the Indian route, not the ancestor it grew from.

PITFALL

The recurring real-world error is to let a single opinion travel beyond the question it was written for. A capacity assessment recorded once, undated and unqualified, is read months later as though it still held and covered a different decision; a risk note written for the ward is quoted to a court as if it settled the court's question; a superseded section is copied forward as current law. Each is the same mistake - an opinion detached from the decision, the moment and the forum that gave it meaning - and each reaches a real report, not merely an exam script.

43.7 The map to carry into the hall

The map, when memory fails. If the chapter blanks you under pressure, the fastest way back in is not to grope for a section number but to place the question on the map. Ask which of the two spines it belongs to, and then find the capacity beneath it. Almost every question this paper can set is a statute you practise inside, a question a court asks, or a judgement of capacity underneath both, and naming which one narrows the search until the owned detail surfaces. Even when the exact section will not come, the map gives you a structured stem to write around instead of an empty page.

MNEMONIC

Law inside, court across, capacity beneath

Rebuild the whole chapter from three phrases. **Law inside** is the legislation you practise within - the Mental Healthcare Act, the Rights of Persons with Disabilities Act and the narcotics law. **Court across** is the run of questions a court puts to you - responsibility for an act, competence to will, contract or marry, fitness to stand trial, and risk to others. **Capacity beneath** is the one foundation carrying both, because each of those is finally a question about whether a particular person, for a particular decision, at a particular time, could do what the law asked. Recall the two spines, then the foundation under them, and the chapter reassembles itself from memory.

That is the whole of the synthesis. The tests differ in their words and their forums, but they rhyme, because each is asking one question in a slightly different accent. Hold the question and the accents sort themselves.

Capacity is one construct seen from many benches - always ask which decision, at which moment, before which forum, and the chapter's dozen tests collapse into one question with a dozen answers.

Apply and consolidate

44 · Applying the chapter

Why this closer works you, not the page. You have met every statute and every test in this chapter on its own terms. A worked vignette does the one thing the separate topics cannot: it hands you a presentation with no label on it and asks you to find the legal question inside it, fix the moment at which that question must be answered, and give an answer you could defend to a court. That is precisely what the long case and the viva examine, and it is where otherwise prepared candidates still come undone, because reciting a provision and deploying it against messy facts are different skills that fail independently. Every vignette below runs the same four beats - a short presentation, the decision point it forces, the reasoning a candidate must show, and the answer - and between them they span the four kinds of question the paper builds its scenarios from. The sections, durations, cases and instruments the reasoning deploys are taught, and cited to their source, in the topics that own them; what these pages rehearse is the judgement that puts them to work.

Beneath all four questions sits a single construct, **capacity** - whether a particular person, faced with a particular decision, at a particular time, could do the thing the law asked of them. The four families the paper draws its vignettes from are best held as one set, so that each scenario arrives as a member of a family you already recognise:

- a decision under the mental health legislation about how a person who may be unable to consent is to be admitted and treated;
- a civil assessment of whether a person is competent to a specific act, such as making a will or entering a contract;
- a criminal question of whether unsoundness of mind excuses an act, or unfits a person for trial;
- and a formulation of the risk that a patient will be violent, with the management plan that must follow it.

Read each vignette for the capacity beneath its surface and the answer begins to organise itself.

44.1 How to work a forensic vignette

Before the cases, a word on method, because the order in which you attack a vignette decides whether you answer the question asked or a neighbouring one. The first move is always to identify which of the four questions you are being given, because both the material you deploy and the moment you fix follow from that identification and from nothing else. The second move is to fix the time at which the question must be answered - the time of the act, the time of the

will, the time of the trial, the present moment on the ward - because the same person can hold a capacity at one instant and lack it at another. The third is to apply the specific standard for that decision, not a global impression of the person. The fourth is to answer in the register the forum expects: a ward decision is defended by the statute and the least-restrictive principle, a court opinion by the evidence and the correct current citation.

RULE **Name the question, then fix the moment, before you reach for a section.** A vignette punishes the candidate who recites a provision before deciding which question is being asked. Identify the family the scenario belongs to, anchor the assessment to the exact moment the law cares about, and only then retrieve the standard and its citation. Do it in the other order and you will produce an accurate answer to a question you were not asked, which earns nothing.

Present	Decide	Reason	Answer
READ THE SCENARIO	NAME THE LEGAL QUESTION	FIX THE MOMENT, APPLY THE STANDARD	IN THE FORUM'S REGISTER

44.2 Vignette: an admission that will not be consented to

Presentation. A family brings a man in mid-life to the emergency room. For some weeks he has barely slept, has stopped eating, and believes his neighbours are poisoning the household water; today he has threatened to leave and confront them. He does not accept that he is unwell, and he refuses to remain.

Decision point. On what lawful basis, if any, may he be admitted and treated when he will not consent, and what stops that basis from becoming simple detention at the family's request.

Reasoning to show. First place the question: this is an admission decision under the mental health legislation, not a forensic one, and its pivot is the capacity to make the treatment decision, assessed for this decision at this time and not read off his diagnosis. If, on assessment, he retains that capacity, he cannot be held against his will merely because he is unwell or because relatives wish it; the statute's default and its stated preference is the independent route, but that route runs only on the person's own free request, so a capacitous person who refuses admission cannot be admitted as an independent patient at all. If instead his mental state means he cannot understand the relevant information, appreciate the reasonably foreseeable consequences, or communicate the treatment decision, the **supported admission** route opens - but only where the statutory criteria are also met, namely mental illness of a severity that requires inpatient care together with a likelihood of harm or of an inability to meet basic self-care, and it proceeds through his **nominated representative** rather than on the ward's say-so. Even then the admission is not a blank cheque: it is time-bound, it runs under the statutory review timetable, it is open to scrutiny by the review board, and it must be the least restrictive option that meets the need. What is said to the family throughout is the plan and its purpose in plain terms; the condition itself is not labelled to them.

Answer. He is not detainable simply for being ill. Assess his capacity for the treatment decision now; if it is present, he can be admitted only as an independent patient on his own free request, so a capacitous man who refuses is not admitted at all; if it is absent and the severity-and-risk

criteria are satisfied, admit by the supported route through the nominated representative, least-restrictively and under board oversight, and keep the independent route in view for the moment his capacity returns.

IN INDIA

The Indian mental health legislation replaced a custodial reception model with a rights-and-capacity one, and the machinery in this vignette is the visible proof of that shift. The nominated representative and the review board are the Indian statute's safeguards against exactly the family-driven, open-ended detention the old law permitted, and supported admission is its carefully bounded substitute for the reception order, a route the nominated representative applies for when a person has high support needs and the severity-and-risk threshold is crossed. Answer the Indian route, not a generic Western involuntary-admission framework, because that route and its safeguards are what the paper is testing.

44.3 Vignette: is she fit to change her will

Presentation. An elderly widow, cared for by one of her several adult children, asks whether she is fit to change her will in a way that would favour that child. She has a fluctuating cognitive disorder with clearly better and worse periods within hours of each other.

Decision point. Does she have the capacity to make this will, and at what moment is that capacity to be judged.

Reasoning to show. Place the question: this is a civil capacity assessment, and capacity here is both decision-specific and time-specific. **Testamentary capacity** is not global competence and it is not the capacity to consent to treatment; it is the specific capacity to make a valid will, resting on a sound disposing mind - broadly, that she grasps the nature and effect of making a will, has a workable sense of the property she is disposing of and of those with a claim on her provision, and that no disorder of mind is perverting that judgement. The full limbs and the standard are set out where this chapter teaches testamentary capacity; a vignette applies them to the facts rather than reciting them. Because the capacity the law fixes on is ordinarily judged at execution, her fluctuating disorder settles nothing by itself: she may make a perfectly valid will in a lucid interval at execution, and a recognised exception also validates a will where full capacity was present when she gave the instructions, the will faithfully embodies them, and at execution she still understands enough to know she is executing that instructed will, even without the full disposing mind at that hour. The presence of a diagnosis does not decide it, and the presence of the specific understanding at the specific moment does. Note too the assessor's independence, because an opinion is worth less if the assessor is the instrument of the interested child.

Answer. Assess the specific limbs at execution, the moment the law ordinarily fixes on, not her global state or her worst hour, and hold the recognised exception in reserve for a will faithfully drawn from instructions given in an earlier, fully capacitated interval. A fluctuating disorder is entirely compatible with a valid will made in a lucid interval, so the task is to establish and document the disposing mind at that moment. Whether she carries a diagnosis is not the question; whether she holds the capacity for this decision, now, is.

44.4 Vignette: responsible then, fit now, or neither

Presentation. A man is charged with a serious assault on a stranger. At the time of the act he was acutely psychotic and believed the stranger was about to kill him. Some months later, awaiting trial and only partially treated, he remains disorganised, cannot follow the charges, and cannot give his lawyer coherent instructions. The court asks for a psychiatric opinion.

Decision point. This is two questions wearing one presentation - was he criminally responsible at the time of the act, and is he fit to stand trial now - and the commonest failure is to answer one with the other.

Reasoning to show. Criminal **responsibility** is judged at the time of the alleged act: the question is whether unsoundness of mind then deprived him of the capacity the substantive provision requires, broadly the capacity to know the nature of what he was doing or that it was wrong or contrary to law. Which provision governs turns on the date of the alleged act: the recodified penal code applies to an act on or after the recodification's commencement, while the superseded penal-code section remains the live law, not mere historical origin, for an act before that date, because the recodifying statute's own savings clause keeps it in force for those earlier acts. The burden of proving the exception rests on the defence, under the recodified law of evidence for a proceeding not already pending when that law commenced, and under the historical evidence provision, likewise kept live by its own savings clause, for a proceeding that already was pending; the wording in both eras descends from the same historical common-law rules. **Fitness to stand trial** is a wholly separate capacity, judged at a different moment - the time of the trial - and it asks only whether he can now understand the proceedings and the charges, appreciate their consequences, and instruct his defence; it says nothing about his mind at the time of the act. The two run on separate clocks: a man may have been responsible, being well when he acted, yet be unfit now; or be presently unfit but, once treated, become triable for an act whose excusability is still an open question. Whatever is communicated to him and his family is done without labelling the condition to them.

Answer. Separate the questions and anchor each to its own moment. On responsibility, opine on his mental state at the time of the act against the substantive standard that applied on that date, state the alleged-act date because it selects the recodified provision or the superseded provision that its own savings clause keeps live for an earlier act, and place the burden on the defence under whichever evidence provision the proceeding's pendency at commencement in turn selects. On fitness, assess his present ability to understand and participate; as presented he is unfit now, so the live issue is restorability on a timetable the court sets. The trial waits for fitness; it does not answer, or replace, the responsibility inquiry.

TRAP **Answering the responsibility question with the fitness answer, or the reverse.** Because both turn on mental state and both arise in the same case, candidates collapse them into one opinion - concluding that a man too unwell to stand trial must therefore have been insane at the time, or that a man now recovered must have been responsible. They are two capacities at two moments on two clocks. Fix the time first, and the two questions come apart cleanly; skip that step and you will confidently answer the one the court did not ask.

PITFALL

The recurring real-world error on this material is one of currency: writing an opinion or a court report that cites the superseded penal-code insanity section, or the old evidence-law burden provision, as though it were still the live law after the substantive criminal statutes were recodified. The doctrine usually survives the slip almost unchanged, so the reasoning still reads soundly - but the citation does not survive, and an opposing advocate who spots a report resting on a repealed section can weaken the witness before a word of substance is heard. Confirm the provision is the one in force, then cite it.

44.5 Vignette: the threat on the ward

Presentation. An inpatient recovering from a psychotic relapse has begun making specific threats against a named member of staff. He has one documented serious assault during a previous untreated episode, uses a substance intermittently while on leave, and is poorly adherent to medication. The team is asked for a risk formulation and a plan.

Decision point. How to formulate the risk and what to do about it, without either over-detaining him or under-protecting the person he has threatened.

Reasoning to show. Place the question: this is a **violence risk** formulation, not a verdict that the man is dangerous as a fixed trait. The modern task is to separate the factors that cannot move from the factors that can. His past assault and his historical pattern are static: they raise the baseline and must be weighed, but no intervention changes them. The current threats, the untreated psychotic symptoms, the substance use and the non-adherence are **dynamic risk factors**, and they are the entire point of the exercise, because they are where management acts. The estimate itself is best organised by a structured professional judgment approach, which weighs history, present clinical state and future context together, rather than by an actuarial score read in isolation or by unaided clinical intuition; the specific instruments are taught where this chapter owns them and are applied here as the frame. Management then targets the dynamic column - treat the psychosis, address the substance use, restore adherence, adjust leave, and contain the immediate situation - and any physical restraint used in an acute moment is bounded by the statute's limits on that measure, not left to clinical discretion alone, while seclusion and solitary confinement are prohibited outright and have no such bound to work within. The threat against a named person also raises a duty to weigh that person's safety alongside the patient's rights.

Answer. Formulate by separating static from dynamic factors; estimate by structured professional judgment rather than a bare score or a hunch; and build a plan that moves the dynamic factors - treatment, substance-use management, adherence, graded leave - while keeping any acute restraint within the statutory ceiling. Document the reasoning, because a risk opinion is judged on the quality of its method, not the confidence of its conclusion, and reassessment is part of the plan because dynamic risk, by definition, changes.

GOOD TO REMEMBER

A risk formulation that lists factors but never says which of them can be moved is a description, not a plan. On the ward the whole value sits in the dynamic column, because that is the only column you can act on, and a plan is simply the set of interventions aimed at those movable factors plus the date you will look again. If your risk note reads the same after treatment as before it, you have written a character sketch, not a management plan.

44.6 Vignette: the certificate that changes audience

Presentation. An employer asks you to certify whether a patient, recovered from an illness that had kept him off work, is now fit to resume his duties. Midway through, the request expands: the same patient is now a complainant in a criminal matter, and his lawyer asks you for a report the court can rely on.

Decision point. Are these the same task, and are they both yours to perform.

Reasoning to show. They are two different certifications, with two different audiences and two different duties, and the examiner sets exactly this drift to see whether you notice the boundary. The fitness-to-resume-work certificate is an occupational-fitness judgement made for the employer, asking whether the person can safely and effectively perform the role, and it belongs to this chapter's civil-certification material. The report and certificate written for a court are a different instrument altogether, governed by the expert's duty to the court and by its own frame of consent, confidentiality and the form of expert evidence - and that material is owned by the Forensic ethics, consent and legal procedure notes, named here and deliberately not taught. The same discipline governs the other borders a forensic scenario can wander into: were the matter to turn on a child, whether custody or a juvenile in conflict with the law, the governing statutes belong to the Child psychiatry: assessment, treatment, services and protection notes, and the clinical management of any substance use belongs to the Substance use disorders notes. Knowing where your own certificate stops is itself an examined skill.

Answer. Sign the occupational-fitness certificate on its own criteria as this chapter's task, and do not let it slide into a court report, which is a distinct duty owed to a distinct audience and is the business of the Forensic ethics, consent and legal procedure notes. Where a scenario reaches into child law or the clinical side of substance use, name the boundary and cross-refer rather than answering with a neighbour's material.

44.7 The four domains on one grid, the thread, and the map

Set side by side, the vignettes make the chapter's architecture visible in a single view. Each turns on a different family of question, yet each resolves to the same underlying move - name the decision, fix the moment, apply the standard for that decision - so the grid below is less a summary than a demonstration that one habit answers all four.

VIGNETTE	DOMAIN IT EXERCISES	THE DECISION POINT	THE CAPACITY OR QUESTION BENEATH
The unconsented admission	Admission under the mental health legislation	On what lawful basis may an unwilling person be admitted and treated	Capacity to make the treatment decision, now
The changed will	Civil capacity assessment	Is she competent to make this will, and when is that judged	Testamentary capacity, at the moment of the act
Responsible then, fit now	Criminal responsibility and fitness to plead	Was he excused at the act, and can he be tried now	Two capacities at two moments on two clocks
The threat on the ward	Violence risk formulation and management	How to formulate the risk and act on it proportionately	Static versus dynamic factors, and where management can move
The certificate that changes audience	Boundary and scope discipline	Whose task is this, and where does my certificate stop	The duty owed and the audience addressed

The thread, one last time. Every vignette in this closer is, underneath, a capacity question, and capacity has two properties worth committing to memory above any single test. It is **decision-specific**, so a person may hold it for one decision and lack it for another at the very same moment, and one capacity never settles another. And it is time-specific, so it is anchored to a fixed instant and can be present today and absent a month ago, or the reverse. The forensic and civil standards differ in their words, but each is asking whether this person, for this decision, at this moment, could do what the law required of them; and once you see that, the messy presentation in front of you stops being a puzzle and becomes a place on a map you already hold.

MNEMONIC

Law inside, court across, capacity beneath

Rebuild the chapter from three phrases when a vignette empties your head. **Law inside** is the legislation you practise within - the Mental Healthcare Act, the Rights of Persons with Disabilities Act and the narcotics law. **Court across** is the run of questions a court reaches in to ask - was the accused responsible, is a person competent to will, contract, marry or stand trial, and is a patient a risk to others. **Capacity beneath** is the single foundation carrying both, because each is finally a question about whether a particular person, for a particular decision, at a particular time, could do what the law demanded. Place the scenario on the two spines, find the capacity under it, and the answer you could not summon cold usually surfaces on its own.

Every vignette in this chapter is a capacity question - name the decision, name the moment, and name the forum, and the answer is most of the way found.

45 · Consolidation

Why this closer exists. You have read the chapter; the marks come from being able to produce it with the book shut. Everything below is built for **active recall**, so every line is a question and not one of them prints its answer alongside - the instant your eye lands on the answer, the effortful retrieval that actually fixes a fact in memory is spent for nothing. Read each prompt, answer it aloud or on paper from memory, and only then turn back to the relevant teaching section to mark what you produced. If a prompt asks for a section number, a threshold, a case or an instrument, say the number, the case or the name; the whole point is that these pages withhold it.

One idea runs the length of this chapter and is worth holding as you revise: **capacity**. Whether the question is a treatment refusal, a will, a contract, a criminal charge or a fitness-to-plead inquiry, the law is finally asking whether a particular person could make a particular decision at a particular time. Keep that thread in view and the statutes stop looking like unrelated laws and become one subject seen from several benches. The prompts are grouped into the six areas the paper draws from, and a short set of discriminations and a master map close the chapter.

45.1 Working the prompts

Before the content, a word on method, because how you use a prompt list decides whether it does anything. Retrieval is not a test you sit at the end of revision; it is the revision. The act of hauling an answer out of an empty head is what lays down the memory, and it feels harder and less productive than rereading precisely because it is doing the work rereading does not.

RULE **Retrieve first, read second.** Treat every prompt as a closed-book question, commit to the fullest answer you can generate cold, and open the notes only to correct what you generated. Rereading a section you have already read builds fluency with the page, not access to the fact; the effortful, slightly uncomfortable pull of recall is the only part of the loop that actually consolidates. The discomfort is the signal that it is working.

Read	Retrieve	Check
THE PROMPT ONLY	THE ANSWER FROM MEMORY	AGAINST THE SECTION

TRAP **Mistaking recognition for recall.** A model answer read the night before feels obvious on the page, and that fluency is quietly misread as knowledge; in the hall, asked to produce the same answer from nothing, the candidate stalls. Recognising an answer when you see it and generating it when you cannot are different skills, and only the second earns marks. If a prompt feels too easy to bother answering, that is the illusion talking - answer it anyway, out loud, and find out.

IN INDIA

This chapter is Indian statute end to end, and the examiner marks the Indian provision, not the Western test it descends from. When a prompt asks for a rule, retrieve the Indian Act, the Indian certifying instrument and the Indian case law by name and, where you can, the section. A technically correct English or American answer to an Indian question still loses the mark, and the questions are written to catch exactly that substitution.

45.2 The Mental Healthcare Act

The largest statute in the chapter and the one that most rewards precise recall of definition, section and procedure. Answer each strand from memory in a sentence or two before you check.

1. State the definition of mental illness the Act adopts and the test by which a person is judged able to make a mental-healthcare decision; then walk the advance directive - who may make one, how it is revoked, and on what grounds it can be overridden - and say who the nominated representative is, how that person is appointed, and what duties the role carries.
2. Distinguish independent from supported admission with the discharge route and safeguards for each; recall the composition and functions of the review board and how it differs from the central and state authorities; and name the ways this Act breaks from the mental health law that preceded it, with the shift in philosophy behind the change.
3. Which provision decriminalizes attempted suicide, what presumption does it raise and on what conditions does that presumption rest; separate the prohibited from the restricted procedures and give the consent position for modified treatment that induces a seizure, including where the patient is a minor; and recall the statutory ceiling on restraint and seclusion together with the offences the Act creates.

45.3 The Rights of Persons with Disabilities Act and the National Trust

A rights-based statute with a benefits-and-certification machinery attached. The trap in this area is borrowing one certificate's instrument for another purpose, so keep the aim of each in view.

1. Recall the salient features of the rights-based disability statute and where mental illness sits among the disabilities it recognizes; then name the instrument and the authority used to certify disability due to mental illness and the threshold at which it becomes a benchmark disability.
2. State the benefits, reservations and guardianship that follow, and how limited guardianship departs from the older plenary model; then recall the National Trust route to guardianship and the local committee that grants it.

45.4 The narcotics law

Here the recall is of the law only; the de-addiction pharmacology behind these provisions belongs to the Substance use disorders notes and is not what the forensic paper is asking for.

1. Recall how the statute classifies controlled substances and the logic that scales its penalties from lesser to graver quantities.
2. State the treatment and de-addiction provisions and the immunity available to an addict who volunteers for treatment - and, crucially, the conditions on which that immunity depends, since an immunity quoted without its conditions is worth little.

45.5 Criminal responsibility and forensic assessment

The busiest forensic band and the one where currency of the law matters most, because the substantive criminal statutes were recently recodified. Retrieve the transition rule before the

provision: fix the offence date and the proceeding's pendency at the recodification's commencement, then select the saved or the new provision accordingly.

1. Recall the common-law rules that supply India's insanity standard and the limbs a defence must establish; then name the current substantive provision and the code that now houses it, the burden of proof and who bears it, and the older sections these replaced; and contrast the alternative tests of responsibility with the retained standard, saying why India keeps the narrower frame.
2. Distinguish fitness to stand trial from criminal responsibility by the moment at which each is judged, and recall the criteria and assessment of fitness; then define diminished responsibility and automatism and where each operates; and separate mens rea from actus reus with the legal senses of intent.
3. Recall the deception-detection techniques, the case that governs their admissibility, and the constitutional protection and the consent it demands; then recall the indicators of malingering and the approach to a suspected feigned illness; and recall the psychiatric issues that recur in homicide and filicide.

PITFALL

The commonest real-world error on this material is one of **transition logic**: citing the new penal-code provision for an offence that predates the recodification, or the new evidence-code burden provision for a proceeding already pending when the recodification commenced, without first checking what the repeal-and-savings clauses preserve. Confirm the offence date and the proceeding's pendency at commencement before you commit either to a report or to an exam script; an old citation is not wrong merely for being old, and a candidate who forgets the savings clauses and calls it wrong on age alone is the one making the error.

45.6 Civil and family capacity

Several distinct capacities and several distinct certificates crowd this band, and the marks go to keeping them apart. Each is capacity for a specific decision, judged at a specific time.

1. Recall the limbs of testamentary capacity and the standard of a sound disposing mind; then state when a contract is void for want of competence due to unsoundness of mind, distinguish this from a voidable contract arising out of defective free consent, and give the moment at which soundness is judged; and distinguish a marriage that is void or voidable for mental illness from a valid marriage dissolved by divorce on that ground, with the different statutes and the different thresholds each needs.
2. Recall how a psychiatric evaluation informs a child-custody decision, and the routes for guardianship and for management of the property and affairs of a mentally ill person; then separate the certifications that are easily conflated - disability certification, fitness to resume work, and compensation or pension - by purpose and instrument; and recall the psychiatric fitness assessment of prospective adoptive parents.

45.7 Violence risk and dangerousness

Modern forensic practice has largely replaced the older language of **dangerousness** with the language of violence risk, and the prompts track that shift, because a candidate who answers with the trait model rather than the risk model loses the mark the question is testing.

1. Explain how and why the field moved from labelling a person dangerous to assessing violence risk; then recall the principal structured professional judgment instrument and the way it groups its items, and the actuarial tools and the psychopathy checklist beside it, with the trade-off between actuarial prediction and structured clinical judgment.
2. Separate static from dynamic risk factors and recall the factors specific to mental illness; then recall the acute and the longer-term management of the violent and high-risk patient, and the statutory limits that bound any restraint decision you take.

45.8 The discriminations, the thread and the map

A small number of pairings account for most of the avoidable errors on this chapter. For each, the retrieval to rehearse is the distinction itself, not either definition, because the examiner sets these pairs precisely to see whether you can hold them apart under pressure.

DO NOT MERGE	THE DISTINCTION TO RETRIEVE
Prohibited and restricted procedures	Which category bars a procedure outright and which only gates it behind consent or permission, and what falls in each
Marriage nullity and divorce	Which route treats a marriage as never validly formed and which dissolves one that was valid, and the grounds each demands
Criminal responsibility and fitness to plead	Which is judged at the time of the act and which at the time of the trial
Disability, fitness-to-work and compensation certificates	Distinct purposes and distinct instruments; name the aim of each and never lend one certificate's instrument to another
Static and dynamic risk factors	Which shift with treatment and which do not, and why management targets the one it can move
Actuarial and structured clinical judgment	Which yields a probability by rule and which yields a formulation by guided judgment, and the trade-off between them

The thread, one last time. Every prompt in this closer is, underneath, a capacity question, and capacity has two properties worth committing to memory above all else. It is **decision-specific**: a person may have the capacity to make a will and not to run a business, so the answer for one decision never settles another. And it is **time-specific**: capacity can be present today and absent a month ago, or the reverse, so an opinion is anchored to a moment and not to the person for all time. The forensic and civil tests differ in their words, but each is asking whether this person, for this decision, at this moment, could do what the law requires of them.

MNEMONIC

Law inside, court across, capacity beneath

Rebuild the chapter from three phrases. **Law inside** is the legislation you practise within - the Mental Healthcare Act, the Rights of Persons with Disabilities Act and the narcotics law. **Court across** is the run of questions a court puts to you - was the accused responsible, is a person competent to will, contract, marry or stand trial, and is a patient a risk to others. **Capacity beneath** is the single foundation carrying both, because each of those is finally a question about whether a particular person, for a particular decision, at a particular time, could do what the law demanded. Recall the two spines, then the foundation under them, and the chapter reassembles from memory.

GOOD TO REMEMBER

If a legislation-or-forensic question blanks you in the hall, run the map before you panic. Ask which of the three it is: a statute I practise inside, a question a court asks, or a judgment of capacity. Placing the question on the map narrows the search and usually surfaces the section, the test or the instrument you could not summon cold, and even when it does not, it gives you a structured stem to write around rather than an empty page.

Every question in this chapter is a capacity question - name the decision, name the moment, and name the statute, and the answer is most of the way found.

Previously asked

There is no indexed past-question bank for this chapter, so nothing in the table below is a catalogued past question and no board or year is claimed for any of them. Attributing a paper the index does not hold would be a fabrication, so in place of a board of origin each row is marked Representative, and the questions are written in the register an examiner uses. Legislation and forensic psychiatry are examined heavily and in every form the paper allows, as long answers, as short notes and in the viva, so the list maps the examined spine of this chapter rather than one board's recent record. Read it as a high-yield revision map, not as a set of questions on record.

QUESTION	MARKS	ASKED
Enumerate the rights of a person with mental illness under the Mental Healthcare Act 2017, and discuss the capacity to make treatment decisions and the advance directive, including how an advance directive may be reviewed or overridden.	10	Representative
Describe the provisions for admission of a person with mental illness under the Mental Healthcare Act 2017, contrasting independent admission, supported admission up to thirty days, and supported admission beyond it.	10	Representative
Prohibited and restricted procedures under the Mental Healthcare Act 2017.	5	Representative
Decriminalisation of attempted suicide under the Mental Healthcare Act 2017 (section 115).	5	Representative
Composition and functions of the Mental Health Review Board.	5	Representative
Describe the salient features of the Rights of Persons with Disabilities Act 2016 as they apply to mental illness, and outline the procedure for certification of psychiatric disability.	10	Representative
IDEAS (Indian Disability Evaluation and Assessment Scale).	5	Representative
Immunity from prosecution for an addict who volunteers for treatment under the NDPS Act 1985 (section 64A).	5	Representative

QUESTION	MARKS	ASKED
Discuss criminal responsibility in mental illness. Explain the McNaughton rules and the insanity defence under the current Indian law (Bharatiya Nyaya Sanhita section 22), and outline the assessment of fitness to stand trial.	10	Representative
Testamentary capacity and the assessment of a sound and disposing mind.	*5*	Representative
Mental illness as a ground for annulment of a Hindu marriage, and the distinction between a void and a voidable marriage.	*5*	Representative
Structured professional judgement in violence risk assessment.	*5*	Representative

The shape of these questions is worth reading before their content. A ten-mark question that opens with enumerate or describe wants a structured map rather than a definition, and the marks are won on the discriminations this chapter turns on: the disjunctive three-limb capacity test, the boundary between supported admission up to thirty days and supported admission beyond it, the split between a prohibited procedure and a merely restricted one, and the difference between a marriage that is void and one that is voidable. A short note carries fewer marks but the same demand for the exact section and the exact modal verb, because shall and may are not interchangeable and a note that gives the wrong section number reads as a note that has not opened the Act. Legislation is the one part of this paper whose answer is checkable against a single primary text, which is precisely why the examiner rewards the candidate who cites the section and marks down the one who paraphrases it.

TRAP **An unasked topic is not a low-yield topic, and a dated citation is a wrong one.** The absence of a catalogued bank for this chapter is a fact about the index, not about what the examiner may set, and legislation is tested every year in one form or another. Two currency traps decide the criminal-responsibility answer. The substantive insanity exception is now Bharatiya Nyaya Sanhita section 22 and the burden of proof rests on Bharatiya Sakshya Adhiniyam section 108, both in force from 1 July 2024; the Indian Penal Code section 84 that older textbooks name carries word for word the same cognitive test but is the historical provision, and citing it as the current law dates the answer. Inside the Mental Healthcare Act the advance-directive override is section 11, not section 13, which is the professional-liability provision; and the Act's definition of mental illness is a different provision from the Schedule definition in the Rights of Persons with Disabilities Act 2016. Prepare the sections and the discriminations, not the past paper.

The quick review

One table, read down the left column and cover the right. Every line is taught in full somewhere above and nothing here is new: each is that provision's single must-hold line, the section number and its operative rule lifted from the passage that teaches it, so a line you cannot recover is a section to reread rather than a fact to memorise here. Modal verbs are load-bearing: where the statute says shall it is kept as shall and where it says may it is kept as may, because that difference often decides the answer. Current criminal law is stated as current, the Bharatiya Nyaya Sanhita and the Bharatiya Sakshya Adhiniyam in force for offences on or after 1 July 2024; the older Indian Penal Code position is kept only where a candidate must still recognise it as the historical provision.

ASK	HOLD
MENTAL HEALTHCARE ACT 2017: DEFINITIONS AND CAPACITY	
DEFINITION OF MENTAL ILLNESS (S.2(1)(S))	A substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, reality-testing or the ordinary demands of life; it INCLUDES conditions of alcohol and drug use and EXPRESSLY EXCLUDES mental retardation.
DETERMINATION OF MENTAL ILLNESS (S.3)	Determined by nationally or internationally accepted standards including the latest ICD, never by political, economic or social status or moral non-conformity; and s.3(5), a determination of mental illness is not the same as unsound mind unless a competent court so declares.
CAPACITY, THE THREE-LIMB TEST (S.4)	Every person is DEEMED to have capacity if able to understand the relevant information, OR appreciate the reasonably foreseeable consequences, OR communicate the decision; the limbs are disjunctive in the bare text, and a choice others think wrong does not by itself negate capacity.
ADVANCE DIRECTIVE AND NOMINATED REPRESENTATIVE	
ADVANCE DIRECTIVE, THE RIGHT (S.5)	Any person who is not a minor may make a written directive stating how they wish, and wish not, to be treated and who is to be nominated representative; it takes effect only once capacity is lost, and a later capacitous decision over-rides it (s.5(4)).
HOW AN ADVANCE DIRECTIVE IS OVERRIDDEN	Three separate routes, do not conflate: the maker's own later capacitous decision (s.5(4)); the maker's revocation or amendment at any time (s.8); and the Board machinery (s.11), where a mental health professional, relative or care-giver applies and the Board, after hearing all parties, may uphold, modify, alter or cancel it. The override is s.11, not s.13; s.13 is professional liability.

ASK	HOLD
NOMINATED REPRESENTATIVE, DEFAULT ORDER (S.14, S.17)	Where none is appointed the order is the directive-named individual, then relative, then care-giver, then a suitable person appointed by the Board, then the Director of Social Welfare; the duty (s.17) is supported decision-making, not substituted judgment.
RIGHTS, ADMISSION AND REVIEW BOARDS	
CORE RIGHTS (S.18 TO S.23)	Access to mental healthcare (s.18), community living (s.19), protection from cruel or degrading treatment with no compulsory tonsuring or forced labour (s.20), equality with physical illness including insurance parity, every insurer shall cover mental illness on the same basis (s.21(4)), information (s.22) and confidentiality with enumerated exceptions (s.23).
INDEPENDENT ADMISSION (S.85, S.86, S.88)	Admission should be independent wherever possible (s.85); a non-minor may request admission and self-discharge, treated only with informed consent (s.86); but an MHP may hold an independent patient up to twenty-four hours to assess for supported admission (s.88(3)).
SUPPORTED ADMISSION UP TO THIRTY DAYS (S.89)	On the nominated representative's application, examination by one psychiatrist plus one MHP or medical practitioner; LIMITED to thirty days; report to the Board within three days for a woman or minor and seven days for others; Board review only on application, not automatic pre-authorisation.
SUPPORTED ADMISSION BEYOND THIRTY DAYS (S.90)	Two psychiatrists examine independently, harm shown consistently over time (stricter than s.89 recently); Board review is MANDATORY, the Board within twenty-one days permits the admission or orders discharge; up to ninety days first, then 120, then 180 days each time.
MENTAL HEALTH REVIEW BOARD (S.73, S.74, S.82)	Constituted by the State Authority (s.73); chaired by a District Judge with a Collector's representative, one psychiatrist and one medical practitioner, and two members who are persons with mental illness, care-givers or NGO representatives (s.74); it registers or cancels directives, appoints representatives, decides admission appeals, and may impose a penalty up to five lakh rupees (s.82).
AUTHORITIES AND REGISTRATION (S.33, S.43, S.45, S.55)	The Central Mental Health Authority (s.33) registers Central-Government establishments (s.43); every State sets up a State Authority (s.45) which registers all other establishments in the State (s.55); each within nine months of assent.
TREATMENTS, RESTRAINT AND ATTEMPTED SUICIDE	
EMERGENCY TREATMENT (S.94)	Any registered medical practitioner may treat to prevent death, serious self-harm, harm to others or serious property damage, subject to the representative's informed consent where available; it shall not use electro-convulsive therapy; limited to seventy-two hours, extendable to seven days in a declared disaster.

ASK	HOLD
PROHIBITED PROCEDURES (S.95)	Absolutely barred: unmodified ECT (without muscle relaxants and anaesthesia, no exception), ECT for minors, sterilisation as a treatment for mental illness, and chaining in any form; the narrow gate (s.95(2)) allows ECT for a minor only with the guardian's informed consent AND prior Board permission.
RESTRICTED PROCEDURE, PSYCHOSURGERY (S.96)	Psychosurgery is not banned but restricted, permitted only on BOTH the patient's informed consent AND the Board's approval; contrast s.95, an outright ban with the single minor-ECT exception.
RESTRAINT AND SECLUSION (S.97)	Seclusion and solitary confinement are absolutely prohibited; physical restraint only when it is the sole means to prevent imminent harm and is authorised by the psychiatrist in charge, kept time-limited, never as punishment or for staff shortage, the representative informed within twenty-four hours and every instance reported monthly to the Board.
ATTEMPTED SUICIDE (S.115)	Two limbs. Notwithstanding section 309 of the Penal Code, a person who attempts suicide is PRESUMED, unless proved otherwise, to have severe stress and shall not be tried or punished (a rebuttable presumption, not a repeal); and the appropriate Government has a DUTY to provide care, treatment and rehabilitation to reduce recurrence.
GENERAL PENALTY (S.108)	First contravention up to six months or up to ten thousand rupees or both; a subsequent contravention up to two years or a fine of fifty thousand to five lakh rupees or both.
THE SHIFT FROM THE 1987 ACT	The Act repealed the Mental Health Act 1987, moving from a custodial licensing-and-guardianship model to a rights-based, capacity-based framework aligned with the UNCRPD; new are the capacity presumption, the advance directive, the nominated representative, decriminalisation of a suicide attempt, prohibition of unmodified ECT and the Review Boards.
RIGHTS OF PERSONS WITH DISABILITIES ACT 2016 AND DISABILITY CERTIFICATION	
PERSON WITH DISABILITY VS BENCHMARK DISABILITY (S.2(S), S.2(R))	A person with disability has a long-term impairment which, in interaction with barriers, hinders full participation, with NO percentage threshold; a person with BENCHMARK disability has not less than FORTY per cent of a specified disability, the gateway to reservation and scheme entitlements. The forty per cent attaches to benchmark disability, not to person with disability.
LIMITED GUARDIANSHIP (RPWD S.14)	A district court or designated authority may appoint a LIMITED guardian for joint, supported decision-making, in consultation with and according to the will of the person, for a specific period and decision, total support only where required; contrast the National Trust Act 1999 plenary guardian appointed by the Local Level Committee for its four covered conditions.

ASK	HOLD
CERTIFICATION OF DISABILITY (S.56 TO S.58)	The Central Government notifies the assessment guidelines (s.56); designated certifying authorities issue the certificate (s.57), now valid across the country (s.58(3)); for mental illness the notified tool is IDEAS.
IDEAS COMPUTATION	Score four items (self-care, interpersonal activities, communication and understanding, work) each 0 to 4 and sum to a Total; ADD a duration-of-illness weightage from 1 to 4 to get the GLOBAL score (0 to 20); it is the global score, not the item total, that maps to the band, and forty per cent (global 7, the Moderate band) is the welfare cut-off.
NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES ACT 1985	
NARCOTIC DRUG VS PSYCHOTROPIC SUBSTANCE (S.2(XIV), S.2(XXIII))	A narcotic drug is enumerated in the Act itself (coca leaf, cannabis, opium, poppy straw and all manufactured drugs); a psychotropic substance is one INCLUDED in the Schedule; small versus commercial quantity is fixed by Central Government notification, not by the Act.
IMMUNITY FOR ADDICTS WHO VOLUNTEER FOR TREATMENT (S.64A)	CONDITIONAL, every condition matters: an addict charged under s.27 or with a SMALL-quantity offence who voluntarily undergoes de-addiction at a Government-run or recognised institution shall not be liable to prosecution; it does not reach commercial-quantity offences, and the immunity may be withdrawn if he does not complete treatment (the bar is mandatory, the withdrawal discretionary).
RELEASE FOR TREATMENT (S.39, S.71)	A court may, with the offender's consent, release an addict found guilty under s.27 or a small-quantity offence for de-addiction instead of immediate imprisonment (s.39); Government may establish or recognise de-addiction centres (s.71).
CRIMINAL RESPONSIBILITY AND FITNESS TO STAND TRIAL	
INSANITY EXCEPTION, CURRENT LAW (BNS S.22)	Nothing is an offence done by a person who, at the time, by reason of UNSOUNDNESS OF MIND is incapable of knowing the nature of the act, or that it is wrong, or that it is contrary to law; in force for offences on or after 1 July 2024. It is word-for-word identical to the old Penal Code s.84, which survives only as the historical provision for earlier offences.
BURDEN OF PROOF FOR THE EXCEPTION (BSA S.108)	The accused must prove the exception on the balance of probabilities and the court presumes its absence; the prosecution's proof beyond reasonable doubt is not displaced. Current law, reproducing the old Evidence Act s.105.
M'NAGHTEN RULES (1843)	Presumption of sanity; the defence needs clear proof that, from a defect of reason due to disease of the mind, the accused did not know the NATURE AND QUALITY of the act, or, if he did, did not know it was WRONG. This cognitive right-wrong test is what BNS s.22 tracks.

ASK	HOLD
BROADER TESTS (NOT INDIAN LAW)	The ALI Model Penal Code adds a volitional prong (substantial capacity to appreciate wrongfulness OR to conform conduct); Durham is the product test (the act as the product of mental disease); irresistible impulse is a volitional gloss; Indian courts generally do not accept irresistible impulse unless it defeats knowing the nature or wrongfulness of the act.
DIMINISHED RESPONSIBILITY AND AUTOMATISM (INDIAN POSITION)	India has no general diminished-responsibility defence; the nearest partial defence to murder is grave and sudden provocation, reducing murder to culpable homicide not amounting to murder; automatism arising from a disease of the mind falls within the unsound-mind exception.
ACTUS REUS AND MENS REA	An offence ordinarily needs both a prohibited act and a guilty mind, and the two must concur; the insanity exception works by negating mens rea; strict-liability offences are the exception.
FITNESS TO STAND TRIAL (BNSS S.367, S.368)	When an accused appears of unsound mind and incapable of making his defence, the court first tries that fact on medical and other evidence and postpones proceedings, at the inquiry stage (s.367) or at trial (s.368); current law, corresponding to the old CrPC s.328 and s.329.
NARCOANALYSIS, POLYGRAPH, BRAIN MAPPING (SELVI, 2010)	Compulsory administration violates Article 20(3) against self-incrimination and Article 21 and amounts to cruel, inhuman or degrading treatment; no such test without consent, and even voluntary results are governed by the National Human Rights Commission 2000 guidelines.
MALINGERING	Intentional production or gross exaggeration of symptoms for an EXTERNAL incentive, a condition warranting attention rather than a disorder; detected by inconsistency, atypical or over-endorsed patterns, poor validity-test effort and collateral; distinct from factitious disorder, whose incentive is internal, the sick role.
HOMICIDE AND FILICIDE	Homicide by a person with mental illness is uncommon but over-represented in active psychosis and intoxication; filicide is classified by motive (Resnick: altruistic, acutely psychotic, unwanted-child, accidental and spouse-revenge); neonaticide, killing within the first day, links to denied pregnancy; postpartum psychosis is a high-risk context.
CIVIL CAPACITY: WILLS, CONTRACTS AND MARRIAGE	
TESTAMENTARY CAPACITY (SUCCESSION ACT S.59)	Every person of sound mind who is not a minor may dispose of property by will; an ordinarily insane person may make a will in a lucid interval; none can make a will while, from intoxication, illness or any cause, he does not know what he is doing.

ASK	HOLD
BANKS V GOODFELLOW (1870)	The sound-and-disposing-mind test in four limbs: understand the act of making a will and its effects, the extent of the property, and the claims of those who might expect to benefit, with no insane delusion perverting the disposition; a delusion that does not influence the will does not remove capacity.
CONTRACTUAL CAPACITY (CONTRACT ACT S.11, S.12)	Competence needs majority AND sound mind AND not being disqualified (s.11); sound mind for a contract is the capacity, at that moment, to understand it and form a rational judgment as to its effect on one's interests (s.12), a different test from the wills test.
MARRIAGE, THE VOID OR VOIDABLE ASYMMETRY	Same mental-capacity condition, opposite consequence. Under the Hindu Marriage Act a breach of s.5(ii) makes the marriage VOIDABLE (s.12(1)(b)), valid until annulled; under the Special Marriage Act a breach of s.4(b) makes it VOID (s.24). Do not collapse them.
MARRIAGE, THE DISSOLUTION GROUND (HMA S.13(1)(III))	A different provision from the formation defect: either spouse may seek divorce where the other is incurably of unsound mind or has a mental disorder such that the petitioner cannot reasonably be expected to live with them; the Explanation includes schizophrenia.
VIOLENCE RISK ASSESSMENT	
FROM DANGEROUSNESS TO VIOLENCE RISK	Not a fixed personal trait but a probabilistic, contextual judgment described by its nature, magnitude, imminence and frequency; the clinical task is risk assessment and management, not prediction of an attribute.
RISK FACTORS	Static and historical (previous violence, young age at first violence, male sex, childhood maladjustment) and dynamic (active symptoms, especially threat or control-override and command hallucinations, substance misuse, non-adherence, social instability); previous violence is the single strongest predictor, and risk concentrates in active psychosis with co-occurring substance use.
ACTUARIAL VS STRUCTURED PROFESSIONAL JUDGMENT	Actuarial tools score mechanically (VRAG-R, a 12-item actuarial guide); SPJ tools guide the clinician through empirically supported factors (HCR-20 Version 3, twenty factors across Historical, Clinical and Risk-management domains; START, a dynamic strengths-and-vulnerabilities measure); PCL-R rates psychopathy. Know the family and purpose; the items are proprietary.
MANAGING THE VIOLENT PATIENT	Graded: de-escalation first, then offered oral medication, and only if necessary rapid tranquillisation and time-limited restraint within s.97 (seclusion banned, restraint conditional); longer term, treat the illness, address substance use, support adherence and keep structured follow-up.

References

Every specific in this chapter is bound to one of the sources below, and the count is the number of claim rows each carried. 65 of those rows are statutory and were read at the primary Act on India Code or an equivalent primary text rather than from any textbook summary, because a stale or paraphrased section changes what a clinician is legally obliged to do. The substantive criminal-responsibility law was read at its current form (Bharatiya Nyaya Sanhita section 22 and Bharatiya Sakshya Adhiniyam section 108, in force 1 July 2024), with the historical Indian Penal Code section 84 named as the superseded provision. 79 row(s) are recorded at verified confidence and 12 at partial, the latter authored from established forensic and clinical knowledge and checked by the adversarial content pass rather than bound to a single primary quote. The must-have-papers cross-check was NOT performed for this Paper III chapter, because the paper lists do not yet exist in the intel index; for Paper III the topic bank plus the syllabus scaffolding is the completeness authority. This table records provenance, not proof: it says where each specific came from, not that the chapter's prose uses it correctly, which the content pass and the ship review test.

SOURCE	CLAIMS CARRIED
India Code, Ministry of Law and Justice (primary Act text)	**52**
Primary source (URL on file)	**16**
Indian Kanoon (primary Act and case-law text)	**13**
Standard forensic and clinical psychiatry (general construct, no single primary source)	**10**

PART VII

VII

Forensic Ethics, Consent and Legal Procedure

Consent, capacity and confidentiality as legal acts, and how a psychiatrist gives evidence and writes for a court.

01 Orientation: forensic ethics and the legal interface

02 Professional ethics, consent and confidentiality

03 Disaster, prisoners and forensic special topics

04 Forensic Indian statutes and legal procedure

05 Cross-cutting synthesis

06 Apply and consolidate

PAPER III

Forensic ethics, consent and legal procedure

Five bands . one complete notes document

Orientation: forensic ethics and the legal interface

1 · Orientation: forensic ethics and the legal interface

Why this chapter earns its marks. Almost every question in forensic and ethical psychiatry is, underneath, a question about a single person standing in two places at once. The same clinician who sits with a patient in the consulting room may later sit in a witness box and be asked to give an opinion that helps convict that patient, or a different one. These two positions do not merely differ in setting; they impose opposing duties, answer to different masters, and are governed by different rules about what may be said and to whom. The candidate who holds that tension steadily can reason their way through unfamiliar vignettes; the candidate who has only memorised isolated rules cannot.

This opening section is the chapter's **advance organizer**: the map you should carry in your head while you read everything that follows. It asserts nothing new of its own and teaches no section numbers. Its whole job is to give the later material a shape, so that each rule you meet later has a place to sit rather than floating free. The accompanying figure sets out the same structure visually; read it alongside this text.

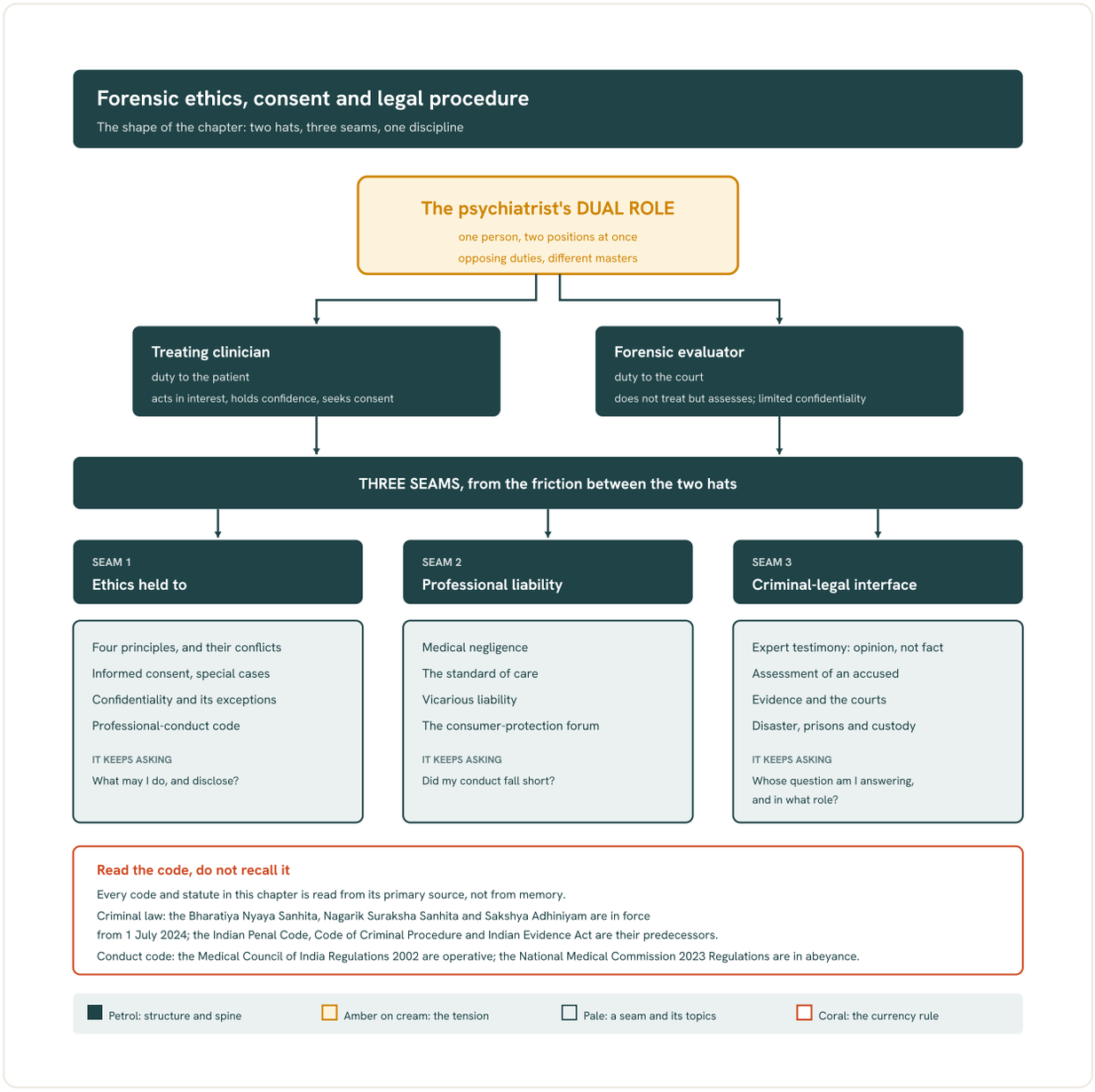


Fig 26.1. The chapter's architecture: one psychiatrist in a dual role, treating clinician on one side and forensic evaluator on the other, and from that friction three seams - the ethics held to, professional liability, and the criminal-legal interface - each read from its primary source with the law current as of 1 July 2024.

1.1 The two hats: the psychiatrist's dual role

The organising tension of this whole chapter is a **dual role**. In one role the psychiatrist is the **treating clinician**, who owes a set of duties to the patient in front of them: to act in that patient's interest, to hold their disclosures in confidence, to obtain their consent before acting. In the other role the psychiatrist is a **forensic evaluator**, who does not treat but assesses, and whose duty runs not to the person being examined but to the court that has asked the question. The forensic evaluator is not the person's doctor, owes them no therapeutic loyalty, and must say plainly, before beginning, that the ordinary clinical duty of confidentiality does not apply and that what is said may be set down in a report for whoever asked for the assessment.

Almost every controversy in the chapter is a friction between these two roles. The obligations that protect a patient in the first role become the very things a court needs the evaluator to set aside in the second. When a treating psychiatrist is dragged into a case about their own patient,

the two hats collide directly, and knowing which hat is being worn at a given moment is what tells you which duty controls.

MNEMONIC

Two Hats, Three Seams

The **two hats** are the treating clinician and the forensic evaluator. From that one tension follow the **three seams** the chapter is stitched along: the ethics a psychiatrist is held to, professional liability, and the criminal-legal interface. Hold the two hats and you can reconstruct the three seams; hold the three seams and you can place any rule the chapter teaches.

1.2 The first seam: the ethics a psychiatrist is held to

The first seam is the ordinary ethical scaffolding of practice, examined more strictly here because the forensic setting stresses it. It runs through the four principles of biomedical ethics and how they conflict; through informed consent and the special situations that complicate it; through confidentiality and, more importantly, the recognised grounds on which confidentiality may be broken; and through professional conduct under the statutory code and the profession's own code of ethics. The recurring exam move in this seam is to take a duty you think is absolute and show you its edge - the point at which a competing duty, or a statutory permission, lets it give way.

1.3 The second seam: professional liability

The second seam is what happens when practice is alleged to have fallen short. This is **professional liability**: the law of medical negligence, the standard of care against which a doctor is judged, the idea of vicarious liability for the acts of others, and the consumer-protection forum through which a patient can pursue a claim for a deficiency in medical service. The seam matters because it converts abstract ethical duty into concrete, enforceable consequence, and because candidates routinely underestimate how far the consumer-protection route reaches into medical practice.

1.4 The third seam: the criminal-legal interface

The third seam is where the psychiatrist meets the criminal justice system: as an expert witness whose opinion evidence must be kept distinct from fact evidence, in the assessment of an accused person, in the rules of evidence and the structure of the courts, and in the special settings of disaster, prisons and custody where a vulnerable population meets a coercive institution. This is the seam where the second hat is worn most consciously, and where the difference between treating and evaluating is not a nicety but the whole point.

SEAM	WHAT IT GOVERNS	THE QUESTION IT KEEPS ASKING
Ethics	Principles, consent, confidentiality, professional conduct	What am I permitted to do, and to disclose?
Professional liability	Negligence, standard of care, the consumer forum	Did my conduct fall below what was owed?
Criminal-legal interface	Expert testimony, assessment of the accused, evidence, custody	Whose question am I answering, and in what role?

1.5 One discipline throughout: the primary source and the currency problem

One habit binds the three seams together. Every code and statute in this chapter is read from its **primary source**, not from a summary or a remembered lecture, because this is precisely the ground that has been shifting under the profession's feet. Two live currency problems run across the whole chapter. The substantive criminal law has been recodified wholesale, so that the older penal, procedural and evidence statutes have given way to their successors, with a savings rule that decides which regime applies to a given case. And the professional-conduct code has its own complication: the long-standing Medical Council of India conduct regulations remain the operative code, while the successor National Medical Commission regulations, though formally notified, have been held in abeyance and are not operative pending a further notification. An answer written from memory of the old law, or from the assumption that the newest notified rule must be the live one, will be confidently wrong.

RULE **Read the code, do not recall it.** On this chapter the currency of the source is itself the examinable content. Name the statute you are relying on, confirm it is the version in force, and check the savings position before you apply it. The forensic seam punishes stale knowledge more than any other part of the syllabus.

TRAP **Citing the superseded criminal statutes as current law.** The Indian Penal Code, the Code of Criminal Procedure and the Indian Evidence Act read as the natural answers because they were the answers for a generation. After the recodification they are historical; the successor codes govern, subject to the savings rule. Candidates lose easy marks by naming the old statute by reflex.

PITFALL

The mirror-image real-world error is to treat the newest *notified* professional-conduct regulations as the live code. The newest notified regulations were themselves held in abeyance by a later amendment, which restored the earlier Medical Council of India code as the operative one, so that is the code a disciplinary body actually applies. Acting on the wrong code is a governance error, not merely an exam slip.

IN INDIA

This is an Indian statutory chapter, and its answers are Indian primary sources that differ from the Western textbook defaults: an Indian criminal law recently recodified, an Indian professional-conduct code with a live-versus-notified split, an Indian consumer-protection route into medical liability, and an Indian confidentiality regime that *permits* proportionate disclosure rather than importing a foreign duty to warn. Where a chapter topic has an Indian answer, that is the answer the examiner wants.

1.6 The edges of the map: what is named here and taught elsewhere

An advance organizer is as much about what lies outside the frame as inside it. Several bodies of law are touched by this chapter but owned by others, and are named here only so you know where they live:

- The Mental Healthcare Act machinery, the criminal-responsibility doctrine with its insanity-defence test and its burden of proof, the disability-rights and narcotics statutes, and the violence-risk instruments belong to the Mental health legislation and forensic psychiatry notes.
- The child-sexual-offences framework, the juvenile justice law and child custody belong to the Child psychiatry: assessment, treatment, services and protection notes.
- The clinical management of substance use in custodial and de-addiction settings belongs to the Substance use disorders notes.

Within this chapter, the material moves from the ethical foundations, through consent and confidentiality, into liability, and out to the criminal-legal interface and its special settings, before drawing the seams back together. Keep the two hats and the three seams in view and the sequence will read as one argument rather than a list.

Every duty in this chapter resolves to one question - what may be disclosed, to whom, and on whose authority - and the answer changes depending on which hat the psychiatrist is wearing.

Professional ethics, consent and confidentiality

2 · Principles of medical ethics (autonomy, beneficence, non-maleficence, justice)

The four principles are the grammar every ethical argument in medicine is written in. When a psychiatrist has to defend a decision - to admit a refusing patient, to withhold a diagnosis a family demands, to ration a scarce bed - the reasons that carry weight almost always reduce to four familiar considerations: the patient's right to decide for themselves, the duty to do them good, the duty not to harm them, and the duty to treat people fairly. These are not rules that dictate answers. They are the standing obligations a clinician must be able to name and weigh,

and an examiner who asks about medical ethics is asking whether the candidate can do that weighing out loud.

The marks here are for precision and for the hard part, which is conflict. Any candidate can list the four principles; the discriminating answer shows that they are separate obligations that routinely pull against one another, that none automatically defeats the others, and that resolving a real case is a matter of judged balance rather than a lookup. This account defines each principle at the depth the exam expects, then shows how they collide inside an ordinary psychiatric decision and how a defensible clinician reasons through the collision. The professional codes that translate these principles into enforceable conduct rules, and the specific law on consent, confidentiality and negligence, are each owned elsewhere in this chapter and are named here, not re-taught.

4
PRINCIPLES OF BIOMEDICAL ETHICS

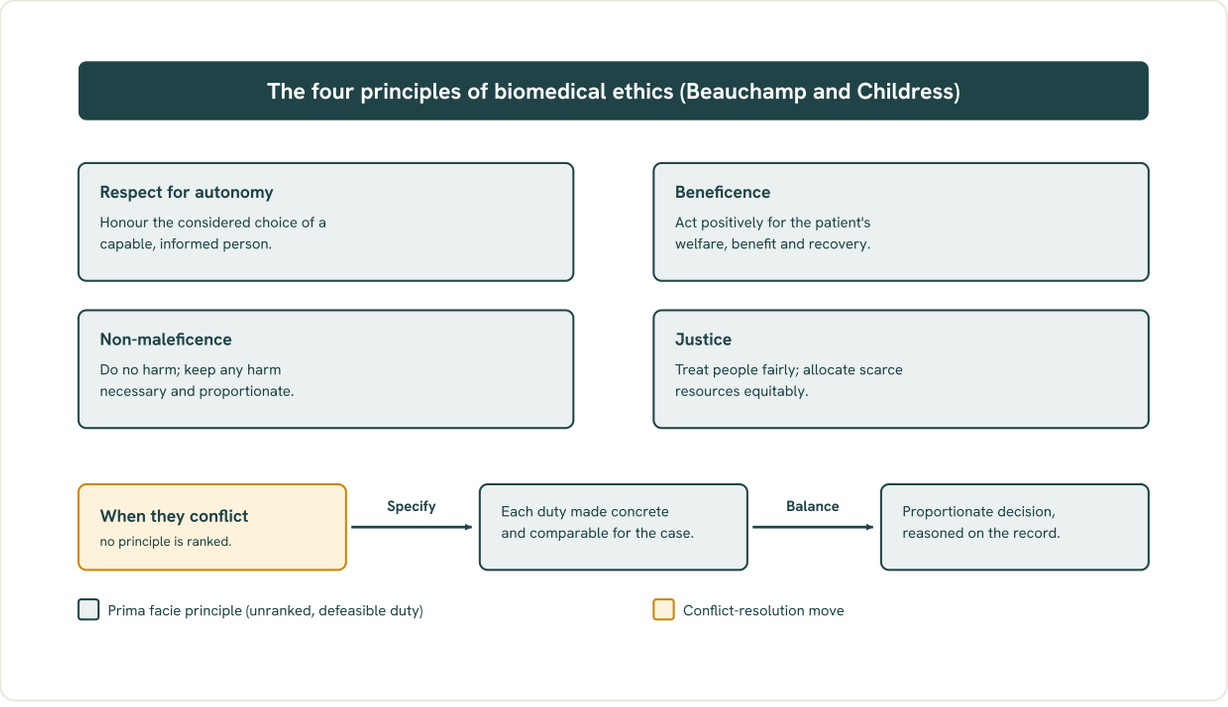


Fig 26.2. The four principles of biomedical ethics (Beauchamp and Childress) as unranked prima facie duties; at conflict, specify each then balance them into a proportionate, recorded decision.

2.1 The framework: four prima facie principles

The dominant framework in medical ethics is the four-principles approach set out by **Beauchamp and Childress**, who argued that a small set of general obligations, drawn from the morality that thoughtful people across traditions already share, can organise almost any clinical ethical problem. On this account there are **four** such obligations: respect for autonomy, beneficence, non-maleficence and justice. Their appeal is practical. They are neutral between the deeper moral theories a clinician may privately hold, so a consequentialist and a duty-based colleague can reason together in the same terms.

The single most important structural fact about the framework is that each principle is a **prima facie** obligation: it binds absolutely unless, in the particular case, it is outweighed by a competing obligation of equal or greater force. A prima facie duty is real and demanding, but it is defeasible. This is what separates the four principles from a code of commandments. There is no fixed ranking in which autonomy always beats beneficence, or non-maleficence always beats justice; the weight each carries is settled case by case. A candidate who writes that "autonomy is the highest principle" has misunderstood the model at its root, because a framework of prima facie obligations has no permanent highest.

MNEMONIC

A Bee Never Judges

The four principles of biomedical ethics: **A**utonomy (respect the capable patient's own choice), **Be**neficence (act for their good), **N**on-maleficence (do not harm), **J**ustice (treat people fairly and distribute resources justly). The phrase fixes the list; it deliberately encodes no ranking, because the framework sets none.

RULE **Each principle is a prima facie obligation with no fixed priority, so ethical reasoning is balancing, not ranking.** A principle can only be overridden by a competing principle that carries greater weight in the specific circumstances, and the clinician must be able to state which principle yielded to which, and why. An answer that resolves a dilemma by declaring one principle supreme has replaced the framework with a hierarchy the framework rejects.

2.2 Respect for autonomy

Respect for **autonomy** is the obligation to honour the considered choices of a person who is competent to make them. Its positive content is not merely leaving the patient alone; it is the duty to enable genuine self-determination - to tell the truth, to disclose what a reasonable patient needs in order to decide, to protect against coercion, and then to abide by the decision a capable person reaches, including a decision the clinician thinks unwise. Autonomy is the ethical engine behind the law of informed consent, whose elements, the assessment of decision-making capacity, and the special situations in which consent is complicated are set out in this chapter's account of informed consent and are not restated here.

Two clarifications earn marks. First, respect for autonomy presupposes capacity; it is a duty owed to a person who has the capacity to make the particular choice, so a decision made without that capacity is not an exercise of autonomy to be respected but an absence of it to be managed. The functional test for that capacity, and its statutory form under the Mental Healthcare Act, belong to this chapter's account of informed consent and to the Mental health legislation and forensic psychiatry notes, and are named here rather than stated. Where a patient lacks capacity, the clinician does not abandon autonomy but shifts to protecting the person's known will and preferences, a reframing the Mental Healthcare Act makes central and whose machinery belongs to the Mental health legislation and forensic psychiatry notes. Second, autonomy is not the same as getting whatever one asks for: a patient may refuse an offered treatment, but the right to

demand a treatment that is not indicated is not part of the principle, because the clinician's own duties of beneficence and non-maleficence remain in force.

2.3 Beneficence

Beneficence is the positive obligation to act for the patient's benefit - to prevent and remove harm, and to promote the patient's welfare and interests. It is the principle that makes medicine a helping profession rather than a merely technical one. In psychiatry beneficence is unusually demanding because the conditions treated can themselves impair the patient's ability to seek or accept help, so acting for the patient's good sometimes means acting before, or even against, what the patient currently says they want.

That is precisely where beneficence becomes dangerous, and the discrimination the exam wants is between beneficence and **paternalism**. Beneficence exercised over a capable patient's contrary wishes is paternalism, and paternalism is defensible only in narrow circumstances - broadly, where the patient's capacity for the decision is genuinely absent or compromised, and the benefit at stake is significant. When a clinician overrides a capable refusal in the name of the patient's own good, they have not applied beneficence cleanly; they have set beneficence against autonomy and must justify the trade. The habit of reaching for "it was in the patient's best interests" as though beneficence settled the matter is the commonest way this principle is abused.

> **PITFALL**
>
> Invoking beneficence to override a capable patient's refusal without ever naming the conflict. In real wards, "it is for their own good" is used to close a decision that the four-principles framework says is still open: acting for the patient's good against their competent choice is not beneficence operating alone, it is beneficence defeating autonomy, and it needs the higher justification that overriding a capable choice always demands. Clinicians who never notice they have made that trade drift into routine paternalism and cannot defend the individual decision when it is later questioned.

2.4 Non-maleficence

Non-maleficence is the obligation not to inflict harm, the principle behind the old maxim primum non nocere, first do no harm. It is often paired with beneficence, and in Beauchamp and Childress's own account the two are distinct obligations rather than two faces of one: beneficence requires positive acts to help, while non-maleficence sets a floor by forbidding acts that harm. The distinction matters because the two carry different stringency. The duty not to harm is generally the more stringent - a clinician is expected to refrain from harming everyone, always, whereas the duty to actively benefit is owed within the specific therapeutic relationship and is bounded by what is feasible and proportionate.

Non-maleficence has sharp teeth in psychiatry, where the treatments themselves carry real burdens: the metabolic and neurological costs of medication, the harms of seclusion and restraint, the stigma that a careless disclosure can cause. Because almost every effective intervention carries some risk of harm, the principle is not a prohibition on all risk but a demand that harm be necessary, proportionate to the expected benefit, and reduced to the least that

achieves the aim - the ethical root of the least-restrictive-option requirement that runs through mental health law. The professional liability that follows when a clinician causes harm by falling below the standard of care - the law of negligence - is the subject of this chapter's account of professional negligence and is named, not developed, here.

The framework also supplies the tool for the case where doing good and doing harm are inseparable: the doctrine of **double effect**, by which an action with both a good intended effect and a harmful foreseen one may be permissible only when strict conditions hold together:

- the act itself is good, or at least morally neutral, and not wrong in its own right;
- the harmful effect is genuinely not the aim but a tolerated side effect;
- the good effect is not achieved by means of the harm; and
- the good is proportionate to the harm risked.

It is the reasoning that lets a clinician offer a treatment whose necessary benefit comes with a foreseen burden, without thereby intending the burden.

2.5 Justice

Justice is the obligation to treat people fairly - to give each their due, to treat like cases alike, and to distribute the benefits and burdens of care equitably. It is the principle that looks beyond the individual consultation to the patient's standing relative to others, and it is the one clinicians are least trained to reason about, which is exactly why it is examined. In its distributive form, **distributive justice** governs how a genuinely scarce resource - an inpatient bed, a slot in a specialist clinic, staff time, a costly medication in a public system - is allocated when not everyone who could benefit can be served.

Justice in psychiatry carries an added weight because of the population served. People with mental illness are among the most likely to face discrimination, to be denied parity with physical health in funding and access, and to have their preferences discounted; a serious commitment to justice therefore includes non-discrimination and the protection of a vulnerable group's fair claim on care, not merely the arithmetic of dividing a resource. Fairness also has a procedural dimension: an allocation decision is more defensible when the criteria are explicit, consistent and applied without regard to a patient's social worth.

PRINCIPLE	CORE OBLIGATION	WHAT IT PROTECTS	SIGNATURE TENSION	PSYCHIATRIC APPLICATION
RESPECT FOR AUTONOMY	Honour the considered choice of a capable person	Self-determination, truth, freedom from coercion	Against beneficence when a capable patient refuses help	Consent to and refusal of treatment; enabling choice where capacity is intact
BENEFICENCE	Act positively for the patient's welfare	The patient's interests and recovery	Against autonomy; slides into paternalism if it overrides a capable choice	Treating a disorder that impairs the will to be treated
NON-MALEFICENCE	Do not inflict harm; keep harm necessary and proportionate	The patient's safety from iatrogenic harm	Against beneficence when the helpful act also burdens	Medication burden, seclusion and restraint, least restriction
JUSTICE	Treat people fairly and allocate resources equitably	Equity, non-discrimination, parity of the vulnerable	Against beneficence to the individual when the resource is shared	Bed and clinic rationing; parity for mental illness

2.6 How the principles conflict, and how a clinician resolves it

The framework earns its keep at the point of conflict, not in the list. Because each principle is prima facie and none is ranked above the rest, a real case can present two or more principles that cannot all be satisfied, and the framework does not resolve this by producing a winner from a formula. It resolves it by two disciplined moves. The first is **specification**: taking an abstract principle and making it concrete for the situation, so that "respect autonomy" becomes "abide by this patient's refusal of this medication given their intact capacity to make it", narrowing a vague obligation into one that can actually be acted on and compared. The second is **balancing**: weighing the specified obligations against each other in the particular circumstances to decide which should prevail here.

Balancing is not licence to prefer whichever principle the clinician favours. A defensible override of one principle by another should meet recognisable conditions: the overriding principle must have a realistic prospect of achieving its aim, no less restrictive action would achieve it, the harm to the overridden principle is the least necessary, and the balance of benefit over harm is proportionate. Set out this way, "I decided on balance" becomes an argument that can be examined and defended.

- **Specify each principle** for the actual patient and decision, so the obligations are concrete enough to compare rather than slogans.
- **Identify the genuine conflict** - which specified obligations cannot both be honoured - rather than pretending one principle simply does not apply.
- **Weigh them** against the conditions above: prospect of success, necessity, least infringement, proportionality.

- **Record the reasoning**, naming which principle yielded to which and why, because a balancing judgement is only as defensible as the account that can be given of it.

TRAP **Treating the four principles as a fixed hierarchy, usually with autonomy on top.** Candidates resolve a dilemma by asserting that autonomy always prevails, or that beneficence does, and stop. The framework is explicit that the principles are prima facie and unranked; the whole task is to show the specification and the balance, not to crown a winner. An answer that names a permanent top principle scores below one that shows two principles in genuine tension and reasons to a proportionate resolution.

2.7 The conflicts in a psychiatric decision

Psychiatry concentrates the classic conflict of medical ethics into its sharpest form, because the disorders it treats can impair the very capacity on which respect for autonomy depends. The signature tension is autonomy against the paired duties of beneficence and non-maleficence: a patient whose illness drives a refusal that threatens their health or safety. The clinician who simply defers to the stated wish may abandon a patient who cannot, in this moment, choose freely; the one who simply overrides it may trample a capable person's right to decide. The framework insists that the decision turns first on capacity - the hinge that determines whether there is an autonomous choice to respect at all - and that assessment, together with the legal thresholds for acting without consent, belongs to this chapter's account of informed consent and to the Mental health legislation and forensic psychiatry notes, and is applied here rather than re-derived.

The conflict rarely stays a clean two-way contest. Non-maleficence enters through the harms of the very interventions that beneficence recommends, so that admitting or medicating a refusing patient to do them good also imposes the burdens of coercion and side effect that the duty not to harm requires be minimised - which is the ethical source of the demand that the least restrictive effective option be used. Justice enters whenever the resource is shared: the bed given to one acutely unwell patient is a bed denied another, so beneficence to the individual is checked by fairness to the population. A mature answer to a psychiatric ethics question therefore does not pick a principle; it maps which principles are engaged, shows where they conflict, and reasons to a proportionate resolution that respects capacity, uses the least restriction, minimises harm and remains fair.

IN INDIA

Indian mental health law has taken a deliberately autonomy-forward turn, and the four principles have to be read in that light. The Mental Healthcare Act reframes the autonomy of a person with mental illness around their will and preferences and supported decision-making rather than around substitute judgement made over their head, and it embeds least restriction and non-discrimination as legal duties, not merely ethical aspirations - the statutory machinery for all of which belongs to the Mental health legislation and forensic psychiatry notes. Justice also bites harder in the Indian setting, where a public system serves large numbers with scarce inpatient and specialist resources and where parity for mental illness against physical illness is still being won, so distributive fairness is a live daily judgement and not a seminar abstraction. The principles are universal; their weighting in Indian practice is shaped by a statute that puts the patient's own will near the centre and by a resource reality that keeps justice in the room.

GOOD TO REMEMBER

When a case feels like an ethical knot, name the four principles for that specific patient before reaching for a conclusion: what does respecting this person's choice require, what would do them good, what would harm them, and what does fairness to others demand. The knot almost always turns out to be two of the four in genuine tension, most often autonomy against beneficence, with capacity as the hinge. Decide which principle should yield, choose the least restrictive way to honour the one that prevails, and write down the reasoning. A decision reasoned that way is far easier to defend than one reached by instinct and dressed up afterwards.

The four principles - respect for autonomy, beneficence, non-maleficence and justice - are prima facie obligations with no fixed ranking, so medical ethics is the balancing of principles that conflict, not the application of one that wins; in psychiatry the signature conflict is autonomy against beneficence and non-maleficence, turning on the patient's capacity, and the defensible decision is the one that respects a capable choice, does good, minimises harm, stays fair, and is reasoned on the record.

3 · Informed consent in psychiatry (elements, capacity, special situations)

Consent is where the patient's autonomy stops being an abstraction and starts governing what a doctor may lawfully do. Nothing a psychiatrist proposes, from a first prescription to admission to electroconvulsive therapy, is lawful merely because it is clinically indicated; it is lawful because the person it is done to has agreed, or because a specific legal exception has displaced the need for agreement. Informed consent is how that agreement is made real, and the examinable weight of the topic sits in its structure: what makes a consent valid rather than a formality, how the capacity to give it is judged, how much the patient must be told, and what happens where the ordinary rule cannot apply.

Marks are lost when a candidate treats consent as a signature on a form. The signed form is evidence that a conversation happened; it is not the consent, and a form signed by a patient who did not understand, was not free, or was not told what mattered is worth nothing in law. This

account sets out the three elements of a valid consent as the Indian courts define them, the standard of disclosure, the scope to which a consent is confined, the documentation the conduct code requires, and the special situations where consent is modified or displaced. Where the Mental Healthcare Act's own machinery governs, this account names the provision and points to the Mental health legislation and forensic psychiatry notes for its full working.

2008	3	19	4
SAMIRA KOHLI, THE INDIAN AUTHORITY ON REAL AND VALID CONSENT	ELEMENTS OF A VALID CONSENT: CAPACITY, VOLUNTARINESS, ADEQUATE INFORMATION	INFORMED-CONSENT REGULATION IN THE MOST RECENTLY NOTIFIED CONDUCT CODE	MENTAL HEALTHCARE ACT SECTION STATING THE STATUTORY CAPACITY TEST

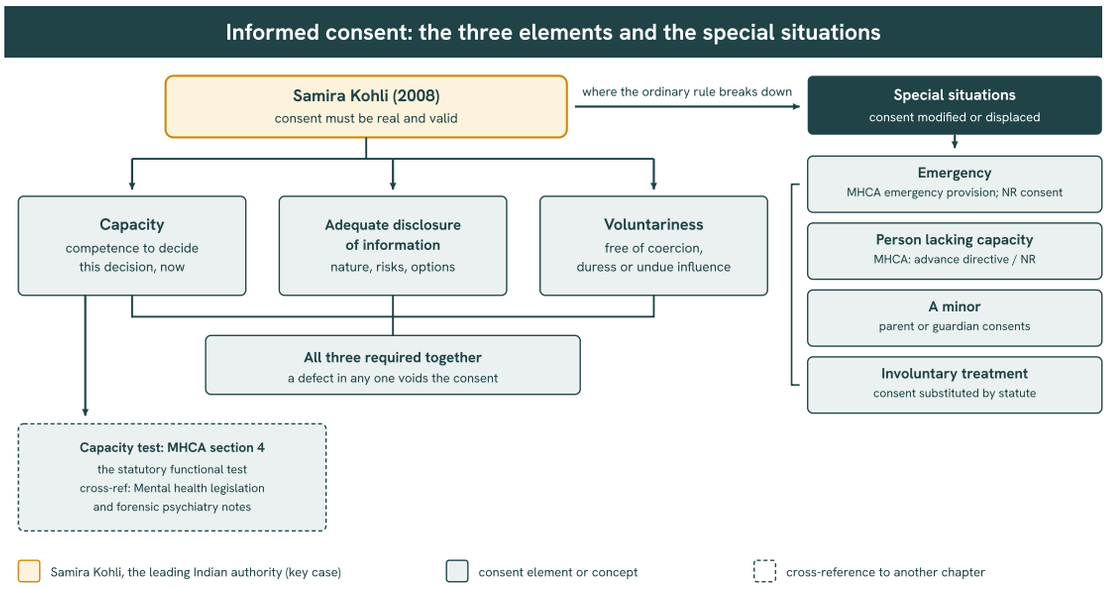


Fig 26.3. Informed consent has three cumulative elements - capacity, adequate disclosure of information and voluntariness - all required together for a valid consent (Samira Kohli, 2008), with a defined alternative for each special situation where consent is modified or displaced.

3.1 What informed consent is, and why the form is not the consent

Informed consent is a patient's voluntary, competent and informed agreement to a proposed procedure, given before it is begun. It rests on two footings that reinforce each other. Ethically it is the operational expression of respect for autonomy, the principle whose full treatment belongs to this chapter's account of the principles of medical ethics: a person has the right to decide what is done to their own body, and consent is how that right is exercised. Legally, treating a competent adult without valid consent is not merely poor practice but a wrong: it can found a claim in negligence where the failure lies in inadequate disclosure, and can amount to assault and battery where there was no agreement to the touching at all.

The conceptual correction to make early is that consent is a process, not a document. The conversation in which the clinician explains and the patient asks, weighs and decides is the consent; the signature merely records that it took place. A form can be exhaustive and the consent still invalid where the patient lacked capacity, was pressured, or was told nothing that

mattered, and a consent can be valid though its record is thin. The document protects the clinician evidentially but neither creates nor cures the underlying agreement, which is why the elements below attach to the patient's actual state of mind and freedom, not to the paperwork.

RULE **A consent is lawful only if it is real and valid, which means the patient had the capacity to decide, decided voluntarily, and decided on adequate information.** All three must be present together; a defect in any one voids the consent however well the other two are satisfied. The signature is evidence that consent was sought, not proof that it was valid.

3.2 The three elements: Samira Kohli

The Indian leading authority on what makes a treatment consent valid is **Samira Kohli**, decided in **2008**. The court held that a doctor must seek and secure the patient's consent before commencing treatment, and that the consent obtained must be real and valid. It then unpacked that phrase into **three** requirements that every candidate should be able to state and defend: the patient must have the capacity and competence to consent; the consent must be voluntary; and it must rest on adequate information about the nature of the treatment, so that the patient knows what they are agreeing to.

The value of the case is that it converts a vague ideal into a checklist that can be tested against the facts, with each element answering a different question. **Capacity** asks whether this patient, at this moment, can make this decision at all. **Voluntariness** asks whether the decision was the patient's own or the product of pressure. **Adequate disclosure** asks whether the patient was given enough to decide on. The three are cumulative and independent, and the following subtopics take each in turn.

MNEMONIC

Capable, Free, Informed, and Specific

A consent is valid only if the patient is **Capable** of deciding, decides **Free** of coercion, decides **Informed** by adequate disclosure, and the agreement is **Specific** to the procedure actually done. The first three are the elements of validity; the fourth is the limit on its scope, taken up below.

3.3 The first element: capacity to decide

Capacity is the ability to make a particular decision at the time it must be made, and three properties of it are examinable. It is **functional**: judged by the patient's actual reasoning about the decision in front of them, not by their diagnosis, their age, or how others rate the wisdom of the outcome. It is **decision-specific and time-specific**: a person may have capacity for a simple choice and lack it for a complex one, and may lack it in the morning and regain it by evening, so capacity is assessed for this decision now, never certified once for all purposes. And it is **presumed**: every adult is taken to have capacity unless the contrary is shown, so the burden lies on whoever asserts incapacity, and mental illness never by itself removes it.

The Mental Healthcare Act gives this a statutory form. At section **4** it provides that every person, including a person with mental illness, shall be deemed to have the capacity to make treatment decisions if they can understand the information relevant to the decision, appreciate the

reasonably foreseeable consequences of deciding or of not deciding, or communicate the decision, which is the Act's own disjunctive formulation. Two features of the statutory test are the ones candidates get wrong, and both matter directly to consent. The full working of the section, and how capacity interacts with advance directives, nominated representatives, admission and the review boards, belongs to the Mental health legislation and forensic psychiatry notes; what the consent doctrine needs from it is the functional standard and the discriminations below.

TRAP **A decision that looks wrong does not prove incapacity, and the statutory abilities are read disjunctively, not as a set all of which must be present.** Candidates infer incapacity from an unwise refusal, but a competent patient is entitled to make a decision others consider mistaken, and a choice perceived as inappropriate does not by itself negate capacity. The second error is to treat the statutory abilities as a conjunctive checklist; in the bare text of the Act they are joined by "or", and capacity is a rebuttable deeming rather than a hurdle the patient must clear.

3.4 The second element: voluntariness

Voluntariness means the decision was the patient's own, made free of coercion, duress and undue influence. It is the element most easily overlooked because it leaves no trace on a form, yet it is the one most often compromised in psychiatric settings, where the pressures are structural rather than crude. The test is whether the patient's choice was improperly controlled, not whether a consequence was mentioned: a patient pressured by a threat that refusal will be punished, or by a controlling inducement, may not be deciding freely even where no crude threat is spoken, whereas explaining a genuine clinical consequence of refusal, or offering a proportionate incentive, does not by itself negate voluntariness. Family pressure is a particular hazard in Indian practice, where treatment decisions are frequently made collectively and the identified patient may have the least voice in the room.

The clinician's task is not only to avoid applying pressure but to notice and, where possible, neutralise it: separating the consent conversation from any implied consequence, giving the patient a genuine and unpenalised option to decline, and staying alert to the difference between a family reaching a shared decision and a family overriding the patient's own. The distinction between a voluntary agreement and a merely compliant one is the distinction the law draws between a valid consent and an invalid one.

3.5 The third element: adequate disclosure and its standard

The third element asks how much the clinician must tell the patient, and here the Indian courts made a deliberate choice between two rival standards. One is the professional or **Bolam** standard, which measures disclosure against what a responsible body of skilled practitioners in the field would regard as normal and proper. The other is the patient-centred **Canterbury** standard, which measures it against what a reasonably prudent patient would want to know. In Samira Kohli the court adopted the former: the information a doctor must furnish to secure consent need not reach the more stringent degree required by the patient-centred approach, but should be of the extent accepted as normal and proper by a responsible body of skilled and experienced practitioners in that field, adjusted to the patient's condition and the treatment's risks.

The practical content of adequate disclosure follows from this: the nature and purpose of the proposed treatment, its risks and likely consequences, the reasonable alternatives including doing nothing, and enough about the illness for the choice to make sense. Two points sharpen it. The standard is not a licence to tell the patient as little as the profession can get away with; it sets a floor of what a responsible practitioner would disclose, and defensive minimalism does not meet it. And the measure is relevance to the decision, not exhaustiveness; a patient buried in every conceivable rare risk is no better placed to decide than one told too little.

AXIS	PROFESSIONAL STANDARD (BOLAM, REAL CONSENT)	PATIENT-CENTRED STANDARD (CANTERBURY)
THE QUESTION ASKED	What would a responsible body of practitioners disclose?	What would a reasonably prudent patient want to know?
WHOSE VIEWPOINT SETS THE MEASURE	The profession's accepted practice	The reasonable patient's information needs
RELATIVE DEMAND ON THE DOCTOR	Lower; the accepted and proper extent for the field	Higher; a more stringent degree of disclosure
POSITION ADOPTED IN INDIAN LAW	Adopted in Samira Kohli as the governing standard	Expressly not required to the stringent degree it sets

3.6 The scope of consent: specific, not general

A valid consent authorises only what it was given for. This is **specific consent**, and Samira Kohli states it with unusual clarity: consent given for a diagnostic procedure cannot be treated as consent for therapeutic treatment, and consent given for one specified treatment procedure will not be valid for conducting some other procedure. A patient who agreed to an assessment has not agreed to whatever the assessment reveals may be needed.

The court closed the obvious escape route as well. The fact that an unauthorised additional procedure turned out to benefit the patient, saved time or expense, or spared future suffering is no defence to an action in negligence or in assault and battery. Benefit does not backfill absent consent. For psychiatry the point bites wherever one intervention opens onto another; each step requires its own agreement, and the reasoning that "it was for the patient's good" is precisely the reasoning the court rejected.

GOOD TO REMEMBER

Treat consent as reopened whenever the plan moves beyond what the patient actually agreed to. If the working diagnosis, the drug class, the route, or the setting of care changes materially, consent afresh for the new proposal rather than reading the old agreement forward: a short documented second conversation is cheaper than defending an intervention the patient never agreed to.

3.7 Documentation and the conduct code

The professional-conduct code turns the doctrine into a documentation duty. The most recently notified conduct regulations set out informed consent at regulation **19**: before any diagnostic or therapeutic procedure or operation the registered medical practitioner should obtain the patient's

signed documented informed consent; where the patient is unable to consent, the consent of the legal guardian or a family member must be taken; an operation that may result in sterility requires the consent of both spouses; and assisted-reproduction procedures require the written consent of the female patient, the spouse and the donor. The modal verbs are not interchangeable and carry the marks: the practitioner should obtain the patient's consent, the guardian's consent must be taken where the patient cannot, and both spouses' consent is required for a sterilising operation.

A currency caution attaches to this. Whether the most recently notified regulations are the edition currently in force is a separate question, settled in this chapter's account of the professional-conduct codes; the operative professional-conduct code remains the earlier one, and the most recent regulations, though notified, were held in abeyance and are not yet in force. Both editions impose a documented consent duty, but the precise scope and wording of each edition's consent provision belong to this chapter's account of the professional-conduct codes; what matters here is that an answer presenting the most recent regulations as the live code states a currency that does not hold.

PITFALL

Citing the most recently notified professional-conduct regulations as the operative code. They were notified and then held in abeyance, and the earlier professional-conduct code remains the one in force; naming the newer set as live misstates the governing law even though the substance of the consent duty is largely unchanged. Name the provision actually in force, and defer any contested currency to this chapter's account of the professional-conduct codes rather than asserting it in passing.

3.8 The special situations

The elements describe the ordinary case; the marks cluster in the situations where the ordinary case breaks down. Four recur, and each modifies or displaces one element of consent rather than abolishing the requirement.

- **Emergency.** Where a patient needs immediate treatment to avert death or serious harm and cannot give consent, the practitioner should still try to obtain it, and if that is not possible must act in the patient's best interest and record the basis for doing so. Where the Mental Healthcare Act governs an emergency in a person with mental illness, the Act's own emergency-treatment provision supplies the rule rather than the general one: it requires the informed consent of the nominated representative where one is available, and attaches its own indications, time limit and excluded treatments; the full working of that provision belongs to the Mental health legislation and forensic psychiatry notes. The exception is necessity and is bounded by it: it authorises only what the emergency requires, not a general power to treat without agreement.
- **The person who lacks capacity.** Where an adult cannot give a valid consent, the most recently notified conduct regulations direct that the consent of the legal guardian or a family member be taken, subject to the currency caution above, and the decision must serve the

patient's interests rather than the convenience of others. Where the Mental Healthcare Act governs, a family member is not a generic substitute decision-maker: the advance directive carries the person's own earlier choice forward, and the nominated representative supports the person's decision-making and gives consent in their place only where a provision of the Act expressly says so; the full working of both belongs to the Mental health legislation and forensic psychiatry notes. Capacity being decision-specific and often fluctuating, the clinician should reassess it and return the decision to the patient once it is regained.

- **Minors.** A child below the age at which the law recognises a valid consent cannot give one, and consent is taken from the parent or legal guardian on the child's behalf, again in the child's interest. The statutory age thresholds and the child-protection framework, including the law on child sexual offences and juvenile justice, belong to the Child psychiatry: assessment, treatment, services and protection notes.
- **Consent under involuntary treatment.** Involuntary admission and treatment are precisely the situation in which ordinary consent has been lawfully displaced by a statutory framework, which substitutes its own safeguards, the nominated representative and independent review, for the patient's contemporaneous agreement, while the advance directive preserves the person's own earlier choice rather than replacing it. The mechanics of that framework belong to the Mental health legislation and forensic psychiatry notes, and its ethical frame to this chapter's account of the ethics of involuntary treatment and restraint; the consent point is that involuntary treatment is not consent-free but consent-substituted, and the safeguards are what police the substitution.

Consent to research, and the distinct criminal-law meaning of consent in sexual-offences law, are separate constructs treated in this chapter's accounts of the ethics of research and of sexual-offences law; each invokes the clinical elements set out here but adds rules of its own.

IN INDIA

The Indian consent doctrine is anchored in a single case and a statute a candidate should be able to pair. Samira Kohli supplies the three elements and the choice of the professional standard of disclosure over the more demanding patient-centred one, so an Indian answer asserting a Canterbury-level duty overstates the law. The Mental Healthcare Act supplies the statutory, functional capacity test and the framework under which consent is displaced in involuntary care, and the conduct code supplies the documentation duty. Together they make consent in Indian psychiatry a valid agreement properly recorded, with the statute governing the situations where agreement cannot be obtained.

TRAP **Reciting the three elements while omitting the special situations, or treating a signed form as conclusive proof of a valid consent.** The question on consent almost always turns on the hard case, the emergency, the incapacitated adult, the minor, the involuntary patient, so an answer that stops at capacity, voluntariness and disclosure has answered half the question. The paired error is evidential: producing a signed form as if it settled validity, when a form signed without capacity, freedom or adequate information is no consent at all.

A consent is lawful only if it is real and valid, meaning the patient had the capacity to make this decision, decided voluntarily, and decided on adequate information, and it authorises only the specific procedure agreed to; where the patient cannot give it, the emergency, the incapacitated adult, the minor and the patient under involuntary treatment each substitute a defined alternative rather than dispensing with the requirement.

4 · Confidentiality and its limits (duty to warn, Tarasoff)

Confidentiality is the promise that makes psychiatry possible. A patient tells a psychiatrist things they may never have said aloud, and does so only because they trust that what is spoken in the consulting room stays there. That trust is the working condition of honest disclosure, which is the raw material of every assessment and treatment decision, so the law and the professional codes treat confidentiality as a default duty the clinician owes, not a favour the clinician grants. The duty is not absolute, however, and the examinable heart of this topic is the exact shape of its limits: when the clinician may lift the veil, on whose authority, and how far.

Marks are lost in two opposite directions: one candidate treats confidentiality as sacrosanct and freezes when a patient names a person they mean to harm, another treats any hint of risk as a licence to broadcast the record. Both misread a rule that is conditional and whose conditions are specific. This account sets out the default duty, the principal grounds on which a disclosure is permitted, the American case that gave the world the language of a duty to warn, and the very different Indian position, in which a protective disclosure to an endangered other is permitted rather than commanded, alongside the separate mandatory-reporting duties that particular statutes impose in their own defined situations. Where the Mental Healthcare Act's own internal machinery is concerned, this account names the provision and points to the Mental health legislation and forensic psychiatry notes for its full working.

1976	1998	23	24
TARASOFF, THE UNITED STATES ORIGIN OF THE DUTY TO PROTECT	MR X V HOSPITAL Z, THE INDIAN AUTHORITY ON PROTECTIVE DISCLOSURE	MENTAL HEALTHCARE ACT SECTION, THE STATUTORY RIGHT TO CONFIDENTIALITY	PROFESSIONAL-CONDUCT REGULATION ON CONFIDENTIALITY

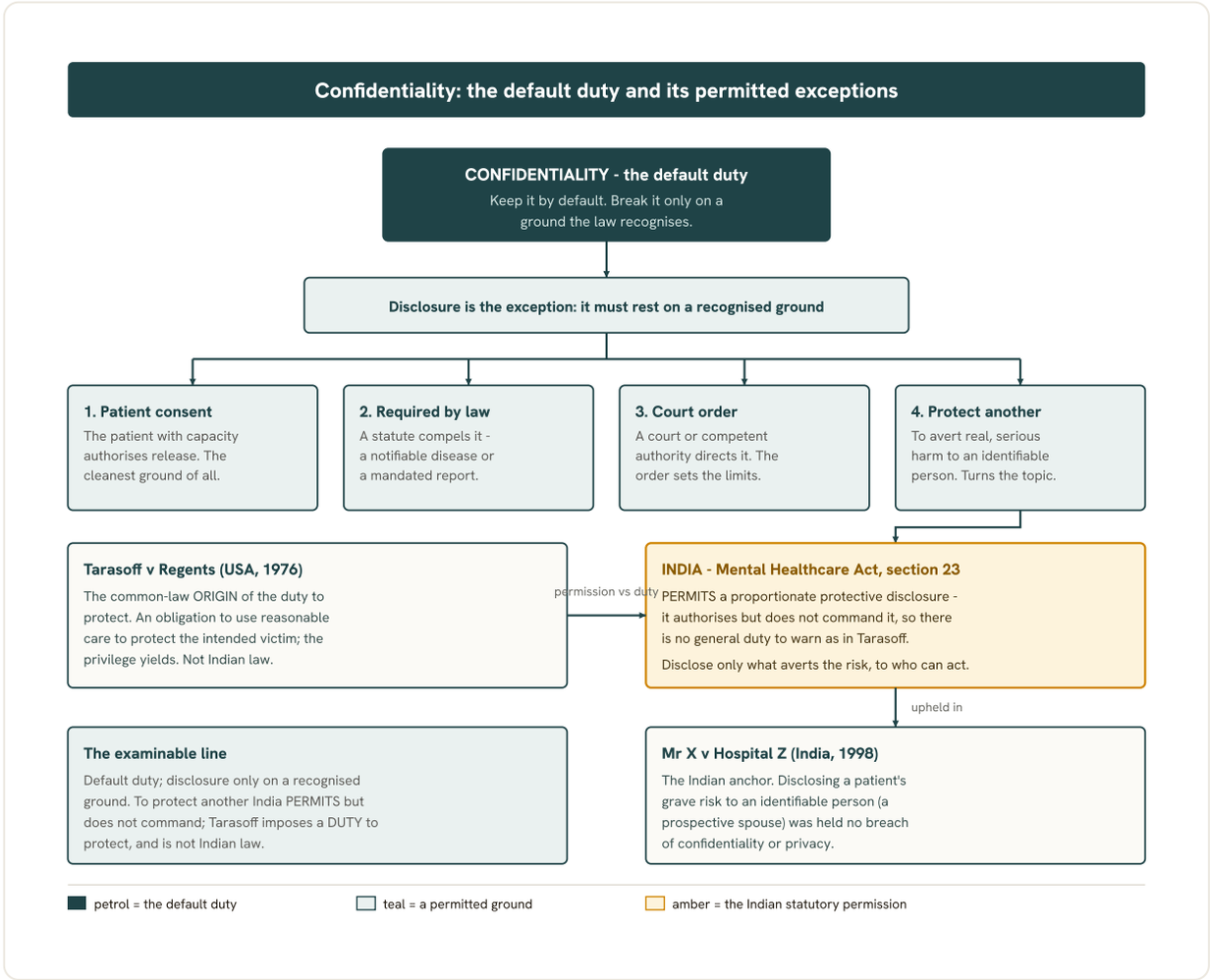


Fig 26.4. Confidentiality is a default duty that yields only on a recognised ground, principally consent, a requirement of law, a court order, or protecting an identifiable other, and for that last ground India permits but does not command disclosure, unlike the United States Tarasoff duty to protect the intended victim, with Mr X v Hospital Z holding a protective disclosure to a person at real risk no breach.

4.1 The default duty and where it comes from

At its core, **confidentiality** is the obligation not to disclose information a patient shares in the course of care to anyone outside that care without a justification the law recognises. It rests on more than one footing. Ethically it protects the patient's autonomy and privacy and secures the trust without which candour collapses; legally it is a duty imposed by both statute and the conduct code, and a serious breach can expose the clinician to complaint and to a civil claim.

Two sources give the duty its force in Indian practice. The statutory source is the Mental Healthcare Act, whose section **23** gives a person with mental illness a right to confidentiality over their mental health, mental healthcare and treatment, and places a corresponding duty on every health professional to keep that information confidential, subject to defined exceptions. The professional source is the medical conduct code. The most recently notified conduct regulations state the duty at regulation **24**: every communication between a practitioner and a patient shall be kept confidential and shall not be revealed except in stated circumstances. Whether that most recent edition is the one currently in force is a separate currency question, settled in this chapter's account of the codes of professional conduct; the duty is stated in the same mandatory terms across the editions and in the statute, so the doctrine does not turn on which edition governs.

One distinction should be fixed at the outset. Confidentiality is the clinician's ethical and statutory duty not to disclose. **Testimonial privilege** is a separate, courtroom creature: whether a clinician can be compelled to testify to what a patient said, and the rules that govern it. Both concern keeping a patient's words private, but they answer to different masters, confidentiality to the codes and the Act, privilege to the law of evidence. What the rules of evidence permit in the witness box is taken up in this chapter's treatment of the expert witness and the rules of evidence; the duty examined here is the clinical one.

RULE **Confidentiality is the default, and disclosure is the exception that must find a specific footing.** The clinician does not need a reason to keep a confidence; they need a reason the law recognises to break one. Every lawful disclosure must rest on a recognised ground, and a disclosure that cannot name its ground is a breach, however well meant.

4.2 When the veil may be lifted: the principal grounds

Because disclosure must justify itself, the circumstances that justify it form a defined set of recognised grounds, each carrying its own conditions. The conditions are where the marks sit, because collapsing a conditional rule to its headline is how a candidate loses the point. The principal grounds are these, and the Mental Healthcare Act's own statutory list of exceptions is fuller than this teaching set and is set out in the Mental health legislation and forensic psychiatry notes.

- **The patient's own consent.** A patient with capacity may authorise the release of their information, the first and cleanest ground of all. What consent requires, how capacity is judged and how special situations are handled are set out in this chapter's account of informed consent; here it is simply the ground needing no further justification once validly given.
- **Disclosure required by law.** Certain statutes compel a practitioner to disclose defined information, and where a law of the state requires the disclosure the duty of confidentiality gives way to it. The conduct code's own exception preserves exactly this, permitting a communication to be revealed where it is required by the laws of the state.
- **An order of a court or a competent authority.** A court or other authority empowered by law may direct the production of records or the giving of testimony, and confidentiality yields to a lawful order. The order defines and limits what must be produced; it is not a general waiver.
- **Protection of an identifiable other from serious harm.** Where withholding information would expose another person to a real risk to health or life, a proportionate disclosure to avert that risk is permitted. This is the ground the rest of the topic turns on.

MNEMONIC

Consent, Compulsion, Court, Caution

The principal grounds on which a confidence may lawfully be broken. **Consent** of the patient; **Compulsion** by a law of the state; a **Court** order or the direction of a competent authority; and **Caution** for an identifiable other in serious danger. A disclosure that fits no recognised ground has no footing and is a breach.

The last ground generates the hard cases and the examination questions, because it turns on judgement rather than on a document. It is available only when the danger is to an **identifiable other** and is serious, and even then it authorises only the disclosure necessary to avert the harm, made to the person who can act on it. It is a permission tightly bounded by proportionality, not a general waiver.

4.3 Tarasoff and the origin of the duty to warn

The vocabulary of a **duty to warn** entered clinical practice from a single American case. **Tarasoff**, decided by the California Supreme Court in **1976**, held that when a therapist determines, or under the standards of their profession should determine, that a patient presents a serious danger of violence to another, the therapist incurs an obligation to use reasonable care to protect the intended victim. The discharge of that obligation may require warning the intended victim, warning others likely to alert the victim, notifying the police, or taking whatever other steps are reasonably necessary in the circumstances. The confidentiality privilege yields to this duty: the protective purpose of the profession does not extend to guarding a patient's confidences at the cost of the intended victim's life.

The popular name understates the holding, and the discrimination is worth marking. The case did not create a narrow duty to send a warning; it created a broader **duty to protect**, of which warning is only one possible discharge. A therapist might protect the victim by warning them, by alerting someone able to warn them, by informing the police, or by intensifying treatment or arranging admission. Reducing the whole of it to a mechanical duty to warn shrinks a flexible standard of reasonable care into a single required act.

Two features of the case must travel with it into any Indian answer. First, it is United States common law, the decision of a state court, and it binds no Indian clinician; it is the origin of a concept, not a rule of practice here. Second, it frames a positive obligation, a duty the therapist incurs, which is a stronger thing than a permission to disclose, and it is on this second point that the Indian rule departs from it.

TRAP **Tarasoff is the United States origin of the duty to warn, not Indian law, and India permits protective disclosure without compelling it.** Candidates import Tarasoff wholesale and write that an Indian psychiatrist is under a legal duty to warn a third party. There is no such positive statutory duty in India. The Mental Healthcare Act's confidentiality section permits a proportionate disclosure to protect another; a permission is "may" and a duty is "shall", and the two are different laws. Answering with a duty where the statute gives only a permission loses the mark.

4.4 The Indian position: permission, not command

India has no case and no statute that imposes a Tarasoff-style positive duty to warn an endangered victim; what the law provides instead is a permission. That is a distinct question from the specific mandatory-reporting duties that particular statutes impose in defined situations, such as the reporting of child sexual abuse set out in the Child psychiatry: assessment, treatment, services and protection notes; those duties, where they apply, must be complied with on their own terms and are not displaced by anything said here. The Mental Healthcare Act's

confidentiality provision keeps confidentiality as the patient's right and the professional's duty, then lists the exceptions to it; among them is disclosure to protect any other person from harm or violence, releasing only the information necessary for that protection. The provision is permissive in character: it authorises the professional to make the protective disclosure and shields them when they do, but does not oblige them to make it. The full working of that section, its complete list of exceptions and the machinery around them, belongs to the Mental health legislation and forensic psychiatry notes and is named here rather than reworked; the point is the character of the provision, that it authorises and does not oblige.

The professional conduct code points the same way. Its confidentiality regulation allows a communication to be revealed where non-disclosure may itself be detrimental to the health of the patient or of another human being, again a permission to protect and not a duty to warn. Statute and code therefore converge on a single Indian rule: confidentiality yields to the protection of an identifiable other, but the yielding is discretionary and proportionate, exercised by a clinician who has judged the risk, not triggered automatically by the fact of a threat. A clinician who never discloses to protect an endangered third party may be criticised for poor judgement, but breaches no general duty to warn the victim, because Indian law imposes none; any separate mandatory-reporting duty a specific statute may create in a defined situation is a different matter and continues to apply on its own terms.

AXIS	TARASOFF (UNITED STATES)	MENTAL HEALTHCARE ACT CONFIDENTIALITY SECTION (INDIA)	MR X V HOSPITAL Z (INDIA)
SOURCE OF THE RULE	State supreme court, common law	Statute	Supreme Court judgment
LEGAL CHARACTER	A positive duty to protect	A permission to disclose	A holding that a protective disclosure was lawful
WHAT TRIGGERS IT	A serious danger of violence to another that the therapist determines or should determine	A need to protect any other person from harm or violence	A real risk to an identifiable person, a prospective spouse, from a life-threatening condition
EFFECT ON THE CLINICIAN	Must take reasonable steps to protect; the privilege yields	May disclose the information necessary to protect; the duty yields but is not compelled	The disclosure made was held not to breach confidentiality or privacy
WHAT IT DOES NOT DO	Does not fix one required act; warning is one option among several	Does not impose a duty to warn	Does not make privacy absolute, nor command disclosure in every case

4.5 Mr X v Hospital Z: the Indian judicial anchor

The Indian courts have addressed the limits of medical confidentiality directly, and the case every candidate should be able to name is **Mr X v Hospital Z**, decided in **1998**. A hospital disclosed a

patient's HIV-positive status to the woman he was about to marry. The court held that the disclosure violated neither the rule of confidentiality nor the patient's right to privacy, because the prospective spouse, an identifiable other, was thereby saved in time from a real risk to her health and life. The reasoning is the load-bearing part and repays exact memory: the right to privacy is not absolute and may be restricted to protect the rights, the health and the freedom of others.

Read carefully, the case supports the Indian permission and no more. It justified a disclosure that protected a specific person from a grave and avoidable harm; it did not announce a general duty on doctors to warn, nor make every disclosure lawful. Its principle is a limit on privacy, not an engine of disclosure: where a specific other faces a specific serious risk, protecting them is a legitimate reason to reveal what would otherwise be confidential. That is the same shape as the statutory permission and the protective ground in the general list.

IN INDIA

The Indian picture is coherent once its pieces are named: a statutory right to confidentiality with a protective exception in the Mental Healthcare Act, a professional conduct code that permits disclosure where silence would endanger the patient or another, and a Supreme Court holding that a protective disclosure to an identifiable person at real risk breaches neither confidentiality nor privacy. Nowhere in that picture is a positive duty to warn. The working rule for an Indian psychiatrist is therefore a permission exercised with judgement, not an American duty transplanted whole, and the difference between "may" and "shall" is what an answer must make explicit.

4.6 Making a protective disclosure well

Knowing that you may disclose is only the start; disclosing well is the harder part. Because the protective ground turns on judgement, the quality of the decision is what protects both the endangered third party and the clinician who acts. The organising idea is **proportionality**: the disclosure must be matched to the risk in its target, its content and its recipient, and no wider. The practical discipline runs as follows.

- Establish that the risk is to an identifiable person and is serious and real, not a vague unease that names no one.
- Prefer the least intrusive step that will actually avert the harm, whether intensifying treatment, arranging admission, or warning where a warning is what protects; escalation should track the danger.
- Disclose only the minimum necessary to the person able to act on it, not the whole clinical record and not to an audience wider than protection requires.
- Record the reasoning as it is made: the risk assessed, the options weighed, the ground relied on, and what was disclosed to whom. The contemporaneous note is what distinguishes a considered protective disclosure from a careless one.

GOOD TO REMEMBER

When a patient names a person they intend to harm, the move is neither silence nor a broadcast. Confirm that the threat is serious and the target identifiable, choose the least intrusive step that will actually protect them, disclose only what that step needs to whoever can act on it, and write down why. The defensible position is the proportionate one, and the record is what makes it defensible.

PITFALL

Treating a justified risk as a licence to empty the file. Once a clinician has decided that a protective disclosure is warranted, the temptation is to hand over the entire history to be safe, or to tell more people than need to know. The permission is to reveal what is necessary to avert the specific harm, to whoever can act on it, and no further; a disclosure wider than the risk requires is itself a breach, even where a narrower one would have been entirely lawful. Over-disclosure and non-disclosure are opposite failures of the same judgement.

4.7 The other direction of flow: the right to information

Confidentiality governs what leaves the consulting room about the patient, and it has a mirror-image companion governing what must reach the patient. The Mental Healthcare Act's section **22** gives a person with mental illness, together with their nominated representative, a right to information: about the provision under which they are admitted and its criteria, their right to seek review of that admission, and the nature of the illness and the proposed treatment plan with its known side effects, all in a language and form the person can understand. The complete machinery of this right, like that of the confidentiality right, belongs to the Mental health legislation and forensic psychiatry notes; it is named here to complete the picture.

The two rights are complementary rather than opposed. The patient is entitled to be told the truth about their own condition and care, and entitled to have what they disclose held in confidence. Confidentiality is not secrecy from the patient; it is the protection of the patient's information from the world outside the care they have entered, coupled with candour toward them within it.

Confidentiality is the default duty and disclosure the exception: it is lawful on a recognised ground, principally the patient's consent, a requirement of law, an order of a court or competent authority, or the protection of an identifiable other from serious harm, and even then only so far as the risk requires. Tarasoff is the United States origin of the duty to warn and does not bind Indian practice; in India the Mental Healthcare Act's confidentiality section permits, but does not command, a proportionate protective disclosure, and Mr X v Hospital Z holds that such a disclosure to an identifiable person at real risk is no breach.

5 · IPS code of ethics (Cuttack 1989)

A psychiatrist in India answers to two written standards of conduct at once, and they are not the same kind of thing. One is the profession's own **code of ethics**, drawn up by psychiatrists for

psychiatrists, which states the ideals the discipline holds itself to. The other is the statutory **professional-conduct code** made under the law that governs the medical register, which carries the disciplinary machinery and can end a career. The examiner who sets a question on the Indian Psychiatric Society code is really testing two things: whether the candidate knows the profession's own code and its history, and whether the candidate knows which statutory code is actually in force, because that second fact reversed itself recently and a great many textbooks now print the wrong answer.

This topic therefore has an unusually high yield relative to its size. The substance a candidate must carry is small and quotable, but it sits on a moving legal floor. The professional code is an ethical and professional standard; the statutory code is the enforceable one, and it has changed on paper without yet changing in force. Getting the currency right is the single discriminator between a safe answer and one that confidently states a regulation that does not operate. The underlying principles this code applies, the four principles of biomedical ethics, are set out in this chapter's account of the principles of medical ethics and are named here rather than relisted.

1989	2 Aug 2023	23 Aug 2023	2002
THE IPS CODE OF ETHICS APPROVED AT CUTTACK	THE 2023 REGULATIONS NOTIFIED	HELD IN ABEYANCE, DAYS LATER	THE MCI CODE THAT IS CURRENTLY OPERATIVE

5.1 Two codes, two kinds of force

The first discrimination to hold is between a professional code and a statutory code, because candidates blur them and the blur costs marks. A professional code of ethics is issued by a professional body to its own members; it articulates the standards the profession aspires to and expects, and it educates and guides more than it punishes. A statutory professional-conduct code is subordinate legislation made under the statute that regulates the medical profession; it defines misconduct and attaches consequences to it, and a breach can lead to erasure from the register. The two are not rivals. The professional code supplies the moral content and the statutory code supplies the enforceable floor, and in practice a serious breach of the profession's own ethics will usually also be a breach of the statutory conduct rules the regulator can act on.

For psychiatry the distinction has extra bite, because psychiatric practice raises ethical problems the general codes handle only thinly: consent where capacity is in question, confidentiality where a third party may be at risk, treatment that may be given against a patient's stated wishes. A discipline-specific code exists precisely to speak to these, which is why the Indian Psychiatric Society drew up its own rather than resting on the general medical code alone.

5.2 The Indian Psychiatric Society code and Cuttack, 1989

The Indian Psychiatric Society appointed a committee to prepare a code of ethics specifically for psychiatrists practising in India, and that code was approved at the Society's annual conference held in **Cuttack** in **1989**. This is the foundational Indian psychiatry-specific code of ethics, and its significance is as much symbolic as textual: it marked the point at which Indian psychiatry set down a written ethical standard of its own. For the examination the year and the place are the memorable pair, and they are the part most reliably asked.

The code is not a static document. What began at Cuttack has been revised and republished by the Society since, so the version a clinician reads today is the descendant of that original text rather than the original itself. The examinable spine is the lineage: a psychiatry-specific ethical code, originated by an IPS committee and adopted at Cuttack, which the profession has kept current. The content that follows is drawn from the Society's current published statement of that code.

IN INDIA

The IPS code sits alongside, not instead of, the statutory conduct rules that bind every registered medical practitioner. A psychiatrist is a doctor first, so the general professional-conduct code applies in full; the IPS code adds the discipline-specific ethical detail the general code cannot supply. Where the IPS code speaks of confidentiality, it is careful to tie the duty to the law of the land, which in Indian mental-health practice means the framework taught in the Mental health legislation and forensic psychiatry notes. The code guides the psychiatrist's conduct; the statute and the regulator supply the consequences.

5.3 What the code asks of the psychiatrist: the Fourteen Codes

The current published form of the code sets out the psychiatrist's duties as **fourteen** numbered codes. They do not need to be memorised verbatim, but a candidate should be able to reproduce their shape, because they map neatly onto the principles this chapter teaches elsewhere and onto the consent and confidentiality duties taught in their own fragments here. The core duties the code lays down are these:

- **The patient comes first.** The patient's care, well-being and best interests are the paramount consideration for the psychiatrist, which is the code's governing clause and the one everything else serves.
- **Competent, dignified care.** The psychiatrist provides competent care while respecting the humanity, dignity and autonomy of the person, so that skill and respect are held together rather than traded off.
- **Valid informed consent.** The psychiatrist acts to establish valid, informed consent with people living with mental illness; the elements of that consent and its special situations are taught in this chapter's account of informed consent in psychiatry and are not reworked here.
- **Professionalism and conflicts of interest.** The psychiatrist maintains professional standards, which includes recognising and managing conflicts of interest rather than pretending they do not arise.
- **Confidentiality within the law.** The psychiatrist upholds the patient's right to confidentiality, but expressly within the provisions the law of the land prescribes; the default duty and its permitted exceptions belong to this chapter's account of confidentiality and its limits.
- **Ethical research.** Research is conducted ethically and under the oversight of ethics committees or institutional review boards, a duty this chapter's account of the ethics of research develops in full.

- **No exploitation of the relationship.** The psychiatrist upholds the sanctity of the doctor-patient relationship and does not exploit it for personal, social, business or sexual gain, which is the code's firmest prohibition and the seam it shares with the topic of boundary violations.

Read together, the codes are less a checklist than a description of a trustworthy psychiatrist: one whose skill is placed at the patient's service, who seeks genuine agreement, who guards what is told in confidence, and who never turns the relationship to private advantage. That last duty, against **exploitation** of the relationship, is the one the code states most absolutely, and it is worth carrying as the code's moral centre.

5.4 The statutory code and the currency trap: 2002 operative, 2023 in abeyance

Here is the fact that decides the mark. The professional-conduct code currently operative for Indian doctors is the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, commonly abbreviated the MCI 2002 code after the Council that made it. It is tempting to assume the newer instrument has replaced it, and the newer instrument does exist: the National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations, 2023 were notified by the Commission on 2 August 2023 and were to come into force from the date of their publication in the Official Gazette. On the face of the notification, the 2023 Regulations looked like the new code.

They did not survive the month. On 23 August 2023 the Commission held the 2023 Regulations in **abeyance** with immediate effect, clarifying that they would not be operative or effective until a further Gazette notification, and in the same instrument it re-adopted and made effective the Indian Medical Council 2002 Regulations. The net position is precise and counter-intuitive: the 2023 code is notified but suspended, and the 2002 code is the one that governs conduct today. A candidate who writes that the NMC 2023 Regulations are the current professional-conduct code is stating a regulation that does not operate.

RULE **The operative statutory professional-conduct code is the MCI 2002 Regulations; the NMC RMP 2023 Regulations are notified but held in abeyance and are not in force.** The 2023 Regulations were notified and were to commence on Gazette publication, but the Commission suspended them within weeks and re-adopted the 2002 Regulations with immediate effect. Until a further Gazette notification revives the 2023 code, conduct is judged against the 2002 code. State the 2002 code as live and the 2023 code as notified-but-in-abeyance; do not present the 2023 Regulations as the current law.

TRAP **Naming the NMC 2023 Regulations as the code in force.** Because the 2023 Regulations were formally notified and are widely reported as the new ethics code, candidates and even recent textbooks cite them as operative. They are not: they were held in abeyance days after notification and remain suspended pending a further Gazette notification, while the 2002 MCI Regulations were re-adopted and are the code actually applied. The examinable point is not the content of either code but the currency: the newer, notified instrument is dormant and the older one governs.

5.5 Professional misconduct and graded discipline

Even though it does not currently operate, the suspended 2023 code repays study as a proposed framework, though its future operative form is uncertain: a further Gazette notification could revive, amend or replace it. Its treatment of misconduct is exam-friendly. In that code, professional misconduct is defined broadly at Regulation **37**: any violation of the Regulations, or of other applicable Acts relating to medical practice in force, shall constitute professional misconduct. The definition is deliberately open-ended, so that conduct need not be separately itemised to be actionable; a breach of the conduct rules is itself the misconduct.

The consequences are graded rather than binary. The 2023 code arranges disciplinary action across **five** levels, running from exoneration through a reformative warning and fixed periods of suspension of increasing length up to permanent debarment from practice. This graduated structure matters clinically: the regulator's response is meant to be proportionate to the gravity of the breach, so a first, minor lapse and a serious, repeated one do not attract the same sanction. A separate provision addresses criminal conviction: where a practitioner is convicted of a cognizable offence involving **moral turpitude**, that conviction may result in suspension of the licence to practise.

> **PITFALL**
>
> Reading conviction as automatic erasure. The provision on a cognizable offence involving moral turpitude says such a conviction may result in suspension, not that it must; the sanction is discretionary and sits within the graded scheme, not outside it. Telling a colleague that any conviction ends the registration overstates the rule and misreads the modal verb. A conviction opens the disciplinary process and permits suspension; it does not, of itself, strike the name off.

5.6 How the two codes bind together

The profession's code and the statute's code are two faces of one duty. The IPS code tells the psychiatrist what good practice looks like; the statutory conduct code is the instrument through which failures of that practice are called to account. A psychiatrist who exploits the therapeutic relationship, for instance, breaches the IPS code's firmest prohibition and, at the same time, commits professional misconduct the regulator can act on. The moral standard and the enforceable standard converge on the same conduct from different directions, which is why a candidate should be able to move between them: cite the IPS code for the ethical content and the statutory code for the consequence.

AXIS	IPS CODE OF ETHICS (CUTTACK LINEAGE)	STATUTORY PROFESSIONAL-CONDUCT CODE
WHO ISSUES IT	The Indian Psychiatric Society, for psychiatrists	The statutory medical regulator, for all registered practitioners
NATURE	Professional and aspirational; discipline-specific	Subordinate legislation; enforceable
PRIMARY FUNCTION	Guides and educates on ethical practice	Defines misconduct and attaches sanctions
CURRENCY	Originated at Cuttack, kept current by the Society	MCI 2002 Regulations operative; NMC 2023 Regulations in abeyance
CONSEQUENCE OF BREACH	Professional and reputational; feeds the statutory process	Graded action up to erasure from the register

GOOD TO REMEMBER

When a conduct question arises in real practice, ask two questions in order. First, what does good psychiatric ethics require here, for which the IPS code and the four principles are the guide. Second, which enforceable rule is engaged, and against which code, for which the answer today is the MCI 2002 Regulations and not the suspended 2023 code. Keeping the aspirational and the enforceable separate stops a clinician from either dismissing the profession's own code as toothless or mistaking the dormant statute for the live one.

The Indian Psychiatric Society's psychiatry-specific code of ethics was approved at Cuttack in 1989 and, in its current published form, states the psychiatrist's duties as fourteen codes centred on the patient's paramount interest, valid consent, confidentiality within the law and no exploitation of the relationship; the operative statutory conduct code is the MCI 2002 Regulations, while the NMC RMP 2023 Regulations, though notified, are held in abeyance and are not in force.

6 · Professional negligence and medical malpractice (four Ds, vicarious liability)

Every clinical act carries the standing risk that a bad outcome will be read as a wrong done. A patient who is harmed in the course of care may frame that harm as the doctor's fault, and the law of negligence is the machinery that decides whether the framing is right. For the psychiatrist the stakes are peculiar, because so much of the work is judgement exercised under uncertainty, with outcomes that are probabilistic and diagnoses that are contested; the discipline of this topic is learning exactly what turns an adverse outcome into an actionable wrong, and what does not. The examiner is testing whether a candidate can separate the two.

The account here is built around four questions that a negligence claim must answer in turn: was a duty owed, was it breached, did the breach cause harm, and was there harm to be caused. Those four questions are the "four Ds" that every candidate can recite, but the more precise formulation is what the Supreme Court of India actually said, and the discrimination between the mnemonic

and the holding is where marks are made and lost. On the standard against which a breach is judged, on the higher bar the criminal law sets, and on the liability an employer carries for its staff, the rules are settled and quotable. The forum in which a patient brings such a claim, chiefly the consumer forum, belongs to this chapter's account of the Consumer Protection Act and medical practice, and is named here rather than reworked.

1957	1997	1996	2005
BOLAM, THE ORIGIN OF THE PROFESSIONAL STANDARD OF CARE	BOLITHO, THE LOGICAL-BASIS GLOSS ON BOLAM	ACHUTRAO, THE INDIAN AUTHORITY ON HOSPITAL LIABILITY	JACOB MATHEW, THE INDIAN SETTLEMENT OF MEDICAL NEGLIGENCE

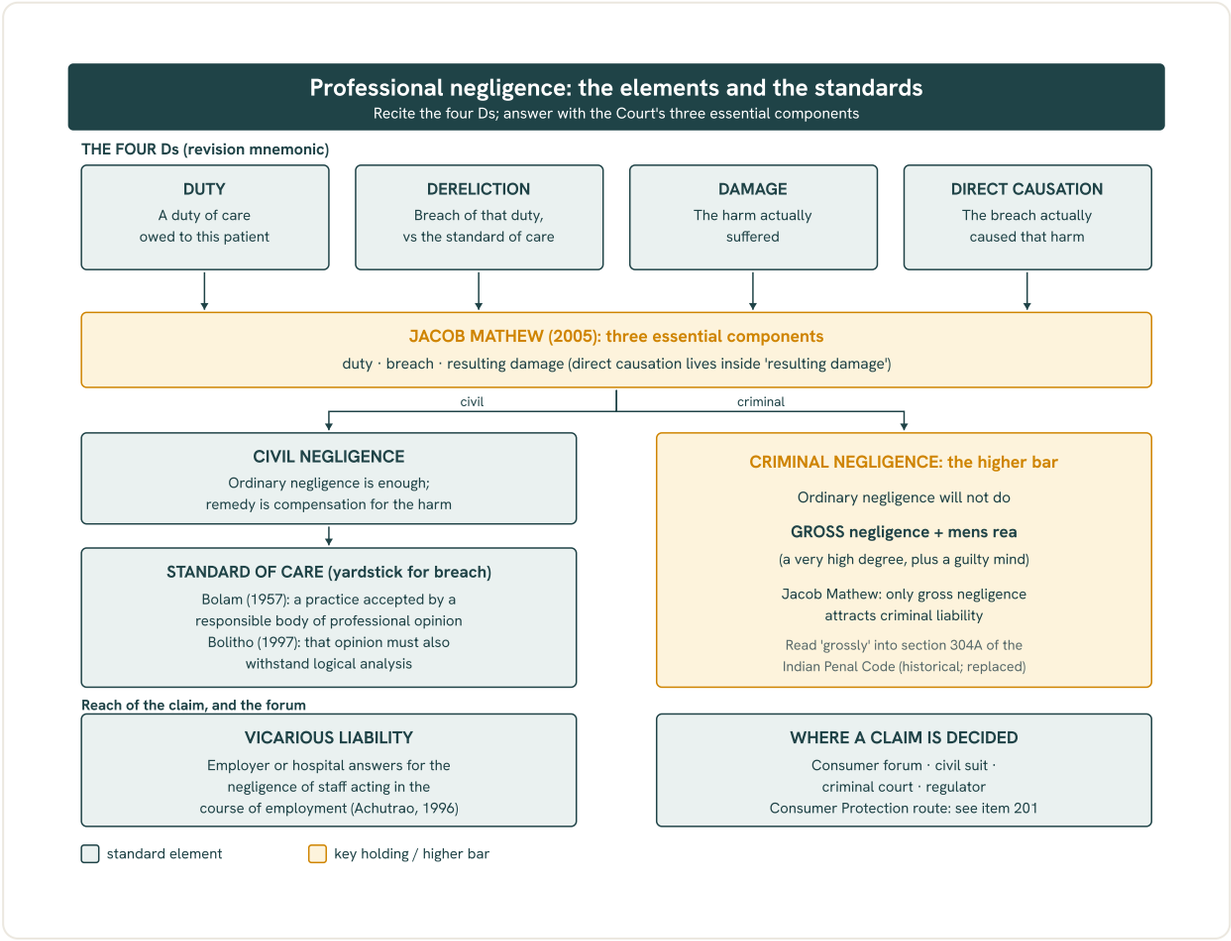


Fig 26.5. Professional negligence: the four Ds unpack the three essential components of Jacob Mathew (2005), breach is judged by Bolam as qualified by Bolitho, and criminal liability needs gross negligence plus mens rea.

6.1 What actionable negligence is: the four Ds and the three components

In ordinary language **negligence** is carelessness, but as a cause of action it is a structured thing with parts that must all be present. It is the breach of a duty caused by an omission to do what a reasonable person, guided by the considerations that ordinarily regulate human affairs, would do, or the doing of what a prudent and reasonable person would not do. A patient who alleges it must establish each of its elements; the absence of any one defeats the claim entirely, however grievous the outcome.

The revision mnemonic gathers those elements as the four Ds: a **Duty** of care owed to the patient, a **Dereliction** or breach of that duty, resulting **Damage**, and **Direct causation** linking the breach to the damage. The mnemonic is a useful scaffold and worth keeping, but it must be

married to what the Court actually held. In **Jacob Mathew** the Supreme Court of India stated that the essential components of negligence are **three**: duty, breach and resulting damage. Causation is not dropped; it lives inside "resulting damage", because damage that does not result from the breach is not the defendant's damage at all. The four Ds and the three components describe the same law: the mnemonic simply unfolds the causation that the holding keeps folded into its third element.

MNEMONIC

Duty, Dereliction, Damage, Direct causation

The four Ds of the negligence action: a **Duty** of care owed to this patient; a **Dereliction**, the breach of that duty measured against the standard of care; the **Damage** actually suffered; and the **Direct causation** that ties the breach to the harm. Recite the four for structure, but answer with the Court's three components, causation embedded in resulting damage, when asked for the authority.

TRAP **The Supreme Court states three essential components, not four Ds.** Candidates write that the Court laid down "four Ds" and lose the mark for putting a teaching mnemonic in the Court's mouth. The holding in Jacob Mathew names three components, duty, breach and resulting damage, with causation carried inside the third. State the three as the law, then offer the four Ds as the device that unpacks the causation requirement. Getting the direction of that relationship right, mnemonic derived from holding and not the reverse, is what a careful answer shows.

6.2 The standard of care: the Bolam test

The second element, breach, cannot be judged without a yardstick, and the yardstick is the heart of medical negligence law. A doctor is not measured against the ordinary reasonable person, because the ordinary person does not possess the special skill in question. This is the insight of the **standard of care** for skilled work, given its classical statement in **Bolam**. Where an act involves a special skill or competence, negligence is judged by the standard of the ordinary skilled person exercising and professing to have that skill, not by the standard of the ordinary person on the street. The practitioner need not possess the highest expert skill; it is enough that they exercise the ordinary skill of an ordinarily competent practitioner of that art.

The operative principle follows: a practitioner is not negligent if they have acted in accordance with a practice accepted as proper by a responsible body of professional opinion, even if other practitioners would have taken a different view. Medicine tolerates genuine differences of approach, and the law protects the doctor who has followed one recognised school of thought against the charge that a different school would have done otherwise. This is why a mere error of judgement, or the existence of a better alternative in hindsight, is not by itself negligence.

IN INDIA

The Bolam standard is not merely borrowed here; the Supreme Court in Jacob Mathew adopted it expressly, holding that the test for determining medical negligence laid down in Bolam holds good in its applicability in India. The practical consequence for civil liability is precise: so long as a doctor follows a practice acceptable to the medical profession of the day, they are not negligent merely because a better alternative existed, or because a more skilled doctor might have chosen differently. The Indian civil standard is therefore the accepted-practice standard, applied to Indian conditions and the resources actually available, not a counsel of perfection.

6.3 Bolam qualified: the Bolitho gloss

Bolam left an obvious gap. If any body of professional opinion could shelter a defendant, then a defendant needed only to find one supportive expert, and the profession, rather than the court, would decide what counted as reasonable care. The correction came in **Bolitho**, which glosses rather than overturns Bolam. A body of professional opinion protects a defendant only if that opinion can be shown to rest on a logical basis. The adjectives the law uses, that the body of opinion be responsible, reasonable and respectable, require the court to be satisfied that its exponents have actually weighed the comparative risks and benefits and reached a defensible conclusion. In the rare case where the opinion relied on is not capable of withstanding logical analysis, the judge is entitled to hold that it is not reasonable or responsible, and the shelter falls away.

The combined rule, Bolam as qualified by Bolitho, is the single most examinable proposition in this topic. The standard of care is set by a responsible body of professional opinion, but the court retains a residual power to reject that opinion when it cannot survive logical scrutiny. This keeps the final judgement of reasonableness with the court while giving proper weight to genuine professional practice, and it forecloses the defence built on an opinion that is merely asserted rather than reasoned.

RULE **The standard of care is Bolam as qualified by Bolitho: a responsible body of professional opinion sets the standard, but only where that opinion withstands logical analysis.** A doctor who acts in line with an accepted professional practice is not negligent, and this protects legitimate differences of clinical approach. Bolitho adds the safety catch: the practice relied on must have a logical basis, weighing risks against benefits, or the court may find it neither reasonable nor responsible. Both halves must appear in a full answer, because Bolam alone overstates the doctor's protection and misses where Indian and English law now stand.

GOOD TO REMEMBER

What protects the clinician is not a good outcome, which cannot be guaranteed, but a defensible process. Choose a management that a responsible body of your profession would accept, be able to say why the comparative risks and benefits pointed that way, and write that reasoning in the notes as it is made. A documented choice within accepted practice is answerable to Bolam and Bolitho even when the result is poor; an undocumented departure from it is exposed even when the result is good.

6.4 Causation: the fourth D and where the burden lies

Even a proven breach of duty does not by itself make a case, and this is the element candidates most often skate over. **Causation** is the requirement that the breach actually produced the injury complained of, and it is a distinct hurdle the claimant must clear. Bolitho is authority for the point as well as for the standard of care: where a breach of the duty of care is proved or even admitted, the burden still lies on the plaintiff to prove that the breach caused the injury suffered. A patient who was negligently managed but who would have come to the same harm regardless has suffered a breach without a remedy, because the breach caused nothing.

This is the "direct causation" the fourth D names, and it is why the mnemonic is a fair unpacking of the three components rather than an inflation of them. The link between breach and damage must be shown, not assumed from the coincidence of a lapse and a bad result. For the psychiatrist, where outcomes are multiply determined and the natural course of an illness may itself account for the harm, the causation question is frequently the strongest ground of defence: the illness, not the treatment, may be the operative cause.

6.5 Civil and criminal negligence: the higher bar

The same careless act can be met with a civil claim for compensation or, in a serious case, a criminal prosecution, and the two run on entirely different standards. The distinction is grounded and load-bearing. For civil liability the accepted-practice standard of Bolam and Bolitho governs, and ordinary negligence suffices. For criminal liability the bar is far higher: **mens rea** must be shown, and the degree of negligence must be **gross negligence**, or negligence of a very high degree. Negligence that is neither gross nor of a high degree may found a civil action but cannot form the basis of a prosecution. In Jacob Mathew the Court read the words "rash or negligent act" in the historical penal provision, Section **304A** of the Indian Penal Code, as qualified by "grossly", so that only gross negligence would attract criminal liability.

The rationale is protective. A doctor who acts in good faith and within accepted practice should not face the criminal law every time treatment fails, because that would make defensive medicine the rule and deter the very risk-taking that patients need. The criminal law is reserved for negligence so gross that it approaches recklessness, coupled with the guilty mind the offence requires. The insanity-defence doctrine and the burden of proof that attend criminal responsibility more generally belong to the Mental health legislation and forensic psychiatry notes and are not reworked here; the point retained is the standard specific to negligence.

AXIS	CIVIL MEDICAL NEGLIGENCE	CRIMINAL MEDICAL NEGLIGENCE
STANDARD APPLIED	Bolam, as qualified by Bolitho: departure from accepted responsible practice	Gross negligence, or negligence of a very high degree
MENTAL ELEMENT	None required; the act and its consequences are judged objectively	Mens rea must be shown to exist
DEGREE OF FAULT	Ordinary negligence is enough	Ordinary negligence will not do; the lapse must be gross
WHAT THE CLAIMANT SEEKS	Compensation for the damage caused	Punishment of the practitioner by the State
PURPOSE OF THE STANDARD	To make good the harm to the patient	To protect the good-faith doctor from prosecution for every failure

PITFALL

Citing the Indian Penal Code as the current source of the criminal-negligence provision. Jacob Mathew construed Section 304A of the Indian Penal Code, which was the operative penal code when the case was decided, but the substantive criminal law has since been replaced and the old codes are now historical. Quoting the Court on the qualifying word "grossly" is correct; presenting the Indian Penal Code as the code in force today is not. The current penal framework and the savings rule that decides which code applies to a given prosecution are set out in this chapter's account of the penal-code framework and its transition; name the new provision as current and the old as historical.

6.6 Vicarious liability: the employer answers for the servant

A negligence claim does not stop at the individual who erred. **Vicarious liability** is the principle that an employer, though personally without fault, is answerable for the harm done by the fault or negligence of a servant acting in the course of employment. The doctrine matters intensely in practice, because the individual clinician may be uninsured or of modest means while the hospital that employs them is not, and because the harm done by any of the doctors or other employees through whom a hospital delivers care is answered for by the hospital itself. The rule is stated authoritatively in **Achutrao**: an employer, though guilty of no fault himself, is liable for the damage done by the fault or negligence of his servant acting in the course of his employment.

The liability is not unlimited, and its boundaries are where the marks sit. Applied to the hospital, the Court held that running a hospital is a welfare activity and not a sovereign function, so the State or the hospital cannot claim sovereign immunity and is vicariously liable for the negligence of its doctors and other employees. The claimant may sue the individual, the institution, or both. The requirements that must hold, and the defence that fails, are these:

- **An employer-servant relationship.** The person who erred must be an employee, not an independent contractor beyond the employer's control; the closer the control over how the work is done, the firmer the liability.

- **Acting in the course of employment.** The negligent act must be part of, or reasonably incidental to, the work the servant is engaged to perform, not a personal venture unconnected with it.
- **A welfare, not a sovereign, function.** Because running a hospital is a welfare activity, the defence of sovereign immunity does not shield a public hospital from vicarious liability for its staff.

6.7 Where a negligence claim is decided

A patient harmed by alleged negligence is not confined to a single door, and the available tracks run on different standards and to different ends:

- **The consumer forum.** A dedicated statutory route treats a deficiency in a medical service as consumer redress; that forum, its remedy and the settled position that paid medical services fall within it belong to this chapter's account of the Consumer Protection Act and medical practice, and are named here without being reworked.
- **An ordinary civil suit.** A patient may sue for damages in the courts, where ordinary negligence against the accepted-practice standard suffices.
- **A criminal prosecution.** Available only where the negligence is gross and accompanied by the guilty mind the offence requires.
- **A complaint to the regulator.** Engaging the professional-conduct code, this track is concerned with fitness to practise rather than with compensation.

The tracks are independent and may run in parallel: a single episode of negligent care can generate a consumer complaint, a civil suit, a criminal case and a disciplinary inquiry at once, each on its own standard and to its own end. What travels across the civil and consumer forums is the substance taught in this fragment, the elements of the action and the standard of care: each asks whether a duty was breached against the Bolam-Bolitho yardstick and whether the breach caused the harm. The criminal court demands more, gross negligence and mens rea, and the regulator asks about fitness to practise rather than compensation, so the yardstick is not identical everywhere. The forum changes the procedure, the degree of fault required and the remedy; the underlying account of what negligent care is remains the reference point each forum starts from.

Actionable negligence has three essential components in Jacob Mathew, duty, breach and resulting damage, with causation embedded in the third and unpacked by the four-D mnemonic; the standard for breach is Bolam as qualified by Bolitho, an accepted responsible practice that must also withstand logical analysis; civil liability needs ordinary negligence while criminal liability needs gross negligence plus mens rea; and by vicarious liability the hospital, running a welfare and not a sovereign function, answers for the negligence of its servants acting in the course of employment.

7 · Consumer Protection Act and medical practice

A doctor who charges for care has, in the eye of the law, supplied a service, and a patient who feels short-changed by that service can come after the doctor not only as an injured plaintiff but as a dissatisfied consumer. That single move, treating the clinical encounter as a transaction in services, is what brought medical practice within consumer law and gave the aggrieved patient a forum that is faster and cheaper than an ordinary civil suit. The marks are for knowing which statute is actually in force, what the Act means by "service" and by "deficiency", and how the landmark judgment settled that a doctor's work is a service the Act can reach: each a discrete, quotable point, and each a place a hurried candidate goes wrong.

This fragment owns the consumer forum and its definitions, not the law of negligence itself. Whether a doctor was negligent, the elements of the action and the standard of care against which a breach is measured, belongs to this chapter's account of professional negligence and medical malpractice and is named here, not reworked. The Consumer Protection Act does not invent a new standard of care; it opens a door to a particular tribunal and calls the wrong a "deficiency in service". Keeping that boundary clear, forum here, standard there, is the discipline the examiner is testing.

2019	1986	1995
THE CONSUMER PROTECTION ACT NOW IN FORCE	THE EARLIER ACT, SINCE REPEALED	IMA V V.P. SHANTHA BROUGHT MEDICINE WITHIN THE ACT

7.1 The current statute and what it replaced

The first thing to fix is currency, because the obvious answer is now the wrong one. The operative law is the Consumer Protection Act, 2019, enacted as Act 35 of 2019, which received assent on 9 August 2019. By Section **107(1)** it repealed the earlier Consumer Protection Act, 1986. The older Act is historical, and a candidate who cites it as governing law is quoting a repealed statute.

The Act's commencement is itself a conditional worth stating precisely, because it is not a single switch. It comes into force on such date or dates as the Central Government appoints by notification, and different dates may be appointed for different provisions of the Act and for different States. That staggered commencement means the practical answer to "when did it apply" is a matter of notification rather than of the date of assent. What matters for medical practice is that the core concepts, service, deficiency and consumer, are carried forward from the old Act with their sense intact.

7.2 What the Act means by "service"

Everything turns first on whether the doctor supplies a **service** the Act recognises, because only then can the patient be a consumer of it. Section **2(42)** defines service expansively as service of any description made available to potential users, with an illustrative sweep from banking and insurance through transport and housing construction. The breadth is deliberate: the definition is inclusive, not a closed list, so a service is not excluded merely because it is unnamed.

Against that breadth the section sets two express exclusions, and stating the definition without them is how a candidate loses the mark:

- **Service rendered free of charge.** A service rendered free of charge is outside the definition, a carve-out decisive for camps, charitable care and government facilities; but as the discussion of free versus paid care below shows, whether care is "free" is read by how the facility is funded, not by what a given patient paid.
- **Service under a contract of personal service.** A master-and-servant employment relationship is excluded, so that the ordinary grievance of an employee against an employer does not become a consumer complaint.

The free-of-charge limb generates almost all the medical litigation, because it forces the question of exactly when treatment counts as free.

7.3 What the Act means by "deficiency"

If the encounter is a service, the actionable wrong is a **deficiency** in it. Section **2(11)** defines deficiency as any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance that is required to be maintained by law or has been undertaken by contract in relation to a service. Critically for medicine, the definition expressly includes any act of negligence, or omission or commission, by the provider that causes loss or injury to the consumer. This is the bridge that lets a negligence complaint be pursued as a consumer matter at all.

What the Act does not do is tell you when negligence exists. The **deficiency in service** is defined by reference to the performance "required to be maintained by law", and the content of that requirement, the four-part structure of the negligence action and the standard of care by which a breach is judged, is drawn from the general law set out in this chapter's account of professional negligence and medical malpractice. The consumer forum applies that standard; it does not lower it. A poor outcome is not a deficiency unless the care fell below the standard the law already demands, which is why the same fact may be a deficiency in one case and a non-negligent misadventure in another.

7.4 The landmark: medicine is a "service"

For years it was argued that a learned profession stood apart from consumer law, and that a doctor answerable to the medical regulator could not also be hauled before a consumer tribunal. That argument was settled by **IMA v V.P. Shantha**, which remains the governing precedent. The Court held that service rendered to a patient by a medical practitioner, by way of consultation, diagnosis and treatment, both medicinal and surgical, falls within the expression "service" as then defined in Section **2(1)(o)** of the 1986 Act, the historical predecessor of the current definition. Two exceptions were carried over from the statute itself: service rendered free of charge to every patient, and service under a contract of personal service.

The judgment also disposed of the profession's favourite escape route. The fact that a doctor is subject to the disciplinary control of the Medical Council does not take the doctor's service outside the Act. Regulatory oversight and consumer liability are parallel, not alternative; a clinician can face both a disciplinary inquiry into fitness to practise and a consumer complaint for compensation arising from the same episode. That the Court read a professional's work as a

marketed service, rather than as a calling immune from commercial law, is the conceptual core of the whole topic.

RULE **A doctor's diagnostic and therapeutic service is "service" under the Act, and a deficiency in it is actionable in the consumer forum, unless the service is rendered free of charge to everybody or under a contract of personal service.** The default is coverage; the exclusion is narrow and must be stated with its condition. Where a practitioner or facility charges no fee from any patient, the service is outside the Act, and the payment of a token amount for registration only does not change that position. The rule is not "free treatment is never covered" but "treatment free to everyone is not covered", and the difference between those two sentences is where the marks live.

7.5 The free-versus-paid distinction

The single most examined product of Shantha is the way it worked the free-of-charge exclusion out across the mixed economy of Indian hospitals, where paying and non-paying patients are treated side by side. Rather than a crude "did this patient pay" test, it asks how the facility is funded, so that a patient treated free at a hospital that charges others is still a **consumer**. The accompanying grid sets out the four situations the Court distinguished.

SITUATION	IS IT "SERVICE" UNDER THE ACT?	IS THE RECIPIENT A "CONSUMER"?
CHARGES ARE PAYABLE AND THE PATIENT PAYS	Yes; paid medical service falls squarely within the Act	Yes; may complain of a deficiency
CROSS-SUBSIDISED: THOSE WHO CAN PAY ARE CHARGED, THOSE WHO CANNOT ARE TREATED FREE	Yes; even the free treatment is "service"	Yes; the non-paying patient is also a consumer
FREE TO EVERYBODY, NO CHARGE TAKEN FROM ANY PATIENT	No; wholly free service is outside the Act	No
ONLY A TOKEN REGISTRATION FEE IS TAKEN, ALL ARE TREATED FREE	No; the token fee does not alter the free character	No

The organising idea is that the paying patients underwrite the free ones, so the institution supplies a service for consideration and the benefit of that service reaches the non-paying patient too. Coverage follows the economic character of the facility, not the receipt in a given patient's hand, and only where the service is free to all comers does the exclusion truly bite.

TRAP **Reading the free-of-charge exclusion too widely, so that any free treatment is treated as outside the Act.** Candidates state the exclusion correctly, then apply it as though a patient who paid nothing can never complain. Shantha holds the opposite for the cross-subsidised case: where a hospital charges paying patients and treats others free, the free treatment is still "service" and its recipient a consumer. The exclusion is confined to the facility that charges no one at all. Answer with the four situations, not with the headline, because the headline states a rule the judgment expressly rejected.

7.6 The forum, the remedy and the boundary with negligence

What the Act really gives the patient is a place to go. Beyond defining service and deficiency, it establishes a dedicated tier of consumer commissions, sitting at the district, State and national

levels, before which a consumer may bring a complaint of deficiency and seek redress, most commonly an award of compensation. The attraction over an ordinary civil suit is procedural: the consumer route offers a dedicated statutory forum and a compensation remedy, and it became a common route for medical grievances once Shantha confirmed doctors were within reach of it. The exact pecuniary jurisdiction of each tier, the limitation period for a complaint, and the statutory definitions of "consumer" and "complaint" are matters of the Act's machinery not reproduced here.

The boundary with the law of negligence is the point to carry away. The commission decides the forum question, is this a service, is the complainant a consumer, has there been a deficiency, but the deficiency question still turns on the ordinary negligence standard, the accepted-practice test qualified by the requirement of a logical basis, taught in this chapter's account of professional negligence and medical malpractice. The Consumer Protection Act is thus best understood as a remedy and a forum bolted onto the substantive law of negligence, not as a separate or stricter code of medical liability. A clinician who satisfies the standard of care has committed no clinical negligence, though the statutory definition reaches wider than negligence alone: a fault, imperfection, shortcoming or inadequacy in a performance the law requires or a contract undertook can still be a deficiency.

IN INDIA

Since IMA v V.P. Shantha the consumer commission has been the workhorse of medical-liability litigation in India, because it spares the patient the cost and delay of a regular civil action. For the practising psychiatrist the Act bites at the ordinary paid consultation: consultation, diagnosis and treatment given for a fee is service within the Act, so a dissatisfied patient may bring a complaint alleging a deficiency in it. The fee-paying private consultation is the paradigm covered service, so the everyday out-patient encounter falls squarely within the Act's reach.

GOOD TO REMEMBER

Do not treat a fee waiver as a shield. If your clinic charges other patients, the concession you extend to one does not put that patient's care outside the Act; a camp or charitable service is exempt only when nobody is charged at all. Because coverage follows how the service is funded rather than what this patient paid, hold every episode of care, subsidised, discounted or free within a paying practice, to the same documented standard, so that the deficiency question is answered by your notes whichever forum asks it.

PITFALL

Citing the Consumer Protection Act, 1986 as the statute in force. It was repealed by the 2019 Act, and quoting the old Act, or its old section for the definition of service, in a report, an opinion or an examination answer marks the writer as working from a superseded source. The case law decided under the 1986 Act, IMA v V.P. Shantha among it, remains good authority on the concepts, but the section it construed is historical. Name the 2019 Act as current and treat the 1986 provisions as the predecessor they now are.

The operative statute is the Consumer Protection Act, 2019, which repealed the 1986 Act; a doctor's paid diagnostic and therapeutic work is "service" and its negligent shortcoming a "deficiency", so IMA v V.P. Shantha lets a patient sue as a consumer, with only service that is free to everybody, unaltered by a token registration fee, falling outside the Act, while the standard of negligence itself is drawn from the account of professional negligence.

8 · Expert testimony and the psychiatrist as expert witness

Why the marks are here. Forensic work asks the psychiatrist to do something the rest of medicine never demands: to serve a master other than the patient. The clinician who, in the consulting room, owes undivided loyalty to the person in front of them may later be asked by a court to examine a litigant, an accused or a claimant and to report - not for that person's benefit, but for the administration of justice. The two examinations can look almost identical across the desk, yet they pull the clinician in different directions: to whom the duty is owed, and what confidentiality and stance the encounter carries, invert between them, even though duties of honesty, respect and competence hold in both. Evaluators who miss this produce reports that are partisan, poorly received, or quietly damaging to the very patient they meant to help; candidates who miss it lose an easy viva question that examiners return to year after year.

This section teaches the psychiatrist as an **expert witness**: how the treating role is held apart from the expert role, and how the law separates the opinion the expert is uniquely permitted to give from the facts to which an ordinary witness is confined. The rules of admissibility, the court hierarchy and the mechanics of how an opinion is received in evidence are set out elsewhere in this chapter and are only named here; the criteria of criminal responsibility and of fitness to stand trial belong to the Mental health legislation and forensic psychiatry notes.

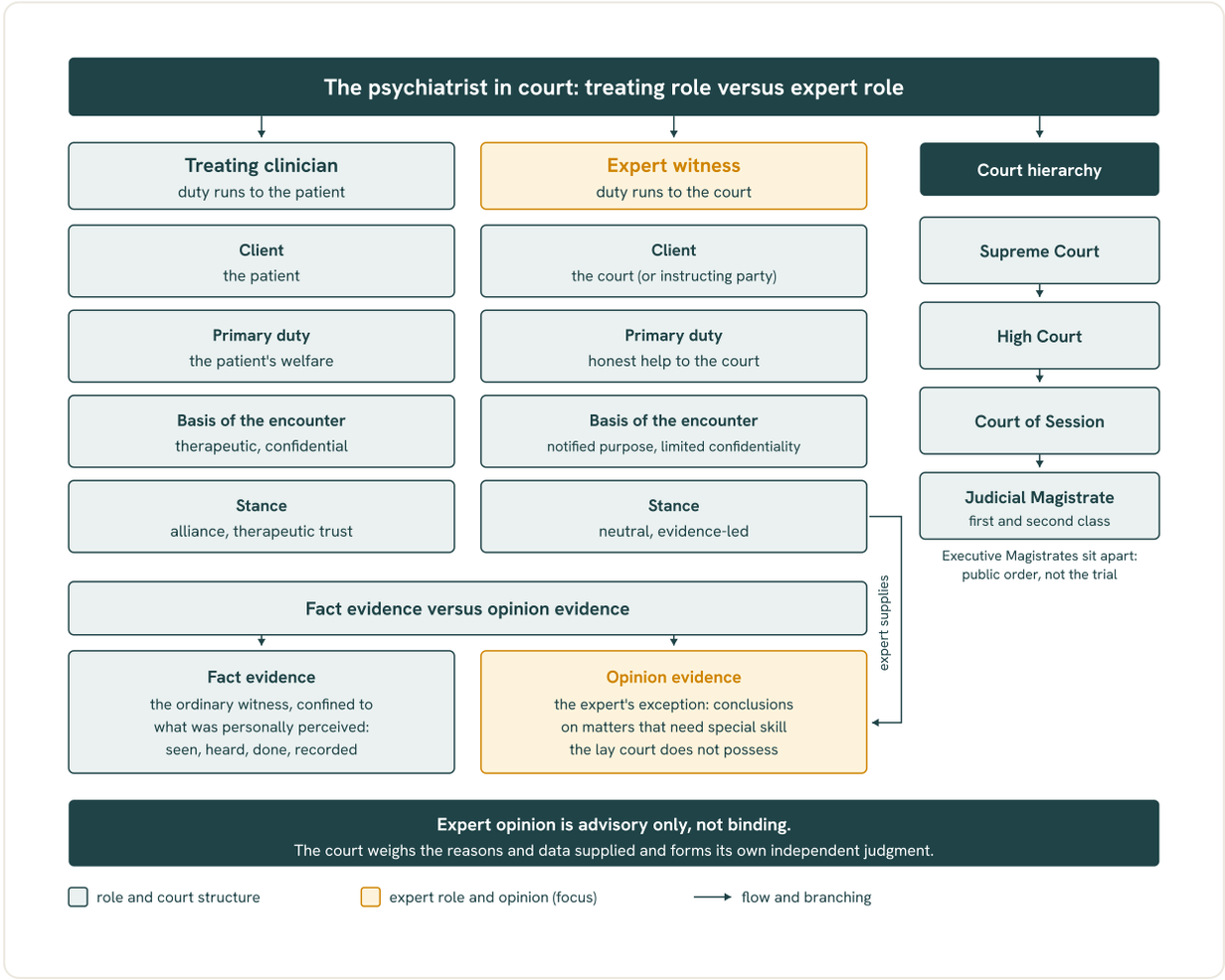


Fig 26.6. The treating role serves the patient and the expert role serves the court; the ordinary witness gives fact while the expert alone gives opinion on matters needing special skill, and that opinion is advisory only, the court never bound by it (Ramesh Chandra Agrawal, 2009).

8.1 Two roles, one clinician: treatment and evaluation

The confusion at the heart of forensic psychiatry is that one professional, with one set of skills, is asked to occupy two structurally different positions. In the **treating role** the client is the patient. The primary obligation is to that patient's welfare, resting on the principles of beneficence and non-maleficence (the four principles of biomedical ethics are set out elsewhere in this chapter and named here only). Consent is therapeutic consent to be helped; confidentiality is the default posture, breached only within the narrow permitted circumstances taught elsewhere in this chapter. The stance is one of alliance and therapeutic trust, because trust is itself part of the treatment, while clinical assessment stays objective.

In the **forensic evaluator** role almost every one of those settings inverts. The functional client is the court, or a retaining party whose instructions the evaluator accepts but whose interests do not command the opinion. There is no therapeutic purpose, and confidentiality is correspondingly limited rather than absent: before anything is said, the person examined must be told that the encounter is not treatment, that what they disclose is not held in the usual clinical confidence and may be set out in a report, and who will receive that report. The goal is not the person's welfare but an accurate answer to a legal question, and the stance is neutral and, where the data demand it, sceptical. When these two roles are forced into one person at one time - the treating

psychiatrist asked to be the court's expert on their own patient - a dual relationship forms that corrodes both the objectivity the court needs and the alliance the patient needs.

AXIS	TREATING ROLE	EXPERT ROLE
Who is the client	The patient	The court (or an instructing party)
Primary duty	The patient's welfare	Honest assistance to the court
Basis of the encounter	Therapeutic consent	Notified purpose, limited confidentiality
Confidentiality	Default, narrowly limited	Limited by the forensic purpose
Goal of the contact	To help the person	To answer a legal question accurately
Stance toward the person	Alliance, therapeutic trust	Neutral, evidence-led

8.2 Opinion and fact: why the expert is the courtroom's exception

A court is a machine for finding facts and drawing inferences from them, and it reserves the drawing of inferences to itself. The ordinary witness is therefore confined to **fact evidence**: what they personally perceived - saw, heard, did, recorded. They are not permitted to offer their conclusions, because inference is the court's own work. The expert is the deliberate exception to this rule. Where a question turns on specialised knowledge the lay judge does not possess, the law admits **opinion evidence** from a person qualified in that field, precisely so the court can reason about matters it could not otherwise understand.

The distinction has a direct and frequently examined consequence for the psychiatrist. A treating psychiatrist summoned to testify about a patient they have managed is, in that capacity, usually a witness of fact: they speak to their own observations, their records, the treatment given. That is fact evidence, even though the witness happens to be an expert by training. Giving an opinion on a legal question about someone the witness has not evaluated for that purpose is a different act, requiring the expert footing. The same psychiatrist may therefore be a witness of fact in one proceeding and an expert in another; the discipline is to know, at every moment, which capacity is being exercised, because the permissions and the duties differ.

8.3 The advisory character of the opinion

Because opinion is admitted only by way of exception, the law is careful to fix its weight. The governing Indian authority is **Ramesh Chandra Agrawal v. Regency Hospital Ltd.** (Supreme Court, **2009**), which states the principle plainly: an expert is not a witness of fact, and the evidence is really of an advisory character. The expert's duty is to furnish the judge with the necessary scientific criteria for testing the accuracy of the conclusions, so as to enable the judge to form an independent judgment by applying those criteria to the facts proved in the case. It is not the province of the expert to act as judge or jury; the court is not bound by the opinion, and weighs it against the reasons and the data the expert has actually supplied.

2009

RAMESH CHANDRA AGRAWAL: THE SUPREME COURT ON THE EXPERT'S ROLE

Two things follow, and both are examinable. First, the opinion is only ever an aid to the court's own reasoning, never a substitute for it, so a decision-maker who simply adopts an expert's conclusion has abdicated the very function the law reserves to it. Second, and more useful at the bedside of report-writing, an opinion carries weight in large part according to how far it exposes the criteria and data on which it rests. A bare conclusion, however eminent its author, gives the court nothing to test and therefore earns little. The reasoning is the evidence; the conclusion is merely its endpoint.

> An expert witness is not a witness of fact: the opinion is advisory only, and the court, never bound by it, forms its own independent judgment on the reasons and data supplied.

RULE **The expert advises; the court decides.** Expert evidence is of an advisory character. Its job is to hand the court the scientific criteria for testing a conclusion, not to deliver the conclusion the court is bound to accept. Weight tracks the transparency of the criteria and data offered.

8.4 Objectivity, and the partisan-expert trap

If the opinion is advice to the court, then the expert's overriding duty runs to the court and to the truth, not to whoever pays the fee. This is the ethical spine of the role and the point at which it most often fails in practice. The **partisan expert** - the hired opinion that shades every ambiguity in the instructing party's favour - is not merely distasteful; it is worthless in exactly the terms the governing authority sets out, because an opinion shaped to a conclusion cannot honestly furnish the criteria by which that conclusion could be falsified. Independence is not a courtesy the expert extends to the other side; it is the condition on which the evidence has any value at all.

Signs that an opinion has slipped from expert to advocate include:

- a conclusion stated with a confidence the underlying data cannot support;
- selective use of the record, with inconvenient findings omitted rather than addressed;
- straying beyond the witness's actual field of competence;
- answering the ultimate legal question directly instead of supplying the material the court needs to answer it.

TRAP **Deciding the ultimate legal issue.** The expert may give the clinical opinion, including whether the person was, by reason of unsoundness of mind, in a particular mental state, which the evidence code names as a paradigm expert question. What the expert must not do is announce the verdict: whether the statutory defence is made out, or whether the doctor is legally liable. That legal conclusion is the court's province. The expert furnishes the clinical criteria and findings; the judge, not bound by the opinion, applies the law.

IN INDIA

Indian courts treat expert medical and psychiatric opinion as advisory rather than conclusive, and the Supreme Court's statement of that position is the authority discussed above. A well-reasoned report that lays out its criteria and data will be given weight; an assertion offered on authority alone will not. The practical lesson for the Indian evaluator is to write for a reader who is entitled to disagree.

8.5 From consulting room to witness box

The expert's product is the written report, and it is prepared on the assumption that it will be read by an adversary and tested under cross-examination. A defensible report therefore does the opposite of what a clinical note does for a colleague: it spells out its own workings so that a hostile reader can retrace them. The psychiatrist states the instructions received and the question asked, records who was examined and on what material, distinguishes what was observed from what was inferred, and confines every opinion to matters within genuine competence. Where the data are thin or the literature divided, the honest report says so, because a candid limitation strengthens the parts that remain and a concealed one collapses the whole under cross-examination.

A defensible expert report characteristically:

- identifies the instructing party, the question, and the material relied on;
- separates facts observed from opinions drawn;
- gives the reasoning and criteria behind each opinion, not the conclusion alone;
- stays within the author's field and flags the limits of the data.

GOOD TO REMEMBER

Keep the two roles physically separate whenever you can: if you are the treating psychiatrist, resist accepting an expert brief on your own patient, and if you must give evidence about them, give it as a witness of fact - what you saw, recorded and did. Because those treating records can themselves be summoned as fact evidence, contemporaneous, legible and complete documentation is a medico-legal protection long before any court is involved.

PITFALL

A common and damaging real-world error is not a courtroom blunder but an acceptance made months earlier: agreeing to serve as the court's expert on a patient one is actively treating. The clinician believes they are best placed because they know the patient, but they arrive with a therapeutic loyalty and a prior belief that no amount of good faith can neutralise, and the resulting opinion is both ethically compromised and easily discredited. Decline the dual role at the outset, and refer the evaluation to an independent colleague.

8.6 Where the expert role meets the rest of forensic practice

The advisory posture set out above is not confined to one kind of case; it is the common footing on which the psychiatrist enters every legal forum. The psychiatric assessment of an accused,

whose procedural pathway of court referral and reporting is dealt with elsewhere in this chapter, is an application of exactly this role: the psychiatrist furnishes the court with clinical findings and criteria, while the substantive question of criminal responsibility, and the tests and burden of proof that govern it, belong to the Mental health legislation and forensic psychiatry notes. In a professional-negligence action the standard of care, taught elsewhere in this chapter, is itself proved through expert testimony about accepted practice, so the credibility of the whole claim can turn on how transparently that expert reasons. And the rules of evidence and the court structure that decide how an opinion is admitted and received, also treated elsewhere in this chapter, are the procedural frame within which the advisory character of the opinion actually operates.

The unifying idea. Across all of these settings the psychiatrist is doing one thing: translating clinical observation into criteria a court can test, while leaving the decision to the court. Hold the treating role and the expert role apart, remember that opinion is admitted only as an aid and never as a verdict, and the harder forensic tasks in this chapter become variations on a single, well-understood discipline.

9 · Boundary violations and ethics of the therapeutic relationship

The therapeutic relationship is the instrument of psychiatric treatment, and boundaries are what keep that instrument safe to use. Psychiatry works through a relationship in which a distressed person discloses the most private material of a life to a clinician trusted to hold it and to act only in that person's interest. That trust rests on an asymmetry of power, knowledge and dependence that does not reverse itself, and it is that asymmetry which makes the relationship both healing and dangerous. The ethics of the therapeutic relationship is the discipline of managing that danger, and its central examinable idea is the distinction between a departure from the frame that remains safe and one that has become harmful. A candidate who can define a boundary crossing and a boundary violation, hold the two apart on stated grounds, and trace the progression that carries one into the other has this topic; one who treats every deviation as misconduct, or reserves the word violation for sexual contact alone, has misunderstood it.



Fig 26.7 A boundary crossing is a departure from the usual therapeutic frame that may remain clinically justified; a boundary violation exploits the asymmetry of the relationship and harms the patient. Context, purpose, cumulative drift and patient welfare determine the distinction.

What is owned here is the doctrine of the relationship itself. The four principles of biomedical ethics, informed consent, confidentiality and its limits, and the professional-conduct codes each have their own treatment in this chapter and are named here, not re-derived; so too the disciplinary, civil and consumer-forum consequences of a breach.

Fiduciary	**Clinician**	**Absolute**
THE NATURE OF THE DUTY THE RELATIONSHIP IMPOSES	WHO OWNS THE BOUNDARY, IN EVERY CASE	THE PROHIBITION ON SEXUAL CONTACT WITH A CURRENT PATIENT

9.1 The therapeutic frame and the fiduciary duty

Every treatment proceeds inside a set of expectations about how the clinician and patient will relate: the length, time and place of appointments, what is discussed, the handling of money, touch and personal information, and the understanding that the encounter exists for the patient's benefit alone. This set of expectations is the **therapeutic frame**, and boundaries are its edges.

They are not coldness or rigidity but the conditions under which a patient can safely regress, disclose and depend, knowing the clinician will not exploit the openness that treatment requires.

The frame is necessary because the relationship is a **fiduciary** one: the patient entrusts their welfare to a clinician who holds greater power and knowledge and is bound, in return, to place the patient's interests first, subject to the law and to the narrowly defined duties owed to others, and never to convert the relationship to their own advantage. Two features of psychiatric treatment sharpen this duty beyond that of most specialties. The first is **transference**, in which the patient unconsciously experiences the clinician through the template of earlier significant relationships, investing them with an authority, intimacy or idealisation carried from those earlier relationships rather than earned by the real person; realistic reactions to what the clinician actually says and does run alongside it, and the two are not always easy to separate. The second is **countertransference**, the clinician's own emotional responses to the patient, ordinary and useful in the work but which, unexamined, can pull the clinician toward gratifying their own needs under the guise of helping. Because transference makes the patient especially susceptible and countertransference makes the clinician especially fallible, responsibility for the boundary can never be shared with the patient; it rests wholly and permanently with the clinician.

RULE **The relationship is fiduciary, and the duty to maintain its boundaries rests entirely with the clinician, never with the patient.** Because transference and the power asymmetry leave the patient unable to protect themselves within the relationship, the patient's apparent willingness, invitation or even initiation never transfers responsibility: whatever the patient does, the clinician is answerable for the boundary, at every stage.

9.2 Boundary crossing versus boundary violation

The pivotal distinction of this topic is between two kinds of departure from the frame. A **boundary crossing** is a deviation from usual practice that is minor, non-exploitative and potentially benign or even helpful, and that can be openly acknowledged and discussed. Offering a distressed patient a tissue, briefly extending a session at a moment of crisis, or a small self-disclosure that normalises a fear may all be crossings: they step outside the frame, but they serve the patient, are reversible, and survive being talked about in supervision or written in the notes.

A **boundary violation** is a departure that is exploitative and harmful, that serves the clinician's needs rather than the patient's, and that damages the treatment. The difference is not the size of the step but its direction and effect: whose need it meets, whether it can be reversed, whether it can be discussed honestly, and whether it stands alone or forms part of a drift away from the patient's interest. A crossing that recurs, escalates, is concealed and begins to gratify the clinician has stopped being a crossing. The two therefore describe points on a single continuum, not unrelated categories, which is why the same act can be either depending on context and motive.

AXIS	BOUNDARY CROSSING	BOUNDARY VIOLATION
WHOSE NEED IS SERVED	The patient's; consistent with the treatment	The clinician's; the treatment is subordinated to it
EFFECT ON THE PATIENT	Neutral or beneficial	Harmful; exploits the patient's vulnerability
EXPLOITATION	Absent	Present, by definition
DISCUSSABILITY	Openly acknowledged and documented	Concealed, rationalised or kept secret
REVERSIBILITY	Reversible; the frame is easily restored	Damages the frame, often irreparably
PATTERN	Isolated and self-limiting	Recurrent, escalating, part of a drift

MNEMONIC

Whose need? Reversible? Discussable? A pattern?

The four questions that sort a crossing from a violation. **Whose need** is served, the patient's or the clinician's (beneficence against self-interest). **Reversible**, can the frame be restored or is the harm done (non-maleficence). **Discussable**, could it be said aloud in supervision and the notes, or must it be hidden. **A pattern**, does it stand alone or is it one step in an escalating drift. Answer patient, yes, yes, no and it is a crossing; the reverse and it is a violation.

9.3 The domains in which boundaries operate

Boundaries are not confined to physical contact; they run through every dimension of the clinical encounter, and a violation can occur in any of them. Naming the domains matters because clinicians tend to watch only the most obvious one and miss a breach in another. The recurring domains are:

- **Role.** Keeping the clinical role distinct from social, business or personal roles; a **dual relationship** arises when a second relationship is superimposed on the treating one.
- **Time and place.** The scheduling, duration and location of contact; appointments drifting to the end of the working day, lengthening without clinical reason, or moving outside the clinical setting.
- **Money and gifts.** Fees, business dealings, borrowing or lending, and the giving or receiving of gifts and services beyond token courtesy.
- **Self-disclosure and language.** How much of the clinician's own life enters the room, and a shift toward an intimate or personal register.
- **Physical contact.** Touch of any kind, at the far end of which lies sexual contact, the gravest breach of all.

The value of the list is that it makes the drift visible. Serious violations rarely begin with the act that finally destroys the treatment; they begin with small, defensible-looking changes across

several domains at once, each innocuous in isolation. Watching all the domains, not only the physical one, is how a clinician catches a problem while it remains a crossing.

9.4 The slippery slope

The **slippery slope** is the observation that boundary violations characteristically develop by gradual progression rather than a single decisive act. A clinician rarely moves directly from correct practice to gross exploitation; instead a series of minor crossings accumulates, each normalising the next, until the relationship has slid far from its therapeutic purpose. A common progression begins with a subtle shift toward the personal and a growing sense that one patient is special, moves through appointments lengthened or rescheduled to the end of the working day, extra-clinical contact, the exchange of confidences and gifts, and meetings outside the clinical setting, and ends in sexual involvement. The precise sequence varies, but the shape is consistent: incremental, mutually reinforcing steps, each small enough to be rationalised.

The mechanism is what makes the concept clinically useful rather than merely descriptive. Because each step is small, it evades the clinician's own alarm; because transference makes the patient receptive and countertransference makes the clinician gratified, both are drawn along the slope rather than pulled back; and because the steps are concealed, the ordinary corrective of open discussion never operates. The practical implication is decisive: a violation is reliably prevented early, at the first crossings and the first stirrings of specialness, not at the edge of the sexual act, where the clinician's judgement has usually already been captured. This is why the doctrine treats trivial-looking early crossings with a seriousness that seems disproportionate until the trajectory is understood.

TRAP **Equating any boundary crossing with a boundary violation, or reserving the word violation for sexual contact alone.** Both errors lose marks. A crossing is not automatically wrong; a rigidly withholding clinician who never adapts the frame may serve the patient badly, and a crossing is distinguished from a violation by exploitation, harm and concealment, not by the mere fact of deviation. Equally, violations occur across every domain, and financial, social or dual-relationship exploitation is a genuine violation even where no sexual contact occurs. The candidate who defines the distinction correctly, and locates sexual misconduct as the gravest point on a continuum rather than the whole of it, answers the question actually asked.

9.5 Sexual misconduct: the paradigm violation

Of all boundary violations, sexual contact with a patient is treated as categorically the most serious. **Sexual misconduct** covers any sexual contact, relationship or exploitation of a patient by the treating clinician, and both professional consensus and the conduct codes treat it as absolutely prohibited for the duration of the clinical relationship. The prohibition is not softened by the patient's apparent willingness, and apparent consent is never a defence: even where the patient appears willing and has full decision-making capacity, the power asymmetry and the transference that treatment generates mean that agreement cannot make the clinician's sexual conduct permissible, and responsibility for avoiding exploitation remains entirely with the clinician. This clinical meaning of consent is distinct from the criminal-law meaning of consent in sexual-offences law, which has its own treatment in this chapter.

The harm is severe: exploited patients suffer damage resembling other betrayals of trust by a person in authority, including lasting difficulty ever trusting a clinician again. The former-patient question is the harder discrimination and a favourite of examiners. Because the transference and the imbalance of power do not end cleanly at the final appointment, the strictest professional position, often summarised as once a patient, always a patient, holds that a sexual relationship with a former patient remains unethical for as long as the residue of the therapeutic power imbalance persists. A candidate should state the in-treatment prohibition as absolute and treat the post-termination question as governed by the persistence of that imbalance, not by the mere ending of treatment. Where the patient is a minor, the conduct additionally engages the child-protection statutes, which belong to the Child psychiatry: assessment, treatment, services and protection notes and are named here rather than worked through.

GOOD TO REMEMBER

Treat the feeling of specialness as a clinical sign, not a private matter. When a clinician notices that one patient has become an exception, wanting to give them extra time, thinking of them between sessions, quietly bending the frame in their favour, the right response is to take it to supervision, not to act on it. Boundaries are protected far more reliably by routine self-monitoring, consultation and honest documentation than by willpower at the edge of the slope. The safe working test is that anything you would be unwilling to record in the notes or describe to a supervisor is already the problem.

9.6 Risk, prevention and the Indian setting

Boundary violations are not confined to a few predatory clinicians; ordinary practitioners are vulnerable under particular conditions. Recognised risk situations include the clinician passing through personal crisis, loss or loneliness, professional isolation without supervision, idealising or being idealised by a patient, and the seductive belief that this relationship is a unique exception to the rules. The protective measures follow from the mechanism of the slippery slope: regular supervision and consultation that make countertransference discussable, transparent documentation, attention to all the boundary domains rather than only the physical, judicious use of a chaperone, and a low threshold for referral where a conflict of interest cannot be contained.

The professional-conduct codes give this discipline its formal force. The duty not to exploit the therapeutic relationship for personal, social, business or sexual gain is stated in those four terms by the Indian Psychiatric Society's code of ethics; the operative statutory conduct code supplies the disciplinary consequence in its own terms, which are set out in this chapter's account of the professional codes of ethics and applied here rather than restated.

IN INDIA

The unavoidability of dual relationships in Indian practice makes the boundary discipline more demanding, not less. In a small town or close community the psychiatrist often cannot be a stranger to the patient outside the clinic, and shared social circles and family referrals are the norm. The frame then has to be defended deliberately: naming the clinical role where social and clinical worlds overlap, declining business or financial entanglement with patients, guarding confidentiality where relationships are interconnected, and referring on where a conflict of interest cannot be managed. The overlap of worlds is a fact of the setting; the exploitation of it is still a violation.

9.7 Accountability and the currency of the code

A proven boundary violation engages several distinct forms of accountability at once, and a complete answer names each. It is professional misconduct under the conduct code and can lead to disciplinary action up to erasure from the medical register. It can support a civil claim in professional negligence, whose elements must still be proved, and a deficiency in service can be pursued in the consumer forum; both have their own accounts in this chapter and are named here, not reworked. Where the conduct is itself criminal, the ordinary criminal law applies. A single violation can be actionable at once before a disciplinary body, a civil court and a consumer forum, and none forgives the others.

One currency point must be got right, because examiners use it to separate candidates. The provisions a clinician is held to are those of the operative Medical Council professional-conduct code; a more recent set of registered-medical-practitioner conduct regulations was notified by the National Medical Commission, came into force on publication, but was then held in abeyance and is not operative until a further Gazette notification. The earlier Council code therefore remains operative, including for a boundary violation. The exact editions, citations and dates belong to this chapter's account of the professional codes of ethics and are not asserted here.

PITFALL

Anchoring a misconduct analysis to the most recently notified conduct regulations as though they were the live code. It is natural to assume the newest professional-conduct regulations must be in force, and a clinician who does so will apply the wrong standard to a boundary breach. The recently notified registered-medical-practitioner conduct regulations came into force on publication but were then placed in abeyance and are not currently operative, so the earlier Medical Council code remains operative. Judging a disciplinary matter against a code not yet in force is a live-practice error with real consequences.

A boundary crossing is a minor, non-exploitative, discussable departure from the therapeutic frame that may even help the patient; a boundary violation is an exploitative, harmful departure that serves the clinician and betrays the fiduciary duty, and the slippery slope is the progression of unmonitored crossings that carries one into the other; sexual contact with a current patient is the paradigm violation, absolutely prohibited and never excused by apparent consent, because the patient's willingness cannot make the clinician's conduct permissible, and responsibility for every boundary rests always with the clinician.

10 · Ethics of research, publication and conflicts of interest

Why the marks sit here. Research is where a psychiatrist's two loyalties collide most sharply. Ordinary clinical work exists to help the person in the room; research exists to answer a question that may benefit no current patient at all. When the same doctor holds both roles over the same person, the informal safeguards of the consulting room are no longer enough, and a candidate is expected to show exactly how the ethical frame changes once a patient becomes a participant. Publication and conflict of interest share this subtopic because they are the downstream expressions of the same problem: whose interest is being served when data are gathered, written up and rewarded.

What this topic genuinely owns is the ethics specific to doing and reporting research: the way the general duties are re-shaped in the research setting, the Indian regulatory frame for clinical research, the management of competing interests, and the integrity of the published record. The principles of biomedical ethics and the elements of valid consent are taught elsewhere in these notes and are only invoked here, never relisted.

19(C)	2018
THE CONDUCT REGULATION TYING RESEARCH TO ICMR GUIDELINES	THE YEAR THE SUSPENDED 2023 CODE CITES FOR THE DRUG-TRIAL RULES

10.1 The dual role: treatment versus research

Clinical care is governed by a primary loyalty to the person in the room, so that, subject to the law and the narrow duties owed to others, everything the psychiatrist does is meant to help the patient being treated. Research answers to a different master. Its purpose is to produce generalisable knowledge, and the participant may gain nothing personally from taking part. This is not a flaw of research; it is its definition, and it is precisely why research needs a stricter apparatus than treatment. The error the examiner is probing is the **therapeutic misconception**: the participant, and sometimes the doctor, believing that study procedures are individualised treatment chosen for this person's benefit, when in fact they are dictated by a protocol and by the needs of the question.

Because the two roles pull in different directions, they must be held analytically apart even when one person carries both. The accompanying comparison sets out the axes on which they diverge, and the pattern to carry is that at every axis the research column demands an external check that clinical care can leave implicit.

AXIS	CLINICAL CARE	RESEARCH
Primary purpose	Benefit this patient	Generate generalisable knowledge
Duty runs to	The individual before you	The participant, whose welfare stays primary over science and society
What consent is to	An offered treatment	Voluntary participation, freely withdrawable
Independent oversight	Clinical governance	A prior, formal ethics-committee review
How risk is justified	Expected benefit to the patient	A favourable balance of risk against knowledge, with added protections

10.2 Informed consent for research

The same requirements, at a higher bar. The requirements of valid consent are taught in full under informed consent in psychiatry in these notes and are not reworked here. What changes in the research setting is their weight and their content. Voluntariness carries far more strain, because the person is often the doctor's own patient and may agree out of gratitude, dependence or fear that refusal will sour their care. The disclosure must be fuller and more honest than a treatment discussion, and it must be explicit about the things a therapeutic conversation can take for granted. A research consent conversation should establish:

- that the activity is research rather than individualised treatment, and what it is trying to find out;
- that participation is voluntary and that refusal will not compromise their ongoing care in any way;
- the right to withdraw at any time, without penalty and without giving a reason;
- the foreseeable risks and burdens, and the honest possibility of no personal benefit;
- the alternatives, including the standard treatment they would receive outside the study;
- how the confidentiality of their data will be protected, the duty and its permitted exceptions being set out under confidentiality and its limits in these notes.

Where a prospective participant's capacity to consent is impaired, as it may be in acute psychosis, severe mood disorder or cognitive impairment, the additional protections of the mental-health law apply, and these are addressed in the Mental health legislation and forensic psychiatry notes. Research involving children carries its own protective framework, addressed in the Child psychiatry: assessment, treatment, services and protection notes. The candidate's task is to name these safeguards and route to them, not to reconstruct them.

TRAP **Treating research consent as ordinary treatment consent.** Candidates assume that a patient who has agreed to be in a trial has consented the way they consent to a prescription. Research consent is a distinct, heavier act: it must name the research nature explicitly, promise that refusal will not affect care, and preserve an unconditional right to withdraw. A consent that a treating clinician obtains from their own patient without these features is the classic setting for the therapeutic misconception, and it is exactly what the examiner wants flagged.

10.3 The Indian regulatory frame

Research on patients or volunteers in India is governed by dedicated national instruments rather than by clinical convention. Under the newer National Medical Commission professional-conduct Regulations, at regulation 19(C), clinical drug trials and other research involving patients or volunteers must comply with **ICMR guidelines** and the **New Drugs and Clinical Trials Rules, 2018** - the year as the suspended 2023 regulation itself records it. Consent that is not taken in accordance with those guidelines shall be construed as professional misconduct. The force of that phrasing repays attention: in that code's own terms a defect in the research consent process is not a documentary technicality but misconduct. Because that code is in abeyance, what makes such a defect actionable today has to be found in the operative conduct code, in the national research guidelines and the drug-trial Rules, and in the conditions of the ethics committee's own approval.

Two layers therefore sit over the same activity. The research-conduct layer routes the study through independent ethics-committee review and the national research guidelines; the professional-conduct layer makes a breach of those requirements a matter for the regulator. A candidate should be able to say that Indian research is anchored to primary national instruments, and should be careful about which conduct code is actually in force, because that is where the confident answer most often goes wrong.

IN INDIA

The practical machinery a clinician meets is the registered ethics committee and the national ethical guidelines for biomedical and health research. Regulated drug trials sit additionally under the New Drugs and Clinical Trials Rules and their consent and oversight requirements. The suspended 2023 professional-conduct code expressly requires the practitioner to disclose the dual role of treating doctor and investigator; independently of that suspended text, such disclosure remains sound ethical practice under the conflict-of-interest and consent principles, so that the participant understands the two hats being worn at once.

PITFALL

Do not cite the newer National Medical Commission Regulations as the professional-conduct code currently in force. They were notified and then held in abeyance, so the earlier Medical Council of India professional-conduct code remains the operative one. The codes themselves are set out under the Indian Psychiatric Society code of ethics in these notes; here the point is only that the research and conflict-of-interest duties are read from the code that actually governs, not from a notified-but-suspended one.

10.4 Conflict of interest

A **conflict of interest** arises whenever a secondary interest threatens to distort the primary duty owed to the patient or participant. The secondary interest need not be sinister: industry sponsorship, a gift or honorarium, academic advancement, the desire to publish, or simply the pressure to meet a recruitment target can all bend judgement without any conscious intent to do harm. That is why the profession treats the situation, and not merely the bad act, as the thing to manage.

The code does not pretend such situations can always be abolished. It requires the practitioner to recognise them, and to avoid or minimise them; where a conflict cannot be removed, the patient's interest should take precedence over any other consideration, and the honest course is to disclose the competing role rather than conceal it. In the research setting this bites hardest when the investigator is the patient's own psychiatrist, which is why separating the consent conversation from the treating relationship is the single most protective step available.

RULE **Disclosure does not resolve a conflict; it only makes it visible.** Naming a competing interest is the beginning of managing it, not a substitute for putting the patient first. Where the two genuinely cannot be reconciled, it is the research that yields, not the patient's welfare.

GOOD TO REMEMBER

Whenever you recruit your own patient into a study, say so out loud. Name your dual role, make explicit that declining will not change their care, and record that you did both. Routing the consent through an independent colleague, rather than obtaining it yourself at the bedside, protects the patient from the therapeutic misconception and protects you from the charge of exploiting the relationship. The ethics committee's part in this is the prior review that approves the consent process; it does not take the consent for you.

10.5 Publication and research integrity

The published record is the currency of science, and guarding its integrity is an ethical obligation continuous with the duties owed to participants. If consent protects the person, publication ethics protect everyone who will later rely on the result. Authorship is the first pressure point: it should reflect a genuine substantial contribution together with accountability for the work, and the recognised authorship criteria exist to keep credit and responsibility joined. Where they come apart, the familiar abuses appear:

- **gift authorship**, awarding or accepting authorship without a real contribution, often to a senior figure;
- **ghost authorship**, omitting a genuine contributor, classically an industry-employed writer;
- **redundant publication**, presenting the same data as though new, including slicing one study into several thin papers;
- **plagiarism**, presenting another's work, words or ideas as one's own;
- undisclosed conflicts of interest, and the selective or non-reporting of unwelcome results.

Beneath these lie the cardinal breaches of integrity, the ones that corrupt the data themselves rather than the credit around them. Prospective registration of trials, transparent reporting of methods and outcomes, and a willingness to share data are the countermeasures the field has adopted, and they matter clinically because the psychiatrist at the other end of the literature prescribes on the basis of what was published.

MNEMONIC

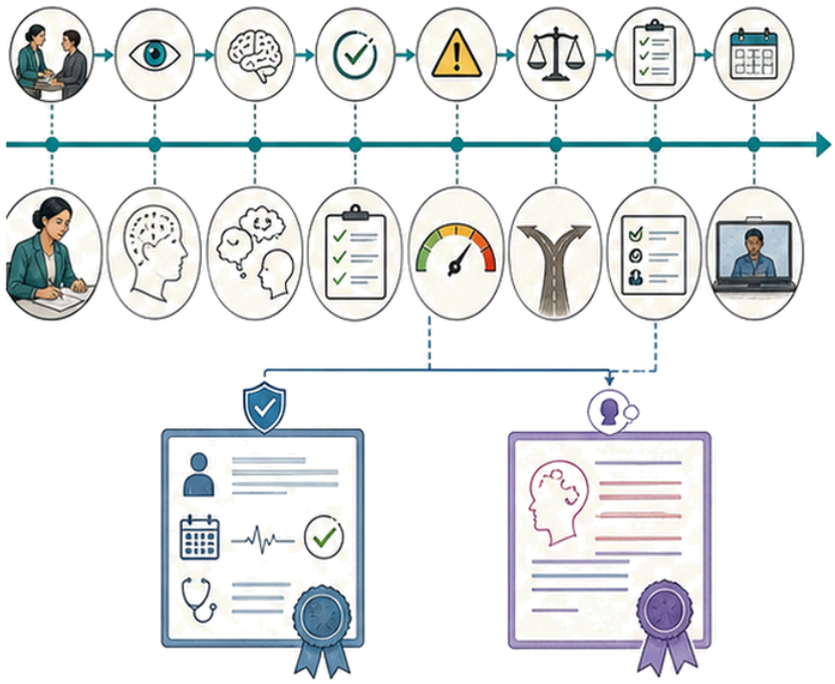
Fabricate, Falsify, Plagiarise

The three cardinal breaches of research integrity: inventing data that were never collected, altering data that were, and passing off another's work as one's own. Everything else, from gift authorship to redundant publication to a hidden conflict of interest, erodes the record more quietly, but these three are the ones that make a result simply false.

Research does not suspend the psychiatrist's duty to the patient; it adds a second, competing duty, and when the two collide the patient's welfare comes first. In India the research and conflict-of-interest duties are read from the professional-conduct code that is actually operative, research on patients or volunteers must comply with the national research guidelines and the drug-trial Rules, and a consent taken outside them is a substantive breach and not a paperwork slip, though which code makes it actionable depends on the code in force.

11 · Medical records, documentation and certification standards

Every duty in this chapter leaves a paper trail, and the paper is where the duty is proved or lost. Consent, the mental state examination, the risk assessment, the disclosure made to a third party, the opinion handed to a court - each of these is invisible after the encounter unless it was written down, so the record is the physical substrate on which the whole of forensic ethics rests. The marks in this topic are for knowing what a defensible record contains, how long it must be kept and who may see it, and the standard a psychiatrist is held to when signing a certificate. These are discrete, quotable points, and each is a place a hurried clinician, and a hurried candidate, comes to grief.



- Contemporaneous
- Objective
- Relevant negatives
- Clinical reasoning
- Plan and review
- Certificate: fact before opinion

Fig 26.8 A defensible psychiatric record is contemporaneous, objective and sufficient to show assessment, relevant negative findings, clinical reasoning, decisions and review. A certificate separates verified fact from professional opinion and states its purpose.

This fragment owns the record itself: its making, its keeping and the certificates drawn from it. It does not own the confidentiality rule that governs when the contents may be released, which belongs to the separate account of confidentiality and its limits in this chapter; nor the professional-conduct code whose provisions it applies, which belongs to this chapter's account of the professional-conduct codes. Keeping those boundaries clear - the document here, the disclosure rule there, the code elsewhere - is the discipline the examiner is testing.

11.1 Why the record carries the marks

The **medical record** is at once a clinical instrument and a legal document, and the two functions pull in the same direction. Clinically it is the memory of the treating team, the substrate of continuity when care passes between hands, and the audit trail that lets a later reviewer reconstruct what was known and decided at each point. Legally it is the doctor's first and best evidence: in any dispute over what was done, the contemporaneous note carries a weight that

recollection years later cannot, because it was made before anyone had a reason to shade the account. The medicolegal maxim - that what is not recorded is, in the eye of the court, treated as not done - is less a rule of evidence than a warning about the burden a silent chart throws back on the doctor.

Psychiatry sharpens this. The findings a psychiatrist relies on - the form and content of thought, the assessment of capacity, the judgement that a patient did or did not pose a risk - are matters of clinical opinion that leave no radiograph and no laboratory value behind them. If the reasoning is not on the page there is nothing to show it was ever done, and a note that records only a conclusion is far weaker in defence than one that shows the work.

> In law a clinical entry that was never recorded is hard to prove was ever done, and a silent chart throws the burden back on the doctor, so the record is the psychiatrist's primary evidence of what was known and decided.

11.2 The anatomy of a defensible entry

A record earns its evidentiary weight through the manner of its making. The qualities a court looks for, and that distinguish a defensible chart from a liability, are few and can be stated plainly:

- **Contemporaneous.** Made at the time of the encounter or as soon as practicable after it, so that the entry precedes any dispute and cannot be said to have been composed for the occasion.
- **Legible and attributable.** Readable, dated and timed, and signed with an identifiable name and designation, so that every entry can be traced to an author.
- **Accurate and factual.** Recording observation and reasoning, not speculation or gratuitous remarks about the patient, which serve no clinical purpose and read badly when the file is opened in public.
- **Complete for its purpose.** Carrying the findings, the assessment and the plan, and, for the decisions that matter medicolegally, the reasoning - the consent taken, the capacity judged, the risk weighed.
- **Unaltered.** Corrected only in the open: an error struck through with a single line that leaves the original readable, initialled and dated, never erased, overwritten or made to disappear.

The last of these is the one that turns a weak case into an indefensible one. An honest error in a note is forgivable and often irrelevant; a note that has been quietly changed after the event destroys the credibility of the whole record and, with it, the doctor's. This is why **tampering** - backdating, insertion, obliteration - is treated so gravely, and why the correct way to amend is always additive and transparent rather than concealing.

RULE **A record's value is a function of its being contemporaneous and unaltered; a correction is made by open amendment, never by erasure.** The point is not perfection at the moment of writing but honesty over time. An entry made late should be dated to the true date of writing and marked as retrospective, not slipped in under an earlier date, and an error should be struck through so the original stays legible, with the correction, initials and date beside it. A chart that can be shown never to have been secretly changed will defend a clinician who erred in good faith; a chart that has been doctored will sink one who did not.

GOOD TO REMEMBER

Write the note as though it will be read aloud in a courtroom with the patient present, because one day it may be. Record the reasoning behind decisions that carry legal weight - why capacity was accepted, why a risk was judged manageable - not just the conclusion. If you must add to a note after the event, say so openly and date the addition to the day you wrote it; the habit costs seconds and is the best protection you have.

11.3 Retention, ownership and the patient's right of access

Two questions follow the making of a record: how long it must be kept, and who may have it. On ownership the settled position is that the custodian - the institution or the self-employed practitioner - holds and preserves the physical record, while the patient has an enforceable right of access to the information within it and to a copy of it. The patient is entitled to a copy, not to carry off the original, and the duty to supply it runs to the patient, an authorised attendant, or a legal authority making a proper request.

3 years
INPATIENT RECORD RETENTION UNDER THE 2023 REGULATIONS (IN ABEYANCE)

5 working days
SUPPLY OF RECORDS ON A PROPER REQUEST

Currency is where this topic is won or lost. The clearest recent statement of a retention standard is the National Medical Commission's Registered Medical Practitioner (Professional Conduct) Regulations 2023; but those Regulations, though notified, were held in abeyance shortly afterwards and are therefore not the operative code. The live professional-conduct code remains the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002, whose provisions are set out in this chapter's account of the professional-conduct codes. Read with that caveat, the 2023 Regulations provide at Regulation **13** that a self-employed practitioner shall maintain inpatient medical records for **3 years** from the date of last contact with the patient, in a standard **proforma** laid down by the Commission, and that records requested by the patient, an authorised attendant or a legal authority shall be supplied within **5 working days**. The same regulation would also require records to be fully digitised in due course, in compliance with information-technology and data-protection law. All of this describes the suspended 2023 text, not a prediction of the eventual operative code, which a further Gazette notification could revive, amend or replace; the requirement that binds a practitioner today is the one the operative 2002 code lays down.

TRAP **Quoting a retention period without the event it runs from, or across the wrong code.** Under the suspended 2023 Regulations the inpatient clock runs from the date of last treatment contact, not from admission and not from discharge, so a return for follow-up would reset it; the operative 2002 code's own starting point is owned by this chapter's account of the professional-conduct codes and must not be assumed identical to the suspended one. Candidates who quote a bare number of years without its starting point answer half the rule, and the starting point is exactly the half an examiner tests. State the period, the event it runs from, and which code you are quoting, or the figure means nothing.

IN INDIA

Access to records in India runs on parallel tracks. The professional-conduct code obliges the treating practitioner to furnish records on request; for a public hospital the same information is reachable through the right-to-information machinery; and the Mental Healthcare Act carries its own provisions on records and on a patient's access to information, which belong to the Mental health legislation and forensic psychiatry notes and are named, not restated, here. What may actually be released, and when confidentiality is set aside, is governed not by the retention rule but by the duty of confidentiality set out in this chapter's account of confidentiality and its limits.

PITFALL

Quoting the National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations 2023 as the code in force. They were notified and then held in abeyance, and the operative professional-conduct code remains the Indian Medical Council Regulations 2002. Citing them as live - in a report, an opinion or an examination answer - states as currently binding a code that commenced on publication but was then held in abeyance, and is the commonest currency error here. Name the 2002 code as operative and the 2023 Regulations as notified but in abeyance.

11.4 Certification and the duty of truthful attestation

A **medical certificate** is a formal attestation, over the doctor's signature, of a clinical fact - fitness or unfitness, the presence or absence of illness, a capacity or its lack. Its authority rests entirely on two things: that the signing doctor personally examined the patient and formed the opinion, and that the record behind it supports what the certificate asserts. A certificate is thus only as good as the notes from which it is drawn. The governing duty is truthfulness: the practitioner attests only what has been personally verified and does not issue a false, misleading or loosely worded certificate, a failing the professional-conduct code treats as misconduct, as set out in this chapter's account of the professional-conduct codes.

Psychiatric certification spans a distinctive range, and each type carries its own evidential demand:

CERTIFICATE	WHAT IT ATTESTS	WHAT THE RECORD MUST SHOW
SICKNESS AND FITNESS	Unfitness for, or fitness to resume, work or duty over a stated period	Dated examination findings and the functional basis for the opinion
MENTAL ILLNESS OR SOUNDNESS	The presence or absence of a mental disorder for a defined legal purpose	A recorded mental state examination and the clinical reasoning behind the finding
TESTAMENTARY AND OTHER CAPACITY	That the person could, at the material time, understand and weigh a specific decision	A contemporaneous, decision-specific capacity assessment, ideally at the time of the act
DISABILITY CERTIFICATION	The degree of disability arising from a mental condition, for statutory benefit	Assessment against the applicable schedule, with the instrument and findings on file

Two need a word of care. The **testamentary capacity** certificate is decision-specific and time-specific: it speaks to the person's ability to make a particular disposition at the particular moment, so a general statement of soundness recorded weeks before or after is of little value, and the strongest evidence is a capacity assessment documented at the time of the act itself. And a certificate touching a person's fitness to face criminal proceedings engages criteria that are not this fragment's to teach - the fitness-to-stand-trial criteria belong to the Mental health legislation and forensic psychiatry notes and are named, not restated, here; what this topic owns is the standard for the certificate and the record beneath it, not the legal test it serves.

11.5 When the record becomes evidence

The record's final role is one the clinician does not control. A chart can be summoned to court, produced under a legal authority's request, or made the foundation of an expert opinion, and at that point every quality discussed above is examined by an adversary. The treating record and the forensic report are different documents made for different masters - the first for the patient's care, the second for the court - and the discipline of keeping the treating role separate from the expert role belongs to this chapter's discussion of the psychiatrist as expert witness, named here rather than reworked. What the records topic contributes is the raw material: an opinion offered to a court is only as sound as the contemporaneous notes it is built on, and a report that cannot point back to a dated, unaltered record is opinion floating free of evidence. This is why documentation is not clerical housekeeping but the load-bearing wall of forensic practice, the place where good clinical care and defensible legal standing turn out to be the same thing.

12 · Ethical issues in involuntary treatment, restraint and end-of-life care

Every coercive act in psychiatry has to be justifiable to the person it is done to. Involuntary treatment, physical restraint and decisions about life-prolonging care are the three moments at which what a person wants is most openly at stake: the first two override an expressed wish, while withholding or withdrawing life-prolonging treatment is often instead the way a capacitous refusal or a recorded wish is honoured. They are examined together because one ethical spine runs through all three: coercion is defensible only as the narrowest, most proportionate response

to a genuine necessity, and it must stay answerable to the person's own will and preferences. The statutory machinery that gives that spine force - the emergency-treatment power, the prohibited and restricted procedures, the seclusion-and-restraint provision and the advance directive - is set out in the Mental health legislation and forensic psychiatry notes and is named here, not re-worked.

The four principles of biomedical ethics are invoked by name rather than re-defined, as laid out in this chapter's account of the principles of medical ethics; valid consent belongs to its account of informed consent in psychiatry, and the legal safeguards around seclusion and restraint to its account of the legal aspects of seclusion, restraint and involuntary treatment. What this topic owns is narrower: how those principles are weighed when a patient refuses the treatment thought to be in their interest, and how the weighing shifts from acute crisis, through restraint, to the end of life.

12.1 The ethical spine: least restriction, proportionality and will

Three ideas together decide whether an override of a patient's choice can be defended. The first is the **least restrictive alternative**: of the options that meet the clinical need, the one chosen must intrude least on liberty, bodily integrity and dignity, so restraint is used only when nothing milder will do and is stepped down the moment a gentler option becomes safe. The second is **proportionality**: the degree and duration of coercion must match the seriousness and imminence of the harm it prevents, so open-ended control is never the answer to a transient risk. The third, which most separates the current Indian frame from older paternalism, is that care must be anchored to the person's **will and preferences** - what this patient, knowing themselves, would want - not what a clinician judges good for a generic patient in that position.

These five conditions - necessary, proportionate, least restrictive, time-limited and reviewable - turn a vague sense that coercion is regrettable into a standard testable at the bedside and in the witness box. A measure that fails any one is not merely suboptimal; it is unethical, and increasingly unlawful.

RULE **Coercion is justified only as the least restrictive measure proportionate to a genuine and present necessity, and only for as long as that necessity lasts.** This one sentence is the whole topic in miniature. The question is never simply "is this good for the patient" but "is this the mildest thing that will meet a real and immediate danger, and can I stop it the moment the danger passes". Every rule that follows is an application of it.

MNEMONIC

Necessary, Proportionate, Least-restrictive, Time-limited, Reviewable

The five tests any coercive measure must pass. **N**ecessary (no non-coercive route will do); **P**roportionate (matched to the danger); **L**east-restrictive (the mildest effective form); **T**ime-limited (no longer than the necessity); **R**eviewable (open to reassessment and challenge). A measure you can defend on all five, you can defend anywhere.

12.2 Involuntary treatment and the narrow window of emergency

Treatment given against a refusal is the sharpest form of coercion, and the ethical burden is correspondingly heavy. It rests not on the fact of illness or the clinician's confidence that treatment would help, but on necessity, the absence of a less intrusive route, and wherever possible a substitute decision made through the person's chosen representative. Indian law keeps the power to treat outside ordinary consent exceptional and tightly bounded. The Act's emergency-treatment provision allows treatment only where it is immediately necessary to prevent death or irreversible harm, serious harm by the person to self or others, or serious damage to property flowing from the illness; where the nominated representative is available, emergency treatment is subject to their informed consent; and, most tellingly for proportionality, the power is capped in time. Emergency treatment is limited to **seventy-two hours**, or until the person is assessed at a mental health establishment, whichever comes first, and may extend to **seven days** only during a disaster or emergency declared by the appropriate Government.

Two features are ethically load-bearing. It is a bridge, not a treatment plan: it holds a person safely until proper assessment and consent can happen, which is why it expires. And it is no licence for any intervention the clinician thinks necessary; the emergency power shall not extend to electroconvulsive therapy, which cannot be given under cover of emergency at all. The detailed conditions are set out in the Mental health legislation and forensic psychiatry notes; what matters here is the shape - a power that is necessary, proportionate and self-terminating.

> **GOOD TO REMEMBER**
>
> Your defence for an emergency intervention is a contemporaneous note of the specific danger, the less restrictive options you weighed and why they failed, and the point at which you sought the nominated representative. "The patient was unwell" is not a justification; "the patient was about to act on a command to jump and refused oral medication" is. Record it while it is in front of you: the power is short-lived and the note is what proportionality is later judged against.

12.3 Restraint and seclusion: the least-restrictive ladder

Physical containment is where least restriction does its hardest work, because the measures form a ladder and the demand is to stay as low on it as safety allows and climb down fast. Restraint manages an immediate risk; it is never a treatment or a convenience, uses minimum force for the shortest duration that will contain the danger, and is released the moment that danger recedes.

- **Verbal de-escalation and environmental measures:** the first resort whenever it is safe and feasible, and often enough on their own; the least intrusive rung. Immediate physical restraint may still be required where it is the only means available to prevent imminent and immediate harm.
- **Seclusion and solitary confinement:** not a rung on the ladder at all; a person with mental illness shall not be subjected to seclusion or solitary confinement, which are barred outright and cannot be made lawful by monitoring or a time limit.
- **Physical restraint:** the highest rung short of the floor, minimum force for the shortest time; its exact authorisation and monitoring safeguards are set out in the Mental health legislation

and forensic psychiatry notes.

How physical restraint may lawfully be used, and its safeguards, belongs to the Mental health legislation and forensic psychiatry notes and to this chapter's account of the legal aspects of seclusion, restraint and involuntary treatment; seclusion and solitary confinement of a person with mental illness are prohibited outright. What the ethics fixes as an absolute is the floor beneath the ladder: no person with mental illness **shall be chained** in any manner or form whatsoever, and the bar holds because chaining is degrading regardless of the danger it might contain. Below a certain point, restraint stops being a graded response and becomes an assault on dignity, and the law draws that line without exception.

12.4 The absolute bars and the one conditional gate

The clearest ethical teaching here is the small set of procedures the law places out of bounds, each a point where consent and best interests are judged insufficient protection. Three are absolute. **Unmodified electroconvulsive therapy**, meaning electroconvulsive therapy given without muscle relaxants and anaesthesia, is prohibited outright and cannot be rescued by consent, because the harm it risks is not one a patient can validly agree to run. Sterilisation intended as a treatment for mental illness is prohibited, closing off a historic abuse in which reproductive capacity was removed under a therapeutic pretext. And chaining is barred in any form. The single conditional gate is electroconvulsive therapy for a minor: prohibited by default, but where the psychiatrist in charge of the minor's treatment is of the opinion that it is required, it shall be given only with the informed consent of the guardian and the prior permission of the concerned Board. The structure to carry is an absolute prohibition softened by a narrow, externally checked exception, not by clinician discretion alone.

MEASURE	ETHICAL AND LEGAL STATUS	WHAT THE FLOOR TURNS ON
CHAINING, IN ANY FORM	Barred absolutely	Degrading regardless of the danger contained
UNMODIFIED ELECTROCONVULSIVE THERAPY	Barred absolutely; consent cannot cure it	A harm a patient cannot validly agree to run
STERILISATION AS A TREATMENT FOR MENTAL ILLNESS	Barred	Closes a historic reproductive abuse
ELECTROCONVULSIVE THERAPY FOR A MINOR	Barred by default; a narrow gate	Guardian's informed consent plus prior Board permission
EMERGENCY INVOLUNTARY TREATMENT	Permitted but tightly bounded	Time-limited, and excludes electroconvulsive therapy

TRAP **Believing that consent can license an absolutely prohibited procedure, or that a grave enough emergency justifies electroconvulsive therapy.** Candidates reason that guardian or patient consent makes unmodified electroconvulsive therapy or a "therapeutic" sterilisation permissible, and that a serious enough emergency lets a clinician reach for electroconvulsive therapy. Both are wrong: the absolute bars operate above the level of consent, and the emergency power is defined so as to exclude electroconvulsive therapy. Consent is a gateway for permitted treatment, not a key to prohibited treatment.

12.5 End-of-life care: autonomy at the close of life

The same spine bends at the end of life, but it does not break. End-of-life care tests the will-and-preferences principle at its limit, because the patient may be dying, may have fluctuating or absent capacity, and may have recorded wishes long before the crisis. The psychiatrist's role is often not to decide but to assess: whether this patient can accept or refuse a life-prolonging intervention, and whether a treatable mental illness, depression above all, is so distorting the decision that an apparent wish to die is a symptom to treat rather than a settled preference to honour. Making that discrimination well, and documenting it, is the examinable core of the psychiatrist's end-of-life contribution.

Three distinctions carry the ethical weight. A refusal by a person with capacity, or through a valid advance instruction, is not the same as a request that the clinician actively bring about death; respecting the first is autonomy, the second a separate legal and moral question. Withholding or withdrawing an intervention of no proportionate benefit is not abandonment, because comfort, symptom relief and dignity are owed whatever else is stopped. And the **doctrine of double effect** is the frame invoked for proportionate sedation or analgesia given to relieve suffering where shortening of life is a foreseen risk rather than the aim; a relief-directed intention is necessary to it, but the doctrine's conditions are not reducible to intention alone, so it cannot be cited as a single-condition licence. Wishes recorded in advance should guide care as an expression of will and preferences; the statutory form and force of the advance directive belong to the Mental health legislation and forensic psychiatry notes.

12.6 Will and preferences over best interests

The deepest change the current Indian frame makes is a shift of default. The older posture was best-interests: the clinician decided what was good for the patient and acted on it. The newer posture is **supported decision-making**, in which the patient's own will and preferences govern and the clinician helps the person exercise their capacity rather than substitute a judgment for it. Coercion does not vanish but retreats to the margins, permitted only where a real necessity cannot be met any other way. The broader disability-rights statute underpinning this posture is set out in the Mental health legislation and forensic psychiatry notes.

> **PITFALL**
>
> The commonest real-world error is not cruelty but well-meant paternalism: a clinician sure they know best treats "best interests" as the deciding standard and reads the patient's stated wishes as an obstacle to manage rather than the thing that governs. Under a will-and-preferences frame that inversion is itself the fault. Start from what the person wants, treat capacity as something to be supported rather than presumed absent, and reserve override for genuine, documented necessity.

IN INDIA

The current mental health law is explicitly rights-based: it abolishes chaining outright, channels the most invasive procedures through consent and independent review, keeps the emergency power short and ring-fenced from electroconvulsive therapy, and subordinates treatment to the person's will and preferences rather than an unaided best-interests judgment. The working question shifts from "what is best for this patient" answered alone to "what does this patient want, and what is the least I must do to keep them safe".

94
EMERGENCY TREATMENT: TIME-LIMITED, AND NO ELECTROCONVULSIVE THERAPY

95
PROHIBITED PROCEDURES: CHAINING, UNMODIFIED ELECTROCONVULSIVE THERAPY, STERILISATION

One test governs involuntary treatment, restraint and end-of-life care: coercion is permissible only as the least restrictive, proportionate response to a genuine and present necessity, no longer than that necessity lasts, and always anchored to the person's will and preferences rather than the clinician's unaided view of their best interests; chaining and unmodified electroconvulsive therapy are barred absolutely, sterilisation as treatment is barred, and electroconvulsive therapy for a minor is permitted only through guardian consent and prior Board permission.

13 · Telepsychiatry ethics and social media professionalism

Why the marks are here. Telepsychiatry moved from a fringe convenience to routine practice almost overnight, and the ethics did not keep pace with the technology. The examiner's interest is precise: does the candidate understand that a consultation delivered down a video link owes the patient exactly the same duties as one delivered across a desk, and does the candidate know which code actually governs it in India today. Both halves of the topic - the clinical encounter conducted remotely, and the doctor's separate life on social and public media - test the same instinct, which is that the medium never dilutes the obligation. The currency of the governing rules has also shifted recently, and that shift is a favourite trap.

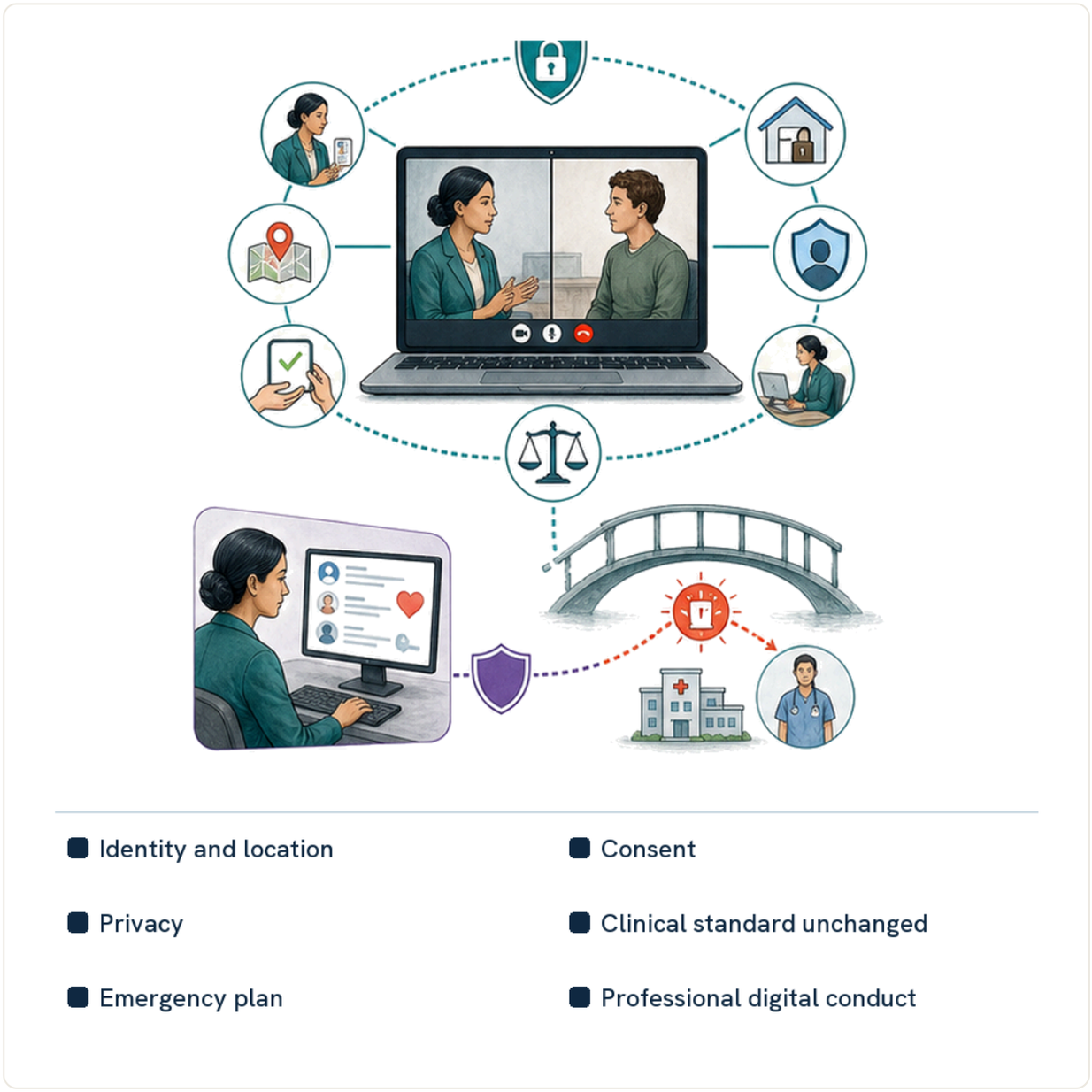


Fig 26.9 Telepsychiatry changes the medium, not the clinical standard. Identity and location, consent, privacy, documentation and an emergency contingency are established for remote care, while public and social-media conduct remains professionally bounded.

What this section owns is the ethics of remote consultation and of a psychiatrist's conduct in the public digital sphere. The four principles that frame every ethical judgement are set out with the principles of medical ethics in these notes; the anatomy of valid consent is taught with informed consent in these notes; the default duty of confidentiality and the closed list of when a disclosure is permitted are taught with confidentiality and its limits in these notes; and the professional-conduct code itself is treated with the professional-conduct codes in these notes. Those are invoked here, not restated.

13.1 What telepsychiatry is, and why the medium raises the stakes

Telepsychiatry is the delivery of psychiatric assessment, treatment and consultation through information and communication technology when patient and clinician are not in the same room. It spans real-time video and telephone contact and the store-and-forward exchange of clinical information, and it reaches rural and underserved populations that would otherwise

never see a psychiatrist. That reach is its ethical justification and also its hazard: a discipline whose primary instrument is the interview loses part of that instrument at a distance. Subtle motor signs, the smell of alcohol, the atmosphere of a household, the collateral in the waiting room - a proportion of the mental-state examination simply does not travel down a video link. The ethical task is to decide, case by case, whether what remains is enough to discharge the standard of care, and to recognise when it is not.

The peculiar risk of psychiatry is that the high-risk presentations a remote service must be ready for - acute distress, suicidality, psychosis with impaired insight - are exactly those in which a remote encounter is least able to contain risk. Convenience and access must therefore be weighed against the clinical adequacy of the channel, not assumed to settle the matter.

13.2 The regulatory basis, and the currency question

Telepsychiatry in India is not a legal vacuum, but candidates routinely cite the wrong instrument as its source. The recently notified National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations address it directly: at Regulation **29**, consultation by telemedicine *is permissible*, but only on the condition that it follows the **Telemedicine Practice Guidelines**. That conditionality is the point: the permission and its precondition are a single rule, and telemedicine detached from the Guidelines is not authorised practice. The Guidelines themselves supply the operational scaffold - the modes of consultation, the identification of both parties, the framework for prescribing at a distance - which is applied, not reproduced, here.

The currency trap sits one layer up. Those Regulations came into force on publication but were then held in abeyance and are **not** currently operative; the code that actually governs a psychiatrist's conduct remains the earlier Medical Council of India professional-conduct code, treated with the professional-conduct codes in these notes. The safe posture in the exam and in practice is to take the substance of remote-consultation practice from the Telemedicine Practice Guidelines themselves, and to treat that regulation as notified-but-suspended text rather than transplanting it into the live code. A written answer that names the newer Regulations as the operative code is stating a code that came into force on publication but was then held in abeyance and is not currently operative.

IN INDIA

Remote consultation received its first clear national footing through the Telemedicine Practice Guidelines, later carried into the newer National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations at Regulation **29**. Those Regulations stand notified but in abeyance; the operative statutory code is still the Medical Council of India professional-conduct code, taught with the professional-conduct codes in these notes. Ground your answer in the live code and read the newer provision for its content.

13.3 Consent, confidentiality and the standard of care at a distance

Every ethical obligation of an in-person consultation survives the move to a screen; what changes is the effort needed to satisfy it. Valid consent, whose three elements are taught with informed consent in these notes, must additionally cover the modality itself: the patient should understand

that this is a remote consultation, its limits, what happens if the connection fails, and how an emergency will be handled. Confidentiality is governed by the same default duty and the same closed list of permitted disclosures taught with confidentiality and its limits in these notes; the remote setting does not create a fresh licence to disclose, but it multiplies the ways confidentiality can leak - an unsecured platform, a household member off-camera, a session recorded without consent, records held on a personal device. The **standard of care** is the anchoring construct: it is set by what a reasonable psychiatrist would do, and it does not fall because the encounter is remote.

OBLIGATION	IN-PERSON CONSULTATION	TELEPSYCHIATRY CONSULTATION
Consent	To assessment and treatment	Also to the remote modality and its limits
Standard of care	Reasonable clinical practice	The same standard, or refer to in-person care
Confidentiality	The room and the record	The platform, the setting at both ends, the stored data
Identity	Established directly; verified where required	Actively verified for patient and clinician
Emergency and risk	Managed in the room	Needs a pre-agreed local escalation plan

RULE **The medium changes the method, never the duty.** A remote consultation is held to the same standard of care, the same consent and the same confidentiality as a face-to-face one. Where the channel cannot support that standard for a given patient, the ethical answer is to convert to in-person care, not to lower the bar to fit the link.

TRAP **Believing the duties relax because the encounter is remote.** Candidates treat telepsychiatry as a lighter form of practice with softer obligations. The reverse is true: the same duties apply, and several - identity, confidentiality, emergency planning - actually demand more work to discharge at a distance.

13.4 When a remote encounter is not enough

Recognising the limits of the channel is itself an ethical duty, because persisting with an inadequate medium is a breach of the standard of care. Remote consultation is poorly suited, and often should give way to in-person assessment, in situations such as:

- acute suicidality or a patient who cannot be kept safe remotely;
- a first presentation of possible psychosis where insight and reality-testing must be examined directly;
- the need for a physical examination, an injectable, or supervised administration;
- a patient who cannot consent to or operate the technology, or lacks a private space;
- any encounter where identity, or the presence of a coercive third party off-camera, cannot be assured.

None of these forbids telepsychiatry outright; each demands a judgement that the remote channel can still deliver safe care, and a readiness to escalate to a physical review when it cannot.

13.5 Social media and public professionalism

A psychiatrist's conduct online is a professional matter and not merely a private one: the duties of confidentiality, restraint in advertising and general professional conduct that the operative code imposes follow the doctor onto the screen. The newer Regulations go further and address the medium directly: at Regulation **20**, a practitioner's conduct on social, electronic and print media *shall follow* the prescribed **Social Media Guidelines**, a dedicated framework that stands notified but in abeyance with the rest of that code. That provision is the codified form of what is better called **digital professionalism**: the recognition that a doctor carries the profession's standards into every public post. The recurring failures are specific to psychiatry. Confidentiality is breached by a case detail vivid enough to identify a patient even when the name is withheld. Boundaries erode when a treating psychiatrist accepts a patient's friend request or drifts into personal messaging, blurring the therapeutic frame that the work depends on. And the reach of a post multiplies both harms: an indiscretion that a corridor would swallow can travel to thousands. The corrective is to treat every public communication as though a patient, a colleague and a regulator will all read it, because any of them may.

GOOD TO REMEMBER

Keep one clear line between a professional presence and a personal account, and never take a treating relationship into either. Do not accept patients into your private social networks, do not discuss identifiable cases even in disguised form, and assume any post is permanent and public. If you use messaging for clinical contact, agree its scope with the patient and keep it inside the record, not on a personal phone.

13.6 Advertising, self-promotion and the boundary of legitimate announcement

The same conduct code that governs the consulting room governs how a psychiatrist may present a practice to the public, and here too the digital age has widened the temptation. The newer Regulations draw the line tightly: at Regulation **11** a practitioner may make only limited formal announcements - the starting, change or resumption of practice, a change of address, and a declaration of charges - and an institutional advertisement may not carry more than the name, the type of patients treated, the staff, the facilities and the fees. Everything beyond that factual minimum, particularly the soliciting of patients or the claiming of superiority, falls outside what an announcement may contain. The principle is old and survives the change of medium: a doctor informs the public of a service, and does not tout for custom. A polished website, a sponsored post or a testimonial reel is subject to the same restraint as a newspaper notice once was.

PITFALL

The commonest real-world error on this topic is citing the newer National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations as the operative code. They came into force on publication and were then held in abeyance, so a clinician who governs their advertising, telemedicine or social-media conduct by them alone is following rules that are not currently in force. The live code remains the Medical Council of India professional-conduct code, taught with the professional-conduct codes in these notes; read the newer provisions for substance but comply with the code that is actually operative.

Whatever the channel - a video link, a public post or an advertisement - the psychiatrist owes the same duty of care, confidentiality and honesty, and the currently operative code is the Medical Council of India professional-conduct code, not the newer Regulations still held in abeyance.

Disaster, prisoners and forensic special topics

14 · Disaster Management Act 2005 (psychiatric relevance)

A disaster statute earns its place on a forensic syllabus because it is administrative law the psychiatrist has to work inside, not around. Mass-casualty events - floods, earthquakes, industrial and transport accidents, epidemics - produce a predictable surge of acute stress reactions, grief, sleep disturbance, exacerbation of pre-existing illness and, in a minority, persistent post-traumatic and depressive morbidity. The clinician who wants to deliver care in that setting does not command the response; a statutory authority does. The examinable content is deliberately narrow: the architecture the Act builds, who heads each level of it, what the Act says disaster management is, and - the point most candidates miss - what it conspicuously does not say. Get those, and you can locate the psychiatric role precisely; miss them, and you will keep looking for a legal mandate the statute never wrote down.

Teach this as what it is: a piece of administrative machinery. The Act does not create clinical duties, define capacity, or authorise treatment; those belong to the mental-health statute and are developed in the Mental health legislation and forensic psychiatry notes. What it does is build a chain of authority from the national government down to the individual district, and then define the process those authorities are to run. The psychiatric role has to be read into that structure, because the structure will not hand it over.

14.1 A tiered command structure, not a clinical statute

The Act builds authorities at successive levels of government. It constructs a vertical chain: a national authority at the apex, a mirror authority in every State, and an operational authority in every district. Each is headed **ex officio** by the executive of its level, which is the deliberate design point - disaster response is treated as a whole-of-government function commanded from the top of government rather than by a technical body advising from the sidelines. At the

national and State tiers that head is the elected political executive; at the district tier it is the administrative executive - the Collector, District Magistrate or Deputy Commissioner - sitting alongside an elected local-authority co-chairperson. The comparison below fixes the section, the head and the establishing duty for each level; commit the section numbers, because a report or an answer that misplaces them signals unfamiliarity with the primary Act.

LEVEL	STATUTORY SECTION	CHAIRPERSON, EX OFFICIO	THE ESTABLISHING DUTY
National (apex)	section **3**	the Prime Minister	an authority shall be established for the purposes of the Act
State	section **14**	the Chief Minister of the State	every State Government shall establish an authority for the State
District	section **25**	the Collector, District Magistrate or Deputy Commissioner (co-chaired by the elected local-authority representative)	every State Government shall establish an authority for every district

The chain of authority the Act creates. Note that the head of each level is fixed by office, not appointed for expertise, and that the duty to establish the State and district authorities is mandatory and lies with the State Government.

Read the establishing duties for the modal verb, because it is examinable. At every level the statute is mandatory: the national authority *shall be established*, and every State Government *shall establish* both its State authority and a district authority for every district. There is no discretion in whether the machinery exists. What the Act leaves open is operational - how each authority discharges its functions - not whether it comes into being.

14.2 The apex and the State tiers

The national authority sets the policy floor. At the top the Act establishes the **National Disaster Management Authority**, under the establishment section set out above, chaired ex officio by the Prime Minister with not more than **nine** other nominated members. As the apex body its work is national in scope: it is the source of country-wide policy, plans and guidance, which is exactly why any national statement on how mental-health and psychosocial needs are to be met in disasters is issued from this level rather than written into the parent Act. Hold that distinction, because it explains where the mental-health content actually lives - in guidance under the machinery, not in the sections that build it.

The State authority mirrors the apex. One level down, the Act requires each State to constitute a **State Disaster Management Authority**, under its State-tier section, chaired ex officio by the Chief Minister. Its role is to translate national policy into a State plan and to coordinate the State's departments - health among them - so that a directive from the apex becomes a deliverable service on the ground. For the psychiatrist this is the tier at which mental-health

services are meant to be built into the State's disaster health response, alongside the rest of the health system.

14.3 The district tier, and why it is the one you will meet

This is where response actually happens. The **District Disaster Management Authority**, established under the Act's district-tier section, is the operational cutting edge of the whole structure - the level closest to survivors and the one that runs relief, rescue and coordination on the affected ground. Its chairperson is fixed by office: the Collector, District Magistrate or Deputy Commissioner heads it ex officio, and, distinctively at this level, the elected local-authority representative sits as ex officio co-chairperson, pairing the administrative head with local political representation. A clinician deployed into a disaster response is, in practice, working within this district authority's plan and under the district administration's coordination, not answering directly to the State or national bodies.

MNEMONIC

Prime Minister for the nation, Chief Minister for the State, Collector for the district

The head of each authority is the political or administrative executive of its own level, sitting by virtue of office rather than expertise. Only the district level adds a co-chairperson - the elected local-authority representative - which flags it as the tier where administration and local representation meet the survivor.

RULE **The Disaster Management Act is a chain of administrative authority, not a mental-health statute.** It mandates authorities at national, State and district level, each headed ex officio by the executive of that level, and defines the process they must run. It creates no clinical duty and names no psychiatric service, so the mental-health role must be located within its general functions, not read off an express provision.

14.4 What the Act means by disaster management - and its silence on mental health

The definition is broad, cyclical and process-oriented. The Act defines **disaster management**, at section **2(e)**, as a continuous and integrated process rather than a one-off emergency reaction. That process runs across the whole disaster cycle: preventing danger, mitigating risk and severity, building capacity, preparing to respond, mounting a prompt response, assessing the magnitude of effects, carrying out evacuation, rescue and relief, and finally rehabilitation and reconstruction. The pedagogical point is the shape: the statute conceives of management as spanning the time before, during and long after the event, which is precisely the time-course over which psychiatric morbidity emerges and recovers.

Now the omission that carries the marks. Read that definition again for what is absent. Nowhere in it does the Act name psychosocial or mental-health support as an express limb of disaster management. The functions it enumerates are physical and administrative - risk, rescue, relief, reconstruction - and the psychological dimension is simply not written in as a category of its own. This is not a drafting accident to be corrected in an answer; it is the settled position of

the primary text, and the honest teaching is to state it plainly and then show where the mental-health role has to be fitted instead: inside **capacity-building**, preparedness, response and rehabilitation, each of which can carry a psychosocial component even though none is labelled as such.

> **PITFALL**
>
> Assuming the Act itself contains an express psychosocial or mental-health provision, and then waiting for a statutory mandate that does not exist. Because national guidance on psychosocial support and mental-health services in disasters does exist, it is easy to project that content back onto the parent Act. It is not there. The clinician who understands this does not wait to be named in a section; they embed mental-health care within capacity-building, preparedness and rehabilitation, which is where the general functions leave room for it.

14.5 Locating the psychiatric role within the machinery

The role is real even though the statute is silent. The absence of a named limb does not make mental health optional; it makes it the clinician's job to insert it into the general process the Act defines. Disaster mental-health work maps onto that same cycle. Across it, the psychiatrist's contributions cluster into a few recognisable tasks:

- before the event - training first responders and building local capacity, so that psychological needs are anticipated rather than discovered;
- in the acute phase - **psychological first aid** and the triage of acute distress, distinguishing normal acute reactions from those needing active intervention;
- in relief and rehabilitation - continuity of treatment for people with severe mental illness whose medication and follow-up have been interrupted, and detection of the delayed post-traumatic and depressive morbidity that surfaces weeks to months later.

Continuity of care is the quiet emergency. The most avoidable harm in a disaster is not the new-onset disorder but the interruption of existing treatment: a person already stabilised on psychotropic medication who loses their supply, their prescriber and their records when services collapse. Restoring that continuity, and where necessary arranging care under the ordinary mental-health law, is squarely within the response and relief functions of the district authority, and the legal framework for such care sits in the Mental health legislation and forensic psychiatry notes, not in this Act. The disaster statute tells you which authority coordinates the response; the mental-health statute tells you how care may lawfully be given.

Equity is the ethical hinge. Disaster settings force allocation decisions - whose distress is attended to first when the need vastly exceeds the resource - and the principle of justice in the fair distribution of scarce care is the frame the psychiatrist brings to that. The principles of biomedical ethics are developed elsewhere in this chapter and are invoked, not re-listed, here; what matters for this topic is that the machinery gives you the coordinating authority, and the ethics gives you the priority rule for working within it.

IN INDIA

Because the definition of disaster management names no psychosocial limb, mental-health and psychosocial support in Indian disasters is delivered through guidance issued under the national authority and operationalised down the chain to the district level, rather than through an express section of the Act. In practice the clinician interfaces with the district authority under the Collector or District Magistrate, whose plan coordinates the response on the ground. Read the governing plan and the current national guidance from primary sources rather than from memory, because the Act itself will not point you to the mental-health role.

GOOD TO REMEMBER

If you are deployed, the authority you actually work within is the district one, headed by the Collector or District Magistrate, with the elected local representative as co-chair. That is where you register your service, plug into the coordinated response, and locate mental-health care inside the relief, response and rehabilitation functions. Do not wait for a statutory instruction naming psychiatry; the Act does not give one, and the role is yours to insert.

TRAP **Misassigning the heads of the three authorities.** The apex authority is chaired by the Prime Minister, the State authority by the Chief Minister, and the district authority by the Collector, District Magistrate or Deputy Commissioner, with the elected local-authority representative as co-chairperson. Candidates lose the mark by handing the State authority to the Governor or the district authority to the Superintendent of Police; each head is fixed by office at its own level, and only the district tier carries a co-chair.

3	14	25	2(e)
SECTION ESTABLISHING THE NATIONAL AUTHORITY, CHAIRED BY THE PRIME MINISTER	SECTION REQUIRING A STATE AUTHORITY, CHAIRED BY THE CHIEF MINISTER	SECTION REQUIRING A DISTRICT AUTHORITY, CHAIRED BY THE COLLECTOR	THE DEFINITION OF DISASTER MANAGEMENT

The Disaster Management Act builds authorities at national, State and district level, each headed ex officio - by the Prime Minister, the Chief Minister and the Collector or District Magistrate respectively, the district tier alone carrying an elected co-chairperson. Its definition of disaster management spans the whole cycle from prevention to reconstruction but names no psychosocial or mental-health limb, so the psychiatric role must be located within the general functions of capacity-building, preparedness, response and rehabilitation.

15 · Mental health of prisoners and forensic psychiatry services

Where this topic sits. A prison gathers, into one closed population, almost every risk factor a psychiatrist studies separately: poverty, substance use, head injury, trauma, social exclusion and untreated illness. It then strips away most of what protects mental health. The predictable result is that psychiatric morbidity in custody runs far above the community rate, while the services meant to answer it are thinnest exactly where the need is greatest. This topic asks two linked

questions: what is the mental health of prisoners, and what services, inside the prison and across the wider **forensic psychiatry** system, meet it.

What earns the marks here is not a table of prevalence figures but a service architecture and the single principle that organises it. You are expected to describe how psychiatric care actually reaches a prisoner, to place the Indian statutory backdrop correctly, and to keep a forensic psychiatry service distinct from the medico-legal assessments taught in neighbouring topics. The route by which a mentally ill prisoner is transferred into hospital care is developed in the companion account of the transfer and treatment of mentally ill prisoners, and the dignity and rights framing in the account of human rights and ethical issues in custodial psychiatry; the focus here is the burden and the service response to it.

15.1 The burden: psychiatric morbidity is concentrated in custody

Prisoners carry a marked excess of mental disorder across the whole diagnostic range. Relative to an age-matched community sample, custodial populations show more psychotic illness, more mood and anxiety disorders, far more substance use disorder, a high load of personality disorder, and an over-representation of intellectual disability and acquired cognitive impairment. This is a compounded burden, not a single condition, which is why a prison mental health service cannot be built around one diagnosis. The excess is real, large and consistent across settings; the precise magnitudes vary by jurisdiction and instrument.

Two mechanisms produce the concentration, and a good answer names both. The first is selection: people with mental illness are over-represented among those who enter custody in the first place, through offending linked to untreated illness, homelessness, substance use and the criminalisation of the mentally ill when community care is absent. The second is the effect of custody itself. Juvenile detainees sit under an entirely separate statutory framework and are dealt with in the Child psychiatry: assessment, treatment, services and protection notes; the clinical management of substance withdrawal and dependence in custodial settings belongs to the Substance use disorders notes. Both are named here, not taught.

15.2 Importation and deprivation: why prison generates and worsens disorder

The environment is part of the formulation. The excess morbidity is usually understood through two complementary models. The **importation** model holds that prisoners bring pre-existing vulnerability in with them: prior illness, developmental adversity, substance use and low social capital. The **deprivation** model holds that the custodial environment itself is pathogenic, independent of what a person arrives with. Neither model alone is sufficient; they operate together, and the clinical implication is that a prisoner's disorder cannot be treated as if it were context-free.

The deprivations of custody are specific and psychologically active. Loss of liberty and autonomy, overcrowding, enforced idleness, the threat of violence and bullying, separation from family and children, uncertainty about the future, and the collapse of privacy together constitute a chronic stressor field. Solitary confinement is the most concentrated form and is associated with acute deterioration, self-harm and psychotic phenomena. Because these are environmental

drivers, part of the treatment is sometimes environmental: relocation, occupation, family contact and the removal from isolation, alongside conventional psychiatric care.

15.3 The Indian statutory backdrop: the Prisons Act and its silence

Prison administration in India is still substantially governed by a colonial-era statute, and its treatment of mentally ill prisoners is notable for an absence. The Prisons Act of **1894** contains no substantive stand-alone section devoted to the care of mentally ill prisoners. The only hook is the State Government's rule-making power at section **59**, which at clause **(23)** authorises rules for the treatment, transfer and disposal of criminal lunatics or recovered criminal lunatics confined in prisons. Read the provision precisely: it is a discretionary power under which the State Government *may* make rules, not a substantive duty of care, and it uses the archaic term **criminal lunatic** that both modern law and clinical practice have long abandoned.

The lesson is structural: the primary prison statute does not itself build a mental health service or confer a right to treatment; it merely enables subordinate rules. The substantive machinery for actually moving a mentally ill prisoner into psychiatric care sits elsewhere, combining the older warrant power for removal with the mental-health statute's prisoner-specific provision, and is developed in the companion account of the transfer and treatment of mentally ill prisoners; the general mental-health law machinery belongs to the Mental health legislation and forensic psychiatry notes. That historical silence is why India's prison mental health provision has depended on the later statute, on prison manuals and on the courts rather than on the parent Act.

IN INDIA

The governing prison statute is over a century old and, on mental health, gives only a rule-making power rather than a service. The practical consequence is that a mentally ill prisoner's care depends on the mental-health law, on State prison manuals, and on directions issued by the constitutional courts, rather than on any express care provision in the Prisons Act. When answering, place the substantive rights and transfer route in the mental-health statute and treat the Prisons Act as the historical backdrop, citing the primary Act and clause rather than a remembered figure.

PITFALL

Reading the Prisons Act rule-making power as if it were a substantive care regime, and then treating a mentally ill prisoner's admission or transfer as a matter of prison rules. The enabling clause lets the State make rules; it does not itself authorise clinical care or lawful transfer. The care standard and the transfer route are set by the mental-health law, not by that rule-making power, and a clinician who looks only to the prison statute will not find the authority they need.

15.4 The architecture of forensic psychiatry services

A forensic service is a pathway, not a place. Forensic psychiatry is the subspecialty concerned with the assessment, treatment and risk management of the **mentally disordered offender** and with the interface between psychiatry and the courts. A mature forensic service is not a single

ward but a tiered system that meets the offender at each point of the criminal-justice pathway, from first contact with the police through to eventual return to the community.

SERVICE COMPONENT	WHERE IT OPERATES	PRIMARY FUNCTION
Court liaison and diversion	police station and courts	identify mentally disordered defendants at the earliest point and divert them to health care rather than custody where that is appropriate
Prison in-reach	within the prison	bring specialist mental health assessment and treatment to prisoners in situ, functioning as the prison's equivalent of a community mental health team
Secure forensic inpatient unit	dedicated secure hospital (graded levels of security)	treat offenders who need hospital-level care under conditions of physical, procedural and relational security
Forensic rehabilitation and community forensic team	step-down and community	rehabilitate, supervise and manage risk as the offender transitions out of secure care

The tiers of a forensic psychiatry service, arranged along the offender's pathway. Each tier answers a different need; a system missing any one tier tends to silt up at the level below it, most visibly when the absence of secure beds strands seriously ill offenders in the prison.

The tiers depend on one another. Diversion works only if there is somewhere to divert to; in-reach can identify a prisoner who needs hospital care but cannot deliver it without secure beds; and secure units block if no rehabilitation tier receives their recovered patients. This is why forensic planning is done as a whole system, and why the commonest failure is a bottleneck rather than an absent service.

RULE **Prisoners are entitled to the same standard of health care as the general community.** This is the principle of **equivalence of care**, and it is the organising rule for every prison and forensic mental health service: the fact of imprisonment removes liberty, not the right to health care. It sets the benchmark against which a custodial service is judged, and it is the reason care that would be routine in the community cannot be rationed away simply because the patient is a prisoner. The broader dignity and rights framing is developed in the account of human rights and ethical issues in custodial psychiatry.

15.5 Mental health services within the prison: screening, in-reach and continuity

The service inside the wall begins at the gate. The single most important service element is **reception screening**: a structured assessment at the point of entry, because the early days of custody are the highest-risk window for both crisis and undetected illness. It is not a formality; it is how a service finds the people it must treat before they deteriorate. Its aims are:

- to detect existing serious mental illness and any current treatment that must be continued without interruption;

- to identify acute suicide and self-harm risk in the first, most dangerous nights of custody;
- to flag substance intoxication or impending withdrawal for management under the appropriate protocol;
- to recognise intellectual disability and cognitive impairment that will shape how the prisoner copes and is managed.

From screening, a referral pathway feeds the prison's tiered response: primary mental health care delivered on the wing, specialist in-reach assessment for those who need it, and onward referral for the minority who require hospital-level care, the transfer route covered in the companion account. The quiet failure of prison mental health is discontinuity: care interrupted at the point of entry, or dropped at the point of release, when a person leaves custody without a prescription, a follow-up appointment or a receiving service. Release is a period of markedly elevated relapse and mortality risk.

GOOD TO REMEMBER

Screen at reception and act on it, rather than waiting for breakdown. The prisoners who die or deteriorate are disproportionately those missed in the first days, and the two decisions that change outcomes are continuing established treatment without a gap on the way in, and arranging a warm handover to a community service on the way out. Build the pathway around those two transitions.

15.6 Suicide, self-harm and the crisis end of custodial care

This is where the service is tested hardest. Suicide and self-harm are the sentinel outcomes of a custodial mental health system, and a disproportionate share occurs early in custody, in remand and in the first period after reception, when uncertainty, withdrawal and the shock of imprisonment converge. A credible service therefore runs a suicide-prevention system rather than relying on individual vigilance: identification at reception and at points of change, safer environments, graded observation for those at acute risk, peer support, staff training to recognise and escalate concern, and structured review after every serious incident so the system learns. This is where equivalence of care stops being abstract: the community standard for a person in suicidal crisis is active, urgent intervention, and custody must meet it.

TRAP **Confusing a forensic psychiatry service with the assessment of criminal responsibility.** The service exists to assess, treat and rehabilitate mentally disordered offenders and to run mental health care in prisons; it operates whether or not any insanity defence is ever raised. The criminal-responsibility doctrine, the insanity-defence test and the fitness-to-stand-trial criteria are a separate matter, taught in the Mental health legislation and forensic psychiatry notes. Candidates lose marks by collapsing the whole of forensic psychiatry into the courtroom question of responsibility, when the great majority of forensic clinical work is service delivery to offenders who are simply unwell.

1894	59	(23)
THE PRISONS ACT STILL FORMING THE BACKDROP TO PRISON ADMINISTRATION	ITS SOLE MENTAL-HEALTH HOOK, THE STATE RULE-MAKING POWER	THE CLAUSE ON TREATMENT, TRANSFER AND DISPOSAL OF CRIMINAL LUNATICS

Prisoners carry a large excess of mental disorder, driven together by importation of pre-existing vulnerability and by the deprivations of custody, and are entitled by the principle of equivalence of care to the same standard of mental health care as the community. In India the Prisons Act of 1894 creates no substantive care provision, only a State rule-making power over criminal lunatics, so the substantive care and transfer machinery lives in the mental-health law and the older warrant power it rests on, not in the Prisons Act; the forensic response is a tiered service running from court diversion through prison in-reach and secure inpatient care to community rehabilitation, anchored at reception screening and at the crisis prevention of suicide and self-harm.

16 · Transfer and treatment of mentally ill prisoners

A term of imprisonment does not suspend a person's mental illness, and the law has to answer a plainly administrative question - on whose authority, and to which bed, is a prisoner who is or becomes mentally ill moved for treatment. The examinable content here is narrow but exact, and the marks reward a candidate who can name the operative provision, state the order of preference it lays down, and keep its mandatory language distinct from the older discretionary power it rests upon. Get the sequence wrong, or soften a "shall" into a "may", and you have described a different rule from the one the statute actually enacts.

This account owns the transfer-and-treatment route only. The wider structure of mental health services inside prisons and the forensic psychiatry service belongs to this chapter's account of the mental health of prisoners and forensic psychiatry services and is named here, not rebuilt; the rights lens - dignity, least restriction, non-discrimination in custody - belongs to this chapter's account of human rights and ethical issues in custodial psychiatry. The general machinery of the Act, its definitions, the review board's constitution and powers, capacity and admission, is taught in the Mental health legislation and forensic psychiatry notes; the prisoner-specific transfer provision is what is grounded and taught in full below.

103	2017	30	1900
MENTAL HEALTHCARE ACT SECTION FOR PRISONERS WITH MENTAL ILLNESS	THE MENTAL HEALTHCARE ACT NOW IN FORCE	PRISONERS ACT SECTION IT CROSS-REFERS TO	THE OLDER ACT THAT PROVISION SITS IN

16.1 The provision that supplies the authority

The governing provision is the Mental Healthcare Act, 2017, at section **103**, and its first job is to solve a purely legal problem: what document is enough to lawfully admit a **prisoner with mental illness** into an establishment for care. The answer the section gives is that an order directing such admission, made under any of a specified set of Acts, is by itself enough. Among those specified sources is section **30** of the Prisoners Act, 1900, alongside orders made under the armed-forces Acts and under the criminal procedure law.

The operative words are that such an order "shall be sufficient authority" for admitting the person to the establishment to which they may lawfully be transferred for care and treatment. That

modal verb is the whole point. The section does not create a fresh discretion to be exercised at the prison gate; it declares that a validly made order already carries the legal weight needed, so the receiving establishment need not look behind it for some further sanction. This is **sufficient authority** in the technical sense - a completed legal warrant, not an invitation to reassess.

16.2 The first door: the prison's own psychiatric ward

Having settled authority, the section settles destination, and it does so with an order of preference that is the single most tested feature of the whole topic. The first proviso states that transfer of a prisoner with mental illness to the **psychiatric ward in the medical wing of the prison** shall be sufficient to meet the requirements of the section. In other words, the default and preferred response is to treat the prisoner inside the prison, in a dedicated psychiatric ward, rather than to move them out of custody into an external hospital.

The reasoning behind this preference matters for the answer, not only for practice. Keeping treatment within the prison medical wing avoids the security and continuity problems of moving a prisoner to and from an outside facility, keeps the person within a single accountable custodial system, and reflects the Act's commitment to the least disruptive appropriate setting. The examiner is testing whether you know that the in-prison ward is the statutory first line, because the intuitive answer - send the mentally ill prisoner to a mental hospital - is the second line, not the first.

16.3 The second door, the Board's permission, and the continuing safeguards

The second proviso supplies the fallback and hedges it with a condition. Where there is no provision for a psychiatric ward in the medical wing, the prisoner may be transferred to a **mental health establishment** with the prior permission of **the Board**. Two elements have to be stated together for the mark. First, the external transfer is contingent - it becomes available only when the in-prison ward does not exist, not as a free alternative. Second, it is gated: it requires the Board's permission in advance, not a post-hoc ratification. The review board itself, how it is constituted and what else it does, is a matter for the Mental health legislation and forensic psychiatry notes; here it functions as the authorising gate on the out-of-prison route.

The section does not stop at the moment of transfer. It builds in continuing oversight so that a prisoner moved for mental illness is not simply lost inside the system, and these duties are worth listing because a "state the safeguards" question turns on them:

- a quarterly reporting duty on the prison medical officer;
- powers of visitation exercisable by the Board;
- special reports at six-monthly intervals, giving a fixed rhythm of scrutiny beyond the routine quarterly report;
- a duty on the appropriate Government to establish a mental health establishment in the medical wing of at least **one** prison in each State and Union Territory, so that the preferred in-prison route is actually available and does not collapse into the external transfer for want of a ward.

That last duty is the structural safeguard behind the whole preference: the first-line option only means something if a psychiatric ward physically exists to receive the prisoner, so the statute obliges the Government to build the capacity its own order of preference assumes.

RULE **An order directing admission of a prisoner with mental illness is itself sufficient authority; the first option is the psychiatric ward in the prison's medical wing, and only where no such ward exists may the prisoner be transferred to a mental health establishment, and then only with the Board's prior permission.** The sequence is fixed and conditional, not a menu. Sufficiency of authority is declared in mandatory terms; the in-prison ward "shall be sufficient" to meet the section; the external transfer is the exception, unlocked by the absence of a ward and licensed by the Board in advance. Collapsing this to "a mentally ill prisoner is sent to a mental health establishment" states the fallback as if it were the rule.

16.4 The older statute the section rests on: the Prisoners Act warrant

Section **30** of the Prisoners Act, 1900, is the provision the current section expressly cross-refers to, and it is the historical engine that produces the very "order directing admission" the modern Act then treats as sufficient. Its language is of its era and should be read as such, but its structure is still live. Where it appears to the State Government that a person detained or imprisoned under any order or sentence of a court is of unsound mind, the State Government may, by a **warrant** setting out the grounds of that belief, order the person's removal to a lunatic asylum or other **place of safe custody** within the State, there to be kept and treated as the Government directs for the remainder of the term of detention or sentence.

Two features carry the marks. The power is discretionary - "may, by a warrant" - and it is exercised by the State Government on a stated belief of unsound mind, with the grounds recorded in the warrant itself, which is the accountability check built into an otherwise wide power. And it contains a continuation clause that reaches beyond the sentence: if, on the expiry of the term, a medical officer certifies that further detention under medical care or treatment is necessary for the safety of the prisoner or of others, the person may be kept until discharged according to law. That is how a person can lawfully remain in medical custody after the original sentence has run - not on the executive's say-so alone, but on a medical certification of necessity tied to safety.

16.5 Reading the two provisions together

The clean way to hold this is as one modern authority-and-destination rule sitting on top of an older warrant power. The Prisoners Act warrant produces the order; the Mental Healthcare Act declares that order sufficient and then dictates where the prisoner should go, ward first, external establishment only by exception. Keeping the two verbs straight - the discretionary "may" of the warrant, the declaratory "shall be sufficient" of the modern authority - is what separates a precise answer from an approximate one. The grid sets the contrast out.

AXIS	PRISONERS ACT WARRANT	MENTAL HEALTHCARE ACT PROVISION
FUNCTION	Creates the power to remove a prisoner of unsound mind	Declares an admission order sufficient authority and fixes the destination
WHO ACTS	The State Government, by warrant recording its grounds	The prison system, under the order, subject to the Board for external transfer
MODAL CHARACTER	Discretionary: "may, by a warrant" order removal	Mandatory/declaratory: the order "shall be sufficient authority"
DESTINATION	A lunatic asylum or other place of safe custody within the State	First the prison's psychiatric ward; an external establishment only if no ward exists, with the Board's prior permission
DURATION	Remainder of the term, and beyond it if a medical officer certifies continued detention necessary for safety	Governed by the originating order and applicable law, with quarterly and six-monthly reporting and Board oversight

TRAP **Stating external transfer to a mental health establishment as the standard response for a mentally ill prisoner.** Candidates recall that the prisoner is "sent for treatment" and name the outside hospital, missing that the section makes the psychiatric ward in the prison's own medical wing the first option and treats the external establishment as the exception - available only where no such ward exists, and only with the Board's prior permission. Answer with the order of preference, not with the fallback, because the fallback is the very thing the section is drafted to make secondary.

IN INDIA

This is an entirely Indian statutory scheme with no Western template to borrow. The current authority is the Mental Healthcare Act, 2017, which folded the prisoner provision into the same rights-based Act that governs civil admission, while expressly preserving the older removal power in the Prisoners Act, 1900. The practical gap the Act tries to close is the historical shortage of in-prison psychiatric wards, which is precisely why it lays a duty on the appropriate Government to build a mental health establishment in the medical wing of at least one prison per State and Union Territory.

GOOD TO REMEMBER

When advising on a prisoner who has become mentally ill, look first to the prison's own psychiatric ward, because that is the statutory first line, and reserve transfer to an outside establishment for where no such ward exists - flagging that the external move needs the Board's prior permission before it happens, not after. If care will be needed beyond the end of the sentence, the lawful route to continuation is a medical officer's certification that further detention is necessary for the safety of the person or of others, which is what turns the end of a sentence into grounded continued care rather than unlawful detention.

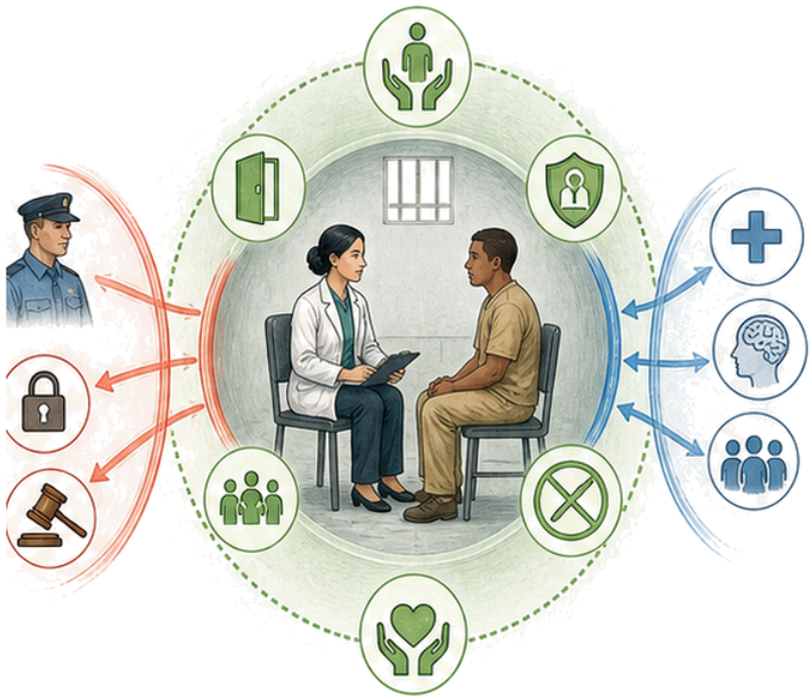
PITFALL

The section cross-refers to orders made under the criminal procedure law, and those references are to the provisions of the 1973 Code as they stood when the Act was passed. Since the criminal statutes changed on the first of July 2024, an author who cites the old procedural sections as current is quoting a superseded code; the savings position and the current successor provisions are treated in this chapter's account of the current penal-code framework and its transition to the new criminal codes, and should be cross-referred rather than restated here. Name the transfer authority from the Mental Healthcare Act and the Prisoners Act, which are grounded, and do not attach a procedural section number from memory.

An order directing admission of a prisoner with mental illness is sufficient authority under the Mental Healthcare Act, 2017; the first option is the psychiatric ward in the prison's medical wing, and only where no such ward exists may the prisoner be transferred to a mental health establishment, and then only with the Board's prior permission - the power to remove being drawn from the discretionary warrant of the Prisoners Act, 1900.

17 · Human rights and ethical issues in custodial psychiatry

A person does not surrender the right to health, to dignity or to protection from cruelty at the prison gate. Custodial psychiatry is where the ordinary ethics of the profession meet the extraordinary fact that the patient cannot walk away and often cannot freely refuse. The setting concentrates every rights problem the discipline has: liberty is already removed, the environment is coercive, the clinician answers to an institution as well as to the patient, and the people most affected are among the least able to assert a claim for themselves. The marks here are for the rights-and-ethics lens itself, not for the plumbing of prison mental health, and an examiner rewards the candidate who can name the rights at stake, the Indian authority that protects them and the ethical trap the custodial role sets.



- Dignity
- Equivalent care
- Confidentiality
- Protection from cruelty
- Clinical independence
- Dual loyalty

Fig 26.10 A person in custody retains the rights to dignity, health care and protection from cruel or degrading treatment. The psychiatrist must preserve clinical independence and confidentiality while recognising the dual-loyalty pressures created by the institution.

What this topic owns is that lens. The structure of mental health services for prisoners belongs to this chapter's account of the mental health of prisoners and forensic psychiatry services, and the pathway for moving and treating a mentally ill prisoner belongs to this chapter's account of the transfer and treatment of mentally ill prisoners; both are named here and cross-referred, not reworked. The ethical frame for coercion and restraint in general is developed in this chapter's account of the ethical issues in involuntary treatment, restraint and end-of-life care, and its legal frame in the account of the legal aspects of seclusion, restraint and involuntary treatment. The clinical management of drug and alcohol problems in custody sits in the Substance use disorders notes.

17 Aug 1993	3 Oct 1994	19 Jun 2023
SUPREME COURT BARRED JAILING THE NON-CRIMINAL MENTALLY ILL	THE FOLLOW-UP ORDER ENFORCING THAT BAR	NHRC ADVISORY ON CUSTODIAL SELF-HARM AND SUICIDE

17.1 The rights lens: dual loyalty and the equivalence of care

Two ideas organise the whole topic. The first is the psychiatrist's problem of **dual loyalty**: a clinician working inside a custodial system owes the ordinary fiduciary duty to the patient in front of them, but the institution that pays and permits them wants order, security and compliance, and those two pulls do not always point the same way. A request to certify a prisoner fit for punishment, to medicate a difficult inmate for the convenience of the wing, or to disclose clinical information to custodial staff for reasons that are not the patient's, are all moments where loyalty to the patient and loyalty to the institution collide. The rights lens resolves the collision in one direction: the clinical relationship, and the patient's rights within it, come first, and the doctor's role is never to be an instrument of punishment or control dressed as treatment.

The second idea is the principle of **equivalence of care**: a person deprived of liberty is entitled to a standard of health care equivalent to what is available in the community, without discrimination on the ground of their legal status. Detention removes freedom of movement; it is not a sentence to worse medicine. Because the detained person cannot seek a second opinion, cannot easily complain and cannot leave, equivalence is a corrective for a captive population's structural disadvantage. Taken together, dual loyalty tells the clinician whom they serve, and equivalence tells them to what standard.

RULE **Loss of liberty is not loss of the right to health, to dignity or to consent; care in custody must be equivalent to care in the community and must never become an instrument of the institution against the patient.** Every specific rule that follows, the bar on jailing the non-criminal ill, the duty to screen, the limits on coercion, is an application of this one sentence. When a custodial question puzzles you, return to it: what would this person be owed outside, and what is the least the institution may do to them inside.

17.2 Sheela Barse: the non-criminal mentally ill do not belong in jail

The single most examinable Indian authority in this area is the **Sheela Barse** litigation, in which the Supreme Court confronted the practice of holding mentally ill persons who had committed no offence in ordinary jails, frequently under the label of "safe" or protective custody, for want of anywhere else to put them. By its judgment dated **17 August 1993** the Court strictly prohibited the confinement of non-criminal mentally ill persons in jails. The prohibition was not advisory and not conditional: a person whose only "offence" is their illness may not be warehoused in a penal institution, because a jail is a place of punishment and this person is not being punished.

The force of the ruling lies in how the Court framed the wrong. Confining the non-criminal mentally ill in jail was treated as a violation of their constitutional rights, and therefore as a matter attracting the Court's compensatory jurisdiction: not merely bad administration but an actionable breach for which the State could be held answerable. That the point had to be restated is itself the lesson: by the follow-up order dated **3 October 1994** the Court recorded its dismay that the earlier prohibition was still not understood, and reiterated it. For the exam, the case stands for a clean proposition: illness is not criminality, and the response to a person found wandering and unwell is care in a health facility, never a cell.

TRAP **Treating "protective" or "safe" custody of the non-criminal mentally ill as a benign holding measure.** Candidates soften the Sheela Barse bar into a matter of resources, reasoning that a jail is acceptable when no hospital bed is free. It is not: the prohibition on confining the non-criminal mentally ill in jail is a rights bar, not a preference, and the absence of an alternative is the State's problem to solve, not a defence to the wrong. The correct answer is always diversion to a health facility, and the pathway for a prisoner who does need psychiatric care sits in this chapter's account of the transfer and treatment of mentally ill prisoners.

17.3 Custodial self-harm and suicide: the duty to look

Suicide and deliberate self-harm are the sharpest rights problem inside the wall, because the State that has taken a person into its exclusive control has assumed a corresponding duty to keep them alive, and a custodial death raises at once the questions of what was known and what was done. The population is high-risk by construction: the shock of first reception, withdrawal from substances, isolation from family, the loss of autonomy and the concentration of untreated mental illness make the early days of custody especially dangerous. A rights-respecting system therefore treats detection as an active duty rather than waiting for a prisoner to declare distress they may be least able to voice.

The Indian regulatory answer is captured in the National Human Rights Commission advisory dated **19 June 2023** on mitigating deliberate self-harm and suicide attempts by prisoners, which recommends, among other measures, that mental health screening be included in the initial health screening report of every prisoner and that prison staff be trained in **Psychological First Aid** and mental health literacy. Note the two moves. Screening at reception catches the risk when it is highest and before the system has lost sight of the person; training the frontline staff, who see prisoners far more than any clinician does, turns wing officers into the first line of recognition rather than bystanders. These are recommendations of a rights body, not a statutory command, but they set the standard of humane practice against which a custodial system's failures are now measured.

GOOD TO REMEMBER

When you assess anyone entering custody, screen for suicide risk as a routine part of the reception health check, not only when a threat is voiced. Document what you asked and what you found, and flag those at risk to the staff who will actually be watching them overnight. In a custodial death the contemporaneous reception note is the first thing scrutinised, and "no concerns raised" is not the same as "screened and none found".

17.4 Consent, confidentiality and coercion behind the wall

The everyday ethics of the encounter are distorted by the setting. Consent given in custody is suspect on its voluntariness: a person who believes that refusing treatment will affect their parole, their classification or their handling by staff is not consenting freely, so the clinician must work harder to separate a genuine choice from a coerced one. Confidentiality is under constant pressure, because custodial staff routinely want clinical information, yet the duty follows the patient into custody and is not waived by their status; disclosure to the institution is justified only on the same narrow grounds that would justify it outside. The elements of valid consent and the

permitted grounds for breaching confidence are taught in this chapter's own accounts of those topics and are applied here, not restated.

Coercive control is the third pressure, and custody offers instruments a hospital does not. The ways the setting erodes rights are worth holding as a list, because each is a distinct place a clinician can be co-opted:

- segregation imposed for order being passed off as therapeutic seclusion;
- medication used for the convenience of the regime rather than the patient's illness, so-called chemical restraint;
- solitary confinement of a mentally ill prisoner, which can itself cause or worsen psychiatric harm;
- clinical information fed to custodial or disciplinary processes without the patient's interest in view.

The general ethics of restraint and seclusion, and their legal safeguards, belong to this chapter's accounts of the ethics and of the legal aspects of seclusion, restraint and involuntary treatment; the statutory restraint machinery itself sits in the Mental health legislation and forensic psychiatry notes. What the rights lens adds is the reminder that in custody every one of these instruments is more available and less visible, so the clinician's refusal to lend clinical authority to punishment is the safeguard that matters most.

PITFALL

The commonest real-world error is accepting a prisoner's consent, or their apparent calm, at face value. A man who agrees to depot medication because he fears the consequences of refusal has not truly consented, and a prisoner segregated "for his own safety" may be deteriorating in isolation rather than being protected by it. Read voluntariness in the light of the coercive environment, and do not treat isolation of a mentally ill person as a neutral administrative fact: a person with mental illness shall not be subjected to seclusion or solitary confinement, so safety must be met through lawful alternatives rather than isolation.

17.5 Non-discrimination and the standard-setting frame

Underlying all of the above is the principle of **non-discrimination**: legal status is not a permissible ground for delivering worse care, and the detained mentally ill are entitled to the same rights and quality of treatment as any other patient. This is why equivalence of care is stated as a right and not an aspiration, and why the Sheela Barse bar and the NHRC's reception-screening recommendation are best read together, one keeping the wrong person out of the penal system entirely, the other protecting the right person once lawfully within it.

The topic also sits within a wider architecture of standards. International minimum standards for the treatment of prisoners and for the protection of persons with mental illness, and India's own disability-rights and mental-health statutes, all articulate versions of dignity, equivalence and non-discrimination in custody; the domestic statutory machinery is set out in the Mental health legislation and forensic psychiatry notes and is applied here rather than restated. For the

practising psychiatrist the message survives the detail: the rights of the person in custody are the rights of any patient, made more fragile by captivity and therefore owed more vigilance, not less.

RIGHT AT STAKE IN CUSTODY	HOW THE SETTING THREATENS IT	THE RIGHTS ANSWER
LIBERTY OF THE NON-CRIMINAL ILL	Held in jail as "protective" custody for want of a bed	Absolute bar on jailing them; divert to a health facility
LIFE (PROTECTION FROM SELF-HARM)	High-risk population, distress unvoiced, watch diffuse	Mental health screening at reception; trained frontline staff
VOLUNTARY CONSENT	Refusal feared to affect parole, classification or handling	Test voluntariness against the coercive environment
CONFIDENTIALITY	Staff demand clinical information; no private space	Duty follows the patient; disclose only on the usual narrow grounds
EQUAL STANDARD OF CARE	Legal status used to justify inferior treatment	Equivalence of care and non-discrimination

A person in custody keeps every health-related right they had outside, made more fragile by captivity and so owed more vigilance: care must be equivalent to the community standard and free of discrimination, the non-criminal mentally ill may not be confined in jail at all, self-harm and suicide risk should be actively screened at reception as the NHRC advises, and the psychiatrist's clinical authority must never become an instrument of the institution against the patient.

Forensic Indian statutes and legal procedure

18 · Sexual offences law and Criminal Law Amendment (rape, consent, psychiatric assessment of survivors)

The law changed its numbers, not the reader's duty to get them right. This topic is the criminal law of sexual offences as it now stands: the definition of rape and its punishment in the current penal code, the exact legal meaning of consent on which the offence turns, and the part a psychiatrist plays when a survivor is examined or when a court needs to know whether a complainant could consent. The marks cluster in three places, and each is one where confident memory of the old law is a liability. The first is currency: the provisions were re-enacted when the colonial-era penal code was replaced, so the section a report cites must be the live one. The second is a conceptual trap: the criminal law's "consent" is a different construct from the consent a clinician takes before treatment, and the two are examined together precisely so that candidates conflate them. The third is the narrow but genuinely psychiatric interface, the short list of conditions - unsoundness of mind, intoxication, an inability to communicate - in which whether there was consent at all becomes a question a psychiatrist is competent to address.

A psychiatrist who assesses a survivor, or who is asked to opine on capacity to consent, works entirely inside this statutory frame. The full account of how the penal code changed, and the savings rule that decides which code governs a given matter, belongs to this chapter's account of the current penal code and its predecessor, and is named here rather than re-derived; the task here is the sexual-offences provisions themselves and the clinician who stands beside them.

18.1 The reform lineage: from a committee's report to the current code

Why the modern definition looks the way it does. The shape of the present offence is the direct product of a single wave of reform. After the Delhi gang-rape case that provoked national reform, the **Justice Verma Committee** was convened, and its recommendations were substantially enacted as the **Criminal Law (Amendment) Act 2013**. That amendment did two things that still dominate the topic. It broadened the offence of rape well beyond the older, narrow idea of peno-vaginal intercourse, replacing it with a defined set of sexual acts, penetrative and oral; and it recast consent as something that must be affirmatively communicated rather than merely not refused. When the penal code was later rewritten, these post-2013 amendments were not reopened: the broadened definition and the affirmative-communication consent standard were carried forward substantively unchanged into the current code. For the examinee this continuity is a gift and a trap at once: the settled understanding of the amended offence survives intact, but the section numbers moved, so an answer written in the old citations describes the right law under the wrong name.

18.2 The offence defined: rape under the current penal code

An act, done in a defined circumstance. The offence of **rape** is defined in the current penal code, the **Bharatiya Nyaya Sanhita**, at section **63**, the successor to the repealed penal code's rape provision. Its architecture is two-part, and the discipline is to hold both parts together: a defined physical act, performed under one of a defined set of circumstances. The amendment carried into this section widened the physical act into **four** categories of sexual conduct: penile penetration of the vagina, mouth, urethra or anus; insertion of an object or a body part other than the penis; manipulation of a part of the body so as to cause penetration; and application of the mouth to the vagina, anus or urethra. The first three turn on penetration or insertion; the fourth is complete on the application of the mouth, without proof of penetration, and a candidate who calls all four penetrative has narrowed the section. None of these is an offence in the abstract; each becomes rape only when done in one of the listed circumstances.

The circumstances, and where the psychiatry lives. The circumstances that make an act rape are a closed statutory list, and they repay grouping rather than rote recall. They run:

- against the woman's will, or without her consent at all;
- with a consent extracted by putting her, or someone she cares about, in fear of death or of hurt;
- with her consent, where the man knows he is not her husband and she consents because she believes he is another man to whom she is, or believes herself to be, lawfully married;

- with a consent given when, by reason of unsoundness of mind, intoxication, or a stupefying or unwholesome substance, she is unable to understand the nature and consequences of that to which she consents;
- where she is below the age the section fixes, in which case her consent is immaterial; and
- where she is unable to communicate consent.

The fourth and the last of these are the psychiatric heartland of the whole topic. Whether a person could, at the material time, understand the nature and consequences of a sexual act, or could communicate a choice about it, is not a lay judgement; it is a capacity assessment, and it is the point at which a court is most likely to want a psychiatrist. The section itself, by writing unsoundness of mind and intoxication into the definition, makes the clinician's assessment part of the legal question rather than a bystander to it.

MNEMONIC

Mind, Substance, Speech

The three circumstances in the rape definition that turn on the complainant's capacity rather than on the surrounding facts: **M**ind (unsoundness of mind), **S**ubstance (intoxication or an administered stupefying or unwholesome substance), and **S**peech (an inability to communicate consent). Each may call for clinical expert evidence rather than lay judgement, and the cause decides which expert: intoxication may turn on toxicological evidence and an inability to communicate on neurological or physical evidence, while the psychiatrist speaks only to the psychiatric question. Where the cause is psychiatric, whether there was consent has become, in part, a question about capacity, and that is the clinician's territory.

18.3 The legal meaning of consent, and why it is not clinical consent

Consent defined by the section, not by the clinic. The definition the offence turns on is the criminal-law meaning of **consent**, set out in Explanation **2** to the rape section, and it is the single most examined line in the topic. Consent means an **unequivocal voluntary agreement**, in which the woman, by words, gestures, or any form of verbal or non-verbal communication, communicates willingness to participate in the specific sexual act. The definition then closes a door that the older law had left ajar: a woman who does not physically resist the act shall not, by reason only of that fact, be regarded as consenting. Two features are load-bearing. Consent is affirmative and communicated, not inferred from the absence of a "no"; and it is act-specific, so agreement to one thing is not agreement to another.

A different construct that shares a word. This is where candidates lose marks, because the clinical doctrine of informed consent, its elements of capacity, adequate disclosure and voluntariness, is taught in this chapter's account of informed consent in psychiatry, and the two doctrines overlap far less than the shared noun suggests. Both ask for voluntariness, and both attach to a specific act rather than to a general willingness, and there the resemblance stops. Clinical consent is a prospective authorisation a competent patient gives a clinician for an intervention, built on capacity and on disclosure of risks and alternatives; the criminal law's consent is a retrospective factual question about whether an unequivocal, communicated

willingness to a specific act existed at a particular moment. The comparison below fixes the contrast so it cannot be blurred under pressure.

AXIS	CLINICAL (INFORMED) CONSENT	CONSENT IN THE LAW OF SEXUAL OFFENCES
The question it answers	May this clinician proceed with this intervention?	Did an unequivocal, communicated willingness to this specific act exist?
Where it is defined	The general doctrine of informed consent (its own topic in this chapter)	The Explanation to the rape section of the current penal code
Its core standard	Capacity, adequate disclosure of information, and voluntariness	An unequivocal voluntary agreement, communicated by word, gesture or other means, to the specific act
Orientation in time	Prospective: an authorisation given before the act	Retrospective: a finding of fact about a past moment
Effect of silence or non-resistance	Silence is not authorisation; a positive agreement is required	Failure to physically resist is not, by that fact alone, consent
Whose interest it protects	The patient's autonomy over their own treatment	The complainant's sexual autonomy against a criminal wrong

Two constructs that share the word "consent" and, beyond voluntariness and an act-specific agreement, little else. A report that answers the clinical-capacity question when the court asked the criminal-law-consent question, or the reverse, has misread the brief before it has misread the facts.

RULE **Criminal-law consent is an unequivocal, communicated, act-specific willingness, and the absence of physical resistance is not consent.** The definition is affirmative and positive: it asks what the woman communicated, not what she failed to do. It is tied to the specific sexual act, so agreement to one act does not extend to another. And it stands apart from the clinical doctrine of informed consent, which is a prospective authorisation for treatment built on capacity and disclosure. The two are examined side by side so that they will be confused; the mark is in keeping them separate.

TRAP **Answering the criminal-law consent question with the clinical capacity-and-disclosure test.** Asked whether a complainant consented, the unwary candidate reaches for the informed-consent checklist - was there capacity, was there disclosure, was it voluntary - and imports a treatment doctrine into a criminal statute. The section does not ask whether a valid clinical authorisation was obtained; it asks whether an unequivocal, communicated willingness to the specific act existed, and it treats the absence of resistance as no answer at all. Capacity enters the criminal analysis only through the circumstances the section names, unsoundness of mind, intoxication and inability to communicate, not as a free-standing test.

18.4 The exceptions and the punishment

Two exceptions, each with its condition. The offence carries two carve-outs, and each must be stated with its condition or not at all. A medical procedure or intervention shall not constitute rape, which shields the clinician performing a lawful examination or treatment. Separately, intercourse or sexual acts by a man with his own wife are not rape, provided the wife is not below

the age the section fixes: the exception operates only at or above that age threshold, and where the wife is below it the exception does not apply. Naming the **marital-rape exception** without its age condition is how a candidate turns a precise carve-out into a wrong general statement.

Punishment. The punishment for rape is prescribed at the section that follows the definition, section **64**, the successor to the repealed penal code's punishment provision. An offender shall be punished with rigorous imprisonment for a term which shall not be less than **ten** years, which may extend to imprisonment for life, and shall also be liable to fine. The modal verbs are the law: the minimum term is mandatory ("shall not be less than"), the extension to life is discretionary ("may extend"), and the fine is a mandatory addition ("shall also be liable"). A separate sub-section lists aggravated categories - among them a police officer, a public servant, a person in a custodial or fiduciary position of trust - for which a heavier term is prescribed, reflecting the abuse of power the section singles out.

PITFALL

Citing the repealed Indian Penal Code's rape and punishment sections as the governing law for a current offence, or without first establishing when the offence was committed. The wording of the offence was carried across largely intact, which is exactly why the error is so easy: the substance feels current even though the citation is dead. A medico-legal report that names a repealed code as the live one reads as out of date and invites the court to discount the opinion. Read the governing section from the current code, and let this chapter's account of the transition settle which code applies to an older matter.

18.5 The psychiatrist and the survivor

The clinician's role is real but bounded. The psychiatrist's involvement with a survivor of a sexual offence runs along several tracks, and the examinable skill is knowing which one is in play: assessing and documenting the survivor's mental state and the psychological sequelae, as treating clinician; assessing **capacity to consent** where the section's own circumstances of unsoundness of mind, intoxication or an inability to communicate are in issue; supporting a vulnerable survivor through the process of giving evidence; and providing continuing treatment for the psychiatric consequences.

The dual role, and the line not to cross. These tracks map onto the two roles that organise all forensic work, the treating clinician who owes duties to a patient and the forensic evaluator who serves the court, and the distinction between them is developed in this chapter's account of the psychiatrist as expert witness. The critical discipline is that a psychiatrist assesses mental state and capacity but does not pronounce on the ultimate legal question of whether there was consent, which is for the court alone to decide on all the evidence. An opinion that a survivor "did not consent", or that an account is true, usurps the court's function and is worth less, not more, for its overreach. The proper contribution is narrower: whether, at the material time, this person had the capacity to understand the nature and consequences of the act, or to communicate a choice about it.

How the assessment is conducted matters as much as what it finds. A survivor examination is itself a potential source of further harm, so the assessment is trauma-informed and unhurried, with the survivor's own authorisation sought for each step and the findings recorded contemporaneously and precisely. Where the survivor is a child, the dedicated child-protection statute applies alongside the applicable general provisions, and both the substantive framework and the special procedures for a child are the province of the Child psychiatry: assessment, treatment, services and protection notes, which are named here and cross-referred, not re-taught.

IN INDIA

The sexual-offences law is one of the most heavily reformed corners of the Indian criminal code, and the psychiatrist sits inside a defined medico-legal pathway. A survivor presenting after an assault is examined under a standardised medico-legal protocol, and a psychiatric opinion on capacity to consent is sought specifically where the statute's own circumstances - unsoundness of mind, intoxication or an inability to communicate - are raised. The practical safeguard is to write every such opinion against the current code read from the primary source, and to keep the clinical capacity finding distinct from the legal conclusion the court will draw from it.

GOOD TO REMEMBER

Before you commit any opinion in a sexual-offences matter, settle two things. First, which question the court is actually asking: a clinical-capacity question about whether this person could understand or communicate, or something the law reserves to itself. Second, that your report answers the first and never trespasses on the second. State the mental state and the capacity, document how you assessed both, and stop short of the ultimate issue of consent, which is the court's to decide.

63	64	10
CURRENT PENAL-CODE SECTION THAT DEFINES RAPE	THE SECTION THAT PRESCRIBES THE PUNISHMENT	YEARS, THE MANDATORY MINIMUM RIGOROUS IMPRISONMENT

Rape is defined and punished under those two sections of the current penal code by a mandatory minimum of rigorous imprisonment extendable to life; the definition, broadened after the post-2013 reforms and carried forward unchanged, turns on the criminal-law meaning of consent in Explanation 2, an unequivocal, communicated, act-specific willingness in which non-resistance is not consent. That construct is not the clinical doctrine of informed consent. The psychiatrist assesses a survivor's mental state and capacity to consent where unsoundness of mind, intoxication or an inability to communicate is in issue, and never pronounces on the ultimate legal question of consent, which is the court's.

19 · Section 105 BSA (formerly Section 84 IPC under BNS) and updated penal code provisions

Get the citation right, or the opinion is worthless. The examinable core of this topic is small, exact and unforgiving. The insanity defence and the rule about who must prove it are two

different provisions, sitting in two different codes, and the penal and evidence codes carrying these two provisions changed on **1 July 2024**. A psychiatrist who cites the wrong section, or a repealed code, in a report to a criminal court has undermined the one thing an expert is there to supply: a precise, current and defensible statement of the law the opinion is built on. The marks here reward accuracy, not breadth, and the commonest way to lose them is to answer confidently in the language of a code that no longer governs.

The heading a candidate is most likely to meet, pairing an evidence-code section number with the old insanity section, is itself wrong, and correcting it is half the answer. This topic fixes the mapping, states what each current section actually provides, and then teaches the transition rule that decides which code governs a given case. The cognitive test that the defence turns on, and the doctrine of the burden of proof, are developed in the Mental health legislation and forensic psychiatry notes and are named here, not re-taught; the courtroom procedure for referring and assessing an accused is carried in the accompanying forensic-procedure material.

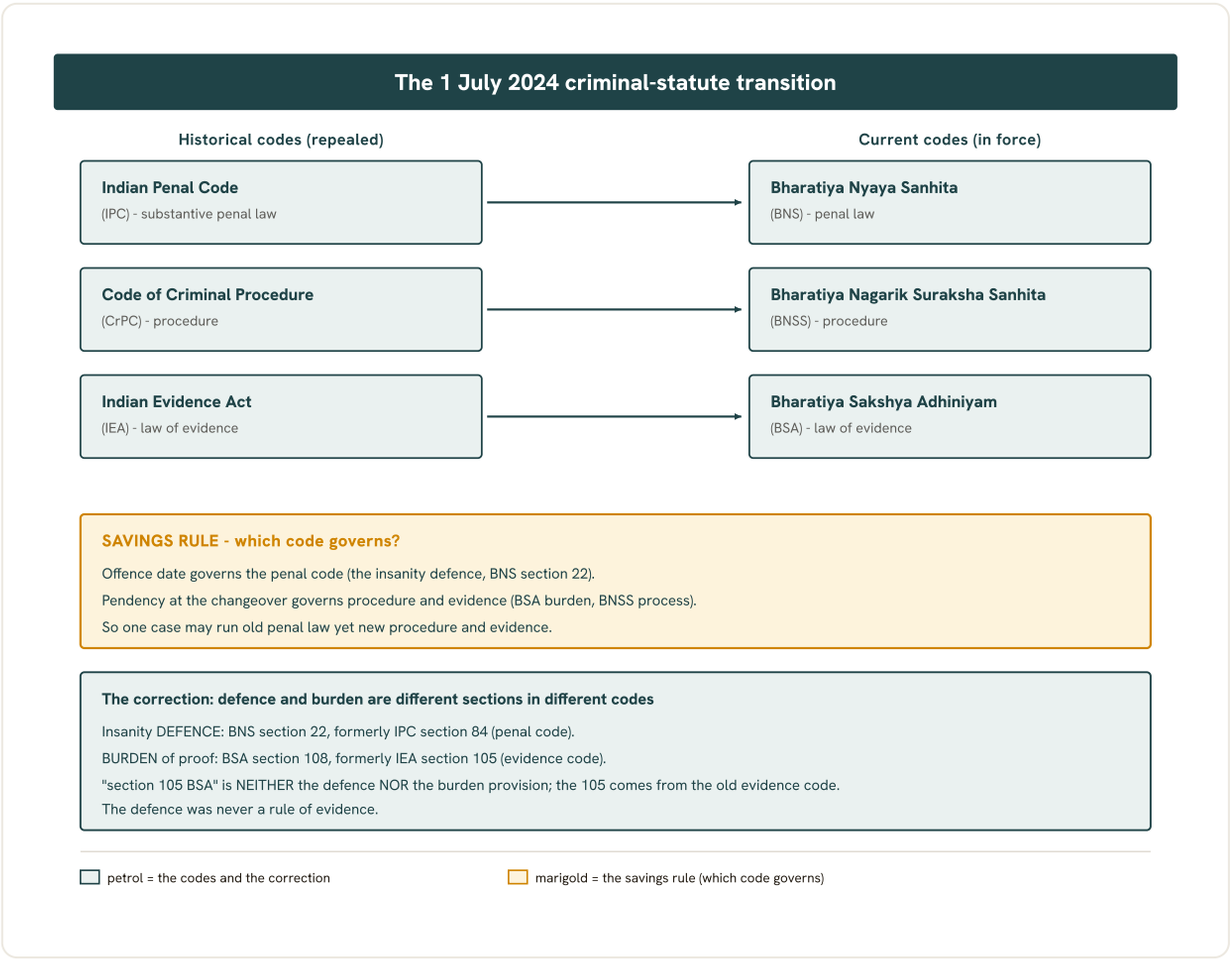


Fig 26.11. On 1 July 2024 the three colonial codes were replaced together, the Indian Penal Code by the Bharatiya Nyaya Sanhita, the Code of Criminal Procedure by the Bharatiya Nagarik Suraksha Sanhita and the Indian Evidence Act by the Bharatiya Sakshya Adhiniyam, with the offence date governing the penal code and pendency at the changeover governing procedure and evidence, so the insanity defence is BNS section 22 (formerly IPC section 84) and the burden of proof BSA section 108 (formerly IEA section 105), not section 105 BSA.

19.1 The correction: a defence and a burden, in two separate codes

Two functions, two statutes, two section numbers. The loose shorthand that files the insanity defence under an evidence-code section number collapses two entirely separate provisions into

one. The **general exceptions** to criminal liability, among them the exemption for the **act of a person of unsound mind**, live in the penal code; the rule about who must prove that an accused falls within such an exception lives in the law of evidence. These are not two names for one thing. One asks whether the act is an offence at all; the other asks who carries the risk of not proving the answer. The comparison below fixes both the function and the location.

AXIS	THE INSANITY DEFENCE	THE BURDEN OF PROVING IT
Question it answers	Given the accused's state of mind at the time, is the act an offence at all?	Once the defence is raised, who must establish that the accused was of unsound mind?
Where it lives	The penal code, among the general exceptions (the Bharatiya Nyaya Sanhita, formerly the Indian Penal Code)	The law of evidence (the Bharatiya Sakshya Adhiniyam, formerly the Indian Evidence Act)
Section, current and former	section **22**, formerly section **84**	section **108**, formerly section **105**
Nature of the rule	A general exception that exempts the act from criminal liability	A rule of evidence that places proof on the accused and directs the court to presume the exception absent

The two provisions the garbled heading conflates. Because the defence and the burden are separately located, no single section of the Bharatiya Sakshya Adhiniyam can carry the insanity defence: the popular phrasing borrows the repealed evidence-Act number and pins it to the new code, pointing at neither the defence nor its correct home.

Why the shorthand is not merely sloppy but wrong. The number in the heading was never the defence at all. In the old scheme, the exempting provision was the penal code's insanity section, and its successor is the general-exceptions insanity provision of the Bharatiya Nyaya Sanhita. The number the heading borrows belonged instead to the evidence Act's burden-of-proof provision, whose successor is the current burden section of the Bharatiya Sakshya Adhiniyam. So the correction is not a matter of updating a digit: it is recognising that the defence and the proof of it are different laws, and that the shorthand mixes an old evidence-section number with a new code's name to describe a provision that does not exist.

MNEMONIC

Defence in the Nyaya Sanhita, burden in the Sakshya Adhiniyam

The exemption for the act of a person of unsound mind sits in the penal Sanhita; the rule that the accused must prove it sits in the evidence Adhiniyam. Two functions, two codes: a single evidence-code section can never be the home of the defence, because the defence was never a rule of evidence.

RULE **The defence and the burden are different sections in different codes, and both codes changed at the transition.** The insanity exemption is a penal-code general exception (now the Bharatiya Nyaya Sanhita, formerly the Indian Penal Code); the rule that the accused must prove it is a provision of the evidence code (now the Bharatiya Sakshya Adhiniyam, formerly the Indian Evidence Act). No single provision holds both, so the popular pairing of the defence with an evidence-code number is a category error before it is a numbering error.

19.2 The insanity defence now: the penal code's act of a person of unsound mind

What the current section actually provides. The Bharatiya Nyaya Sanhita's general-exceptions insanity provision exempts from criminal liability an act done by a person who, at the time of doing it, by reason of **unsoundness of mind**, was incapable of knowing the nature of the act, or that it was wrong or contrary to law. Read the clause slowly, because each element does work: the incapacity must arise from unsoundness of mind, it must exist at the time of the act, and it is an incapacity of knowing, that is, a defect of cognition rather than of control or of motive. The exemption is framed as an absolute one, nothing done in that condition is an offence, which is why the defence, when it succeeds, negates criminal responsibility rather than merely mitigating it.

The test has a name, and it is deliberately not re-taught here. The cognitive standard the section encodes is the **M'Naghten standard**. Its limbs, the meaning of knowing the nature of the act, the distinction between legal and moral wrong, and the way the standard is applied and assessed in a real accused, are the doctrine of criminal responsibility and are developed in the Mental health legislation and forensic psychiatry notes; naming the test is the task here, unpacking it is not. One point of continuity is worth holding, however. The statutory wording of the current section is carried across word for word from the repealed penal-code provision, so the substantial body of case-law decided under the old section remains directly instructive, and nothing about the substantive test changed at the transition. What changed is the citation, not the content.

19.3 The burden of proving the defence: the evidence code's exceptions provision

The accused who raises the exception must prove it. The general rule of criminal proof, that the prosecution establishes guilt, does not extend to the general exceptions. When an accused claims to fall within an exception such as unsoundness of mind, the evidence code places the **burden of proof** on the accused: the burden of proving the existence of the circumstances that bring the case within the exception rests on the person asserting it, and the court shall presume the absence of those circumstances until they are established. The section's own first illustration is, tellingly, the insanity case itself, an accused charged with an offence who alleges that by reason of unsoundness of mind he did not know the nature of the act, on whom the burden of proof then lies. The provision does not decide guilt; it allocates who bears the risk on the question of the exception.

Where the statute stops and the doctrine begins. Note the exact structure, because candidates lose the mark by softening it. The burden is placed on the accused, and the court is directed to presume the exception absent, not merely permitted to. How heavy that burden is, and how it

interacts with the presumption of sanity and with the prosecution's own standard, is the doctrine of the burden of proof, which is developed in the Mental health legislation and forensic psychiatry notes and is named, not restated, here. What this topic owns is the location: the burden that used to sit in the repealed evidence Act now sits in the current exceptions provision of the Bharatiya Sakshya Adhiniyam, and that is the provision the garbled heading was reaching for and missing.

TRAP **Naming the evidence code's burden section as the home of the insanity defence.** The number in the garbled heading is borrowed from the repealed evidence Act's burden-of-proof provision, not from the penal code at all, and the defence never lived in the law of evidence. Candidates conflate the two because the exempting section and its burden are examined together, but the provision that exempts the act and the provision that allocates its proof are separate laws in separate codes, and an answer that fuses them has misunderstood the topic, not merely mistyped a digit.

19.4 The transition and the savings rule

The date is not a light switch. On the transition the three colonial-era codes were repealed and replaced together: the penal code, the evidence Act and the code of criminal procedure gave way to the Bharatiya Nyaya Sanhita, the Bharatiya Sakshya Adhiniyam and the **Bharatiya Nagarik Suraksha Sanhita**. Each replacing Act carries its own **repeal and savings** clause, and those clauses are the reason a clinician cannot simply assume that the newest code is the one in force for the matter in front of them. Repeal removes a statute going forward; the savings clause decides what happens to everything already under way.

The penal code follows the date of the offence. The savings clause of the penal Sanhita repeals the Indian Penal Code but preserves its previous operation for what has already happened under it. In particular it keeps the old code alive for offences committed before the change, so that the substantive law, including the insanity defence, is judged by the penal code in force on the **offence date**. Concretely, the savings clause preserves:

- the previous operation of the repealed code, and anything duly done under it;
- any right, obligation or liability already acquired, accrued or incurred;
- any penalty or punishment incurred for an offence already committed against the repealed code;
- any investigation, proceeding or remedy in respect of such a matter, which may be instituted, continued or enforced as if the code had not been repealed.

Procedure and evidence follow pendency, not the offence date. The savings rule for the other two codes turns on a different pivot. Where a trial, inquiry, application, appeal or investigation was already **pendency** pending immediately before the transition, that matter is dealt with under the old evidence Act and the old procedure code, as in force before the change, as if the new codes had not come into force. So the currency of procedure and evidence follows whether the proceeding was pending at the transition, while the currency of the penal code follows when the offence was committed. This asymmetry is the examinable subtlety: a single case can be governed

by the old penal code for its offence and defence, yet by the new procedure and evidence codes for its trial, if the offence predated the change but proceedings began after it.

19.5 Which code governs the matter in front of you

The first question in any criminal referral. The practical payoff of the savings rule is a discipline that must run before any opinion on criminal responsibility is committed to paper. The psychiatrist is not the arbiter of which code applies, that is for the court, but the report must be framed in the law that actually governs, and getting it wrong signals to the court that the expert is working from stale knowledge. Two questions settle the framing:

- When was the offence committed? That fixes the penal code, and therefore the section under which the insanity defence is judged.
- Was the proceeding pending at the transition? That fixes the procedure and evidence law, and therefore the provision under which the burden of proof is allocated.

Name the current provision by its current name. Once the two questions are answered, the report should cite the governing code and section correctly and consistently, and should not drift between old and new names within the same document. Where the current codes govern, the defence is the general-exceptions insanity provision of the Bharatiya Nyaya Sanhita and the burden rule is the exceptions provision of the Bharatiya Sakshya Adhiniyam. Where the savings rule keeps an older matter alive, the report should say so explicitly, rather than silently using whichever names the clinician happens to remember.

IN INDIA

For years to come, Indian forensic practice will run old-code and new-code cases side by side, because the offence date and pendency, not the calendar, decide which law applies. A psychiatrist writing reports today will still meet matters governed by the repealed penal, evidence and procedure codes, alongside matters under the new Sanhita, Adhiniyam and the successor procedure code, sometimes within a single case. The safe habit is to read the governing provision from the primary code rather than from memory or an old handout, and to state, in the report, the code and section the opinion is written against.

GOOD TO REMEMBER

Before you frame any opinion touching criminal responsibility, establish two facts and record them at the top of the report: the date the alleged offence was committed, and whether proceedings were already pending at the transition. Those two facts, not the current year, tell you which penal code carries the defence and which evidence and procedure code carries the burden and the process. Everything else in the medico-legal opinion is built on that footing.

PITFALL

Citing the Indian Penal Code, the Indian Evidence Act or the Code of Criminal Procedure as the current law in a report written after the transition. It is an easy error, because the wording of the insanity defence did not change and the old citations are deeply familiar, but a report that names a repealed code as the governing law reads as out of date and invites the court to discount the opinion. The wording continuing unchanged is exactly why the citation, not the content, is where the mistake hides.

22	84	108	105
BHARATIYA NYAYA SANHITA SECTION CARRYING THE INSANITY DEFENCE	THE REPEALED INDIAN PENAL CODE SECTION IT REPLACED	BHARATIYA SAKSHYA ADHINIYAM SECTION PLACING THE BURDEN ON THE ACCUSED	THE REPEALED INDIAN EVIDENCE ACT SECTION IT REPLACED

The insanity defence is the penal code's general exception for the act of a person of unsound mind (the Bharatiya Nyaya Sanhita, formerly the Indian Penal Code); the burden of proving it rests on the accused under the evidence code, which also directs the court to presume the exception absent (the Bharatiya Sakshya Adhiniyam, formerly the Indian Evidence Act). They are separate sections in separate codes, so an evidence-code number can never be the insanity defence. The penal code follows the date of the offence; procedure and evidence follow whether the matter was pending at the transition.

20 · Procedure for psychiatric assessment of an accused (Sections under CrPC/BNSS, court referral)

A criminal court cannot try a defendant it cannot reach. When an accused's mental state puts their ability to follow and answer the case in doubt, the criminal procedure code does not leave the matter to the clinician's goodwill: it lays down a defined pathway by which the court itself obtains, records and acts on a psychiatric assessment of an accused. This topic is procedure, not doctrine. It governs three linked steps - how the court refers, how the person is examined, and what the court does with the report - and the disposal that follows once a finding of incapacity is recorded. The marks reward the sequence and the exact duties, not the headline that an unfit accused is referred for assessment.

Two features frame everything below. First, the question can surface at two different points in a prosecution, and each has its own section: while a Magistrate is holding an **inquiry** before trial, and once the **trial** itself is under way. Second, the assessment is anchored to a present-tense question - whether the person is **incapable of making his defence** - which is the construct of fitness to stand trial. The criteria that decide fitness are developed in the Mental health legislation and forensic psychiatry notes and are named here, not restated; likewise the separation of the treating from the forensic role belongs to the accompanying material on the psychiatrist as expert witness, and the rules that govern how the resulting opinion is received in court belong to the accompanying material on court structure and the rules of evidence. What this topic owns is the procedural spine that connects them.

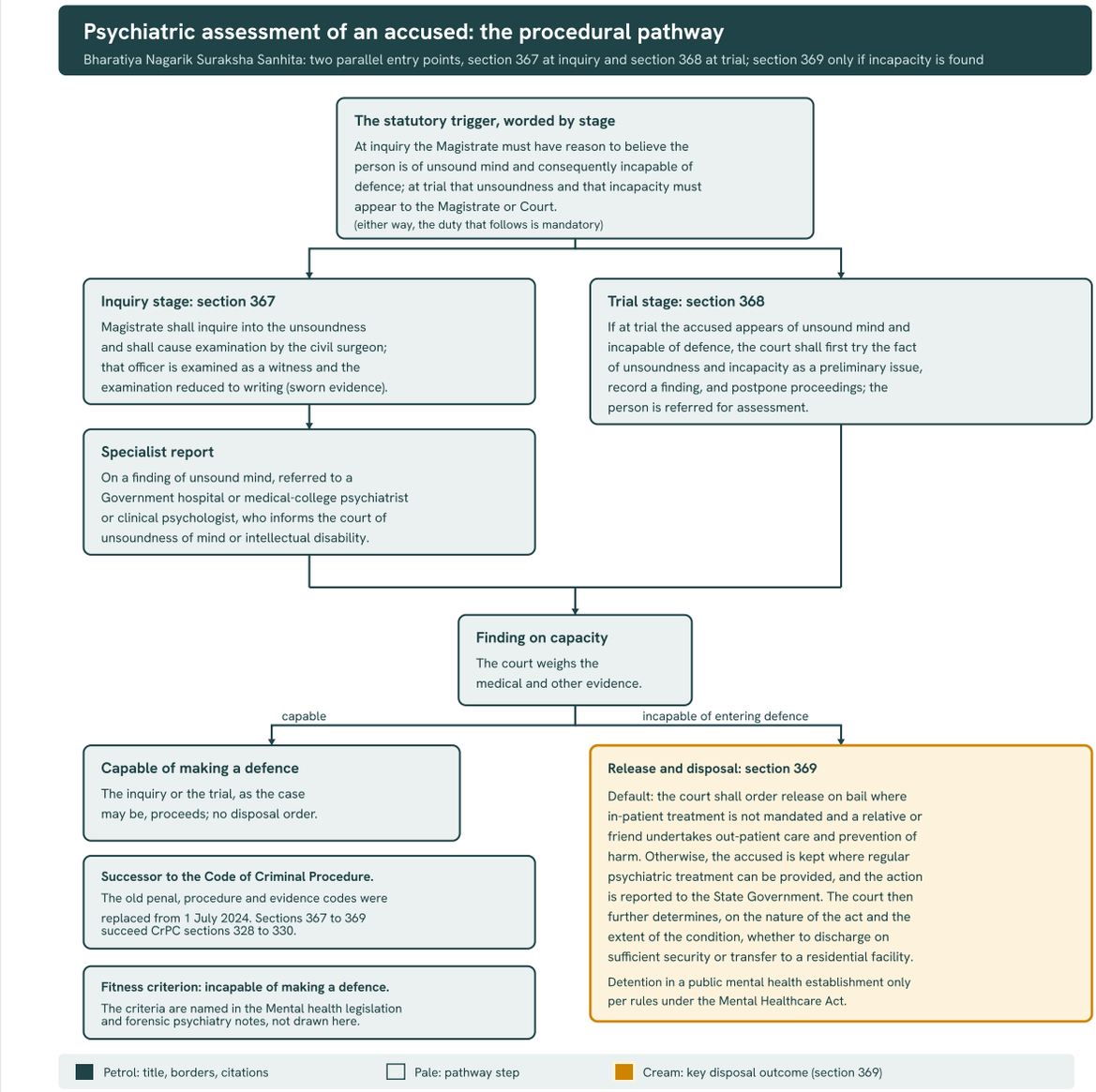


Fig 26.12. The psychiatric assessment of an accused under the Bharatiya Nagarik Suraksha Sanhita has two parallel entry points, worded differently. Under section 367, where a Magistrate holding an inquiry has reason to believe the person is of unsound mind and consequently incapable of defence, the Magistrate shall inquire into that unsoundness and shall cause the prescribed medical examination. Under section 368, where unsoundness and incapacity appear to the Magistrate or Court at trial, the court shall first try the fact of unsoundness and incapacity. A finding of capacity lets the inquiry or the trial proceed; a finding that the accused cannot enter a defence leads to disposal under section 369: release on bail where in-patient treatment is not mandated and an undertaking is given, otherwise safe custody with regular psychiatric treatment reported to the State Government, and a further determination whether to discharge on sufficient security or transfer to a residential facility. These provisions succeed Code of Criminal Procedure sections 328 to 330.

20.1 The pathway and the code it lives in

One question, two entry points, three provisions. The current procedure code is the Bharatiya Nagarik Suraksha Sanhita, the successor to the Code of Criminal Procedure. It carries the unsound-mind machinery in three consecutive sections that read as a single scheme: a referral-and-report provision for the inquiry stage, a parallel provision for the trial stage, and a disposal provision for a person found under either to be unable to enter a defence. The reason the law splits the referral across two sections is that the disability can become apparent before the case is

fully framed or only after evidence has begun, and the safeguard that no one is tried while unable to participate must be available at both moments. The disposal provision sits downstream of both, because a finding of incapacity raises the same practical question however it is reached.

The trigger is worth stating precisely, because it is where the court's duty attaches, and the two entry points word it differently. It is not enough that the accused is unwell or behaving oddly. At the inquiry stage the provision bites when the Magistrate has reason to believe the person is of **unsoundness of mind** and consequently incapable of making a defence; at the trial stage it bites when that unsoundness and that incapacity appear to the Magistrate or Court. The wording differs, the conjunction does not: a mental state together with its consequence for participation opens the pathway, and neither alone will do.

RULE **Once the Magistrate holding an inquiry has reason to believe the accused is of unsound mind and consequently incapable of making a defence, the duty to inquire and to obtain a medical examination is mandatory, not discretionary.** The statute says the Magistrate shall inquire into the fact of unsoundness and shall cause the person to be examined; it is not a power the court may exercise if it chooses. A candidate who writes "the court may refer" has changed the law, because a discretionary power and a mandatory duty are different provisions.

20.2 Referral, examination and report at the inquiry stage

The core provision, step by step. The referral-and-report section of the current code is the one to know in full, because the trial-stage provision and the disposal provision both take their shape from it. When a Magistrate holding an inquiry has reason to believe the person is of unsound mind and consequently incapable of making a defence, four mandatory steps follow in order:

1. inquire into the fact of the unsoundness of mind;
2. cause the person to be examined by the **civil surgeon** of the district, or such other medical officer as the State Government directs;
3. examine that surgeon or officer as a witness; and
4. reduce that examination to writing.

Each step is deliberate: the examination is sworn evidence taken on the record, so the court's later finding rests on testimony that can be tested, not on an informal impression.

From the first-line examiner to the specialist. The section then builds in an escalation. If the civil surgeon finds the accused to be of unsound mind, the surgeon shall refer the person to a psychiatrist or **clinical psychologist** of a Government hospital or Government medical college for **care, treatment and prognosis** of the condition. The specialist, in turn, shall inform the Magistrate whether the accused is suffering from unsoundness of mind or from **intellectual disability**. Two points repay attention. The specialist referral is triggered by the first examiner's finding, so the civil surgeon is the gatekeeper of the pathway rather than its endpoint; and the specialist's report is framed as the binary the court needs, unsoundness of mind or intellectual disability, because the two carry different implications for whether the person can be tried and

treated. An appeal against the specialist's opinion lies to a Medical Board, whose exact composition is recorded in this topic's gaps rather than asserted from memory.

MNEMONIC

Believe, Inquire, Examine, Report, Dispose

The five beats of the pathway in order: the court must have reason to **believe** the accused is of unsound mind and unable to defend; it must **inquire** into the fact; it must have the person **examine**d, first by the civil surgeon and then, on a finding, by a Government-facility specialist; the specialist must **report** unsoundness of mind or intellectual disability; and the court must then **dispose** of the person under the release provision.

20.3 The parallel provision at the trial stage

The same safeguard, one step later in the process. The trial-stage section is the mirror of the inquiry-stage provision for the point at which the case has reached trial. If, at the trial of a person before a Magistrate or a Court of Session, it appears to the court that the person is of unsound mind and consequently incapable of making a defence, the court shall, in the first instance, try the fact of that unsoundness and incapacity. It is a preliminary issue that must be resolved before the substantive trial can go further: the court considers such medical and other evidence as is produced, and if it is satisfied of the fact, it shall record a finding to that effect and shall postpone further proceedings in the case. The structure matters: the court does not simply accept the medical report but tries the fact on evidence, which is why the psychiatric assessment enters as evidence to be weighed rather than as a verdict to be rubber-stamped.

Fitness is the criterion, and it is not decided here. Both this provision and the inquiry-stage one turn on whether the accused is capable of entering a defence, which is the fitness-to-stand-trial question. What that capacity consists of - what the person must be able to understand and do to be tried fairly - is the fitness construct owned by the Mental health legislation and forensic psychiatry notes, and it is named here and cross-referred, not enumerated. This topic owns the machinery that surrounds the criterion: who refers, on what trigger, with what evidence, to what recorded finding. Keeping the fitness question apart from the responsibility question is the discipline the exam is testing.

TRAP **Reading this assessment as an opinion on the insanity defence.** The question this pathway asks is present-tense: can the accused understand and participate in the proceedings now. That is fitness to stand trial, decided by the court after medical evidence. It is a different question from criminal responsibility, which asks about the accused's mind at the time of the offence and is governed by the insanity defence and its burden - the criminal-responsibility doctrine developed in the Mental health legislation and forensic psychiatry notes. A report that answers the responsibility question when the court asked the fitness question has answered the wrong provision, and candidates lose the mark by fusing the two.

20.4 Release and disposal after a finding of incapacity

What happens to the person while the case stands still. The final section of the scheme governs the disposal of a person found, under either of the two referral provisions, to be

incapable of entering a defence by reason of unsoundness of mind or intellectual disability. Its default is liberty with treatment, and the modal force matters: whether or not the case is one in which bail may ordinarily be taken, the court shall order **release on bail** where the person's condition does not mandate in-patient treatment and a relative or friend gives an undertaking that the person will receive out-patient psychiatric treatment and be prevented from harm. Only where, in the court's opinion, bail cannot be granted, or where no appropriate undertaking is given, does the fallback apply: the court shall then order the accused to be kept in a place where **regular psychiatric treatment** can be provided, and shall report the action taken to the State Government. Drop the conditions and the answer is wrong: safe custody is not the norm but what remains when supervised community release is unavailable. The section does not stop there: keeping in view the nature of the act committed and the extent of the unsoundness of mind or intellectual disability, the court further determines whether release can be ordered, and may either discharge the accused on sufficient security or, where discharge cannot be ordered, transfer the accused to a residential facility for persons with unsoundness of mind or intellectual disability.

The one hard limit on where the person may be held. The section closes with a proviso that a candidate should be able to reproduce in substance: no order for the detention of the accused in a public mental health establishment shall be made otherwise than in accordance with the rules made by the State Government under the Mental Healthcare Act, **2017**. This is the seam where criminal procedure hands off to mental health law. The procedure code decides that the person is to be kept and treated; it does not itself authorise admission to a mental health establishment. The definitions, the admission machinery and the review boards under that Act belong to the Mental health legislation and forensic psychiatry notes and are named here, not taught.

> **GOOD TO REMEMBER**
>
> Write the report to the question the court actually asked. The referring provision wants to know two things: whether the person is of unsound mind or has an intellectual disability, and whether that condition makes them unable to follow and answer the case. Address prognosis and treatability, because the disposal provision turns on them, and say plainly whether supervised out-patient care under a relative's undertaking is feasible, the court's preferred route before custody for treatment. An opinion pitched at the wrong question, however clinically sound, does not help the court apply the section.

20.5 The psychiatrist's place in the pathway, and getting the code right

The expert serves the court, not the accused. Within this procedure the psychiatrist or clinical psychologist enters as an examiner and reporter to the court, a role distinct from that of a treating clinician who owes duties to a patient. Where the person is not already under one's care, the assessment is a forensic evaluation whose client is effectively the court, and the report must be framed accordingly: neutral, addressed to the statutory question, and defensible on cross-examination. The full separation of the treating role from the expert role, and the way opinion evidence is distinguished from fact evidence and received by the court, are developed in the

accompanying material on the psychiatrist as expert witness and the accompanying material on court structure and the rules of evidence.

Which code governs the case in front of you. Because the procedure code changed at the recent transition, the psychiatrist must be careful to frame the report in the law that actually governs. For matters already under way before the change, the corresponding provisions of the repealed Code of Criminal Procedure may still govern the proceeding, while current matters run under the successor sections described above. The savings rule that decides which code applies to a given case, and the wider transition from the old penal, procedure and evidence codes, is owned by the accompanying material on the current penal-code framework and the transition. What this topic asks of the clinician: read the governing section from the primary code, cite it correctly, and do not drift between the old and new names within a single report.

IN INDIA

The pathway is built around the public system. The first examiner is the district civil surgeon or a medical officer the State Government directs, and the specialist referral runs specifically to a psychiatrist or clinical psychologist of a Government hospital or Government medical college, not to any qualified practitioner the accused might prefer. Detention for treatment, when it comes to that, is permitted only in a place where regular psychiatric treatment can be provided, and admission to a public mental health establishment is tied to the rules made under the Mental Healthcare Act. In practice this concentrates forensic assessment in a small number of Government facilities, which is where delay and waiting-list pressure tend to accumulate.

AXIS	AT THE INQUIRY STAGE	AT THE TRIAL STAGE	ON A FINDING OF INCAPACITY
Governing section (current code)	section **367**	section **368**	section **369**
When it operates	During a Magistrate's inquiry, before trial	During trial before a Magistrate or Court of Session	After a finding under either provision that the person cannot enter a defence
What the court shall do	Inquire into the unsoundness and cause the person to be examined	Try the fact of unsoundness and incapacity as a preliminary issue	Order release on bail with an undertaking, or safe custody with treatment
Who examines or treats	Civil surgeon or directed medical officer, then a Government-facility psychiatrist or clinical psychologist	Court weighs medical and other evidence; specialist assessment on reference	A place where regular psychiatric treatment can be provided
The recorded output	Examination taken as sworn evidence and reduced to writing; report of unsoundness or intellectual disability	A recorded finding of unsoundness and incapacity; proceedings postponed	Action taken reported to the State Government

The three-provision scheme read across its two entry points and its single disposal route. The inquiry-stage and trial-stage provisions are parallel referral routes to the same fitness question; the disposal provision sits downstream of both.

PITFALL

Citing the Code of Criminal Procedure sections as the current law in a report or answer written after the transition. The old numbers are deeply familiar and the scheme has carried across largely intact, which is exactly why the error hides in the citation rather than the content. A report that names a repealed procedure code as the governing law reads as out of date, and a candidate who cannot say whether the old or the new code applies to a given matter has missed the savings rule that decides it.

328	329	330
THE REPEALED PROCEDURE-CODE SECTION FOR THE INQUIRY-STAGE REFERRAL AND REPORT	THE REPEALED TRIAL-STAGE PROVISION IT REPLACED	THE REPEALED DISPOSAL AND REPORTING PROVISION IT REPLACED

The psychiatric assessment of an accused runs on a three-section scheme in the current procedure code: a referral, examination and report at the inquiry stage; a parallel provision at the trial stage where the court shall first try the fact of unsoundness and incapacity; and a disposal provision under which the court shall order release on bail where in-patient treatment is not mandated and an undertaking is given, or safe custody with regular psychiatric treatment reported to the State Government, and shall further determine whether to discharge the accused on sufficient security or transfer them to a residential facility. The trigger is unsound mind that makes the accused incapable of defence, the duty to refer is mandatory, and the criterion is fitness to stand trial, which is named here and taught in the Mental health legislation and forensic psychiatry notes.

21 · Dying declaration and psychiatric assessment of competence

Why this earns marks. The **dying declaration** is one of the few rules of evidence in which the psychiatrist is not a bystander but a participant. The treating team is often the only body present when a fatally injured person names how the injury came about, and a court will later ask whether that person was in a fit enough mental state for the statement to be believed. Two competencies are being tested at once: a point of substantive evidence law, and a bedside psychiatric judgement about capacity. Candidates who can hold the two apart, and then join them, score cleanly. The evidence rule tells you what such a statement is worth in principle; the psychiatric assessment tells you what this particular statement, from this particular declarant, is worth in fact.

The provision must be read from the current code. The substantive criminal law of India was recently recast, and the older evidence statute is now historical; the transitional savings rule that decides which code governs a case already pending at the changeover is set out where this chapter treats the penal-code framework, and is not re-derived here.

21.1 The provision: what the statute makes relevant

The dying declaration is governed by section **26(a)** of the Bharatiya Sakshya Adhiniyam, the successor to what was section **32(1)** of the Indian Evidence Act. Ordinarily a statement made out of court by a person who is not before the court to be cross-examined is hearsay and cannot be received. The dying declaration is a recognised exception: a statement by a person as to the cause of his death, or as to any of the circumstances of the transaction that resulted in his death, is a relevant fact whenever the cause of that person's death comes into question. The rationale traditionally offered is twofold - necessity, because the best witness to the killing is now dead and cannot be produced, and a presumption of trustworthiness, the old intuition that a person who feels death approaching is unlikely to leave the world with a lie on the lips. The second limb of that rationale is exactly where Indian law then parts company with the tradition that produced it.

21.2 The Indian departure: no expectation of death, and any proceeding

This is the discrimination examiners most want to see. In the English common-law tradition the exception is narrow: the maker must have been under a settled, hopeless **expectation of death** at the moment of speaking, and the statement is admissible essentially only on a charge concerning the declarant's own homicide. The Indian statute is deliberately wider. The statement is relevant whether or not the maker was, at the time it was made, under any expectation of death, and whatever the nature of the proceeding in which the cause of death comes into question. A declarant who fully expected to recover, and who only later died, may still have made a relevant dying declaration; and the statement may be used in a civil suit as much as in a criminal trial. The maker's belief about survival has not been abolished from the analysis - it survives as a factor going to how much the statement is trusted - but it has been removed as a precondition of receiving it at all.

RULE **Under Indian law the maker need not have expected to die, and the statement is not confined to a homicide trial.** The statute makes the statement a relevant fact whenever the cause of death is in question, whatever the proceeding; the settled, hopeless expectation of death is the English precondition, not ours. The declarant's belief about survival goes to weight, never to admissibility.

Not required
EXPECTATION OF DEATH

Any proceeding
WHERE CAUSE OF DEATH IS IN ISSUE

Fit mind
WHAT THE STATEMENT'S WEIGHT TURNS ON

AXIS OF COMPARISON	ENGLISH COMMON-LAW TRADITION	INDIAN STATUTORY POSITION
Expectation of death	Required: a settled, hopeless expectation when speaking	Not required; relevant to weight only
Proceedings covered	Essentially the declarant's own homicide	Any proceeding where the cause of death is in question
Use in a civil dispute	Not available	Available
Effect if the maker expected to live	Statement excluded	Statement still relevant

TRAP **Importing the English precondition into Indian law.** Candidates who learned the topic from older or foreign texts write that the declarant must have abandoned all hope of life. In India that is wrong: the expectation of death was deliberately dropped from the statutory test, and stating it as a condition of admissibility loses the mark even when the rest of the answer is sound.

21.3 Admissibility is not reliability: the requirement of a fit mind

Where the psychiatrist enters. That the statement is a relevant fact settles only that the court may receive it. What the court then does with it - how far it relies on it, whether it convicts on it alone - is a separate question of weight, and here the declarant's mental state becomes decisive. A dying declaration carries no oath and cannot be tested by cross-examination, the two ordinary safeguards of testimony, so the court leans heavily on being satisfied that the maker was **compos mentis**. Fitness in this sense has two layers, and it helps to name them separately:

- A **physical capacity to communicate** - the declarant can produce a statement at all, by speech, gesture or sign.
- A **mental capacity** to understand what is asked and to give a rational, self-consistent account of it.

It is the second that is the psychiatric question. Note precisely what it is not: it is not whether the declarant told the truth, which is for the court to decide, but whether the declarant had the **capacity** to give a reliable statement in the first place. The psychiatrist assesses the instrument, not the tune played on it.

IN INDIA

A dying declaration is most safely recorded by a judicial magistrate, but the fatally injured are usually in casualty, and in practice the recording frequently falls to the attending medical officer or the investigating police. The settled expectation is that the treating doctor certifies, ideally both before and after the statement is taken, that the patient was conscious and in a fit state of mind to make it. Where a psychiatrist is available, that certification of mental fitness is exactly the contribution asked of them. The certificate should record the examination actually done, not merely assert a conclusion, because a bare line that the patient "was conscious" is worth little when it is later challenged.

21.4 The competence assessment at the bedside

The assessment is a focused mental-state examination directed at a single question: could this person, at this moment, take in a question, understand it, retrieve the relevant memory, and express a rational answer? The domains to examine are the familiar ones, sharpened to that purpose:

- **Consciousness and the sensorium** - alert, drowsy, fluctuating or obtunded; a clouded sensorium is a leading reason a declaration's weight is later doubted.
- **Attention and comprehension** - can the patient hold attention long enough to follow a question to its end and grasp what is being asked.

- **Coherence and memory** - a connected, internally consistent narrative of the event, drawn from recall rather than confabulated across a gap.
- **Freedom from tutoring** - whether the account was prompted, led or coached by relatives or police crowding the bedside. This goes to the reliability of the recording rather than to the declarant's mental capacity, so the clinician documents what was observed at the bedside and leaves the effect of any tutoring for the court to weigh.

MNEMONIC

Is the mind CLEAR?

Consciousness unclouded; **L**evel of attention sustained; **E**xpression coherent and comprehension intact; **A**nswers rational and internally consistent; **R**ecall of the event in the patient's own words. CLEAR is a bedside prompt, not a formula: fitness remains a case-specific conclusion supported by the recorded examination.

GOOD TO REMEMBER

Document the examination contemporaneously and in the patient's own words: the exact questions put, the exact answers given, the time, and the state of the sensorium at that time. A record showing the questions posed and the rational replies received is far stronger in court than a later assertion that the patient was "conscious and oriented". If the sensorium is fluctuating, assess and certify fitness immediately before the statement is taken, because capacity present an hour earlier does not establish capacity at the moment of the declaration.

21.5 Conditions that cloud the declarant's mind

Where competence actually fails. Almost every dying declaration is taken from a patient who is, by definition, gravely injured or ill, and the same processes that threaten life threaten the sensorium. The psychiatrist should look actively for the states below rather than presume fitness from the fact that the patient is talking; fluent speech and a clear mind are not the same thing. **Delirium** in particular can coexist with apparently purposeful conversation.

THREAT TO COMPETENCE	MECHANISM	WHAT THE ASSESSMENT FOCUSES ON
Extensive burns	Shock, toxaemia and hypoxia cloud the sensorium; pain and dehydration compound it	Alertness and coherence now, not the proportion of surface burnt, which does not by itself decide fitness
Head injury	Raised intracranial pressure, contusion and post-traumatic amnesia	Consciousness, orientation, and whether the event itself can be recalled
Haemorrhage and hypoxia	Cerebral hypoperfusion and hypoxaemia impair attention and thought	Sustained attention and fluctuation over minutes
Acute intoxication	Alcohol or other substances disinhibit and disorganise; withdrawal may bring delirium	Slurring, disinhibition, and the ability to give a consistent account
Sedation and analgesia	Opioids and sedatives blunt the sensorium precisely as pain relief is given	Timing relative to the last dose and the depth of sedation
Delirium	Fluctuating attention, disorganised thinking and altered awareness	Attention, fluctuation, disorganisation and perceptual disturbance
Psychotic or demented state	Delusional content or established cognitive impairment may distort the account	Whether the narrative is reality-based and internally consistent

A recurring bedside error concerns burns. The extent of a burn is frequently taken as a proxy for mental fitness, so that a very large burn is assumed to render the patient incompetent and a smaller one is assumed to leave competence intact. Neither inference is safe. The burnt surface tells you about prognosis and physiology, not directly about the sensorium, and a coherent contemporaneous assessment of mental state is what the question actually requires.

PITFALL

Do not anchor a report or certificate to the repealed evidence statute. The dying-declaration provision now sits in the Bharatiya Sakshya Adhiniyam; the corresponding section of the Indian Evidence Act is historical and reaches a case only through the transitional savings rule. A certificate that cites the old provision as the live law reads as out of date and quietly undermines the very reliability the psychiatrist is there to support.

21.6 Weight, corroboration and the limits of the opinion

Because it is untested by cross-examination, a dying declaration is scrutinised closely for reliability before a court acts on it, and a mentally fit declarant is central to that scrutiny; the general rules of evidence, and how a court treats and corroborates such a statement, are set out where this chapter treats the psychiatrist in court and the rules of evidence. The psychiatrist's contribution stays within its lane. We opine on capacity - whether the declarant was able to perceive, remember and communicate - and not on veracity, which is the court's exclusive

province. The separation of the treating clinician's role from that of the forensic evaluator, and of opinion evidence from fact evidence, is discussed where this chapter treats the psychiatrist as expert witness; the same discipline applies here, because the doctor who both resuscitates the patient and certifies fitness is wearing two hats at once and should say clearly which one each part of the record belongs to.

A dying declaration is relevant under the Bharatiya Sakshya Adhiniyam whether or not the maker expected to die and in any proceeding where the cause of death is in issue; its weight, however, turns on the declarant having been of fit mind, and that fitness is the psychiatric question.

22 · Court structure, the psychiatrist in court and rules of evidence

Why the marks are here. A psychiatric opinion is only as good as the forum that receives it and the rule that lets it in. A report may be clinically impeccable, but if the psychiatrist does not know which court has summoned them, or cites the provision that admits their opinion in the language of a repealed code, the credibility of the whole exercise is undercut before a word of the clinical reasoning is read. Examiners test this because it is where a well-trained clinician is most easily caught out: the medicine is sound, the legal frame is out of date. Two things must be exact - the structure of the courts a psychiatrist may testify before, and the evidentiary rule under which their opinion is admitted.

This section teaches the statutory hierarchy of the criminal courts and the **rules of evidence** that govern how an expert opinion is received, both read from the current codes. The separation of the treating role from the expert role, and the advisory weight an opinion carries once admitted, are set out elsewhere in this chapter and are named here only; the substantive test of criminal responsibility, and the burden of proving it, belong to the Mental health legislation and forensic psychiatry notes and are not re-taught here.

22.1 The statutory ladder of the criminal courts

The current code of criminal procedure sets out, at section **6**, the classes of criminal court that exist in every State, and it is before these classes that a psychiatrist may be called to testify; the powers to summon a witness or to order a psychiatric assessment come from other provisions, not from this section. The provision is framed as a mandatory one: besides the High Courts and any courts constituted under other laws, every State shall have the classes of criminal court it enumerates. The enumerated classes are the **Courts of Session**; the **Judicial Magistrates of the first class**; the Judicial Magistrates of the second class; and the **Executive Magistrates** - the first three exercising judicial trial power in descending order, while the Executive Magistrate exercises executive and public-order functions rather than the trial of offences. The word "besides" does real work: it places the High Courts outside and above this list of State classes. The Supreme Court of India, higher still, is the constitutional apex, but its position is established by the Constitution and not by this section, which does not mention it.

The distinction the section draws between the two kinds of magistrate is the one most often missed. The Judicial Magistrate exercises judicial functions - trying offences, taking evidence, convicting and sentencing within the limits of the class - and it is before a Judicial Magistrate or a Court of Session that a psychiatrist's evidence on a contested criminal question is usually led. The Executive Magistrate performs executive and public-order functions rather than the trial of offences, and a psychiatrist encounters this office in the machinery that surrounds custody and order rather than in the trial.

COURT	PLACE IN THE LADDER	WHERE THE PSYCHIATRIST MEETS IT
Supreme Court of India	Constitutional apex, above the High Courts	Rarely in person; its judgments set the law the report must follow
High Court	Sits besides and above the State classes	Appeals and references turning on a psychiatric question
Court of Session	Highest of the State trial classes	Trial of the graver offences where responsibility is in issue
Judicial Magistrate (first and second class)	The magistracy exercising judicial trial functions	Trial of lesser offences; taking of evidence and committal
Executive Magistrate	Executive and public-order functions, not trial	Order-maintenance and custodial machinery, not the trial itself

The statutory classes under the current procedure code, with the High Courts and the Supreme Court above the State list. The section fixes the classes; which class hears a given matter turns on the offence and the stage of proceedings.

MNEMONIC

Sessions sit highest, Judicial magistrates try, Executive magistrates keep order

Read the State ladder top to bottom: Court of Session, then Judicial Magistrate of the first and then second class, then the Executive Magistrate. The first three are judicial and try offences; the last is executive and keeps public order. The High Courts sit besides and above the whole list, and the Supreme Court above them.

22.2 Why the forum matters to the report

The court decides the shape of the answer. Knowing the ladder is not academic. The court issuing the summons frames the question being asked and identifies the person to whom the duty of the evidence is owed, which is the court and not the party who arranged the attendance; the standard of proof, by contrast, is fixed by the nature of the proceeding and the law that governs it, not by the court that issues the summons. The scope of the opinion is set by the question the court has framed and not by the rank of the court that framed it: a magistrate's inquiry may call for a comprehensive assessment while a Court of Session may want one narrow issue answered, and accuracy, transparency and defensibility are owed in equal measure to every court. A psychiatrist who does not register what was actually asked either over-answers a small question or under-serves a large one. The pathway by which an accused is referred for assessment is a

separate topic set out elsewhere in this chapter; what matters here is that it ordinarily proceeds before one of the courts named above, subject to any special court constituted under another law.

GOOD TO REMEMBER

Before writing a line, establish which court has called you and in what capacity. Match the report to the forum: state the court, the question as the court framed it, and the material examined. Because a treating psychiatrist's own records can be summoned as evidence of fact in any of these courts, contemporaneous and legible documentation is a medico-legal protection long before a summons ever arrives.

22.3 The rule that admits an expert opinion

The ordinary rule of evidence is that a witness may speak only to facts they personally perceived, because drawing inferences from facts is the court's own work. The expert is the deliberate exception, and the current evidence code fixes that exception at section **39**, the successor to the corresponding provision of the repealed Indian Evidence Act. The rule is precise about when it operates: it is only when the court has to form an opinion upon a point of science, art, foreign law, any other field, or the identity of handwriting or finger impressions that the opinions of persons specially skilled in that field are, in the language of the code, **relevant facts**, and the persons who give them are called **experts**. The trigger is the court's own need for specialised knowledge it does not itself possess; where no such need arises, the exception does not open and an opinion is not received.

Two features of the current section repay attention:

- its illustrations expressly include the psychiatric question, one being precisely whether a person was, by reason of unsoundness of mind, in a particular mental state, the evidentiary hook on which psychiatric testimony hangs;
- it has been modernised for the digital age, a sub-section making the **Examiner of Electronic Evidence** an expert so that opinions on electronic records are admitted on the same footing.

For the psychiatrist the first of these is load-bearing: the code does not merely tolerate psychiatric opinion, it names unsoundness of mind as a paradigm of the specialised question an expert exists to address.

RULE **Expert opinion is admitted only where the court needs specialised knowledge to form its own opinion.** When the court has to form an opinion on a point of science, art, foreign law, any other field, or the identity of handwriting or finger impressions, the opinions of persons specially skilled in that field are relevant facts, and those persons are experts. The psychiatric question of unsoundness of mind falls squarely within the field the section describes.

22.4 A relevant fact, not a verdict

Calling the opinion a relevant fact is exact, and it marks the boundary of what the evidence rule delivers. Admissibility is one question and weight is another. The expert-opinion section makes the opinion admissible, that is, something the court is entitled to consider; it does not make it binding, and it does not transfer the decision to the expert. The distinction between fact evidence

and opinion evidence, and the advisory character an admitted opinion carries, is the treating-versus-expert material developed elsewhere in this chapter and is only named here. What the evidence rule itself contributes is narrower: it opens the door through which a specialised opinion may pass, on a defined class of question, given by a person specially skilled. What the court then does with the opinion is a matter of weight, not of the rule that let it in.

TRAP **Citing the repealed evidence and procedure codes as current.** Candidates and clinicians reach for the section numbers of the old Indian Evidence Act and the old Code of Criminal Procedure, the codes they trained on, when stating the rule that admits their opinion or the court that will hear it. Those codes are historical; the expert-opinion rule and the classes of criminal court are now provisions of the current evidence code and the current procedure code. An opinion built on a repealed citation is easy to discredit, however sound the psychiatry beneath it.

22.5 The psychiatric question inside the rules of evidence

Several distinct evidentiary questions bring the psychiatrist into this framework, and it is worth separating them so that each is answered under the right rule and the right owner. They are:

- the admissibility of psychiatric opinion itself, which is the expert-opinion rule owned here, with unsoundness of mind named in the section's own illustration;
- the substantive test of criminal responsibility and the burden of proving it, which the illustration points toward but does not decide, and which belong to the Mental health legislation and forensic psychiatry notes;
- the assessment of a declarant's competence when a dying declaration is offered in evidence, a distinct evidence rule set out elsewhere in this chapter;
- the procedure for referring and assessing an accused, whose pathway is likewise carried elsewhere in this chapter.

Keeping these apart is the discipline the topic rewards. The evidence rule tells you that a psychiatric opinion on unsoundness of mind is receivable; it does not tell you what the test of unsoundness is, nor who must prove it, nor how heavy that burden sits. Those belong to the doctrine of criminal responsibility, and answering them here would blur the very line the evidence rule draws. The section admits the opinion; the doctrine, taught in the Mental health legislation and forensic psychiatry notes, decides what the opinion must establish.

IN INDIA

Both provisions a psychiatrist relies on in a criminal court are now Indian statutes of recent vintage: the classes of criminal court are fixed by the current procedure code, which replaced a post-independence Code of Criminal Procedure, and the admissibility of expert opinion by the current evidence code, which replaced the colonial-era Indian Evidence Act. The Indian evaluator testifies within this specific statutory ladder and under this specific evidentiary rule, not a generic or textbook-Western frame, and the report should name whichever code actually governs the proceeding rather than reaching by habit for the Act it replaced.

22.6 Currency: testifying after the codes changed

The evidence code and the procedure code that carry these two rules are themselves the products of the recent replacement of the three colonial criminal codes, when the old penal, procedure and evidence Acts gave way to their current successors. The rule that decides which code governs a particular matter - the savings rule that turns, for procedure and evidence, on whether the proceeding was already pending at the changeover - is set out elsewhere in this chapter and is not re-derived here. What the psychiatrist must carry from it is practical: a matter that straddles the transition may be tried under the current procedure and evidence codes even where the offence and its defence are judged by the older penal law, so a report should cite whichever codes actually govern and never assume the newest code applies automatically.

Under the current evidence code, its expert-opinion rule makes the opinion of a specially skilled person a relevant fact whenever the court needs specialised knowledge, and unsoundness of mind is named in its illustrations; the current procedure code, through its classes-of-court provision, fixes the classes of criminal court a psychiatrist testifies before.

6	39
PROCEDURE-CODE SECTION FIXING THE CLASSES OF CRIMINAL COURT	EVIDENCE-CODE SECTION ADMITTING EXPERT OPINION

PITFALL

The recurring real-world error is a currency error, not a clinical one: a psychiatrist swears to or writes a report that grounds the admissibility of the opinion, or names the court, in a section of the Indian Evidence Act or the Code of Criminal Procedure. Those Acts have been replaced. The correct citations are the expert-opinion provision of the current evidence code and the classes-of-court provision of the current procedure code, and using the repealed numbers hands the other side an easy line of attack on an otherwise sound opinion.

23 · Legal aspects of seclusion, restraint and involuntary treatment

Why the marks sit here. Coercion is the point at which psychiatry is most likely to injure the very person it sets out to help, and it is therefore the point at which the law watches most closely. When a patient is shut in a room alone, held down, sedated to control behaviour, or treated over refusal, the ordinary architecture of clinical practice - liberty as the default and treatment by consent - has been suspended. The examiner's interest is not in whether these things ever happen, because they do, but in whether the candidate can say exactly what makes each of them lawful rather than an assault or a wrongful detention. This topic is the legal frame around the three coercive interventions: what the law permits, on what conditions, and with what safeguards attached. The moral reasoning behind that frame, and the rights lens that applies in prisons and custody, are developed elsewhere in this chapter; here the task is the legal skeleton.

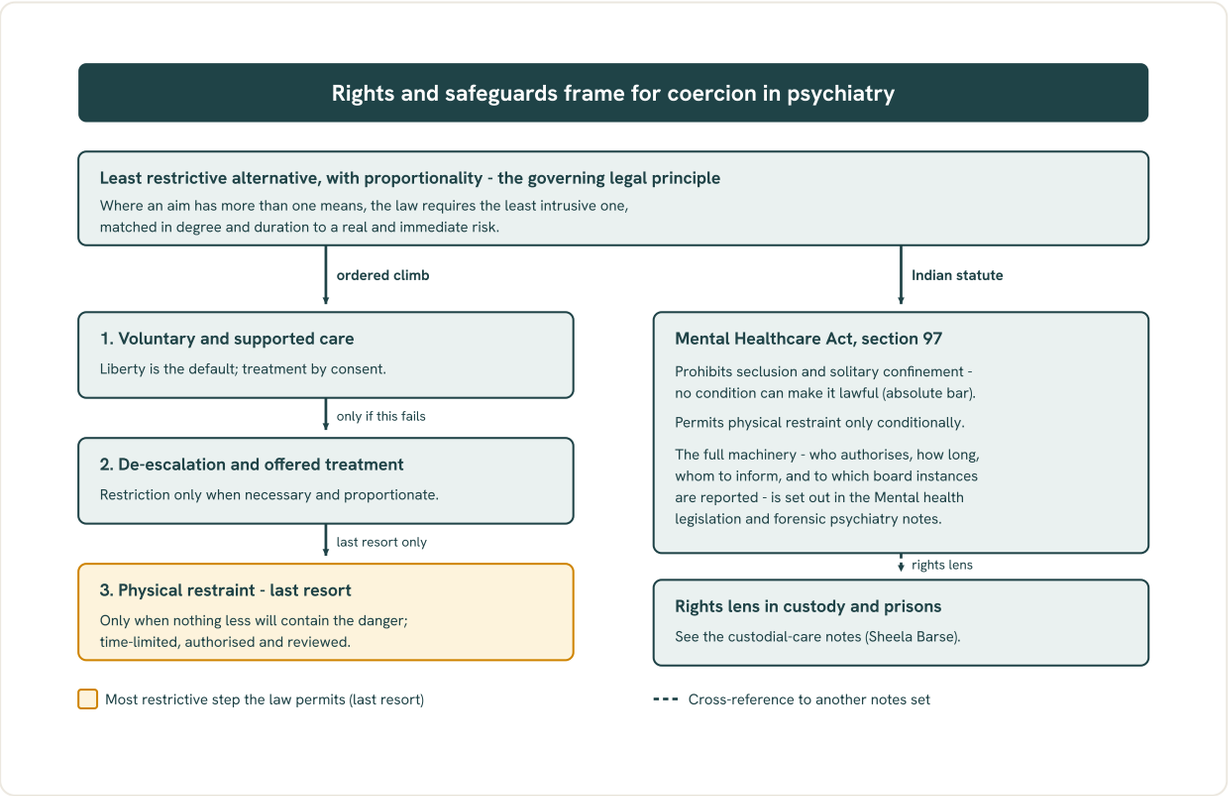


Fig 26.13. The rights-and-safeguards frame for coercion: the least restrictive alternative forces an ordered climb from voluntary care to time-limited, reviewed physical restraint, while Mental Healthcare Act section 97 bars seclusion and solitary confinement outright and permits restraint only conditionally.

23.1 The three coercive interventions and why the law singles them out

Three distinct interventions are gathered under this heading, and the first discipline is to keep them apart, because they carry different legal answers. **Seclusion** is the confinement of a person alone in a room or space they cannot freely leave; its extreme form, **solitary confinement**, isolates the person from all meaningful human contact. **Physical restraint** is the use of manual force or a mechanical device to restrict free movement. A third and quieter category is **chemical restraint**, the administration of medication whose purpose is to control behaviour or movement rather than to treat the underlying condition. Distinct again is **involuntary treatment**, the delivery of a medical intervention to a person who has not consented, or who has refused.

What unites them is that each is an exception to a legal default. The default is that an adult of sound understanding may not be confined, touched, or medicated without agreement; departing from that default requires positive legal authority, and the law grants that authority narrowly and conditionally. This is why coercion is examined as law and not merely as good practice: a restraint that is clinically understandable but legally unauthorised is still a battery, and a confinement that felt safe on the ward is still a false imprisonment if the conditions the statute demands were not met.

23.2 The least restrictive alternative as the governing legal principle

The single organising idea across the whole of coercive care is the **least-restrictive alternative**. It holds that where an aim can be achieved by more than one means, the law requires the means that intrudes least on the person's liberty, dignity and bodily integrity. It is not a counsel of perfection but a legal test with teeth: it makes the more restrictive option unlawful whenever a

less restrictive one would have worked. In practice it forces an ordered climb - environmental change, de-escalation and verbal engagement, offered medication, then, only if these genuinely fail, physical measures - and it treats each higher rung as justifiable only by the failure or inadequacy of the ones below it.

Its companion is **proportionality**: the degree and duration of any coercion must be matched to the seriousness and immediacy of the risk it answers, and no more. Proportionality is what stops the least restrictive option from being applied too hard or too long. Together they convert a vague clinical instinct into something a court can review after the fact: not "was the ward safer" but "was this the least intrusive step that would have contained the specific danger, and was it kept to the shortest span that danger required."

RULE **Coercion is lawful only as the least restrictive, proportionate means, and each form answers to its own threshold: physical restraint to a real and immediate risk, involuntary treatment to the conditions of the statutory pathway relied on.** Every coercive act must be justified twice over: that a less intrusive alternative was tried or genuinely unavailable, and that the intensity and duration were no greater than the danger demanded. A step that skips the ladder, or outlasts the risk, forfeits its lawfulness even if it was well intentioned.

Least	Nil	Exception
RESTRICTIVE ALTERNATIVE IS THE LEGAL DEFAULT	LAWFUL SECLUSION OR SOLITARY CONFINEMENT	INVOLUNTARY CARE DISPLACES CONSENT, NEVER RIGHTS

23.3 The rights and safeguards frame

The law does not simply permit coercion and walk away; it wraps every permitted instance in procedural safeguards whose function is to keep the intervention honest. These safeguards recur, in one form or another, across every jurisdiction and every code, and a candidate who can recite the frame can reconstruct almost any specific provision from first principles. The core safeguards are:

- **Necessity** - a lawful ground exists only on the test the governing provision itself sets: for physical restraint, that coercion is the sole realistic way to prevent serious, imminent harm; for involuntary treatment, the necessity written into the pathway relied on.
- **Proper authorisation** - the decision rests with a defined clinician, not with whoever is nearest or most senior on the floor.
- **Time-limitation** - the measure lasts no longer than the risk that justified it, with active review built in rather than a fixed licence.
- **Documentation** - the reasons, the alternatives tried, and the timing are recorded contemporaneously, because an unrecorded safeguard is indistinguishable from an absent one.
- **Notification** - the person's representative is told, so that coercion is never invisible to those outside the treating team.
- **External oversight** - instances are reported to an independent review body, moving accountability beyond the establishment that imposed the measure.

Reading down that list, the interventions sort themselves onto a continuum from tolerable-under-conditions to never-permitted, and the same axes explain why.

INTERVENTION	LEGAL STATUS	GOVERNING SAFEGUARD
Seclusion / solitary confinement	Prohibited outright	No condition can make it lawful
Physical restraint	Conditionally permitted	Necessity, authorisation, strict time-limit
Chemical restraint	A clinical description; its statutory position is not settled by the grounded text of the restraints and seclusion provision	The consent and involuntary-treatment rules governing the medication itself
Involuntary medication or treatment	Only under statutory authority	Applicable statutory pathway and decision-specific capacity; Board review where prescribed

IN INDIA

The Indian embodiment of this frame is the Mental Healthcare Act, whose restraints-and-seclusion provision is section **97**: it prohibits seclusion and solitary confinement absolutely, and permits physical restraint only conditionally. The full machinery of that section - who authorises, for how long, whom to inform, and to which body instances are reported - together with the Act's definitions, capacity provisions, advance directive, admission pathways and review boards, is set out in the Mental health legislation and forensic psychiatry notes and is named here rather than restated. The point to carry is structural: Indian statute encodes the continuum above, drawing the hard line at seclusion and hedging restraint with cumulative conditions.

23.4 Involuntary treatment as an exception to consent

Involuntary treatment raises a different legal question from restraint, because it engages the doctrine of consent directly. The starting position is that valid treatment requires the patient's informed agreement; the elements of that agreement - capacity, adequate disclosure, and voluntariness - are set out in this chapter's account of consent in psychiatry and are not re-derived here. Treatment without consent is lawful only where a specific legal authority displaces the ordinary requirement, and that authority depends on the applicable statutory pathway and on the patient's decision-making capacity, not on the diagnosis or the setting alone.

Two errors follow from losing sight of this. The first is to treat a mental illness as if it were itself the authority to override refusal; it is not, because many patients with serious illness retain capacity for the particular decision in front of them. The second is to assume that a lawful involuntary admission is a blanket warrant for any and all treatment. Admission answers the question of where the person may be kept; it does not by itself answer whether a given intervention may be imposed over refusal, which is a separate determination with its own conditions. The capacity standard, the advance directive that may speak for the patient's earlier wishes, and the admission categories themselves belong to the Mental health legislation and

forensic psychiatry notes; the legal principle to hold here is that involuntary treatment is a conditional exception and never a default that admission switches on.

PITFALL

The common clinical error is to read an involuntary admission as consent to everything that follows, and to medicate over refusal without a fresh, decision-specific capacity assessment. Admission and treatment authority are distinct legal questions; conflating them exposes the clinician to a claim of treatment without lawful authority even where the detention itself was sound.

23.5 Chemical restraint and the discriminations candidates miss

Chemical restraint is the category that most often escapes the frame, precisely because it looks like ordinary prescribing. A dose of a sedative can be a legitimate treatment of an underlying illness or a device to subdue difficult behaviour; the same drug, the same route, and only the purpose distinguishes them. Ethically the purpose matters more than the pharmacology: medication given to control behaviour rather than to treat is coercion in substance, and the safeguards that keep restraint honest - necessity, authorisation, time-limitation, documentation and review - are the right discipline to hold it to. Its legal authority is a separate question, because the statute's restraints-and-seclusion provision is written for physical restraint; medication over refusal has to be justified under the consent, capacity and involuntary-treatment rules that govern giving the drug at all. Calling it a "PRN" or writing it up as routine does not remove it from either frame.

The discriminations worth rehearsing are therefore three. Restraint answers an immediate danger, whereas treatment answers an illness over time. Restraint is measured against the least restrictive alternative and must climb the ladder of de-escalation first, whereas ordinary treatment is measured against consent and clinical indication. And restraint is time-limited by the risk, whereas a treatment course is governed by the condition. Blur these and a control measure is dressed up as care, which is both a legal exposure and, on the wards, a route to overuse.

TRAP **Treating sedation-for-behaviour as though it were outside the restraint safeguards.** Candidates and clinicians alike assume that because a drug is a treatment in other contexts, giving it here is treatment too. Purpose is what makes the label chemical restraint apt, and it is what the ethical safeguards attach to; the legal authority for giving the drug still has to be found in the consent, capacity and involuntary-treatment rules, however the dose is documented.

23.6 Documentation, oversight and liability

The safeguards frame is only as real as the record that proves it was followed, which is why documentation is the practical hinge of this whole topic. When a coercive act is later questioned - by a review body, a representative, or a court - the contemporaneous note of what danger was faced, what less restrictive steps were tried, who authorised the measure, and when it ended is the evidence that separates a lawful intervention from an actionable one. A coercive act that was in fact necessary and proportionate but was never recorded is, for the purposes of any later scrutiny, an act without a justification.

Liability flows along familiar channels. Coercion applied without a lawful ground can found a claim in the ordinary law of professional negligence, the standard-of-care analysis for which is developed in this chapter's treatment of professional negligence and is not restated here; coercion that is disproportionate or prolonged can breach the person's rights independently of any question of clinical skill. The rights lens that applies with particular force in prisons and custodial settings is taken up separately in this chapter. The through-line is that oversight is not an administrative afterthought but the mechanism by which the least restrictive principle is enforced after the event, when the clinical urgency that prompted the act has passed and only the record remains.

GOOD TO REMEMBER

Before any restraint, and while it is in force, write the ladder down: the danger, the less restrictive steps attempted, the authorising clinician, and the intended and actual end-point. This single habit satisfies the safeguards frame, shortens the intervention by keeping its end in view, and is the strongest protection against a later claim that coercion was imposed without lawful justification.

Every coercive intervention in psychiatry is lawful only as the least restrictive, proportionate, authorised and reviewable response to a genuine necessity; physical restraint answers a real and immediate risk while involuntary treatment runs through its own statutory conditions, and seclusion and solitary confinement have no lawful place at all.

Cross-cutting synthesis

24 · Cross-cutting synthesis

Every topic in this chapter is one question asked over and over. A patient says something in a consulting room. What happens to that sentence next - whether it is guarded, revealed to protect someone, spoken aloud in a witness box, or written into a record an inspector may later read - is not decided by the sentence. It is decided by who the psychiatrist is at that moment, and by what makes the telling lawful. Learn each of this chapter's topics on its own and you have a shelf of separate rules. See that they answer a single recurring question and you have the chapter, because the ethics, the consent, the confidentiality, the liability and the forensic role are not neighbours on a syllabus; they **interlock**, and the joint that holds them together is disclosure governed by role.

The marks for this synthesis are earned in the transitions, not in any one rule. An examiner who wants to separate a candidate who has memorised from a candidate who has understood gives a vignette that crosses roles: the treating doctor who is later summoned to court, the consent that turns out to be a capacity problem, the confidence that collides with a threat to a third person, the complaint that becomes a consumer matter, the accused a magistrate has ordered assessed. In every one of these, the facts do not change; the psychiatrist's relationship to them does, and with it the answer. This account owns that shared logic only. It names each rule in a clause and sends

you to the topic that teaches it in full; if it starts restating a section or a test, it has wandered into a sibling's territory.

Patient	Third party	Court	Regulator
CONFIDENTIAL BY DEFAULT, THE CLINICIAN'S OWN DUTY	A PROPORTIONATE DISCLOSURE THAT IS PERMITTED, NOT COMMANDED	A DISCLOSURE THE COURT'S OWN PROCESS CAN COMPEL	A RECORD REACHABLE ONLY UNDER A LAWFUL ORDER OR AN EXPRESS STATUTORY POWER

24.1 The two roles that decide everything

The organising fact of forensic ethics is that a psychiatrist can stand in one of two fundamentally different relationships to the same person, and the primary allegiance and much of what is owed change between them. In the first, the **treating clinician** owes their duties to the patient: to act for that person's welfare, to hold their confidences, to obtain their consent, to keep faithful records of their care. In the second, the **forensic evaluator** owes their primary duty not to the person in the chair but to the court that has asked for an opinion: to be objective, to serve the process of justice, to tell the tribunal what the clinical findings are even when they do not help the person being examined. This **dual role** is the spine of the whole chapter, and almost every discrimination the examination tests is a consequence of it.

The two roles pull in opposite directions on the one thing both handle, which is information. The treating role's instinct is to protect and withhold; the forensic role's obligation is to examine and report. That is why the same clinical detail is not one fact with one rule but a single fact whose governance shifts as the psychiatrist's relationship to the person shifts. The chapter's individual topics each sit on one side of this divide or describe a crossing between the sides, and the account of the expert witness elsewhere in this chapter, which separates the treating role from the expert role, is the place where the divide is drawn most sharply.

RULE **Ask the role before you answer the question.** No rule in this chapter can be applied until you have fixed which relationship the psychiatrist stands in. The role sets the duty, the duty sets what may be disclosed, and the same information carries a different answer depending on which of the two hats the psychiatrist is wearing when the question arrives.

24.2 One fact, several governances

Take a single piece of clinical information and watch how differently the law treats it as the setting changes. In the consulting room it is confidential, and the default duty not to reveal it is the clinician's own, owed to the patient. If that same information reveals a serious and specific danger to an identifiable other, it becomes something the clinician is permitted to reveal to avert the harm, a permitted **disclosure** that the Indian position allows without ever commanding; the full working of confidentiality and its recognised exceptions is taught in this chapter's account of confidentiality and its limits. Put the same clinician in a witness box under an order of the court, and the information can be compelled from them, because the authority over the telling has passed to the court's own process; being compelled makes them a witness, and the expert's duty to the tribunal arises only where that role has been separately defined. Written into the clinical file, that information becomes a record whose standards of keeping, and whose openness to

inspection by a regulator or a court, are the subject of this chapter's account of medical records and certification.

Nothing about the information itself changed across those four settings; the authority governing it did. This is the single most useful table to carry into the examination, because it turns a set of separate topics into one grid, and a vignette into a question of which column applies.

SETTING	WHO THE PSYCHIATRIST IS	WHAT GOVERNS THE INFORMATION	ON WHOSE AUTHORITY IT MAY BE DISCLOSED
THE CONSULTING ROOM	Treating clinician	The default duty of confidentiality	No one: it is kept, unless a recognised ground arises
A THREAT TO AN IDENTIFIABLE OTHER	Treating clinician exercising judgement	A permission to make a proportionate protective disclosure	The clinician's own bounded discretion, not a command
THE WITNESS BOX	Expert or compellable witness	The rules of evidence and the court's order	The court, which can compel the telling
THE CLINICAL RECORD	Record-keeper and certifier	Documentation and certification standards	The patient's consent, a lawful order, or an express statutory power of inspection
ANY OF THE ABOVE	Either role	Valid consent, where it can be and has been obtained	The patient, whose consent makes an otherwise closed disclosure lawful

24.3 Consent is the hinge, and capacity is the question under it

Running underneath the whole grid is **consent**, because a valid consent is the cleanest authority of all: within the scope of what the patient has actually authorised it can make lawful a disclosure that would otherwise be a breach, and it is the ground on which the treating relationship is built in the first place. This chapter teaches consent in full in its account of informed consent in psychiatry, with its elements and its special situations. The synthesis point is narrower and sharper: consent is not a signature, it is a state of the patient, and the moment you probe it you may find yourself asking a different question altogether.

That different question is **capacity**. A consent form is only as good as the decision-making ability of the person who signed it, so a consent question in a patient whose illness clouds judgement quietly becomes a capacity question, and a capacity finding is what determines whether the treating role can proceed on the patient's own authority or must fall back on the substituted machinery. The capacity determination itself, and the statutory scheme of advance directives, nominated representatives and admission that surrounds it, belong to the Mental health legislation and forensic psychiatry notes and are named here, not reworked. The seam to hold is the slide: an autonomy question about what the patient wants becomes a capacity question about whether they can decide, and only after that is answered does the disclosure or the treatment have a lawful footing.

GOOD TO REMEMBER

When a consent feels shaky, stop treating it as a consent problem and test it as a capacity problem. The two are asked in the same breath but answered by different tools, and the whole lawfulness of what follows - the treatment, the admission, the release of information to a family member - rests on getting that second question right rather than accepting the first answer at face value.

24.4 The handoffs a real case crosses

A single patient can walk the psychiatrist through most of this chapter. Real forensic difficulty comes not from any one rule but from the crossings between them, when a case moves from one role or forum to the next and the governing rule changes at the boundary. The recurring handoffs are these.

- **Treating clinician is summoned as a witness.** The doctor who has cared for a patient is called to speak about them in court. A summons does not by itself turn the treating clinician into the forensic expert: they ordinarily give evidence of fact and of the treatment they provided, and a separate expert role must be defined explicitly rather than assumed at the courtroom door. Keeping the two roles distinct is the discipline taught in this chapter's account of the expert witness.
- **A consent becomes a capacity question.** The autonomy the treating role respects turns out to depend on a decision-making ability the illness has compromised, and the answer moves from what the patient wants to whether they can decide, as above.
- **A confidentiality duty meets a duty to a third party.** The promise to the patient collides with the safety of an identifiable other, and the clinician must decide whether a permitted protective disclosure is warranted and how far it may go, a decision governed by proportionality and taught in this chapter's account of confidentiality.
- **A negligence claim becomes a consumer matter.** A grievance about care crosses from the language of professional negligence into a specific statutory forum with its own remedy, so the same allegation is litigated in a different place under a different frame; the standard of care and the forum are taught in this chapter's accounts of negligence and of the consumer-protection route.
- **An accused becomes a psychiatric subject by order.** A person facing trial is sent for assessment not by their own consent but by a court's direction, which converts a clinical encounter into a court-authorised examination whose procedural pathway this chapter teaches, while the substantive test of criminal responsibility belongs to the Mental health legislation and forensic psychiatry notes.

Notice that every handoff is a change in the authority over information or over the person: a duty owed to one party is joined, and to that extent limited, by a duty owed to another. That is why disclosure, and not any single doctrine, is the thread the chapter is strung on.

24.5 The forum, the code and the currency behind every answer

Two further layers sit behind the grid and quietly decide answers. The first is the forum: the place a dispute is heard shapes the remedy available, so a claim about deficient care is one thing framed as professional negligence and another routed into the consumer-protection forum, and an opinion is received under one set of rules in a courtroom that this chapter's account of the court and the rules of evidence sets out. The second is currency, and it is the trap that most often turns a correct-sounding answer wrong. The rules cited must be the ones actually in force. The professional-conduct code that governs a psychiatrist's ethics, taught in this chapter's account of the codes, is the operative one and not the later edition that was notified but held in abeyance. The substantive criminal law changed, and the framework and its savings rule are taught in this chapter's account of the penal-code transition; naming the superseded statutes as current is a currency error, not a substantive one, and it is caught all the same.

These two layers are why the synthesis is more than a tidy diagram. A candidate can identify the right role, the right duty and the right disclosure and still lose the mark by citing the wrong forum for the remedy or the wrong edition of the code for the duty. The frame tells you what the answer is about; the forum and the currency tell you whether the answer you have written is still the law.

IN INDIA

The Indian shape of this chapter is specific and examinable. Protective disclosure is a permission and not the positive duty of the American case law. The professional-conduct code in force is the earlier statutory edition, the later one being notified but not operative. Deficient medical service reaches a defined consumer forum. The criminal statutes have been recast, and the savings rule decides which version governs: the older penal law still governs offences committed before the change, while proceedings already pending at the change continue under the old procedure and evidence law. The child-protection and juvenile framework, and the general mental-health machinery, sit in the Child psychiatry: assessment, treatment, services and protection notes and the Mental health legislation and forensic psychiatry notes respectively; this chapter points to them rather than restating them.

PITFALL

The commonest real-world slip is not a wrong rule but a blurred role. A treating psychiatrist, asked casually by a lawyer or a relative, writes a forensic-sounding opinion about fitness or responsibility into a discharge summary, without a court's referral or any other properly defined retaining authority, and without flagging that they are no longer speaking as the treating doctor. The opinion then carries the weight of an expert's while resting on none of an expert's safeguards, and the confidences of treatment leak into a quasi-legal document. Fix the role in writing before you offer the opinion, or decline until the proper role and authority are in place.

24.6 How it interlocks: the master frame

Assemble the pieces and the chapter resolves into a single decision procedure that fits every vignette it can throw at you. Fix the role. Identify the information at stake. Ask what may be told,

to whom, and on whose authority. Check that the code, the statute and the forum you are relying on are the ones currently in force. Where a rule belongs to a sibling topic, apply it by name and reason from it rather than restating it. The reason this works is that the whole chapter was built on one seam: the psychiatrist's two roles and the single question of disclosure they govern between them.

MNEMONIC

Two hats, three questions

The master frame for any forensic-ethics vignette. First the **two hats**: is the psychiatrist the treating clinician, who owes duties to the patient, or the forensic evaluator, who owes candour to the court? Then, of the information in play, the **three questions**: **What** may be told, **to Whom**, and on **Whose authority** - the patient's consent, the clinician's bounded discretion, a court's order, or a regulator's power. Fix the hat, run the three questions, and every rule in this chapter falls into its place.

Fix the role first: it decides the duty, the duty decides what may be disclosed, and the same fact carries a different lawful answer under each hat.

TRAP **Answering a role-crossing vignette with a single rule.** Candidates read the clinical detail, reach for the one doctrine it looks like - confidentiality, or consent, or negligence - and answer as though the setting were fixed. The examiner wrote the vignette precisely because the setting moves, and the mark is for tracking the information across the crossing: what was confidential becomes compellable, what looked like consent was a capacity question, what began as negligence is heard as a consumer complaint. Name the role at each stage and the moving answer becomes visible; assume one role throughout and you answer only the first frame.

Apply and consolidate

25 · Applying the chapter

Why worked vignettes earn their marks. The examiner rarely asks you to recite a rule; they hand you a short case in which two rules pull in opposite directions and watch how you reason to a defensible answer. A vignette is therefore a test of judgement under a stated constraint, not of recall, and the candidate who has only memorised isolated provisions freezes precisely where the marks are. The cases below are deliberately built at the seams this chapter has been teaching, so that each one forces the same first move: work out which role the psychiatrist is in, then work out on whose authority anything may be done or disclosed. Everything else follows from those two questions.

These vignettes assert no new rule of their own. Each reuses only what the chapter has already established and cross-refers, by name, to the material owned elsewhere. Read each one as a rehearsal: cover the answer, decide what you would do and why, then check your reasoning

against the model. Between them the four cases span the four families of question this chapter can throw at you, and the closing case draws them back into a single frame.

25.1 How to read a medico-legal vignette

Before the individual cases, fix the method, because the same skeleton unlocks every vignette in this territory. The first and decisive move is to name the psychiatrist's **dual role**: are you the treating clinician, who owes duties of care, confidence and consent to the patient in front of you, or the forensic evaluator, who owes an impartial opinion to a court and owes the person examined no therapeutic loyalty? Almost every trap in this domain is baited by a scenario that quietly switches your role halfway through, or asks you to act in one role using the duties of the other.

With the role fixed, the rest of the reasoning is a short, ordered checklist you can run on any case:

- What exactly is the decision point, and who is asking for the decision - the patient, the family, an employer, a court?
- Which duty is in tension with which, and is one of them a default that may yield rather than an absolute?
- What is the governing authority - the patient's own valid consent, a statutory permission, or a court order - and is that authority actually present here?
- What is the least intrusive action that discharges the duty, and how will you record the reasoning so a later reviewer can follow it?

MNEMONIC

The four C's - Consent, Confidentiality, Conduct, Court

Every question this chapter can set falls into one of four families, and the four C's name them in the order the chapter taught them: **C**onsent and capacity; **C**onfidentiality and its limits; professional **C**onduct, negligence and boundaries; and the **C**ourt, where the psychiatrist becomes an expert and an accused is assessed. Under all four sits the one recurring question - what may be disclosed, to whom, and on whose authority. Place the case in its C, answer that question, and the vignette resolves.

RULE **Name your role before you answer.** Whether you are the treating clinician or the forensic evaluator determines every duty that follows, so it is the first line of any good answer, not an afterthought. A candidate who states the role explicitly has already earned marks and has protected themselves from the commonest way these vignettes are lost, which is answering in the wrong hat.

25.2 Vignette: consent and capacity in a special situation

A man in his thirties is brought to the emergency department by his family after a deliberate act of self-harm. He is now medically stable. He is drowsy, his attention drifts, and he is refusing admission and any further care, saying he wants to leave. The family are divided: some insist he

be kept, one pleads that he be allowed home. The decision point is sharp - may he be allowed to refuse, and if not, on whose authority is he held?

The reasoning a candidate must show turns on **capacity**, and the key insight is that capacity is decision-specific and time-specific, not a fixed property of the person. The task is to assess, at this moment and for this decision, whether he meets the statutory test of decision-making capacity, a test set out in the mental health legislation and taught in the Mental health legislation and forensic psychiatry notes, applied here rather than restated. A fluctuating sensorium immediately after an overdose is a classic special situation, but clouded consciousness does not by itself settle the question: the legislation starts from a presumption of capacity, so the refusal stands unless an immediate, documented assessment against that statutory test shows the required abilities are absent, and the correct response is not to override him permanently but to treat what is immediately necessary, protect him from foreseeable harm, and reassess capacity when he is lucid. The second thread is **voluntariness**: a decision squeezed by family pressure in either direction is not fully free, and that too must be weighed. Where capacity is genuinely absent and the risk is high, the lawful route is the involuntary pathway set out in the mental health legislation, not an open-ended clinical override; the machinery of admission, the capacity provisions and the safeguards belong to the Mental health legislation and forensic psychiatry notes and are applied, not reinvented, here.

The answer, then, is layered: give emergency treatment to the extent necessary to prevent serious harm; do not accept a refusal made without capacity as though it were valid; reassess capacity as the clinical picture clears and honour a capacitous refusal if one emerges; and, if involuntary care is needed, use the statutory pathway and its safeguards rather than force alone. One further point earns marks and protects the patient: the man and his nominated representative have a right to information they can actually understand about the nature of the illness and what the treatment involves, a right set out in the mental health legislation and owned by the Mental health legislation and forensic psychiatry notes; the explanation is pitched in plain terms he can take in - his risk, his current confusion and what the treatment is for - rather than left as unexplained clinical jargon.

25.3 Vignette: confidentiality and the duty to warn

A patient in ongoing treatment discloses persistent, detailed thoughts of seriously harming a named colleague, describing a specific and plausible plan. The colleague is identifiable. The decision point is one candidates reliably mishandle: must the psychiatrist warn the colleague, may they, or must they say nothing?

The reasoning must begin from the default, which is that **confidentiality** is owed, and then locate the edge at which it yields. The chapter's teaching on the **limits of confidentiality** is that what the law permits is the disclosure necessary to protect another person from harm, and even then it must be proportionate and minimal - enough to avert the harm, no more; the seriousness and specificity of the threat guide how far a proportionate disclosure may reasonably go. The distinctively Indian move, and the one the examiner is testing, is that this is a permission, not an American-style blanket mandate to warn: the mental health legislation permits a proportionate

disclosure in the interest of protecting a third party rather than imposing an automatic positive duty, and the exact statutory permission sits in the Mental health legislation and forensic psychiatry notes. Before breaching anything, the candidate should show they considered the alternatives that avert the danger without disclosure at all - intensifying treatment, or arranging admission so the risk is contained clinically.

The defensible answer is graded rather than reflexive: assess the seriousness and specificity of the threat; reduce the risk within the therapeutic frame where you can, and where disclosure is necessary to protect the person threatened from harm, make the narrowest disclosure that will do it, to those who can act on it, without delaying a protective disclosure the danger has already made necessary; and document the reasoning at every step, because the justification for the breach is itself examinable and later reviewable. Taking no reasonable protective step in the face of a credible, specific threat may expose the clinician to criticism, though the Indian position frames this as a permission to disclose rather than a positive command to warn; warning reflexively at the first hostile thought needlessly destroys the alliance and exceeds the permission.

GOOD TO REMEMBER

When you decide a disclosure is justified, disclose to the person who can actually reduce the risk and tell them only what they need to act - not the case history. Proportionality is measured by what averts the harm, and a breach wider than that is itself a fresh wrong, however good the original reason.

25.4 Vignette: professional conduct, negligence and boundaries

A psychiatrist volunteers at a free mental health camp and gives advice to an attendee who, months later, alleges she was harmed by that advice. Separately, over the same period, the psychiatrist has accepted a personal gift from a regular patient, begun exchanging friendly messages outside sessions, and drifted into a relationship that is no longer purely clinical. Two decision points sit in one vignette: is a free service beyond the reach of a consumer complaint, and has the psychiatrist crossed a professional line?

On the first, the reasoning must resist a tempting shortcut. Whether the encounter grounds a claim in **negligence** turns on whether a duty of care arose, whether the conduct fell below the standard expected of a reasonable practitioner, and whether that shortfall actually caused the harm alleged. Whether the consumer-protection forum is even available turns on how the service was charged for: a service given free to every attendee falls outside it, whereas free treatment given at an establishment that charges the patients who can afford to pay is within its reach - so the shortcut that a service given without a fee is always outside, and the opposite assumption that it is always inside, are both wrong, and an ordinary negligence action may lie regardless; the reach of that forum is taught with its own case law elsewhere in this chapter. On the second, the issue is a **boundary violation**, and whether these facts have already become one: gifts, out-of-session contact and dual roles mark the slow slide from a therapeutic relationship into a personal one, and how far along that slide a case has travelled is judged against the test taught in this chapter's account of boundaries, applied here rather than assumed. The reasoning to show is that

boundaries are protective of the patient, not merely proprieties, and that the earliest crossings are the ones to name.

TRAP **Treating the four-D mnemonic as the legal test of negligence.** The familiar teaching list - duty, dereliction of that duty, damage, and direct causation - is a memory aid, not the courts' formulation. The Supreme Court's own statement is tighter: it asks for a duty, a breach of that duty, and resulting damage, with causation embedded in the last, and it holds that criminal negligence needs more still - gross negligence coupled with a guilty mind. Reciting the D's as though they were the ratio, or blurring civil and criminal thresholds, loses the mark.

PITFALL

The recurring real-world error in conduct cases is citing the wrong professional code. The operative code a disciplinary body actually applies is the long-standing Medical Council of India professional-conduct regulations; the successor National Medical Commission practitioner-conduct regulations, though formally notified, were held in abeyance and are not in force. Answering, or worse advising, from the newer notified rules treats notification as though it were commencement, and it is confidently wrong.

25.5 Vignette: the forensic role, the expert and the accused

A psychiatrist has been treating a patient for some months. The patient is now charged with an offence, and the family asks the treating psychiatrist to appear in court and give an opinion on the patient's mental state at the time of the alleged act. The decision point is whether the treating clinician can, or should, also serve as the forensic evaluator in the same case.

The reasoning must foreground the dual-role conflict this whole chapter has been building toward. As the treating clinician the psychiatrist is an advocate for the patient's clinical welfare, bound by the alliance and by confidentiality; as an **expert witness** the same psychiatrist would owe an impartial opinion to the court, must set therapeutic loyalty aside, and gives opinion evidence that is distinct from the fact evidence a witness ordinarily offers. Holding both roles compromises each: the court cannot fully trust an opinion coloured by therapeutic allegiance, and the patient's trust is betrayed if their doctor becomes the instrument of their examination. Best practice is to separate the roles, so that an independent evaluator conducts the forensic assessment. The question the family poses - the patient's mental state at the time of the alleged act - is one of criminal responsibility, whose insanity-defence test and burden of proof are owned by and cross-referred to the Mental health legislation and forensic psychiatry notes, named, not restated, here. It is distinct from fitness to stand trial, which turns on the accused's present capacity to defend; the court-referral procedure for assessing an accused is taught in this chapter, and it is engaged by that present-capacity question alone, never by the question of the mental state at the time of the act. The rules of evidence that govern how the opinion is received are the court's, and the substantive criminal law now runs on the recodified penal, procedure and evidence statutes, with a savings rule deciding which regime applies to a given case - taught in full within this chapter's statute material.

The answer is to decline the conflated role, or at least to make the conflict explicit and let the court decide, and in any event to confine any opinion given to what is within competence and to disclose its limits. A treating psychiatrist dragged into the witness box against their own patient is the sharpest instance of the two hats colliding, and naming the conflict is itself the mark-worthy move.

IN INDIA

The forensic vignette is answered from Indian primary sources, and their currency is itself examinable. The older penal, procedural and evidence codes have been superseded by their successors, so an answer that names the historical statutes as current law is wrong; the offence date governs which penal code applies, while pendency at the point of transition governs procedure and evidence. Where a child is the survivor or the accused, the child-sexual-offences and juvenile-justice framework is not this chapter's to apply - it belongs to the Child psychiatry: assessment, treatment, services and protection notes.

25.6 The common thread across the four cases

One skeleton, four skins. Set side by side, the four vignettes are the same reasoning wearing different clothes. Each opens by fixing the role, each turns on a duty that is a default rather than an absolute, each is decided by locating the governing authority, and each is lost in the same way - by importing a foreign rule, a stale statute or the wrong hat. The table below lays the four domains on shared axes so the pattern is visible at a glance.

DOMAIN	THE DECISION POINT	THE GOVERNING FRAME	THE CLASSIC TRAP
Consent and capacity	May this refusal or agreement stand?	Capacity, voluntariness, and the statutory pathway when capacity is absent	Treating a clouded refusal as valid, or overriding without the lawful route
Confidentiality	May I, or must I, disclose?	A default of confidence, with a proportionate permission at its edge	Importing a foreign mandatory duty to warn instead of a permitted disclosure
Conduct and negligence	Did the conduct fall below what was owed?	Duty, breach and resulting damage; the current professional-conduct code	Reciting the four-D mnemonic as law, or citing the code held in abeyance
Court and the accused	In which role am I answering?	Treating role separated from the impartial expert opinion to the court	Serving as expert for one's own patient, or naming superseded statutes

Notice that the right-hand column is a single family of mistakes: each is a rule applied from the wrong place - the wrong country, the wrong version of a statute, or the wrong role. That is why the method in this closer leads with role and authority. Get those two right and the specific rule usually falls out; get them wrong and even a correctly remembered rule is deployed in the wrong case.

Every forensic-ethics vignette resolves to the same two questions - which role you are in, and on whose authority you may act or disclose - and naming both is the first mark of a defensible answer.

26 · Consolidation

A chapter you have read is not a chapter you can retrieve. This closing section is a self-test, and it works only if you use it as one. The prompts below are questions with no answers printed beside them, and that is deliberate: **active recall** - forcing an answer out of memory before you look it up - is what fixes material for an examination, and an answer sitting next to the question quietly converts the exercise back into rereading, which feels productive and teaches almost nothing. Cover the notes, work down the list, say or write your answer in full, and only then turn back to the topic that owns it to check yourself.

Everything asked here was taught earlier in this chapter; nothing new is introduced and no prompt reaches for a fact the chapter never covered. The questions are grouped into the three sub-areas the chapter is built from - professional ethics with consent and confidentiality, the special settings of disaster, prisoners and custody, and the forensic statutes with legal procedure - and each group ends where the material ends, so that a blank you draw is a topic to revisit, not a trick.

26.1 How to use this list

Before the questions, fix the frame that answers most of them. Two facts run under this whole chapter. The first is the **dual role**: at any moment the psychiatrist is either the **treating clinician**, who owes duties to the patient, or the **forensic evaluator**, whose duty runs to the court. The second is that almost every rule is really a rule about **disclosure** - what may be told, to whom, and on whose authority. Run each prompt through those two facts before you reach for a specific rule, and the specific rule will usually announce itself.

RULE **Retrieve first, review second.** The value of this list is destroyed the instant you read an answer before you have tried to produce one. Attempt every prompt from memory, out loud or on paper, and treat the checking as the reward for the attempt, not a substitute for it. A prompt you cannot answer marks the exact topic to reopen.

26.2 Sub-area one: professional ethics, consent and confidentiality

These prompts sweep the ethical foundations and the two constructs the chapter stresses hardest - consent and disclosure. Answer each fully before checking the owning topic.

1. Name the principles of biomedical ethics, and say what a clinician actually does when two of them pull in opposite directions in a psychiatric decision.
2. State the essential elements of a valid informed consent and name the Indian judgment that anchors them; then explain the moment a consent question quietly becomes a capacity question.

3. Recall the grounds on which the duty of confidentiality may be lifted, and state precisely how the Indian position on disclosing to protect an endangered third party differs from the American doctrine; name the leading Indian judgment on breaching confidentiality to protect an identifiable person at risk, and be clear about what it did and did not decide.
4. Give the teaching mnemonic for the components of negligence, then state the components in the Supreme Court's own formulation, and say what criminal negligence adds to the civil standard.
5. Name the test that fixes the standard of care and the later gloss that qualified it, and explain vicarious liability in a single sentence.
6. Identify the current statute under which a patient pursues a claim for deficient medical service, what it replaced, the landmark that brought medical service within it, and when a free service falls outside it.
7. Separate the treating role from the expert role - to whom does each owe its primary duty - and say why the expert is the courtroom's exception to the bar on opinion evidence.
8. State which edition of the professional-conduct code is operative and which was notified but held in abeyance, and which of the two carries the graduated levels of professional misconduct; then name the profession's own code of ethics and the meeting that adopted it.
9. Distinguish a boundary crossing from a boundary violation, describe the slippery slope between them, and say what makes a clinical record defensible and its certification truthful.

26.3 Sub-area two: disaster, prisoners and custody

Here the vulnerable population meets the coercive institution, and the answers are Indian statutes and Indian judgments. The clinical management of substance use in these settings is not asked, because it belongs to the Substance use disorders notes.

1. Describe the tiered command structure the disaster-management statute creates, and identify the tier a psychiatrist most often works within.
2. State what that Act means by disaster management, and name what is conspicuously absent from its scheme.
3. Explain the two mechanisms by which imprisonment both generates and worsens psychiatric disorder.
4. Say what the principal Indian prisons statute provides for mental health care, and why its position is a problem.
5. State the principle of equivalence of care and the problem of dual loyalty as they arise behind the wall.
6. Name the provision that authorises the transfer of a mentally ill prisoner for treatment, and the two doors it opens.
7. Recall the judgment holding that the non-criminal mentally ill do not belong in jail, and state its practical consequence.

8. Describe the custodial duty around self-harm and suicide, and how consent and confidentiality actually operate for a detained patient.

26.4 Sub-area three: forensic statutes and legal procedure

These prompts cover the recodified criminal-legal interface. Two doctrines the chapter deliberately does not teach - the insanity-defence test with its burden of proof, and the child-sexual-offences framework - are cross-referred, and the prompts respect that boundary.

1. State the savings rule that decides which criminal regime governs a case after the recodification: what governs the penal question, and what governs procedure and evidence?
2. The insanity-defence test itself, and the burden of proof, are taught in the Mental health legislation and forensic psychiatry notes; state only the correction this chapter makes - in which code does the defence now sit, and in which separate code does the burden sit?
3. Distinguish the legal meaning of consent in sexual-offences law from clinical informed consent, and outline the psychiatrist's role with a survivor; the child framework belongs to the Child psychiatry: assessment, treatment, services and protection notes and is only named.
4. Trace the procedural pathway by which an accused is sent for psychiatric assessment: which recodified statute now houses it, what happens at referral and report, and what follows a finding of incapacity - with the fitness criteria themselves left to the Mental health legislation and forensic psychiatry notes.
5. Say what makes a dying declaration relevant and admissible, and how the Indian rule departs from the common-law requirement of a settled expectation of death.
6. Admissibility is not reliability: state what the psychiatrist must assess about a declarant's mind, and the conditions that can cloud it.
7. Recall the statutory ladder of the criminal courts, and the rule of evidence that admits an expert's opinion at all.
8. Explain why the expert's opinion is a relevant fact and not a verdict, and the currency check you must run before testifying after the codes changed.

> **GOOD TO REMEMBER**
>
> Do not run this list once the night before. Retrieval strengthens memory most when it is spaced and repeated - sweep the three groups now, mark the prompts you missed, and return to those alone after a gap of some days. The prompts you answer cleanly need no revisiting; your time belongs to the blanks.

26.5 The currency check that flips answers

A right rule stated as the wrong version is a wrong answer. More marks are lost on this chapter to stale law than to genuine ignorance, because the ground has shifted twice and the superseded answers still read as natural. Before you accept any answer you have retrieved, ask whether the code or statute you named is the one actually in force. The grid below is the coverage map: read across each row to confirm you can answer the recurring question, name the currency or limit

that most often flips it, and place the neighbouring doctrine you must cross-refer rather than re-teach.

SUB-AREA	THE RECURRING QUESTION TO ANSWER FROM MEMORY	THE CURRENCY OR LIMIT THAT FLIPS THE ANSWER	THE NEIGHBOUR TO NAME, NOT RE-TEACH
ETHICS, CONSENT, CONFIDENTIALITY	Whose is the information, and on whose authority may it be disclosed?	Which conduct code is operative, and is protective disclosure a permission or a command?	the Mental health legislation and forensic psychiatry notes (capacity, advance directives, admission)
DISASTER, PRISONERS, CUSTODY	Who owes care to a detained person, and to what standard?	The principal prisons statute's want of a substantive care standard, and the authority that permits transfer	the Substance use disorders notes (substance use in custodial settings)
STATUTES AND PROCEDURE	In which role, and under which code now in force, is the opinion given?	Are you citing the recodified statutes or the superseded ones - and what does the savings rule say?	the Mental health legislation and forensic psychiatry notes (insanity test, burden) and the Child psychiatry: assessment, treatment, services and protection notes (the child framework)

PITFALL

The recurring real-world error this chapter exists to correct is a currency error. Treating the notified-but-suspended successor professional-conduct regulations as the operative code, or citing the superseded criminal, procedure and evidence statutes as current after the recodification, is confidently wrong in exactly the way that reads as right. A disclosure permitted under the Indian regime is also misremembered as a positive duty to warn imported from foreign case law. If a prompt above returns one of these, that is the topic to reopen first.

IN INDIA

Every answer on this list is an Indian primary-source answer, and most of them differ from the Western textbook default: protective disclosure that is permitted rather than commanded, an earlier statutory conduct code still in force while its successor waits in abeyance, a consumer forum that reaches into medical practice, and a criminal law recently recast with a savings rule. When a prompt tempts you toward the familiar Western answer, that temptation is itself the signal to recall the Indian position instead.

26.6 The master frame to run on any vignette

The whole chapter collapses into one short procedure you can run against any question it throws at you. It is not new content; it is the chapter's own spine, gathered into four moves so that a vignette becomes a sequence of decisions rather than a scramble for the one rule it resembles.

MNEMONIC

HATS

The master frame for any forensic-ethics question. **H**at: fix the role first - is the psychiatrist the treating clinician who owes duties to the patient, or the forensic evaluator who owes candour to the court? **A**uthority over the information: of what is in play, ask what may be told, to whom, and on whose authority - the patient's consent, the clinician's bounded discretion, a court's order, or a regulator's power. **T**est the currency: is the conduct code the operative one and not the suspended successor, and is the criminal, procedure or evidence code the version in force under the savings rule? **S**ource and sibling: read the primary source, and where a doctrine belongs to another chapter, name it and reason from it rather than restating it. Fix the hat, run the three, and every rule in this chapter falls into place.

TRAP **Recognition mistaken for recall.** Reading an answer and thinking "yes, of course" feels identical to knowing it, and it is not - recognising a stated answer is a far weaker trace than producing one unprompted. The candidate who reviews by rereading walks into the hall confident and empties out under a blank page. Cover the answer, force the retrieval, and let the failures on this list, not the successes, direct your last days of revision.

Fix the hat, ask what may be disclosed and on whose authority, and check that the code you cite is the one in force - and you can reason through any forensic-ethics vignette this chapter can set.

Previously asked

There is no indexed past-question bank for this chapter, so nothing in the table below is a catalogued past question and no board or year is claimed for any of them. Attributing a paper the index does not hold would be a fabrication, so in place of a board of origin each row is marked Representative, and the questions are written in the register an examiner uses. Forensic ethics, consent and legal procedure are examined heavily and in every form the paper allows, as long answers, as short notes and in the viva, so the list maps the examined spine of this chapter rather than one board's recent record. Read it as a high-yield revision map, not as a set of questions on record.

QUESTION	MARKS	ASKED
Enumerate the four principles of biomedical ethics and discuss how they come into conflict in a psychiatric decision, with an example of how such a conflict is resolved.	10	Representative
Discuss informed consent in psychiatric practice: its essential elements, the assessment of capacity to consent, and the special situations that complicate it.	10	Representative
Confidentiality and its limits in psychiatry. Discuss the duty to warn, the position under the Mental Healthcare Act, and the relevance of Tarasoff and of Mr X v Hospital Z.	10	Representative
Professional negligence and medical malpractice. Explain the four Ds, the standard of care, and the distinction between civil and criminal medical negligence in Indian law.	10	Representative
Medical services under the Consumer Protection Act. Short note.	*5*	Representative
The psychiatrist as an expert witness: the role, the distinction between opinion and fact evidence, and the conduct expected in court.	*5*	Representative
Boundary violations in the therapeutic relationship. Short note.	*5*	Representative
The Indian Psychiatric Society code of ethics and the current statutory professional-conduct code. Short note.	*5*	Representative
The insanity defence and the burden of proving it under the current criminal law, and the transition from the earlier codes on the first of July 2024.	10	Representative

QUESTION	MARKS	ASKED
Describe the procedure for the psychiatric assessment of an accused person, from the court's referral to the report and its consequences.	10	Representative
Sexual offences law and the psychiatric assessment of a survivor. Discuss the legal meaning of consent.	*5*	Representative
Mental health of prisoners: the transfer and treatment of a prisoner with mental illness, and the human-rights safe-guards in custodial psychiatry.	*5*	Representative
The legal aspects of seclusion, restraint and involuntary treatment, and the least-re-strictive principle. Short note.	*5*	Representative

The shape of these questions is worth reading before their content. A ten-mark question that opens with enumerate or describe wants a structured map rather than a definition, and the marks are won on the discriminations this chapter turns on: the difference between a permission to disclose and a positive duty to warn, the difference between the insanity defence and the burden of proving it, the difference between civil and criminal negligence, and the difference between the treating role and the forensic role. A short note carries fewer marks but the same demand for the exact provision and the exact modal verb, because a permission and a duty are not interchangeable and an answer that names a repealed code as the current law reads as one that has not opened the statute. This is the one part of the paper whose answer is checkable against a primary text, which is precisely why the examiner rewards the candidate who cites the current provision and marks down the one who cites the old one by reflex.

The quick review

One table, read down the left column and cover the right. Every line is taught in full somewhere above and nothing here is new: each is that provision's single must-hold line, the rule lifted from the passage that teaches it, so a line you cannot recover is a section to reread rather than a fact to memorise here. Modal verbs are load-bearing: an exception that permits disclosure is not a command to disclose, and where the statute says shall it is kept as shall. Currency is this chapter's spine. The operative professional-conduct code is the Medical Council of India (Professional Conduct, Etiquette and Ethics) Regulations 2002; the National Medical Commission RMP Regulations 2023 were notified, then held in abeyance, and are not operative. The criminal codes are the Bharatiya Nyaya Sanhita, the Bharatiya Nagarik Suraksha Sanhita and the Bharatiya Sakshya Adhiniyam, in force from 1 July 2024, with the

Indian Penal Code, the Code of Criminal Procedure and the Indian Evidence Act as their historical predecessors; the offence date governs the penal code and pendency governs procedure and evidence.

ASK	HOLD
PROFESSIONAL ETHICS, CONSENT AND CONFIDENTIALITY	
THE FOUR PRINCIPLES OF BIOMEDICAL ETHICS	Respect for autonomy, beneficence, non-maleficence and justice, developed by Beauchamp and Childress; each is a prima facie obligation to be balanced against the others when they conflict.
INFORMED CONSENT, THE THREE ELEMENTS (SAMIRA KOHLI)	Consent to treatment must be real and valid, which the Court defines by three elements: the patient must have the capacity to consent, the consent must be voluntary, and it must rest on adequate information about the nature of the treatment.
CONSENT SCOPE AND THE DISCLOSURE STANDARD (SAMIRA KOHLI)	Consent is confined to the specific procedure consented to, so consent for a diagnostic procedure is not consent for therapeutic treatment, and that unauthorised additional surgery benefited the patient is no defence; the disclosure standard adopted is the Bolam real-consent standard, not the higher Canterbury prudent-patient test.
CONFIDENTIALITY, THE RIGHT AND ITS LIMITS (MHCA S.23)	The person has a right to confidentiality and all health professionals a duty to keep the information confidential; the enumerated exceptions (to protect another from harm, to prevent a threat to life, on the order of the Board or a court, for public safety) permit disclosure, they do not command it.
DUTY TO WARN OR PROTECT, THE US ORIGIN (TARASOFF, 1976)	A therapist who determines, or under professional standards should determine, that a patient presents a serious danger of violence to another incurs an obligation to use reasonable care to protect the intended victim; the protective privilege ends where the public peril begins.
CONFIDENTIALITY AGAINST AN IDENTIFIABLE THIRD PARTY (MR X V HOSPITAL Z, 1998)	The Indian analogue: disclosure of the patient's HIV-positive status to the woman he was about to marry was held not to violate confidentiality or the right to privacy, because an identifiable person was saved from a real risk; the right to privacy is not absolute.
THE IPS CODE AND THE OPERATIVE CONDUCT CODE	The Indian Psychiatric Society code of ethics was approved at its Cuttack conference in 1989, the foundational Indian psychiatry-specific code; the operative professional-conduct code for doctors is the MCI 2002 Regulations, because the NMC RMP 2023 Regulations were notified, then held in abeyance, and are not operative.
NEGLIGENCE, THE FOUR DS AND THE COMPONENTS (JACOB MATHEW)	The teaching mnemonic is the four Ds (duty, dereliction, damage, direct causation); the operative law is Jacob Mathew's three essential components, duty, breach and resulting damage, with causation as the fourth element (the plaintiff must prove the breach caused the injury, from Bolitho).

ASK	HOLD
THE STANDARD OF CARE, BOLAM QUALIFIED BY BOLITHO	Bolam: a professional is not negligent if he acts in accordance with a practice accepted as proper by a responsible body of professional opinion (adopted in India via Jacob Mathew); Bolitho qualifies it, so that opinion protects only if it can withstand logical analysis.
CRIMINAL MEDICAL NEGLIGENCE (JACOB MATHEW)	Far higher than the civil bar: mens rea must be shown and the negligence must be gross or of a very high degree; the words rash or negligent act are read as qualified by grossly, and negligence that is neither gross nor of a high degree may ground a civil action but cannot found a prosecution.
CONSUMER PROTECTION ACT 2019 AND IMA V V.P. SHANTHA	The 2019 Act repealed the 1986 Act; service (s.2(42)) excludes any service rendered free of charge or under a contract of personal service, and deficiency (s.2(11)) includes any act of negligence causing loss or injury; IMA v V.P. Shantha holds paid medical service is service, while service rendered free of charge to everybody is not.
THE EXPERT WITNESS, OPINION VERSUS FACT (RAMESH CHANDRA AGRAWAL)	An expert is not a witness of fact; his evidence is of an advisory character, his duty being to furnish the court with the scientific criteria to test the conclusions so the judge can form an independent judgment; the court is not bound by the expert's opinion.
BOUNDARY CROSSING VERSUS BOUNDARY VIOLATION	A crossing is a minor, non-exploitative, discussable departure from the frame that may even help the patient; a violation is an exploitative, harmful departure that serves the clinician and betrays the fiduciary duty; the slippery slope carries one into the other, and sexual contact with a current patient is the paradigm violation, absolutely prohibited and never excused by apparent consent, because responsibility for the boundary rests always with the clinician.
RESEARCH, RECORDS AND TELEPSYCHIATRY ETHICS	Under the NMC 2023 framework (notified, then held in abeyance; the operative code is the MCI 2002): research on patients or volunteers must comply with ICMR guidelines and the New Drugs and Clinical Trials Rules 2018; a self-employed RMP keeps inpatient records for three years from the last contact and supplies them on request within five working days; telepsychiatry follows the Telemedicine Practice Guidelines.
DISASTER, PRISONERS AND FORENSIC SPECIAL TOPICS	
DISASTER MANAGEMENT ACT 2005 STRUCTURE	A three-tier ladder: the National Disaster Management Authority (s.3, Prime Minister ex officio Chairperson), a State Disaster Management Authority in every State (s.14, Chief Minister ex officio Chairperson) and a District Disaster Management Authority in every district (s.25, Collector or District Magistrate or Deputy Commissioner ex officio Chairperson); the Act's own definition does not name psychosocial or mental-health support as an express limb.

ASK	HOLD
PRISONERS WITH MENTAL ILLNESS (MHCA S.103)	An order directing admission of a prisoner with mental illness is sufficient authority; transfer to the psychiatric ward in the medical wing of the prison is the first option and suffices, and only where there is no such ward may the prisoner be transferred to a mental health establishment, with the prior permission of the Board.
THE REMOVAL WARRANT (PRISONERS ACT 1900 S.30)	Where a detained or imprisoned person appears to be of unsound mind, the State Government may, by a warrant setting forth the grounds, order his removal to a lunatic asylum or other place of safe custody for the remainder of the term; this is the provision MHCA s.103 cross-refers.
CUSTODIAL HUMAN RIGHTS (SHEELA BARSE)	The Supreme Court strictly prohibited confining non-criminal mentally ill persons in jails, treating such confinement as a violation of constitutional rights.
FORENSIC STATUTES AND LEGAL PROCEDURE	
SEXUAL OFFENCES, RAPE AND ITS PUNISHMENT (BNS S.63, S.64)	BNS s.63 (successor to IPC s.375) defines rape by four act-types under seven circumstances, the capacity circumstances including consent given when, by reason of unsoundness of mind or intoxication, she is unable to understand the nature and consequences, being under eighteen, and being unable to communicate consent, with a marital exception where the wife is not under eighteen; s.64 punishes rape with rigorous imprisonment of not less than ten years, extendable to life, and fine.
CONSENT IN SEXUAL-OFFENCES LAW (BNS S.63, EXPLANATION 2)	Consent means an unequivocal voluntary agreement, communicated by words, gestures or any verbal or non-verbal communication, of willingness to the specific sexual act; a woman who does not physically resist is not, by that fact alone, to be regarded as consenting.
THE PENAL TRANSITION, SECTION 22 VERSUS SECTION 108 (THE CORRECTION)	The insanity defence is BNS s.22 (formerly IPC s.84); the burden of proving it is BSA s.108 (formerly IEA s.105); they are separate sections in separate codes, so section 105 BSA is not the successor to s.84; the penal code follows the offence date, procedure and evidence follow whether the matter was pending at the transition.
PROCEDURE FOR ASSESSING AN ACCUSED (BNSS S.367 TO S.369)	Where the accused appears of unsound mind and incapable of making his defence, the court shall first try that fact on medical and other evidence and postpone proceedings, at the inquiry stage (s.367) or at trial (s.368); s.369 governs disposal, release on bail where a relative undertakes out-patient treatment, else kept where regular psychiatric treatment can be provided, with the action reported to the State Government. Successors to CrPC s.328 to s.330.

ASK	HOLD
THE DYING DECLARATION (BSA S.26)	A statement by a person as to the cause of his death, or the circumstances of the transaction that resulted in it, is a relevant fact when the cause of that person's death comes into question, and is relevant whether or not the maker was, at the time, under expectation of death (successor to IEA s.32(1)).
COURT STRUCTURE (BNSS S.6)	Besides the High Courts, every State has Courts of Session, Judicial Magistrates of the first class, Judicial Magistrates of the second class and Executive Magistrates; the Supreme Court is the constitutional apex above them.
EXPERT-OPINION EVIDENCE (BSA S.39)	When the court has to form an opinion on a point of science, art, foreign law or any other field, the opinions of persons specially skilled in that field are relevant facts and such persons are called experts; Illustration (b) covers the question of unsoundness of mind (successor to IEA s.45).
SECLUSION AND RESTRAINT, THE LEGAL ASPECTS (MHCA S.97)	Seclusion and solitary confinement are absolutely prohibited; physical restraint may only be used when it is the only means available to prevent imminent and immediate harm and is authorised by the psychiatrist in charge, kept no longer than absolutely necessary, never as punishment or for staff shortage, the nominated representative informed within twenty-four hours and every instance reported monthly to the Board (the least-restrictive principle).

References

Every specific in this chapter is bound to one of the sources below, and the count is the number of claim rows each carried. The statutory and case-law rows were read at the primary Act on India Code, at the primary judgment on Indian Kanoon, or at the primary notification of the National Medical Commission and the Gazette of India, rather than from any textbook summary, because a stale or paraphrased section changes what a clinician is legally obliged to do. Three currency positions were read at their current form and are load-bearing for this chapter: the operative professional-conduct code is the Medical Council of India Regulations of 2002, because the National Medical Commission Registered Medical Practitioner Regulations of 2023 were notified and then held in abeyance, so the 2023 code is named as drafted but not yet in force; the substantive criminal law was read at the Bharatiya Nyaya Sanhita, the Bharatiya Nagarik Suraksha Sanhita and the Bharatiya Sakshya Adhiniyam, in force from the first of July 2024, with the Indian Penal Code, the Code of Criminal Procedure and the Indian Evidence Act named as the superseded predecessors; and the consumer-protection route was read at the 2019 Act, not the 1986 Act. Of the 61 claim rows, 58 are recorded at verified confidence and 3 at partial, the latter authored from established ethical and clinical knowledge and checked by the adversarial content pass rather than bound to a single primary quote; 14 further specifics were declared as gaps and taught around rather than supplied from memory. The must-have-papers cross-check was NOT performed for this Paper III chapter, because the paper lists do not yet exist in the intel index; for Paper III the topic

bank plus the syllabus scaffolding is the completeness authority. This table records provenance, not proof: it says where each specific came from, not that the chapter's prose uses it correctly, which the content pass and the ship review test.

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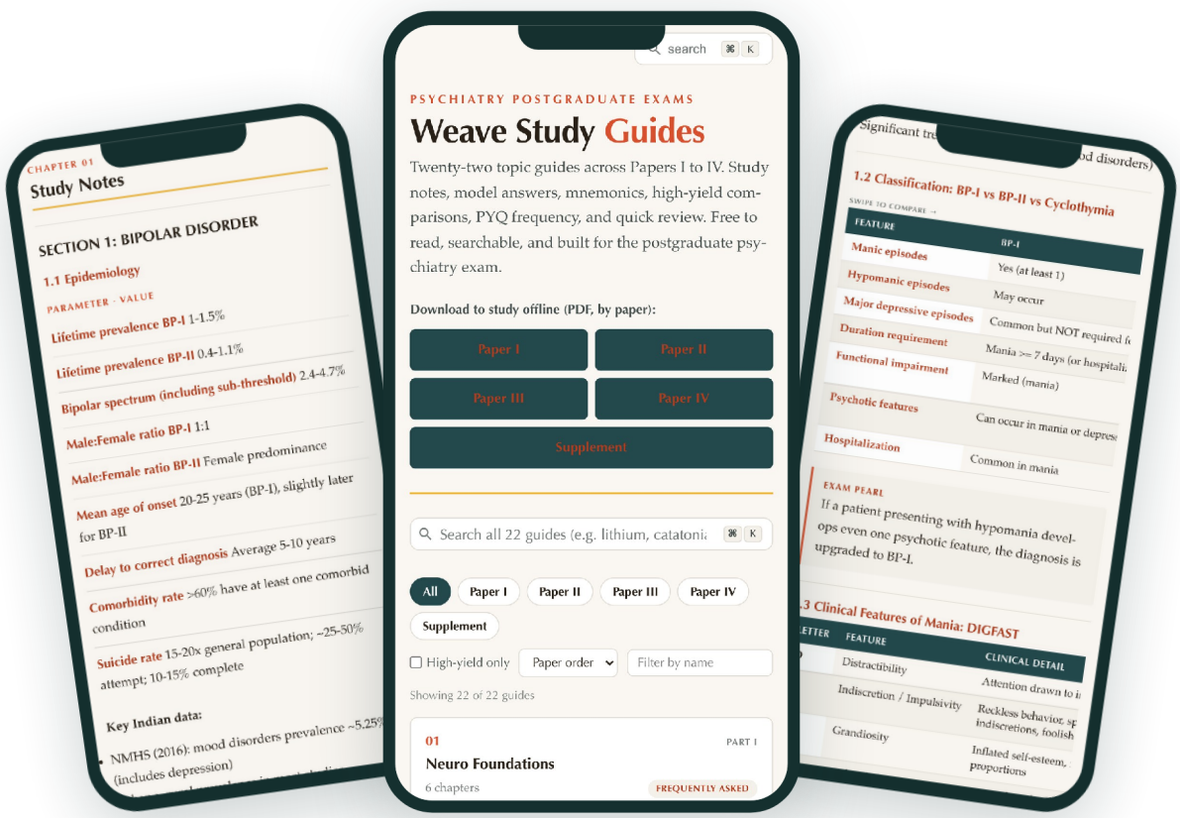
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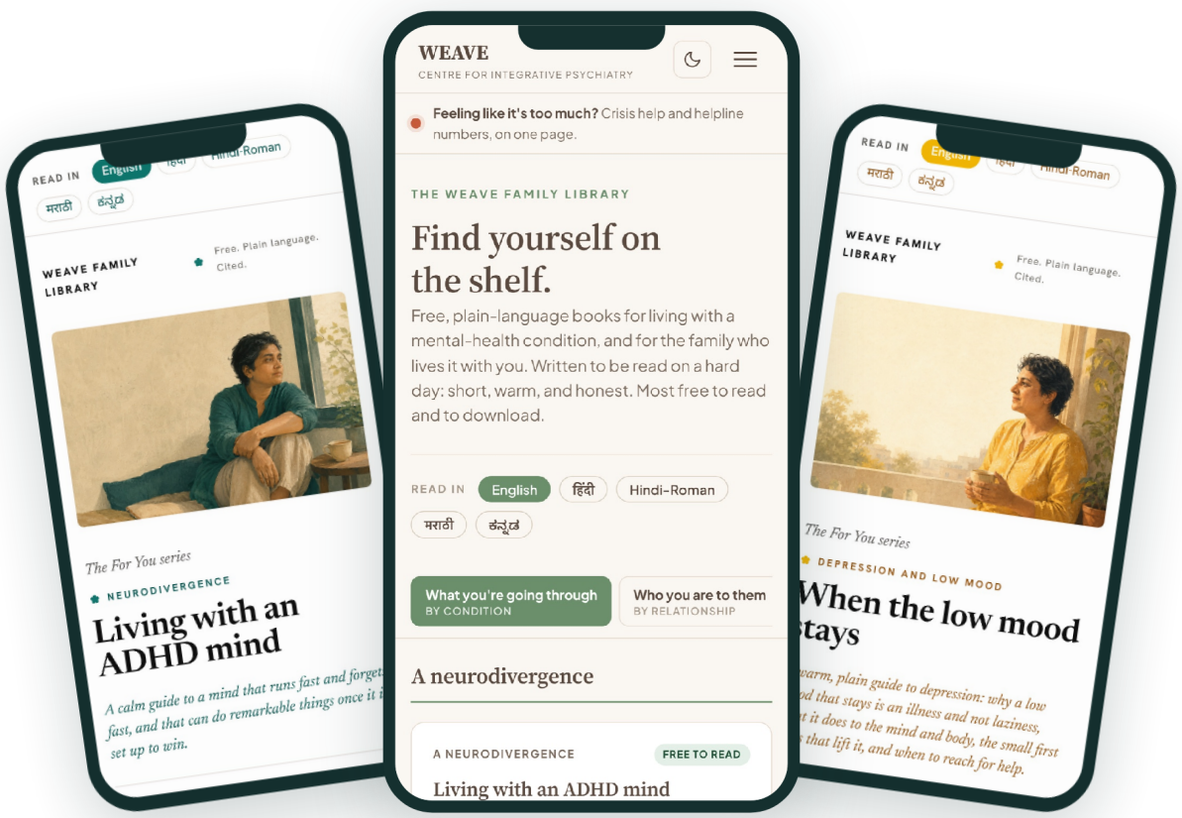
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