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DISSERTATION

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MENTAL HEALTH LAWS IN INDIA: A CRITICAL ANALYSIS

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CERTIFICATE

This is to certify that **Ms**. **ADHITHYA K P,** Reg. No: LM0324001 has submitted her dissertation titled **"MENTAL HEALTH LAWS IN INDIA: A CRITICAL ANALYSIS"** in partial fulfillment of the requirement for the award of the Degree of Master's in Laws in Public Health Law to the National University of Advanced Legal Studies, Kochi, under my guidance and supervision. It is also affirmed that the dissertation she submitted is original, bona fide, and genuine.

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Date :28/05/2025

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DECLARATION

I declare that this dissertation titled "**Mental Health Laws in India: A critical analysis**" is researched and submitted by me to the National University of Advanced Legal Studies, Kochi in partial fulfillment of the requirement for the award of Degree of Master of Laws in Public Health Law, under the guidance and supervision of **Dr. Abhayachandran K**, Associate Professor, NUALS, Kochi. It is an original, bona fide, and legitimate work pursued for an academic interest. This work or any type thereof has not been submitted by me or anyone else for the award of another degree from this university or any other university.

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ADHITHYA K P

PREFACE

The intersection of mental health and legal regulation presents a compelling canvas for critical inquiry, especially in India, where legislative reform often struggles against social stigma, infrastructural inadequacies, and historical legacies. This dissertation, "MENTAL HEALTH LAWS IN INDIA: A CRITICAL ANALYSIS", arises from a profound concern about the persistent marginalization of persons with mental illness and the need for an inclusive legal framework that upholds their dignity, autonomy, and human rights.

As an LLM student specializing in Public Health Law, I was drawn to this subject by the increasing global and national discourse on shifting from a custodial, welfare-oriented approach toward one rooted in rights, recovery, and person-centred care. The enactment of the Mental Healthcare Act, 2017, which marked a legislative leap aligned with India's obligations under the UN Convention on the Rights of Persons with Disabilities (CRPD) , forms the fulcrum of this research. However, while the Act is lauded for its progressive intent, its implementation reveals significant gaps that merit critical scrutiny.

This work is divided into five chapters that trace the evolution of mental health jurisprudence in India, from pre-colonial tolerance through colonial confinement to post-independence reforms. It includes a literature review and a multidisciplinary theoretical framework, drawing from various legal theories to evaluate mental health laws. The analysis covers significant legislative milestones and Supreme Court interventions, placing India's legal framework alongside international standards, such as those set by the CRPD

and WHO. The final chapter identifies shortcomings and proposes actionable policy recommendations to improve alignment with constitutional and international norms.

I hope this dissertation contributes meaningfully to ongoing dialogues on mental health law and serves as a resource for students, scholars, legal professionals, and policymakers committed to building a more inclusive and equitable society.

LIST OF ABBREVIATIONS

Abbreviation	Full Form
AD	Advance Directive
CMHA	Central Mental Health Authority
CRPD	Convention on the Rights of Persons with Disabilities
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECT	Electroconvulsive Therapy
GHPU	General Hospital Psychiatric Unit
ICD	International Classification of Diseases
IHBAS	Institute of Human Behaviour and Allied Sciences
MHA 1987	Mental Health Act, 1987
MHCA 2017	Mental Healthcare Act, 2017
MHRB	Mental Health Review Board
NMHP	National Mental Health Program
NHRC	National Human Rights Commission
NGO	Non-Governmental Organization
NIMHANS	National Institute of Mental Health and Neurosciences
NR	Nominated Representative
NRHM	National Rural Health Mission
PIL	Public Interest Litigation
SCC	Supreme Court Cases

SMHA	State Mental Health Authority
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UOI	Union of India
WHA	World Health Assembly
WHO	World Health Organization

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CHAPTER 1

INTRODUCTION

1.1 THE MEANING AND CONCEPT OF MENTAL HEALTH:

The idea of health encompasses both mental and physical well-being. Although they are complementary, neither appears as such. There is always a greater focus on physical wellness. Only physical health is covered under primary health care. In addition to being denied their rights, those with mental health issues are stigmatized, tabooed, and isolated from society at large. From a human point of view, "mental health" plays a vital role since it forms the basis for personality development. It is also essential for an individual's health. It is possible to say that mental and physical health are inseparable.[1] Social, emotional, and psychological aspects of a person's well-being are all included in mental health. Our thoughts, feelings, perceptions, and reactions are among the impacted behavioral patterns. In our lives, it also aids in determining how we manage stress, interact with others, and make decisions. One of life's fundamental phenomena is mental wellness. Personality, reasoning, conduct, mood, perception, and decision-making skills are all impacted by mental health.[2]

The following factors cause mental health issues:

a) biological elements, such as hormone imbalances and brain chemistry disorders;[3]
b) Life experiences, such as abuse and physical or emotional trauma; and
c) family history of mental health issues.[4]

[1] David Ring, Mental and Social Health Are Inseparable from Physical Health, 103 J. BONE & JOINT SURGERY AM. 951 (2021).
[2] id
[3] Peter Kinderman, Biological Factors and Health, in The Medical Model in Mental Health: An Explanation and Evaluation 47 (Oxford Univ. Press 2014).
[4] Univ. of Rochester Med. Ctr., How Childhood Trauma May Impact Adults, URMC NEWSROOM (May 1, 2024), https://www.urmc.rochester.edu/news/story/how-childhood-trauma-may-impact-adults

Individuals with mental health illnesses frequently face discrimination, denial, and violation of their rights in many ways. They are thus forced to live in a state of relative obscurity, disempowerment, disarticulation, marginalization, and social exclusion. Additionally, they are vulnerable to mistreatment by any enforcement agency member. Therefore, to protect these individuals, a robust legal and social safeguarding system needs to be put in place. Legislation has a crucial role in ensuring the provision of suitable, sufficient, prompt, and compassionate healthcare services.[5]

1.2 BACKGROUND OF THE STUDY

Mental health has emerged as a critical issue in modern India, situated at the nexus of public health, human rights, and social justice. Historically, Indian society cared for persons with mental illness through family and religious institutions, without dedicated legal or medical frameworks.[6] Ancient Hindu law, for example, recognized that "unsound" persons could not manage property and required guardianship.[7]Tolerance and community care, rather than confinement, characterized traditional approaches. With British colonial rule, however, the approach shifted dramatically. Beginning in the late 18th century, the British established lunatic asylums (the first in Bombay in 1745 and Calcutta in 1784) primarily for Europeans and others. In 1912, the colonial government codified psychiatric care in the Indian Lunacy Act, 1912, emphasizing custodial care, confinement, and guardianship under a magistracy-controlled system. This law and the Tamil Nadu successor, the Lunacy Rules, largely guided Indian mental health law throughout the colonial period and into independence.[8]

After independence, India's Constitution (1950) guaranteed fundamental rights but did not explicitly mention mental health. However, the right to life and personal liberty under Article 21 was later interpreted to include the right to health and human dignity. [9]In this

5 S.B. Math, & D. Nagaraja," Mental Health Legislation: An Indian Perspective(1987)

6 R. Raguram, Indianization of Psychiatry Utilizing Indian Mental Concepts, 55 INDIAN J. PSYCHIATRY 6 (2013).

7 Hindu Succession Act, No. 30 of 1956, § 6, INDIA CODE (1956), Hindu Minority & Guardianship Act, No. 32 of 1956, § 8, INDIA CODE (1956).

9 INDIA CONST. art. 21 ("No person shall be deprived of his life or personal liberty except according to procedure established by law.").

climate, the Bhore Committee (1946) urged integrating mental health into general healthcare, and the Indian Psychiatric Society drafted a new mental health bill in 1950. Unfortunately, real reform lagged for decades. The Indian Lunacy Act, 1912, continued in force for 75 years after independence, as India focused on expanding psychiatric hospitals and, in 1982, launched the National Mental Health Program. Only in the late 20th century amidst growing awareness of human rights and constitutional values- did momentum build for legislative overhaul.[10]

A watershed came with the Mental Health Act, 1987 (in force 1993), which repealed the Lunacy Act. The 1987 Act modernized terminology (defining "mental illness" more clinically) and created Central and State Mental Health Authorities for oversight.[11] It detailed admission procedures (including magistrate-supervised "reception orders" for involuntary commitment), recognized patients' right to humane treatment, and introduced guardianship provisions. These reforms signaled a shift from pure custodial detention to treatment and rights. In practice, however, the 1987 law had serious shortcomings. Commentators noted the lack of an independent review or tribunal to challenge detention, limited enforcement of consent and confidentiality, and chronic resource shortfalls (few licensed facilities, unestablished regulatory bodies) rendered it largely unimplemented. The old "magistrate's inquisition" model and institutional focus persisted to some extent, reflecting a model still rooted in control rather than empowerment.[12]

By the 1990s and 2000s, international developments accelerated change. Globally, the United Nations adopted the 2006 Convention on the Rights of Persons with Disabilities (CRPD), which India ratified in 2007. The CRPD demands that persons with disabilities (including psychosocial disabilities) enjoy full legal capacity, autonomy, and non-discrimination. It repudiates involuntary institutionalization and coercive treatments, favoring "supported decision-making" and community integration.[13] In parallel, the World Health Organization (WHO) and other bodies have advanced human rights–oriented mental health norms. WHO's mental health action plans and guidelines emphasize that

[10]R Raguram supra note 6

[11] Mental Health Act, No. 14 of 1987, INDIA CODE (1993).

[12] O. Somasundaram, The Indian Lunacy Act, 1912: The Historic Background, 29 INDIAN J. PSYCHIATRY 95 (1987).

[13] Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3, ratified by India Oct. 1, 2007.

"mental health is an integral part of health" and call for legislative alignment with human rights, reduced stigma, and availability of community-based services.[14] WHO estimates that in India, mental disorders account for an enormous disease burden (e.g., depression and anxiety are leading causes of disability), yet over 70% of affected people receive no evidence-based care. [15]It warns that such a gap undermines social and economic development. In sum, by the early 21st century, there was a clear global consensus: sound mental health law must protect individual autonomy, dignity, and rights on par with other health care, by international obligations like the CRPD.

1.3 CONCEPTUAL SIGNIFICANCE

The evolving paradigm treats mental health as both a medical and a rights issue. The right to health (implicit in Article 21 of India's Constitution) now encompasses mental health as essential to life and dignity.[16] Likewise, the principle of social justice calls for protecting the vulnerable and ensuring equal access to care. Persons with mental illness in India often face intense stigma, discrimination in terms of education, employment, and even access to justice, and marginalization. Safeguarding their rights intersects with broader concerns about equality. [17]And non-discrimination under the Constitution.[18] The CRPD further obliges India to eliminate discrimination based on disability (including psychosocial disability) and to promote autonomy and inclusion. Thus, robust mental health law is a key instrument for fulfilling constitutional values and international commitments, ensuring that people with mental illness are not excluded from the mainstream of life.

In light of these pressures, the Indian Parliament enacted the Mental Healthcare Act, 2017 (MHCA 2017),[19] which came into force in May 2018. This Act repealed the 1987 law and explicitly grounds India's mental health policy in a rights-based framework. The MHCA 2017 declares that persons with mental illness have the same fundamental rights and freedoms as others, and it imposes duties on the state to protect these rights. In the Preamble

[14] Press Info. Bureau, Gov't of India, Advancing Mental Healthcare in India (Feb. 2025), https://pib.gov.in/.
[15] World Health Organization, Mental Health Action Plan 2013–2020, at 7–9, WHO Doc. EB130/9 (2013)..
[16] Article 21 Supranote 9
[17] India Const. art. 14. "The State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India."
[18] India Const. art. 15.
[19] Mental Healthcare Act, No. 10 of 2017https://www.indiacode.nic.in/handle/123456789/2249

and Chapter V ("Rights of Persons with Mental Illness"), the statute guarantees a range of entitlements: the right to access affordable, quality mental healthcare (as close to home as possible), the right to live with dignity in the community, protection from cruel or degrading treatment, equality and non-discrimination, information and confidentiality, legal aid, and redressal for service deficiencies. For example, Section 18(1) provides that "every person shall have a right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government." [20]Making mental health a legally enforceable justiciable right. The Act also incorporates key CRPD-inspired concepts. It presumes that every person, including someone with a mental illness, can make treatment decisions. It also introduces advance directives and nominated representatives to support decision-making. Criminal penalties are abolished for suicide attempts, reflecting the new understanding that such attempts often stem from severe stress, and culpable homicide of an insane person is classified as a lesser offence. The MHCA 2017, in sum, represents on paper one of the world's most progressive mental health laws: it enshrines patient autonomy, consent, and due process in hospital admissions, and it integrates WHO's principle of integrating mental health into general healthcare. The WHO and Indian government even noted that the Act fulfills many commitments under India's CRPD obligations.[21]

While the MHCA 2017 marks a radical shift, implementation remains a challenge. Observers caution that resource constraints (few trained professionals, limited facilities) and lack of clarity on specific provisions may hinder its impact for instance, the Act's success depends on functional Mental Health Review Boards in every state, robust awareness of advance directives, and real investment in community services none of which are guaranteed by the statute itself. Thus, the degree to which the MHCA 2017 will safeguard the rights of persons with mental illness in practice, and fully meet India's international obligations (e.g., under the CRPD and WHO instruments), remains an open and pressing question. This study investigates the evolution of mental health laws in India,

[20] Mental Healthcare Act, No. 10 of 2017, § 18(1), Gazette of India, Apr. 7, 2017
[21] S B Math supra note 5

focusing on legislative reforms and judicial interventions that have shaped the current framework and critically analyzing the Mental Health Care Act 2017.

1.4 RESEARCH PROBLEM

Though progressive in intent, the Mental Healthcare Act of 2017 faces significant implementation challenges that hinder its effectiveness. Key issues include a severe shortage of mental health professionals and facilities, low public awareness of mental health rights, and persistent stigma, especially in rural areas. State-level disparities in establishing functional State Mental Health Authorities further affect the enforcement gaps. These gaps highlight the need for targeted reforms to bridge the divide between the Act's objectives and its practical outcomes, and there are deviations from international standards.

1.5 RATIONALE AND SIGNIFICANCE OF THE STUDY

The rationale for this study lies in the urgent need to critically assess India's contemporary mental health law in light of new international standards and domestic demands. While the MHCA 2017 has been celebrated as a landmark reform, scholarly analysis of its potential and limitations is still emerging. This dissertation fills a gap by synthesizing legislative history, judicial interpretation, and international comparison. It draws attention to areas where legal intent may run into practical constraints. Through this analysis, the research aims to contribute to legal scholarship and policy debate by identifying how Indian law can be further refined to fulfill its social justice objectives and human rights obligations

1.6 SCOPE OF THE STUDY

This dissertation is situated at the intersection of constitutional law, health law, and international human rights. Its scope encompasses a doctrinal and comparative legal analysis of India's mental health laws, primarily focusing on the Mental Healthcare Act, 2017 (MHCA 2017). It explores the legislative trajectory from colonial lunacy frameworks to the rights-based approach embodied in current law. It interrogates how these frameworks engage with judicial interpretation, international legal instruments, and ground-level realities of mental health care in India.

The study does not aim to examine the clinical or psychiatric dimensions of mental illness per se, nor does it include empirical fieldwork involving patients, caregivers, or medical practitioners. Instead, its focus is squarely on how law as a normative and institutional tool has evolved, and how it should further develop, to protect the dignity, autonomy, and rights of individuals with psychosocial disabilities. The research is limited to statutory texts, judicial decisions, and international legal standards, particularly the CRPD and WHO guidelines.

This study significantly contributes to legal scholarship by comprehensively examining Indian mental health laws through a rights-based lens, addressing a notable gap in legal discussions. It compares the Mental Healthcare Act (MHCA) 2017 with the Convention on the Rights of Persons with Disabilities (CRPD) and relevant international frameworks, identifying areas of agreement and conflicting interpretations. The research also highlights the judiciary's influence on mental health rights through key Supreme Court rulings, emphasizing the active role of judicial interpretation. Furthermore, it assesses the strengths and weaknesses of the MHCA 2017, recommending specific reforms to enhance implementation and serve as a valuable resource for lawmakers, advocates, and researchers. Lastly, by incorporating perspectives from public health and global human rights standards, the study fosters essential dialogue between legal and health systems, promoting a more cohesive approach to mental healthcare in India.

In essence, this dissertation seeks to move beyond a textual exegesis of legislation and case law to critically engage with the transformative potential of mental health law in advancing substantive equality. It aspires to make a meaningful academic contribution toward realizing the vision of the CRPD and the constitutional promise of dignity and non-discrimination for all persons, including those with mental illness.

1.7 RESEARCH OBJECTIVES AND HYPOTHESIS

1.7.1 OBJECTIVES OF THE STUDY

The objectives of the study are as follows:

- To analyze key legislative developments in Indian mental health law and their role in addressing historical gaps.

- To evaluate judicial contributions in enforcing and shaping mental health rights under the Constitution
- To compare the provisions of the MHCA 2017 with international standards such as the CRPD and WHO guidelines.
- To identify the shortcomings and areas of improvement in the MHCA 2017 and its Rules.

1.7.2 HYPOTHESIS:

The Mental Healthcare Act 2017 is a progressive statute in design, but its implementation has not satisfied the objectives and needs of society.

1.8 RESEARCH QUESTIONS

1. What are the key legislative developments in Indian mental health law, from the colonial period to the Mental Healthcare Act of 2017?
2. How have judicial interpretations, particularly by the Supreme Court of India, influenced the protection of rights under mental health laws? And what impact have these rulings had on implementing these laws?
3. To what extent do the provisions of the Mental Healthcare Act of 2017 align with key international standards, such as the CRPD and WHO guidelines, particularly in autonomy, informed consent, and dignity?
4. What are the shortcomings and areas of improvement in the MHCA 2017 and its rules?

1.9 RESEARCH METHODOLOGY

1.9.1 LEGAL RESEARCH METHODS

This study adopts a doctrinal legal research methodology for critically analyzing statutes, case law, and international legal instruments in the mental health domain. Doctrinal research often termed "black-letter law" analysis entails a systematic and analytical study of legal texts and their interpretation by courts. This method enables a comprehensive examination of the formal sources of law governing mental healthcare in India, particularly

the Mental Healthcare Act, 2017. It facilitates normative and jurisprudential evaluation in light of constitutional and international human rights frameworks.

The research employs the following techniques explicitly:

- Comparative Legal Analysis: A key component of this study is the comparative analysis between India's MHCA 2017 and international legal instruments, particularly the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and World Health Organization (WHO) mental health standards. This comparative approach allows the study to identify compliance, divergence, and potential reform, situating Indian mental health law within the global rights-based paradigm.
- Case Law Analysis: The study delves into the landmark judgments of the Supreme Court and High Courts of India to trace the judicial contribution to the evolution of mental health jurisprudence. The courts have played a crucial role in expanding mental health rights by interpreting constitutional provisions, particularly Articles 14, 15, and 21. The study critically examines decisions concerning the right to health, liberty, informed consent, decriminalization of suicide, and custodial rights. Using these judgments shows the judiciary's role in operationalizing and enforcing statutory guarantees.
- Statutory and Policy Review: The research examines key legislative developments, including the Indian Lunacy Act, 1912, the Mental Health Act, 1987, and the current Mental Healthcare Act, 2017. In addition, relevant policy frameworks such as the National Mental Health Policy, 2014, and operational mechanisms under the Act, such as Mental Health Review Boards and State Mental Health Authorities, are critically analyzed.
- Theoretical-Doctrinal Engagement: Doctrinal analysis is supplemented by engagement with rights-based legal theories, disability jurisprudence, and normative constitutional principles. This enriches the legal analysis by situating statutory and judicial developments within broader dignity, autonomy, and non-discrimination frameworks.

1.9.2 SOURCES OF DATA

The dissertation relies on primary and secondary legal sources and official institutional reports.

- **Primary Sources:**
  - Statutes: Mental Healthcare Act, 2017; Mental Health Act, 1987; Indian Lunacy Act, 1912; Rights of Persons with Disabilities Act, 2016; and relevant sections of the Indian Penal Code and Constitution of India.
  - Case Law: Judgments of the Supreme Court of India, such as Justice K.S. Puttaswamy v. Union of India, Sheela Barse v. Union of India, Common Cause v. Union of India, among others that interpret mental health, autonomy, privacy, and state obligation.
  - International Instruments: UNCRPD, Universal Declaration of Human Rights, ICESCR, and relevant WHO guidelines, such as the Quality Rights Toolkit and Comprehensive Mental Health Action Plan (2013–2030).
- **Secondary Sources:**
  - Articles: Peer-reviewed journal publications on mental health law, disability rights, and international law.
  - Books: Works by legal scholars and psychiatrists. Institutional Reports: Reports from NIMHANS, National Human Rights Commission (NHRC), Law Commission of India, and WHO country studies.
  - Commentaries: Treatises and legal commentaries on constitutional law, public health law, and human rights.

1.9.3. ETHICAL CONSIDERATIONS

This dissertation is focused on doctrinal analysis and does not include empirical research, human subjects, or sensitive personal information. Nevertheless, it adheres to various ethical standards to maintain the integrity and academic responsibility of the work:

- Accuracy and Attribution: All legal sources and academic opinions are correctly cited according to the Harvard Bluebook 21st Edition. This careful referencing helps to avoid plagiarism and supports academic transparency.

- Respect for Lived Experience (Indirect Engagement): Even though the study does not conduct interviews or fieldwork, it maintains a thoughtful and respectful tone when discussing individuals with mental illness, recognizing how legal narratives can affect marginalized communities.
- Balanced Critique: The research strives for objectivity and avoids ideological bias. It acknowledges the advances and shortcomings of Indian mental health law, offering constructive critiques rather than opposing viewpoints.
- Use of Reliable Legal Sources: The study draws exclusively from credible statutes, court rulings, peer-reviewed literature, and official reports from government and WHO sources, steering clear of unverified online materials or popular secondary sources.

1.10 STRUCTURE OF THE DISSERTATION

This dissertation unfolds five interrelated chapters, each building upon the last to critically examine the development, efficacy, and international alignment of mental health legislation in India**.**

I. Chapter 1: Introduction

The opening chapter lays the groundwork by delving into the historical and conceptual foundations of mental health law in India. It explores the legacy of colonial-era custodial frameworks, the gradual pivot towards rights-based perspectives, and the place of mental health within constitutional protections and international human rights regimes. This section also outlines the central research problem, frames the guiding questions and hypotheses, and clarifies the study's objectives and methodological approach. Additionally, it defines the scope and academic contribution of the dissertation, offering a clear roadmap for the following chapters.

II. Chapter 2: Literature Review and Theoretical Framework

Here, the dissertation surveys key academic, policy, and judicial sources concerning mental health law from both Indian and international viewpoints. It critically engages with existing analyses of the Mental Health Act, 1987, and the Mental Healthcare Act, 2017, highlighting how global frameworks like the CRPD and WHO guidelines have shaped domestic

discourse. This chapter also introduces the theoretical underpinnings of the research, drawing on rights-based legal theory, constitutional interpretation, disability rights jurisprudence, and global health law. These frameworks provide an interdisciplinary lens through which subsequent analysis is grounded.

III. Chapter 3: Legislative and Judicial Analysis of Mental Health Law in India

This chapter undertakes a detailed doctrinal review of the evolution of mental health legislation in India, from customary practices and colonial lunacy laws to the post-independence enactments culminating in the Mental Healthcare Act, 2017. It assesses the shifting legal paradigms, contrasting custodial models with rights-based reforms. The chapter also scrutinizes significant judicial decisions, particularly from the Supreme Court and various High Courts, which have interpreted mental health provisions, broadened the reach of Article 21, decriminalized attempted suicide, and reinforced procedural safeguards. Collectively, these developments illustrate the judiciary's instrumental role in shaping the contours of mental health law.

IV. Chapter 4: International Instruments and Comparative

This section evaluates the 2017 Act through the lens of international legal standards, focusing primarily on the CRPD and WHO's mental health frameworks. It considers the extent to which the Indian statute aligns with global principles concerning autonomy, legal capacity, informed consent, and non-discrimination. The analysis underscores key areas of convergence—such as supported decision-making and the right to community-based care—while highlighting persistent gaps, including continued reliance on substitute decision-making and uneven implementation. The chapter incorporates comparative examples from other jurisdictions that have more fully embedded international standards into domestic law, offering potential models for reform.

V. Chapter 5: Conclusion and Recommendations

The final chapter synthesizes the findings to assess the core hypothesis: while the MHCA 2017 represents a progressive step forward on paper, doctrinal, structural, and institutional limitations compromise its practical efficacy. This section puts forth targeted legal and policy recommendations to reinforce rights protections, enhance the functionality of institutions like Mental Health Review Boards, and foster closer alignment with constitutional and international obligations. It also identifies avenues for future research and policy development, stressing the importance of interdisciplinary collaboration and sustained implementation efforts.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 LITERATURE REVIEW:

The researcher examined India's mental health legislation, concentrating on how it affects people with mental diseases, by conducting a thorough assessment of legal and technical literature to investigate how the government can assist individuals affected by mental illness in improving their lives; the study reviewed a variety of sources, including academic papers, journals, and legislative documents. Additionally, the researcher analyzed the judiciary's role in protecting the rights of people with mental illnesses and systematically organized the relevant research into informative chapters. The study emphasized the significance of mental health laws and reviewed essential international tools about people with cognitive disabilities, even though this field has historically been overlooked because of its technical character.

The study of the following referral books was done, and the material was put forth in the survey:

1. **Mental Health Care and Rights by D. Nagaraja and Pratima Murthy**[22] It provides direction on improving mental health and managing mental illnesses effectively. In India, it has developed into an all-inclusive mental health care system. To safeguard the rights of people with mental illnesses and allow for the monitoring of those rights by all relevant authorities, it outlines the necessities for mental health care. This book creates awareness amongst the officers, academicians, NGOs, and the general public on the rights of mentally ill persons.
2. **Mental Illness: Law and Public Policy, edited by Baruch, A. Brody, and E.H. Tristram; Engelhardt**[23]: Lectures on mental health, mental disease, personal duties, and how the mentally ill are treated by society make up this book. It

[22] D. Nagaraja & Pratima Murthy, Mental Health Care and Rights (1st ed. 2017).
[23] Mental Illness: Law and Public Policy (Baruch A. Brody & E.H. Tristram Engelhardt eds., 1st ed. 1980).

discusses public policy and legislation about the treatment of mental disease, paying particular attention to the legal and general definitions of mental illness. It addresses the problems of involuntary commitment to treatment or institutional care and mental incompetence in criminal and civil responsibility proceedings.

3. **Dignity, Mental Health, and Human Rights –by Brendan. Kelly[24]** :In this book, the implications of human rights are specifically discussed, as well as WHO guidelines and the recent and ongoing amendment of mental health laws in England and Ireland. Human dignity, human rights, and mental health legislation, all of which have contributed to the defense and advancement of the rights of people with mental illnesses, are the primary topics and goals covered in this book.
4. **Organization of Mental Health Services in Developing Countries 16th Report by WHO -1975**[25] **:** The contents deal with the fresh and innovative approaches to the problems faced in mental health care for people who have mental illness. The studies indicate the extent, nature, and consequences of mental health in developing countries. It emphasizes the improvement of the basic standards of living. It illustrates the methods of organizing mental health services. Thus, it makes a significant contribution to general health and social welfare. It exemplifies that mental health is inseparable from general health and community development.
5. **Mental Health and Law: A System in Transition by Alan A Stone, M., Rockville, Maryland- An overview of psychiatry and law**.[26] The book provides an overview of the legal and medical fields. Deinstitutionalization and the right to treatment have been debated. The book recommends that ECT treatment, carbon dioxide inhalation therapy, and psycho-surgery be suggested for a judicial hearing. The topics covered include the well-being of the patients as well as the development of new customs and abilities to win back the confidence of the public and patients.

[24] Brendan Kelly, Dignity, Mental Health, and Human Rights (1st ed. 2015).
[25] World Health Organization, Organization of Mental Health Services in Developing Countries: Report of a WHO Study Group (16th Report, WHO Tech. Rep. Ser. No. 564, 1975).
[26] Alan A. Stone, Mental Health and Law: A System in Transition (U.S. Dep't of Health, Educ. & Welfare, Pub. Health Serv., Alcohol, Drug Abuse, & Mental Health Admin., Nat'l Inst. of Mental Health 1975)

6. **Law, Liberty, and Psychiatry – An Inquiry into the Social Uses of Mental Health Practices by Thomas Stephen Szasz[27] :** The following studies are included: psychiatry as a social institution, psychiatry as a science, psychiatry and the criminal code, and psychiatry and constitutional rights. It goes on to discuss social action, psychiatric power, and mental illness as a disease or degradation. Potential human rights violations in mental health programs and practices are also covered. The book critically looks at psychiatry's social and mostly legal applications today. According to the author, psychiatrists typically work to alter the attitudes and actions of people, organizations, groups, and occasionally entire nations as well.
7. **A Handbook for the Study of Mental Health, edited by Teresa L. and Eric R. Wright,[28]** Explains the three sociological approaches to mental illness.

- The biological and medical streams approach - view as a disease or physical defect in the brain.
- The psychological approach assumes it is an abnormality in the brain.
- When overwhelmed by environmental demands, the sociological approach considers it a breakdown.

Within the sociological approach, three dominant theories are discussed. The cause of the disease is related to stress theory, structural theory, and labeling theory, which are dealt with in detail. Stress theory is based upon evidence that accumulates from social stress, which precipitates mental health problems. The structural theory is based on one ‘s degree of participation in society. Labeling theory is on the people who are labeled as mentally ill and are treated as mentally ill. All these theoretical approaches towards mental illness and coping with mental illness are discussed. Biological and psychological approaches concur that mental diseases are internal, whereas the sociological approach claims they are external.

[27] Thomas S. Szasz, Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices (Macmillan 1963).
[28] A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems (Teresa L. Scheid & Eric R. Wright eds., 2d ed. 2010).

8. **Decade of the Brain: India / USA Research on mental health and Neurosciences[29] -**During the decade of the brain, it gives details of neurosciences which made rapid gains in essential ways, both in scientific and public interest. It showed tremendous advancement in the scientific and technology fields. It inspired the project, Decade of Mind. It enhanced public awareness of the benefits derived from brain research through appropriate programs and activities.

For further information and the purpose of literature on mental illness, psychiatric journals were also reviewed and accessed online. The researcher referred to legal articles and extensively researched mental health and related laws. They include the following;

1. In **"Some Aspects of Mental Health Care in India" (2024),[30]** Brijesh C. Purohit explores the various socio-economic factors that shape mental health outcomes in India. Using data from NIMHANS and applying factorial and regression analysis, he reveals how aspects like education, financial dependency, and gender play crucial roles in influencing mental health. Purohit critically examines the National Mental Health Policy of 2014, pointing out how it aligns with World Health Organization (WHO) standards and embraces a biopsychosocial approach. He highlights the policy's focus on rights and context, particularly addressing the needs of vulnerable groups and promoting collaboration across different sectors. The paper stresses the urgent need to improve access to mental health care, combat stigma, and weave mental health services into primary healthcare systems. Comparing India's approach with that of other countries like the UK and Canada suggests valuable practices that could be beneficial. Moreover, Purohit connects mental health issues to more considerable societal challenges such as poverty, urbanization, and social exclusion. This reinforces that a comprehensive, well-funded, inclusive strategy is essential for effective mental health law and policy. Overall, this paper is an important step toward bringing Indian mental health laws in line with international best practices.

[29] Indian Council of Med. Research, Decade of the Brain – India/USA Research on Mental Health and Neurosciences: Symposium Proceedings (1997).
[30] Brijesh C. Purohit, Some Aspects of Mental Health Care in India, 56 ECON. & POL. WKLY. 43 (2024).

2. In their critical reflection, **"Shortcomings of the Mental Health Care Act 2017 in Indian Context" (2023)**,[31] Nayak, Panja, and Das highlight practical and cultural challenges surrounding implementing the Mental Healthcare Act 2017 (MHCA). While recognizing the Act's alignment with the UNCRPD and its rights-based orientation, the authors emphasize that it fails to address India's socio-cultural realities and clinical exigencies adequately. Notable concerns include inconsistencies in the Act's definition of mental illness, the impracticality of diagnosing certain disorders without inpatient observation, and restrictions placed on psychiatrists' discretion in urgent interventions such as ECT. The article critiques provisions like advance directives and nominated representatives, arguing that in India's diverse and often under-informed population, such concepts may hinder rather than help effective care. It also raises concerns about bureaucratic burdens and the sidelining of families, traditionally the central support system in Indian society, in favor of Western-inspired legalistic models. The authors argue that the Act lacks direct input from psychiatrists during its formulation, undermining its clinical feasibility. Their critique is vital for legal scholarship as it exposes the tension between global rights frameworks and local implementation, reinforcing the need for culturally sensitive mental health legislation in India.
3. **Mental Health Legislation and Social Rights (Anil Kumar Singh, 2022)*[32]*** This paper explores the link between mental health legislation and the social rights of individuals with mental illnesses. It highlights the Mental Healthcare Act of 2017 (MHCA) as a significant reform aimed at medical care and promoting dignity, social inclusion, and community living. Singh argues that the MHCA is the first Indian law that aligns with the UN Convention on the Rights of Persons with Disabilities (CRPD), granting citizens a legally enforceable right to mental healthcare and social protections like housing and safeguards against inhumane treatment. However, he raises concerns about India's capacity to implement these provisions effectively, especially in rural and underserved areas. Singh emphasizes

[31] Sanjeeb Nayak, Srijita Panja & Arindam Das, Shortcomings of the Mental Health Care Act 2017 in Indian Context, 12 INDIAN J. PSYCHIATRY & L. 78 (2023).
[32] Anil Kumar Singh, Mental Health Legislation and Social Rights, 15 INT'L J. SOCIO-LEGAL STUD. 104 (2022).

that legal rights alone are inadequate without trained personnel, adequate funding, and public awareness. This article is essential for assessing whether legislative intent can lead to real change in the enforceability of mental health social rights.

4. In **A Brief History of the Mind (2019),**[33] Braj Mohan Tripathi examines the conceptual and historical development of human cognition using multidisciplinary insights from philosophy, psychology, and neuroscience. He rigorously examines how language, culture, and biological adaptations have influenced human consciousness. By examining classical and modern theories, Tripathi examines the evolution of mental abilities in evolutionary and sociocultural contexts. His work is an essential addition to studying the human mind since it synthesizes previous research and provides a nuanced viewpoint on the interaction between empirical research and philosophical investigation.

5. In **"Mental Health Services in Rural India: Challenges and Prospects"(2011),**[34] Anant Kumar underscores the significant neglect of mental healthcare in rural areas of India despite national initiatives such as the NMHP and DMHP. He identifies issues like inadequate infrastructure, a shortage of trained professionals, and pervasive social stigma. Kumar advocates for integrating mental health services with the National Rural Health Mission (NRHM) and highlights the importance of community health workers, such as ASHAs, in addressing the treatment gap. The paper provides essential insights into the inadequacies in policy and stresses the urgent need for inclusive mental health strategies in rural settings.

6. In **"Concordance of the Indian Mental Healthcare Act 2017 with WHO's Checklist on Mental Health Legislation,"**[35] Duffy and Kelly assess India's Mental Healthcare Act 2017 against the World Health Organization's mental health legislation checklist. They conclude that the Act is one of the most progressive in the Global South, especially for its rights-based approach, decriminalization of suicide, and the introduction of advance directives. However, they point out gaps

[33] Braj Mohan Tripathi, A Brief History of the Mind (1st ed. 2019).
[34] Anant Kumar, Mental Health Services in Rural India: Challenges and Prospects, 3 HEALTH & SOC. CARE IN INDIA 14 (2011).
[35] Rachel Duffy & Brendan Kelly, Concordance of the Indian Mental Healthcare Act 2017 with WHO's Checklist on Mental Health Legislation, 13 INT'L J. MENTAL HEALTH SYS. 25 (2021).

in implementation frameworks and resource constraints. The article provides a global comparative lens and affirms India's alignment with international norms like the UNCRPD.

7. **"Mental health and cultural diversity in India: A rights-based approach"** Jain, S. & Jadhav, S. (2009)[36] Explore the cultural dimensions of mental health and critique the legal framework for its inadequacy in addressing stigma, traditional beliefs, and rural inaccessibility. It argues for greater community involvement and cultural sensitivity in law and policy, asserting that rights-based frameworks must be localized to India's diverse socio-cultural context.
8. In his 2002 paper**, "Mental Health in India: Issues and Concerns,"**[37] Anant Kumar sheds light on some troubling aspects of India's mental healthcare system. He points out critical challenges such as insufficient funding, poor infrastructure, the pervasive stigma surrounding mental health, and laws that haven't kept pace with contemporary needs. Kumar takes a hard look at the Mental Health Act of 1987, criticizing its focus on custodial care rather than the rights of individuals. He advocates for crucial reforms that emphasize the importance of personal autonomy, informed consent, and equal access to mental health services for everyone. His call for a shift from hospital-based care to community-based services resonates strongly with global human rights standards, notably the UN Convention on the Rights of Persons with Disabilities (UNCRPD), which India has committed to uphold. Kumar also discusses the upcoming Mental Healthcare Act of 2017, viewing it as a vital step forward in aligning Indian legislation with international standards. Overall, his analysis offers valuable insights into how mental health issues intersect with human rights within the framework of Indian law and policy.
9. In **"Treatment Gap in Mental Healthcare: Reflections from Policy and Research,"** [38]Reetinder Kaur and R.K. Pathak highlight the significant barriers facing India's mental healthcare system. They analyze how issues like inadequate

[36] Sumeet Jain & Sushrut Jadhav, Mental Health and Cultural Diversity in India: A Rights-Based Approach, 31 ANTHROPOLOGY & MED. 1 (2009).
[37] Anant Kumar, Mental Health in India: Issues and Concerns, 6 INDIAN J. HEALTH & SOC. BEHAV. 123 (2002).
[38] Reetinder Kaur & R.K. Pathak, Treatment Gap in Mental Healthcare: Reflections from Policy and Research, 20 INDIAN J. MENTAL HEALTH POL'Y 47 (2023)

policy enforcement, stigma, gender disparities, cultural beliefs, and a lack of trained professionals limit access to necessary services. Despite efforts like the Mental Healthcare Act of 2017 and the National Mental Health Policy of 2014, the authors argue that structural problems and poor integration with primary healthcare remain. They advocate for community-based mental health models that respect local traditions and emphasize the importance of collaboration between departments, medical education reforms, and capacity building to improve accessibility and effectiveness. This article sheds light on the key challenges that must be addressed for India to comply with international mental health standards.

10. In their article, **"Mental Health Legislation in Egypt and India: Ethical and Practical Aspects,**"[39] Deshpande and colleagues explore the development and implications of mental health laws in two distinct countries, India and Egypt. They focus mainly on India, where they critique the Mental Health Act of 1987 as overly custodial and unclear, resulting in inconsistent implementation across different regions. The authors point out significant gaps, such as the lack of community mental health care, confusing guardianship provisions, and vague definitions of mental health professionals. They argue for essential reforms in light of India's commitment to the UN Convention on the Rights of Persons with Disabilities (UNCRPD), which paved the way for the more rights-focused Mental Healthcare Act of 2017. The piece highlights the delicate balance between medical authority and individual rights, especially regarding advance directives and the legal capacities of those with mental illness. Overall, this article is a crucial contribution to understanding mental health law, tying together historical, ethical, and policy perspectives while framing India's legislative changes within an international human rights context.

[39] Shraddha Deshpande et al., Mental Health Legislation in Egypt and India: Ethical and Practical Aspects, 18 INT'L J. L. & PSYCHIATRY 89 (2022)

2.2 THEORETICAL FRAMEWORK

The theoretical framework is the backbone of this research, guiding our exploration and analysis of mental health laws in India, especially the pivotal Mental Healthcare Act of 2017. It must draw from diverse interdisciplinary theories and legal doctrines to truly understand this area. This dissertation takes a comprehensive approach, engaging with various perspectives, including natural law theory, legal positivism, modern human rights, and critical legal studies. Through these lenses, we aim to explore how the law interacts with the mental health system and broader society.

This analysis begins with foundational legal theories that establish the legitimacy and construction of law. Then it delves into the constitutional and human rights principles that play a vital role in safeguarding the dignity of individuals with mental illnesses. Next, it examines international legal standards and human rights frameworks as benchmarks for necessary reform. Finally, it will incorporate interdisciplinary and critical perspectives to shed light on the contextual factors, social constructions of mental illness, and the impacts of gender, class, and disability on mental health policies. Together, these insights weave a rich narrative that informs our understanding of India's legal framework for mental health.

I Foundational Legal Theories

1. Natural Law Theory

Natural law theory emphasizes that laws should be rooted in basic moral principles and universal truths that reflect human nature. Rather than seeing law as just a set of rules established by governments, this perspective understands it as intertwined with justice and the dignity of every person. When we consider mental health legislation through the lens of natural law, it calls for the state to recognize the intrinsic value of each individual. This means creating laws that foster compassionate treatment and promote social justice for all.[40]

[40] John Finnis, Natural Law and Natural Rights (1980).

- **Historical Context:** The concept of natural law has played a crucial role in shaping international human rights agreements and the protections found in constitutions. It acts as a moral benchmark, helping us gauge the effectiveness and fairness of our legal systems.[41]
- **Impact on Mental Health:** This perspective highlights the need for mental health laws to go beyond just clinical standards; they should also ensure that individuals with mental health conditions are treated with dignity and respect. It challenges the outdated stigmas and exclusionary practices that many laws have perpetuated in the past.
- **Illustrative Example:** Consider significant global human rights cases where judges have drawn on natural law principles to overturn unjust laws. These rulings bolster the case for advancing mental health policies that focus on rights and respect for all individuals.

2. Legal Positivism

Legal positivism suggests that laws are essentially a collection of rules created by those in power, and their legitimacy comes purely from how they are established, without any influence from moral values. This viewpoint is particularly important for grasping how mental health laws are applied in India, as it highlights the need to closely examine the actual wording of the laws, the intentions behind them, and how they are interpreted in court.[42]

- **Statutory Analysis:** Legal positivism guides researchers to thoroughly examine the Mental Healthcare Act of 2017 and relevant legislation, such as the Indian Lunacy Act, using a doctrinal methodology**.**
- **Judicial Interpretation:** This approach emphasizes the importance of court decisions, legislative debates, and purposive interpretations, providing a framework for understanding how the law is applied in practice.

[41] World Health Organization, Mental Health, Human Rights and Legislation: WHO's Guidance on Mental Health and Human Rights 11–20 (2003).
[42] Madhukar Pai, The Indian Mental Health Act 2017: A Legal Positivist Reading, 61(4) INDIAN J. PSYCHIATRY S684 (2019).

- **Critical Reflection:** While legal positivism offers a clear and systematic method for legal analysis, it also raises important questions about whether formally valid laws can sometimes be ethically problematic.[43]

3. Sociological Jurisprudence

Sociological jurisprudence firmly establishes that law should not be viewed as a rigid, unchanging set of rules but as a dynamic and adaptable instrument that responds to society's shifting needs and complexities. This perspective was significantly advanced by renowned legal scholars such as Roscoe Pound, who argued that law must evolve with social progress. By emphasizing the interrelationship between law and social conditions, sociological jurisprudence highlights how legal systems influence and reflect the societal values, norms, and realities of the times. In this view, the law serves as a mechanism for maintaining order and a vital tool for promoting justice and social welfare.[44]

- **Interplay with Society:** This approach delves into how mental health laws shape societal attitudes toward mental illness. It highlights the complex dynamics of how these laws can either reinforce stigma and marginalization or challenge them through legal means. Understanding this interplay is vital as it reveals how legal frameworks can influence public perceptions and treatment of individuals facing mental health challenges.
- **Policy Implications:** By incorporating sociological perspectives, this theory sheds light on the effectiveness of legislative reforms.[45] It raises important questions about whether these reforms have truly dismantled oppressive systems or replaced them with new forms of inequality. This reflective analysis helps us discern the real impact of policies on individuals and communities.
- **Application in the Indian Context:** In a country as diverse and rapidly evolving as India, the principles of sociological jurisprudence are essential for assessing the effectiveness of policies designed to safeguard the rights of vulnerable groups. By

[43] H.L.A. Hart, The Concept of Law (1961).
[44] Roscoe Pound, An Introduction to the Philosophy of Law 18–36 (Yale Univ. Press 1922).
[45] Upendra Baxi, The Crisis of the Indian Legal System 201–215 (1982).

examining how these laws are applied in the real world, we can better understand their ability to prevent discrimination and exploitation. This analysis is crucial in a society where cultural, social, and economic factors significantly influence the experiences of marginalized communities. By carefully evaluating these policies, we can work toward creating a more equitable and inclusive society for all.[46]

4. Therapeutic Jurisprudence

Therapeutic jurisprudence is a field of study that focuses on understanding the psychological effects of legal decisions, procedures, and regulations on individuals' lives. It explores how the law can be leveraged to maintain justice and promote mental health and emotional well-being. This perspective is particularly crucial in the realm of mental health law, where legal actions such as court rulings, treatment mandates, or even detention procedures can significantly influence an individual's mental state. By analyzing these legal interactions, therapeutic jurisprudence aims to identify ways the law can be structured or modified to foster positive psychological outcomes and reduce harm. Ultimately, it emphasizes the importance of considering the mental health implications of legal practices, ensuring that the legal system supports rather than detracts from individuals' overall well-being.[47]

- **Core Concept:** This approach emphasizes that the legal system should aim to reduce harm and enhance mental well-being rather than perpetuating cycles of trauma or marginalization. It recognizes the unique challenges faced by individuals with mental health issues and seeks to foster an environment where they can heal and thrive.[48]
- **Practical Examples:** In examining the practices surrounding involuntary hospitalization and coercive treatments, the focus is on whether the legal frameworks in place genuinely aid in the recovery of individuals or exacerbate

[46] Upendra Baxi, The Crisis of the Indian Legal System 201–215 (1982).
[47] David B. Wexler & Bruce J. Winick, Essays in Therapeutic Jurisprudence 7–24 (Carolina Academic Press 1991).
[48] Bruce J. Winick, Civil Commitment: A Therapeutic Jurisprudence Model, 9 Psychol. Pub. Pol'y & L. 107 (2003).

feelings of alienation and distress. For instance, are these interventions being used as necessary measures for safety, or do they result in more harm than good?

- **Policy Relevance:** The Mental Healthcare Act 2017 embodies a shift towards more compassionate and responsive mental health legislation shaped by contemporary understandings of therapeutic jurisprudence.[49] This act strongly emphasizes recognizing and respecting patient autonomy, honoring their dignity, and involving them in decision-making processes regarding their care. It seeks to empower individuals rather than treat them as passive care recipients.
- **Comparative Insight:** In other countries' similar judicial practices, legal systems grounded in therapeutic jurisprudence principles often lead to significantly better outcomes for those experiencing mental health challenges. Such comparisons highlight the importance of adopting laws that prioritize healing over punishment, ultimately aiming to create a more supportive and understanding legal environment for individuals with mental illness.

5. Feminist Legal Theory

Feminist legal theory delves into the complex ways that gender intersects with mental health, highlighting the importance of understanding women's unique experiences and challenges. It advocates for mental health legislation that is sensitive to these differences, ensuring that women's voices are heard and their needs are met.[50] This focus is particularly crucial in areas such as reproductive rights, where women often face distinct mental health concerns related to pregnancy, childbirth, and access to reproductive healthcare.[51] In custodial settings, the experiences of women can be significantly affected by issues such as trauma and abuse, making tailored mental health support essential. Additionally, the impact of domestic violence on mental health cannot be overlooked, as many women struggle with the psychological effects of such violence long after it has occurred. By addressing these specific issues, feminist legal theory seeks to create a more inclusive and

[49] Id
[50] Catharine A. MacKinnon, Toward a Feminist Theory of the State 161–89 (Harv. Univ. Press 1989).
[51] Rebecca J. Cook & Simone Cusack, Gender Stereotyping: Transnational Legal Perspectives 140–165 (Univ. of Pennsylvania Press 2010).

supportive framework that safeguards the mental well-being of women and promotes their rights.

- **Gendered Dimensions:** Detailed discussion on how social, cultural, and economic factors uniquely impact women, including barriers to accessing mental health care.
- **Legal Critiques:** The analysis covers feminist critiques of legal paternalism and examines cases where legal intervention in mental health has disproportionately affected women.
- **Policy Proposals:** This section seeks to balance the scales of justice in mental health law by proposing reforms incorporating gender-sensitive measures.

II. Constitutional and Human Rights Principles

1. Right to Equality [52]

Article 14 of the Indian Constitution establishes that every citizen is equal before the law, promoting that no individual should be mistreated or discriminated against. This fundamental principle plays a vital role in the realm of mental health, as it empowers individuals to challenge and combat discriminatory practices that may arise due to mental health conditions. By underscoring the right to equal protection, this article serves as a legal foundation for advocating against stigma and ensuring that people with mental health issues receive fair treatment in all aspects of life, including access to healthcare, employment opportunities, and social support.

- **Legal Protections:** The Mental Healthcare Act of 2017 was created to guarantee that people with mental health issues enjoy the same rights and opportunities as everyone else.[53]
- **Legal Developments:** Courts have often broadened the interpretation of these rights, allowing for challenges against forced treatment and unfair treatment based on mental health conditions.[54]

[52] India Const. Art. 14.
[53] The Mental Healthcare Act, 2017, No. 10 of 2017, India Code (2017), §§ 3, 18.
[54] Anilkumar Singh Supranote 11

- **Policy Impact:** By linking mental health rights to the fundamental idea of equality in the Constitution, advocates for reform are making a strong case for mental health services that are both inclusive and accessible to all.

2. Right to Life and Personal Liberty [55]

The right to life, as outlined in Article 21 of the Indian Constitution, has been comprehensively interpreted by the Supreme Court of India. This interpretation goes beyond the mere existence of life; it emphasizes the importance of living with dignity. It recognizes that a meaningful life includes not only the provision of basic needs but also access to essential healthcare services. Furthermore, the court has underscored the need for protection against inhumane treatment, ensuring everyone is treated with respect and compassion. This holistic understanding of the right to life affirms that everyone deserves a life that is not just lived but truly valued and respected.

Implications for Mental Health Care: This principle emphasizes the need to deliver mental health services with a focus on respecting and preserving the dignity of every patient.

Case Law: Important court decisions have consistently affirmed that inadequate mental health care can be viewed as a violation of the right to life. For example, in the case of ***R v. Secretary of State for the Home Department,***[56] The court acknowledged that a lack of proper mental health support could result in tragic outcomes, emphasizing the state's responsibility to provide adequate care.

In India, similar principles have been established. In the case of ***Vishaka v. State of Rajasthan (1997)***[57]The Supreme Court recognized that the state must protect fundamental rights, including mental health care. Additionally, the judgment in ***Paschim Banga Khet Mazdoor Samity v. State of West Bengal (1996)***[58] highlighted that inadequate health

[55] India Const. art. 21.
[56] R v. Secretary of State for the Home Department, [2005] UKHL 71, [2006] 2 AC 221.
[57] Vishaka v. State of Rajasthan, (1997) 6 SCC 241, AIR 1997 SC 3011
[58] Paschim Banga Khet Mazdoor Samity v. State of West Bengal, (1996) 4 SCC 37, AIR 1996 SC 2426.

services could infringe on the right to life as guaranteed by Article 21 of the Indian Constitution. These cases collectively underline the legal responsibility to provide sufficient mental health care to prevent tragic outcomes.

Policy Critique: Examining how the Act protects or fails to uphold these rights is crucial. This analysis helps us understand the actual effectiveness of legal reforms in improving mental health care.

3. Non-Discrimination and Reasonable Accommodation

The ratification of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) has had a substantial impact on mental health legislation in India. This international agreement emphasizes the importance of two fundamental principles: non-discrimination and the requirement for reasonable accommodation.[59] These principles serve as guiding frameworks for policymakers as they strive to develop legislation and initiatives that promote inclusivity and protect the rights of individuals with mental health conditions.[60] By incorporating these principles into mental health policies, India is working toward a more equitable system that acknowledges and addresses the unique needs of all individuals, fostering an environment of acceptance and support.[61]

International Obligations: The UNCRPD mandates that countries provide necessary adjustments to ensure marginalized populations can fully participate in society.

Domestic Application: Indian mental health law reflects these principles by emphasizing community-based care and integration rather than segregation or isolation.[62]

4. Autonomy and Informed Consent

In recent years, modern interpretations of mental health law have strongly emphasized respecting individual autonomy, particularly regarding the right to informed consent. This

[59] Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3.
[60] The Rights of Persons with Disabilities Act, 2016, No. 49 of 2016, India Code (2016), §§ 3, 12, 13, 18.
[61] Amita Dhanda, Legal Capacity in the Disability Rights Convention, 10 HUM. RTS. L. REV. 429 (2010)
[62] The Mental Healthcare Act, 2017, No. 10 of 2017, India Code (2017), §§ 3, 5, 18–20.

shift recognizes the importance of allowing individuals to have a say in their treatment decisions, empowering them to participate in their care actively.[63] The core belief driving this approach is that everyone should be free to choose their mental health treatment based on their values, preferences, and circumstances. This respect for autonomy means that individuals are not merely passive recipients of care; they are active participants with the right to understand their options, ask questions, and make informed decisions.[64]

However, it is also acknowledged that there may be situations where a person's ability to make such decisions is compromised. In these cases, the law requires legal evidence to justify restrictions on an individual's autonomy. This balance aims to ensure that people are treated with dignity and respect while protecting those who cannot make informed decisions for themselves. Ultimately, the goal is to foster a mental health care system prioritizing individual rights and well-being.[65]

- **The Evolution of Consent**: In the past, mental health treatment was frequently provided without obtaining proper patient consent. Thankfully, recent legal reforms have started to promote the importance of individual agency in these situations, ensuring that patients have a voice in their treatment.
- **Practical Challenges**: This section examines the real-world difficulties of applying informed consent procedures in clinical environments. It also highlights the legal protections to safeguard patients' rights and well-being.
- **Relevance to Modern Law**: By examining how the Mental Healthcare Act of 2017 addresses these critical issues or sometimes falls short, we can better understand the current state of mental health policy and the challenges ahead.

5. Parens Patriae Versus Autonomy[66]

The legal doctrine of parens patriae gives the state the authority to act as a guardian for individuals who cannot care for themselves, particularly those suffering from severe mental

[63] The Mental Healthcare Act, 2017, No. 10 of 2017, India Code (2017), §§ 4–8, 89–90
[64] Law Commission of India, 222nd Report on Need for Justice-Delivery Systems for the Mentally Ill (2009).
[65] The Mental Healthcare Act, 2017, s. 4–7
[66] Sir William Blackstone, Commentaries on the Laws of England, Vol. 1, at 304 (Clarendon Press 1765).

illnesses. This principle is rooted in the belief that the state is responsible for protecting vulnerable members of society who cannot make decisions in their best interest. However, while the intention behind such intervention is often compassionate, there are situations where it may lead to excessive government involvement in personal lives. When the state steps in too aggressively, it can unintentionally compromise the autonomy of individuals, limiting their rights to make choices about their lives. Balancing the need to protect those who are vulnerable with the need to respect individual freedom is a complex challenge that society continues to grapple with.[67]

- **Finding the Right Balance:** This framework looks at the challenge of safeguarding vulnerable individuals while respecting their freedoms.
- **Legal Discussions:** By examining various court cases, we can see the different perspectives on how and when the parens patriae doctrine should be applied. This gives us insight into how this principle is utilized in mental health law.[68]
- Impact **on Policy:** This also explores how Indian mental health legislation navigates this delicate balance, its effects on patient rights, and how clinical practices are carried out.[69]

III. International Legal Approaches & Standards

1. Human Rights-Based Approach

This approach places mental health within the essential human rights framework, highlighting the belief that access to mental health care is not simply a policy choice but a fundamental human right everyone deserves. Recognizing mental health as a human right affirms the notion that all individuals, regardless of their circumstances, should have the opportunity to receive the care and support they need to thrive.

[67] Roscoe Pound, The Spirit of the Common Law 124–32 (Marshall Jones Co. 1921).
[68] Michael L. Perlin, Mental Disability Law: Civil and Criminal 157–64 (2d ed. 2005).
[69] Arjun K. Sarin & P. Murthy, Revisiting Parens Patriae in India's Mental Health Context, 59(1) INDIAN J. PSYCHIATRY 15 (2017).

A human rights-based approach emphasizes the concepts of universality, indivisibility, and interdependence of rights. This means that mental health is not isolated from other rights but is interconnected with the right to health, education, and dignity. This part explores global human rights instruments, such as the Universal Declaration of Human Rights, which have significantly shaped mental health policies worldwide. These instruments serve as a foundation for advocating that mental health care is essential for the overall well-being of individuals and communities.[70]

To truly reflect the importance of mental health as a human right, legislation must be thoughtfully crafted to protect and actively promote access to mental health services. This means creating frameworks that ensure services are available, accessible, acceptable, and of good quality for all individuals, particularly marginalized or disadvantaged groups, who may face additional barriers.

Additionally, we will examine how India's Mental Healthcare Act embodies these principles, striving to align national policies with the global human rights framework. By analyzing this legislation, we can see how it aims to safeguard the rights of individuals with mental health conditions and promote their dignity and autonomy.[71]

Furthermore, drawing contrasts with international jurisdictions allows us to identify best practices and innovative approaches that can be adopted or adapted to enhance mental health services. It also highlights areas where improvements are needed, ensuring that we remain committed to advancing mental health as a crucial aspect of human rights for everyone.[72] This journey towards achieving mental health equity is not just about policies and laws; it is about recognizing the humanity in each individual and ensuring that everyone has the support they need to live fulfilling lives.[73]

[70] Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/810, at 71 (Dec. 10, 1948).
[71] The Mental Healthcare Act, 2017, No. 10 of 2017, India Code (2017), §§ 3–5, 18–21, 27–30.
[72] International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3, art. 12.
[73] Universal Declaration of Human Rights, art. 25, G.A. Res. 217 (III) A, U.N. Doc. A/RES/3/217A (Dec. 10, 1948).

2. The UN Convention on the Rights of Persons with Disabilities (UNCRPD)

The UN Convention on the Rights of Persons with Disabilities (UNCRPD) represents a significant change in how we view and address disability, including mental health challenges. It strongly emphasizes ensuring that people with disabilities are fully included and actively participate in all areas of life.[74]

- **Legal Norms:** This section explains the core ideas of the UNCRPD, such as the focus on supported decision-making, the move away from guardianship towards recognizing individuals' legal capacity, and the need to provide reasonable accommodations. It also looks at how these ideas have shaped laws in our country.
- **Implementation in India:** We explore how India has woven these international standards into its laws and judicial practices. We also discuss hurdles in making these changes a reality in everyday life.
- **Critical Perspectives:** This part reflects on the achievements and the challenges of applying these international norms in India's unique social and cultural landscape. Additionally, it compares how India's efforts stack up against those of other nations.[75]

3. WHO Mental Health Action Plan

The World Health Organization (WHO) sets global guidelines to enhance mental health and incorporate mental health services into primary care systems.

- **Policy Guidance**: The WHO's Mental Health Action Plan encourages moving from institutionalization towards community-based care and emphasizes the importance of working together across various sectors. This part will explore these policies and examine how well India's mental health law aligns with them.
- **Health Systems Perspective:** The study will examine how health and legal systems can be integrated. It will also identify areas where reforms have successfully

[74] Supranote 36
[75]Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3.

improved access to care and highlight where progress still needs to be made to meet international standards.

- **Global Comparisons:** By comparing similar reforms in other countries, we can deepen our understanding of the issue and identify potential opportunities for future legislative improvements.[76]

IV. Interdisciplinary and Critical Legal Approaches

1. Law and psychiatry interface

The interface between law and psychiatry is crucial for grasping the practical implications of mental health legislation, as it underscores how legal rules shape clinical decisions and how psychiatric practices, in turn, influence the interpretation of laws. Within this context, it is essential to examine how legal frameworks govern various aspects of psychiatric care, including involuntary admissions, the processes of informed consent for treatment, as well as the rights of institutionalized individuals. Moreover, this intersection presents several interdisciplinary challenges, encompassing accountability, professional ethics, and the potential for abuse within both clinical and legal settings. To illustrate these dynamics, case studies from India, along with comparative examples from other jurisdictions, provide valuable insights into how legal standards impact psychiatric practices and the care of individuals with mental health disorders. This comprehensive examination reveals the complexities and responsibilities that legal and psychiatric professionals face at this critical juncture.[77]

2. Critical Disability Theory

Critical disability theory offers a transformative perspective on disability, shifting the focus from viewing it as an individual deficit to understanding it as a consequence of social and structural inequities. This theory emphasizes that societal structures and practices can actively disable individuals by creating barriers to inclusion and participation. It challenges

[76] World Health Organization, Mental Health Action Plan 2013–2030 (2021).
[77] D.N. Nandi & S. Banerjee, Forensic Psychiatry in India: Past, Present and Future, 47(3) INDIAN J. PSYCHIATRY 126 (2005).

the traditional notions of normality, urging us to reconsider our assumptions about what it means to be "normal" and how those assumptions can lead to the marginalization of people with disabilities, particularly those with mental illnesses.[78]

The implications of critical disability theory for the legal system are profound. It advocates for the dismantling of institutional practices that segregate or stigmatize individuals living with mental health challenges. This perspective highlights the importance of examining laws and policies that may inadvertently perpetuate negative stereotypes and reinforce discrimination. Critiquing these systems, critical disability theory calls for a legal response that recognizes the rights and dignity of all individuals rather than perpetuating harmful practices.

To foster true inclusion, critical disability theory emphasizes reform strategies that prioritize community-based support. It advocates for legislative changes that enhance accessibility and empower individuals with disabilities, enabling them to thrive without relying on coercive measures from the state. Ultimately, this approach seeks to create a society where everyone, regardless of their mental health status, is valued and has equal opportunities to participate fully in all aspects of life.[79]

3. Intersectionality

Intersectionality, a concept introduced by legal scholar Kimberlé Crenshaw, offers a valuable framework for understanding how various social identities intersect and influence individuals' societal experiences. It recognizes that people do not possess a single identity; instead, we carry multiple identities such as caste, class, gender, and disability that can overlap and interact in complex ways. [80]For example, a woman of color with a disability may face unique challenges that are distinct from those experienced by a white woman or a man with the same disability. This layered existence means that discrimination can be compounded, leading to a deeper level of often overlooked marginalization. By

[78] Patrick Devlieger et al., Rethinking Disability: World Perspectives in Culture and Society (2003).
[79] Amita Dhanda, Legal Order, and Mental Disorder, 39 J. INDIAN L. INST. 137 (1997).
[80] Kimberlé Crenshaw, Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color, 43 *STAN. L. REV.* 1241 (1991).

acknowledging these interconnected identities, we can better understand the nuanced ways systemic inequalities operate and work towards more inclusive solutions that address the needs of all individuals, particularly those at the intersection of multiple forms of disadvantage.[81]

- **Complex Identities:** This section looks at how mental health policies affect people with various social identities, highlighting the unique challenges faced by those who belong to more than one marginalized group.
- **Empirical Data:** It draws on qualitative and quantitative research to illustrate how the experience of discrimination at multiple intersections can hinder access to mental health services.
- **Policy Implications:** The discussion highlights the urgent need for legal reforms recognizing these overlapping challenges. By doing so, we can work towards creating mental health care that is truly inclusive and equitable for everyone.

The review of literature and the theoretical framework lay the groundwork for this research, offering both the context and critical insight needed to explore India's evolving mental health laws. The literature review traces how mental health legislation has developed, drawing on academic studies, policy reviews, and legal analyses. It brings attention to key issues like stigma, unequal access to care, challenges in implementation, and the need to align Indian laws with international human rights standards. While the Mental Healthcare Act of 2017 is progressive in its goals, the review shows that putting it into practice is often hindered by deep-rooted social and structural obstacles. The theoretical framework includes various legal perspectives natural law, legal positivism, therapeutic jurisprudence, feminist legal theory, and critical disability theory to analyze mental health laws. It emphasizes principles of equality and dignity while aligning with global guidelines like the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and the WHO's Mental Health Action Plan. Additionally, by integrating concepts from intersectionality and sociological jurisprudence, it highlights how legal protections are shaped by factors such as caste, gender, class, and identity.

[81] Bhargavi Davar, Mental Health from a Gender Perspective, 36(45) ECON. & POL. WKLY. 4179 (2001).

CHAPTER 3

LEGISLATIVE AND JUDICIAL ANALYSIS OF MENTAL HEALTH LAWS IN INDIA

3.1 EVOLUTION OF MENTAL HEALTH LAWS IN INDIA

Mental health laws in India have undergone a long journey from rudimentary ancient norms to a modern rights-based framework. This evolution reflects changing social attitudes, medical understanding, and legal philosophies. What began as customary care under religious and community guidance eventually transformed through colonial regulations focused on custody, and later into post-independence reforms emphasizing patients' rights. This chapter chronicles this trajectory through distinct eras, highlighting key statutes (such as the Indian Lunacy Act 1912, Mental Health Act 1987, etc.), landmark court decisions, and policy milestones that shaped India's mental health jurisprudence.

3.1.1 ANCIENT AND TRADITIONAL PERSPECTIVES

In ancient India, mental illness was recognized in medical and legal thought, though not governed by dedicated statutes. Classical texts like the *Arthashastra* (c. 4th century BCE) and *Manusmriti* (c. 1st century CE) acknowledged the concept of mental incapacity in the context of law and governance. For example, Hindu law traditions held that those of "unsound mind" lacked legal capacity to enter contracts or manage property, implying a need for guardianship by family or community. Ayurvedic medicine also provided detailed descriptions of various mental disorders (referred to as *unmada*, etc.), suggesting therapeutic approaches rooted in diet, herbal remedies, and spiritual healing. However, care for the mentally ill in these times was essentially a familial and social responsibility rather than a state function. There were no formal asylums or legal codes dedicated exclusively to mental health in the pre-colonial era; persons with mental illness were typically cared for at home or in religious institutions, sometimes subject to traditional healing rituals.[82]

[82] K.N. Panikkar, Mental Illness in India: Historical Perspectives, 49 INDIAN J. PSYCHIATRY 165 (2007).

Crucially, the notion of protecting society from the "dangerous insane," which later became a motif of colonial laws, was not a prominent feature of ancient Indian practice. Instead, tolerance and integration were emphasized within the community (consistent with Manu's philosophical outlook of tolerance and pluralism). At the same time, the inherent vulnerability of mentally ill persons meant that customary law often exempted them from punishments or obligations applicable to sane persons. In summary, while mental illness was not ignored in ancient and medieval India, there was an absence of institutional legal frameworks. This traditional approach would soon be upended by the advent of colonial rule, which introduced Western models of confinement and legal oversight for mental illness.[83]

3.1.2 EARLY COLONIAL ERA DEVELOPMENTS

The colonial era introduced a paradigm shift in the management of mental health, starting under the East India Company and later the British Raj. In the 18th and early 19th centuries, the British established the first lunatic asylums in India, marking the subcontinent's initial foray into institutional care for mental illness. The first facility opened in Bombay in 1745, followed by another in Calcutta in 1784, both of which were meant exclusively for European patients, British expatriates, and soldiers. These early asylums were essentially extensions of colonial healthcare for Europeans, reflecting an attitude that separated "European lunatics" from the general population. Over time, however, some Indians were also admitted as the institutions expanded. By the end of the 18th century and early 19th century, a few more establishments had appeared: a private lunatic hospital in Calcutta established in 1787 by Surgeon William Dick and later taken over by the East India Company, the first asylum in southern India at Madras (Kilpauk, opened 1794), and facilities at Monghyr (Bihar, 1795 and Patna (1821) to serve insane soldiers and others. These colonial asylums were often situated away from city centers, sometimes in repurposed barracks, and were designed to segregate the mentally ill from society. High walls and jail-like conditions were common, as the prevailing approach treated mental

[83] id

illness primarily as a threat or nuisance to be removed from the public. The emphasis was on custody and confinement rather than cure or rights of patients.[84]

During this early colonial period, there was little formal legislation specific to mental health besides administrative regulations. Treatment methods remained rudimentary, a mix of prevailing European psychiatric practices like the use of opium, morphia, bloodletting, and restraints. Notably, one of the first legal measures was the Lunatic Removal Act of 1851[85]a law that facilitated the repatriation of British nationals with mental illness to England. This Act was aimed at British patients in India, underscoring that early legal attention was on managing European interests. By the mid-19th century, the need for a more organized approach was evident as the number of "lunatics" in custody grew. The stage was set for a comprehensive legal framework once the British Crown took direct control of India in 1858. Thus, the early colonial era established the infrastructure of mental asylums and introduced the concept of state responsibility for confining the mentally ill, albeit in a limited, Eurocentric way. The experiences of this period, characterized by inadequate care and often deplorable conditions, would later inform demands for legislative reform.[86]

3.1.3 LEGISLATIVE FRAMEWORKS DURING BRITISH RULE

With the power transfer from the East India Company to the British Crown in 1858, mental health governance in India became more systematized. A series of laws were enacted in the late 19th century to regulate the care of persons with mental illness in British India. The flurry of legislation in 1858 laid the foundation for a legal framework that endured for decades:

- **The Lunacy (Supreme Courts) Act, 1858[87]** – provided procedures for the Supreme Courts (in the Presidency towns) to adjudicate cases of "lunacy," including inquests into a person's soundness of mind.

[84] M. Daund et al., Mental Hospitals in India: Reforms for the Future, 60 INDIAN J. PSYCHIATRY S239 (2018).
[85] Lunatic Removal Act, No. 8 of 1851.
[86] Waltraud Ernst, "Colonial Policies and the Institutionalization of the Mentally Ill in India, 1800–1857," History of Psychiatry, Vol. 4, No. 13 (1993): 29–58,
[87] The Lunacy (Supreme Courts) Act, No. 34 of 1858

- **The Lunacy (District Courts) Act, 1858**[88] – extended similar provisions to district courts, covering vast territories outside Presidency towns.
- **The Indian Lunatic Asylum Act, 1858**[89] (amended in 1886 and 1889) – Established guidelines for setting up and regulating lunatic asylums across British India. This law formalized the asylum system: it outlined the admission process (often on the order of magistrates), the conditions of detention, and the authorities' roles in supervising asylums.
- **The Military Lunatic Act, 1877**[90] – a law specifically dealing with members of the military deemed insane, ensuring their segregation and care, reflecting the colonial administration's concern with soldiers and security.[91]

Under these Acts, the regime in asylums remained largely custodial. Patients could be detained indefinitely, with little opportunity for review or discharge, and living conditions were often abysmal. The legal focus was on protecting the public from individuals deemed dangerous or unfit due to mental illness, rather than on treating the individuals or safeguarding their rights. For instance, the law required certification of insanity to prevent sane persons from being wrongfully confined, but it did not guarantee any standard of care for those who were committed. Administration of asylums was typically under the Inspector General of Prisons or local government authorities, reinforcing a jail-like management ethos.[92]

By the turn of the 20th century, the cumulative effect of decades of such policies led to increasing public and professional concern. Indian nationalists and intellectuals began to critique the deplorable conditions of mental hospitals as part of a broader critique of colonial governance. Reports of overcrowding, neglect, and abuse in asylums garnered attention in response to these pressures. In line with reformist trends in England, the colonial government introduced a consolidating legislation: the Indian Lunacy Act, 1912.

[88] The Lunacy (District Courts) Act, No. 35 of 1858.
[89] The Indian Lunatic Asylum Act, No. 36 of 1858.
[90] The Military Lunatic Act, No. 11 of 1877
[91] Military Lunatics Act, No. XI of 1877,
[92] O. Somasundaram, The Indian Lunacy Act, 1912: The Historic Background, 29 INDIAN J. PSYCHIATRY 3 (1987).

This Act repealed the earlier disparate laws (including the Asylum Acts of 1858 and subsequent amendments). It became the first comprehensive statute governing mental health in India.[93]

The Indian Lunacy Act, 1912, brought notable changes. It created central and provincial authorities to oversee asylums officially redesignated as "mental hospitals" in 1922. It prescribed detailed procedures for admission and custody. For the first time, the law allowed voluntary admissions of patients (upon their request or consent of a guardian), which was a progressive step beyond purely custodial admissions. The Act also set out a mechanism for a "judicial inquisition" to declare someone of unsound mind to manage their property. Psychiatrists were to be appointed as full-time medical officers in these institutions, professionalizing their management. Despite these improvements, the core philosophy of the 1912 Act remained one of social protection and control. Its preamble and provisions emphasized safeguarding society from the presumed dangers posed by persons with mental illness, and preventing wrongful confinement of the sane. Treatment and rehabilitation received scant attention in the text of the law. As contemporary observers noted, ILA 1912 was concerned "only with custodial custody of the mentally ill" and virtually ignored human rights or the individuality of patients.[94]

The 1912 Act governed mental health law in independent India for the next 75 years, through late colonial times. Toward the end of the British period, however, global events and ideas began to influence Indian mental health policy. The aftermath of World War II and the adoption of the Universal Declaration of Human Rights in 1948 shifted perspectives internationally. In India, the 1940s and 1950s brought an awakening that mental health needed a more humane, medical, and rights-sensitive approach. Notably, in 1946, the Bhore Committee Report on health services highlighted the need to integrate mental health into general healthcare. By 1950, the Indian Psychiatric Society, recognizing that the old law was obsolete, prepared a draft Mental Health Bill to replace the 1912 Act.

[93] id
[94] S. Sharma & L.P. Verma, History of Mental Hospitals in Indian Subcontinent, 26 INDIAN J. PSYCHIATRY 295 (1984)

The stage was thus set for post-independence reforms, even though the colonial framework had yet to be dismantled.[95]

3.1.4 POST-INDEPENDENCE LEGISLATIVE EVOLUTION

After India gained independence in 1947, the Indian Lunacy Act of 1912 remained in force for several decades. The new Constitution of India (1950) implicitly impacted mental health law by guaranteeing fundamental rights and setting Directive Principles for state policy. Although the Constitution did not explicitly mention mental health, the right to life and personal liberty under Article 21 was later interpreted to include rights to health and human dignity. In the early years of independence, custodial practices continued in old asylums. Still, there was growing acknowledgment that reform was needed to align the law with modern medical science and constitutional values.

A significant milestone was the submission of a draft Mental Health Bill by the Indian Psychiatric Society in 1950, which pointed out that the 1912 Lunacy Act was antiquated. This initiative coincided with India's engagement with international human rights instruments and a general post-colonial law reform impulse. However, progress was slow the proposed bill languished for decades without enactment. In practice, the 1912 Act continued to govern admissions and guardianships, often leading to the same abuses and neglect that had characterized colonial-era asylums. [96]Through the 1960s and 1970s, India's mental health policy focused on establishing new psychiatric institutions and starting community psychiatry experiments, such as the National Mental Health Programme launched in 1982, rather than overhauling the legal framework immediately. Only in the 1980s, spurred by increasing awareness of human rights and a push from jurists and activists, did the legislative reform gain momentum.[97]

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[95] id

[96] S.B. Math & M.C. Nirmala, *National Mental Health Programme–Optimism and Caution*, 57 INDIAN J. PSYCHIATRY 215 (2015).

[97] Ministry of Health and Family Welfare, Government of India. National Mental Health Programme (NMHP). 1982

3.1.5 THE MENTAL HEALTH ACT 1987

The Mental Health Act, 1987 (MHA 1987)[98] was finally passed by Parliament and received Presidential assent in May 1987, 37 years after it was first drafted. The Act came into force on April 1, 1993, repealing the Lunacy Act 1912. This long gestation reflected the complexity of building consensus around mental health law in a developing country. The MHA 1987 was heralded as a shift from the purely custodial approach of the past toward a somewhat more treatment-oriented and liberal regime. Some of the key features of the 1987 Act included:

- **Modern Terminology and Scope:** The Act introduced a more up-to-date definition of "mental illness," explicitly excluding mental retardation (intellectual disability) from its purview and focusing on disorders of mind that necessitate treatment. The language change signaled an intent to reduce stigma and treat mental illness as a medical condition.
- **Central and State Mental Health Authorities:** It provided for establishing Central and State Mental Health Authorities to oversee the licensing and regulation of psychiatric hospitals and nursing homes. These authorities were tasked with maintaining standards and advising governments on policy a response to the earlier lack of oversight in asylums.
- **Admission Procedures:** The Act sets out detailed procedures for the admission of patients. Voluntary admission of persons desirous of treatment was retained and clarified. Importantly, for involuntary admissions, a system of "reception orders" by magistrates was laid down, replacing the old judicial inquisition. Police and magistrates were empowered to intervene in cases of wandering or neglected mentally ill persons, to have them assessed and admitted if necessary. While this maintained state powers to detain individuals, it introduced a more straightforward due process compared to 1912.

[98] Mental Health Act, No. 14 of 1987, INDIA CODE (1993).

- **Protection of Patients' Rights:** For the first time, the law spoke to safeguarding certain fundamental rights of persons with mental illness. It called for humane treatment and prohibited discrimination or harassment in mental health facilities. The Act also, for the first time, provided a vague recognition of the concept of consent to treatment (though in practice this was limited) and required that detention beyond a short period be subject to periodic review.
- **Guardianship and Property Management:** MHA 1987 provided a mechanism for the appointment of guardians for the person and property of mentally ill individuals who were incapable of managing themselves. This was to ensure that a person's affairs could be handled in their best interest during illness, under the supervision of the District Courts.
- **Penal Provisions:** The Act penalized certain abuses, for example, running a psychiatric facility without a license, or willfully mistreating a mentally ill person, with fines or imprisonment. This was intended to deter the kind of gross maltreatment that had been reported in some institutions.

Notably, the ethos of the 1987 Act was still cautious. It sought to balance civil liberties with society's interest, but the balance often tilted in favor of the latter. Nevertheless, it was a step forward. The Act's objectives explicitly emphasized care and treatment rather than custodial detention. The Act also reflected influences from British and international law (it drew from the British Mental Health Act 1959 and 1983 amendments, adapting them to Indian conditions.

Despite its progressive elements, the Mental Health Act 1987 drew substantial criticism from the outset. Commentators pointed out that the Act was still largely procedural, focusing on regulating admissions and institutional management, and did not create enforceable rights to community care or rehabilitation. The procedures for involuntary admission were considered clunky and overly bureaucratic, leading one court to observe that the Act had "defects and absurdities" that made it challenging to implement in practice. Another critique was that while the Act nominally protected patients' rights, it offered no robust mechanism to challenge their detention or treatment, apart from habeas corpus in constitutional courts. Public interest litigants and human rights groups even questioned the

constitutionality of the Act on the ground that it allowed deprivation of liberty without sufficient judicial oversight. Moreover, resource shortages meant many states did not promptly establish the required Mental Health Authorities or improve facilities, limiting the Act's on-ground impact. Indeed, a retrospective view noted that MHA 1987 "was not implemented across the country because of a severe shortage of resources".

Nevertheless, the 1987 Act did signify the beginning of a transition. It coincided with India's greater engagement with international human rights law in the 1990s. By the turn of the millennium, India had signed and later ratified (in 2007) the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which includes mental disability. The UNCRPD paradigm, moving from a welfare to a rights-based model, set the stage for India's most recent and revolutionary mental health law, the Mental Healthcare Act 2017.

3.1.6 THE MENTAL HEALTHCARE ACT, 2017

The Mental Healthcare Act of 2017 (hereinafter "MHCA 2017") represents a watershed moment in the legislative history of mental health in India. Enacted in response to internal demands for reform and international obligations, the Act repealed the 1987 law. It sought to align India's mental health law with contemporary human rights standards. The timing was significant: India had ratified the UN Convention on Rights of Persons with Disabilities (CRPD) in 2007, which mandated a shift from a medical welfare model to a rights-based approach for persons with disabilities, including mental illness. The new Act, passed by Parliament in 2017 and brought into force in May 2018, explicitly states its objectives as the protection and promotion of the rights of persons with mental illness and ensuring access to healthcare. It is often hailed as one of the world's most progressive mental health laws on paper, but it also poses significant challenges in implementation.[99]

Key Features of the Mental Healthcare Act, 2017: The MHCA 2017 is a rights-centric law, structured around the principle that persons with mental illness have the same rights

[99] Chaturvedi S, et al. Perceptions regarding the Indian Mental Healthcare Act 2017 among psychiatrists: Review and critical appraisal in the light of CRPD guidelines. Indian J Psychol Med. 2024;46(2):113–118. doi:10.4103/IJPSYM.IJPSYM_38_19.

and freedoms as all other persons, and that the state must ensure those rights in the context of mental healthcare. Some of the salient features of the Act include:

- **Right to Mental Healthcare:** Every person can access mental health care and treatment from mental health services run or funded by the government. This includes access to affordable, good-quality, and geographically accessible services in every district. The Act mandates the government to integrate mental health services into general healthcare and provide "less restrictive" care as far as possible. It also offers specific rights like the right to community living, the right to confidentiality, and the right to protection from cruel, inhuman, or degrading treatment (such as torture or solitary confinement). Importantly, Section 18 creates a justiciable right to mental healthcare, meaning individuals can seek legal remedy if the state fails to provide adequate services. This is a dramatic shift from earlier laws, which imposed duties on individuals but conferred no direct rights against the state.
- **Advance Directives:** For the first time in Indian law, persons with mental illness are empowered to make advance directives – written statements of how they wish to be treated (or not treated) during future episodes when they might lose the capacity to make decisions. People can specify treatments they consent to or object to and appoint a trusted representative to make decisions. These advance directives must be certified by a medical practitioner or registered with the Mental Health Board to be valid. The concept flows from the CRPD's emphasis on patient autonomy and substituted decision-making mechanisms that respect the individual's preferences. While legally binding, the Act does allow clinicians to override advance directives in life-threatening emergencies or with board approval in some instances a balance between autonomy and clinical judgment.
- **Nominated Representatives:** The Act provides that every person with mental illness (or their guardian) has the right to appoint a "nominated representative" (NR) to make decisions about admission, treatment, and overall care on their behalf when the person is unable to do so. The NR's role is to consider the patient's past wishes, values, and best interests. If a person has not nominated anyone, a relative or caregiver can act as a default representative, or the Board can appoint one as a last resort. This replaces the

older concept of a "guardian" appointed through the court, aiming for a more participatory support-based decision-making model rather than a purely substitute decision-maker.

- **Mental Health Authorities:** The Act establishes a multi-tiered regulatory structure. A Central Mental Health Authority (CMHA) at the national level and State Mental Health Authorities (SMHAs) in each state are created to oversee implementation. These authorities are responsible for registering, licensing, and supervising all mental health establishments (hospitals, clinics, etc.), maintaining a register of clinical psychologists, mental health nurses, and psychiatric social workers, and promoting quality standards. They must also protect patients' rights and train law enforcement and other officials about the Act. This structure is more robust than under the 1987 Act, reflecting lessons learned about the lack of oversight.
- **Mental Health Review Boards (MHRBs):** To provide an independent forum for adjudication, the Act sets up Mental Health Review Boards in every region (with members including a judge, a psychiatrist, a mental health professional, and persons representing patients' interests). These Boards have broad powers to review cases of long-term involuntary admission, to hear appeals against decisions of Nominated Representatives or caregivers, to adjudicate complaints regarding rights violations in mental health establishments, and to oversee advance directives. In essence, they act as guardians of the law within the system, ensuring that its provisions are followed on the ground. This addresses one of the major lacunae of previous laws by creating a dedicated judicial body for mental health matters at the grassroots.
- **Regulation of Treatment:** The Act lays down strict guidelines for treatment to prevent past abuses. It specifies that intrusive procedures like electroconvulsive therapy (ECT) can only be administered with muscle relaxants and anesthesia and cannot be given to minors at all. Similarly, psychosurgery (neurosurgical procedures for mental illness) is permitted only with strict consent and independent Board approval. Physical restraint and seclusion of patients are to be used only as a last resort, under oversight. The overall approach is to ensure treatment is scientific and dignified, avoiding the "barbarous therapies" of the past. Additionally, the law mandates that informed consent of the

patient is required for all treatment except in certain narrow circumstances like emergency treatment to prevent immediate harm.

- **Decriminalization of Suicide:** Section 115 of the MHCA 2017 was widely lauded for effectively decriminalizing attempted suicide. It establishes a presumption that any person who attempts suicide "shall be deemed to have severe stress", and hence not subject to prosecution under Section 309 of the IPC. Instead, the government is tasked with providing care, treatment, and rehabilitation to reduce the risk of recurrence. This provision reflects a compassionate, public health approach to suicide and aligns the law with the Supreme Court's recommendations and global best practices.
- **Insurance Equality:** The Act directs that insurance companies should not discriminate between mental and physical illness when providing medical insurance coverage. This is a significant step, ensuring that treatment costs for mental illness can be reimbursed just like any other illness, thus addressing a substantial barrier to access (though enforcement of this provision has only begun via insurance regulator circulars in subsequent years).
- **Penalties for Non-compliance:** The Act prescribes penalties for violations to give teeth to the rights and standards enumerated. Running unregistered mental health establishments, inhuman treatment, failure to comply with Board orders, or breaches of patients' rights can attract fines and even imprisonment, generally up to 6 months for first offense, and up to 2 years for repeat offenses. While relatively mild, these penalties signal that the law is meant to be taken seriously by providers and officials.

Collectively, these features mark a departure from the older regime. The MHCA 2017 is often summarized as "progressive, patient-centric, and rights-based". It attempts to operationalize India's constitutional duty to uphold the dignity of every individual, as well as the CRPD's mandate to recognize the legal capacity and autonomy of persons with psychosocial disabilities. For example, Chapter V of the Act (Rights of Persons with Mental Illness) is frequently referred to as the heart of the law, affirming rights ranging from access to healthcare and living in the community, to privacy and personal liberty. If effectively implemented, the Act would ensure that no person with mental illness is denied treatment, or is treated in a degrading manner, or is wrongfully confined without recourse.

In theory, it shifts the focus to treatment and reintegration, using hospitals not as prisons but as healthcare institutions.[100]

Critical Appraisal and Challenges: While MHCA 2017 is ambitious in scope, its implementation and practical impact have been subjects of intense discussion. Scholars and practitioners have identified several challenges and shortcomings:

- **Resource and Infrastructure Constraints:** A significant concern is whether the healthcare system can deliver the rights and services the Act promises. India has a severe shortage of mental health professionals, far below the WHO-recommended ratios, and many districts lack any functional mental health facility. The Act mandates the establishment of services in every district and the constitution of Mental Health Review Boards nationwide. In practice, many states struggled to set up the State Authorities and Boards within the stipulated time. Nearly two years after the Act came into force, reports indicated that several states had not notified the Boards or allocated the necessary budget, leading commentators to note that the Act "fails to make an impact even after 22 months" and would need vigorous efforts to fulfill its goals.[101] Without substantial investment in expanding hospitals, community clinics, halfway homes, and human resources, the rights enshrined may remain aspirational on paper.
- **Focus on Institutional Care vs Community Care:** The law has been critiqued for focusing heavily on rights within institutional settings (i.e., during hospital admission and treatment) and being "silent about providing care in the community". Indeed, while the right to community living is mentioned, few concrete provisions exist to develop community-based rehabilitation or outpatient services. The burden of care in India traditionally falls on families, and the Act does little to support or acknowledge the role of family caregivers beyond allowing them to be nominated representatives. This institutional bias may inadvertently encourage hospitalization to avail rights and services that should ideally be available at the community level.[102] Critics argue that a

[100] S. Sarkar & M. Sood, The Mental Healthcare Act 2017 of India: A Challenge and an Opportunity, 36 ASIAN J. PSYCHIATRY 112 (2018).
[101] Suresh Bada Math & Maria Christine Nirmala, Mental Healthcare Act 2017 – Aspiration to Action, 61(4) INDIAN J. PSYCHIATRY 429, 431–33 (2019).
[102] Soumitra Pathare et al., Realising Human Rights-Based Mental Healthcare in India: The Mental Healthcare Act 2017, 6(1) INT'L J. L. & PSYCHIATRY 75, 78–80 (2018).

truly forward-looking mental health law should facilitate de-institutionalization and strengthen primary/community mental health care, areas where MHCA 2017 is relatively weak.

- **Complexity and Idealism of Provisions:** Some provisions, like advance directives and nominated representatives, while conceptually laudable, have been viewed as too idealistic or ill-suited to the Indian context. For instance, creating an advance directive assumes a certain level of awareness, education, and foresight about one's mental health, something that may not be feasible for a large section of the population struggling even to access basic care. Psychiatrists are concerned that registering and respecting advance directives could be cumbersome and conflict with emergency clinical judgments. Similarly, the concept of nominated representative, intended to empower the patient, could be misused or sideline family members who have long been caregivers.[103] There is also an implicit assumption of the availability of legal resources for patients to draft directives or contest decisions, which is often untrue. Thus, while these features align with CRPD's ethos, their evidence base in low-resource settings is limited, leading to questions about their practicality.[104]

- **Continuing Stigma and Unawareness:** Laws alone cannot change deep-seated stigma. Many patients and families remain unaware of their new rights under the Act. There have been instances post-2017 where involuntary admissions or treatments were carried out without adhering to the new safeguards, simply because practitioners were more familiar with old practices or found the new procedures onerous. Bridging this knowledge and attitude gap requires extensive training of healthcare staff, police, judges, and the public, an ongoing effort.

- **Intersection with Other Laws:** The MHCA 2017 had to be harmonized with other legislation, such as the Rights of Persons with Disabilities Act, 2016 (which includes mental illness as one of the disabilities and provides for rights like non-discrimination in employment, etc.), and the National Trust Act (for developmental disabilities). There

[103] S. Chaturvedi et al., Perceptions Regarding the Indian Mental Healthcare Act 2017 Among Psychiatrists: Review and Critical Appraisal in the Light of CRPD Guidelines, 46(2) INDIAN J. PSYCHOL. MED. 113, 115–17 (2024), doi: 10.4103/IJPSYM.IJPSYM_38_19.
[104] id

are also provisions in personal laws (marriage, guardianship) and criminal laws referring to "unsound mind." Some commentators have pointed out potential inconsistencies for example, the bar on using past treatment for mental illness as a ground to deny insurance (in MHCA) versus insurance laws and practices, or the continued existence of Section 309 IPC (attempted suicide) on the statute books even though MHCA neutralizes it. Over time, courts will likely reconcile these, but until then, there's a risk of legal confusion.

- **Enforcement of Rights:** Although the Act allows Mental Health Review Boards to address grievances, their effectiveness is yet to be proven. These Boards need to be easily accessible, procedurally simple, and proactive to truly protect patients' rights. Patients may not get timely remedies if they become mired in delays or legal formalism. The Act also allows individuals to approach the High Courts, a remedy of last resort, given the cost and time. The success of the Act will depend on how these quasi-judicial Boards function in practice.[105]

In conclusion, the Mental Healthcare Act, 2017, is a landmark piece of legislation transforming India's legal landscape for mental health from a predominantly paternalistic framework to a rights-based approach in tune with constitutional principles and international norms. It recognizes that persons with mental illness have a right to treatment and to live with dignity, shifting the state's role from custodial keeper to affirmative service provider. However, the noble intentions of the law face practical hurdles. Ensuring that the rights are not just on paper will require strong political will, substantially increased funding for mental health, training professionals in the ethos of the Act, and public education to reduce stigma. The early years of the Act's operation have revealed gaps between promise and practice, prompting calls for amendments and more grounded rules to make the law workable. Nevertheless, MHCA 2017 remains a critical milestone. It has set in motion significant changes – for instance, many insurance companies have started covering mental illness treatments, and attempted suicide is no longer treated as a crime but as a mental health issue to be addressed. As implementation improves over time, the Act has the

[105] C.N. Kumar et al., Implementation of Mental Health Care Act, 2017: Issues and Way Forward, 66(1) INDIAN J. PUB. HEALTH 5 (2022), https://doi.org/10.1177/00195561221080674.

potential to significantly enhance the rights and welfare of millions of Indians living with mental illness. The evolution of mental health laws in India – from ancient norms to this modern Act – thus reflects an ongoing journey toward a more humane and just system, one that continues to evolve with judicial guidance and societal advocacy.

3.2 JUDICIAL CONTRIBUTIONS TO MENTAL HEALTH JURISPRUDENCE

Indian judiciary, especially the higher courts, has been instrumental in shaping mental health law and safeguarding the rights of persons with mental illness. Without robust statutory mechanisms, courts often functioned as guardians of last resort, intervening through Public Interest Litigations (PILs) and habeas corpus petitions to address gross abuses. Over the years, several landmark judgments filled critical gaps and spurred legislative and policy changes.

3.2.1 Rights of Mentally Ill Prisoners

Indian courts have played a pivotal role in safeguarding the rights of prisoners with mental illnesses. A foundational case was ***Veena Sethi v. State of Bihar*** **(1982)**[106], where the Supreme Court intervened upon learning that several accused persons who had been found "insane" during trial (and even those later declared fit or acquitted) were languishing in jail for decades without legal justification. Treating such indefinite detention as a blatant violation of the right to life and liberty under Article 21, the Court ordered the immediate release of these inmates. This decision underscored that no person may be deprived of freedom merely due to mental illness once they are fit or not found guilty, thereby establishing a precedent that the incarceration of mentally ill persons must be legally justified and periodically reviewed.[107]

In ***Sheela Barse v. Union of India***,[108] The Supreme Court confronted the widespread jailing of non-criminal mentally ill persons (often termed "non-criminal lunatics") in West Bengal prisons. The Court unequivocally declared that housing mentally ill individuals in

[106] Veena Sethi v. State of Bihar, (1982) 2 S.C.C.
[107] id
[108] Sheela Barse v. Union of India, (1993) 4 S.C.C. 204

jails without any criminal charge is illegal and unconstitutional, emphasizing that such persons should be in appropriate mental health facilities, not prisons. It issued comprehensive directives: only a Judicial Magistrate could henceforth authorize the detention of a mentally ill individual, and that too with due process and medical oversight. The Court required that all mentally ill inmates in various jails be immediately medically examined and transferred to psychiatric hospitals if needed, with specialized treatment made available, and that each patient's condition be periodically re-evaluated. *Sheela Barse* thus cemented critical procedural safeguards, ensuring that mentally ill persons are not "lost" in the criminal system without review. It affirmed that incarceration is not a form of treatment and that the dignity of mentally ill persons in custody must be protected by moving them to proper care institutions. These orders also set the stage for High Courts to monitor compliance in their states, reflecting a structural reform approach to protect this vulnerable group.[109]

Decades later, the judiciary again addressed the plight of mentally ill undertrials through a suo motu intervention (inspired by the case of Machal Lalung) in 2007. The Supreme Court, treating a news report as a petition, discovered that an undertrial with mental illness had been confined in a psychiatric institution for 38 years without trial or review. In its orders (October 2007), the Court not only secured his release but also directed all High Courts to identify undertrial prisoners with mental illness who were overstaying in prisons or mental hospitals beyond the maximum possible sentence for their alleged offenses. The ensuing reports revealed many such cases of neglect. The Supreme Court castigated the systemic failure to implement the procedural safeguards already in law.[110] It mandated regular judicial monitoring: undertrial detainees with mental illness must have timely medical evaluations and court reviews so that they are not kept in custody indefinitely without progress in their case. This landmark intervention, often cited as the Supreme Court Legal Aid Committee case, reinforced that the right to speedy trial and humane treatment applies with full force to persons with mental disabilities, compelling authorities to follow

[109] id
[110] Code of Criminal Procedure, 1973, §§ 328–330

due process or release the individual. In sum, it filled the gap between earlier principles and actual practice, further humanizing criminal procedure for the mentally ill.

The rights of convicts with mental illness have likewise been expanded by the higher judiciary, especially in the context of capital punishment. In ***Shatrughan Chauhan v. Union of India*,**[111] the Supreme Court commuted the sentences of several death-row prisoners, holding that mental illness acquired or manifested while awaiting execution is a critical "supervening circumstance" that warrants commutation. The Court reasoned that executing an inmate who has become insane or psychotic violates the constitutional mandate of dignity under Article 21 and would amount to inhuman punishment. It drew on human rights standards and global practice to underscore that no civilized nation executes the insane. The Court thus established that if a condemned prisoner is found to be suffering from severe mental illness, the death sentence cannot be carried out.[112] Building on this, in ***Accused "X" v. State of Maharashtra*,**[113] the Supreme Court further developed the law by explicitly recognizing post-conviction severe mental illness as a mitigating factor. In this case, a death-row convict developed schizophrenia after years in prison. Justice N.V. Ramana, writing for a unanimous bench, held that a person who cannot understand the nature or reason of his punishment cannot be executed without offending the Constitution. The judgment stressed that the ability of the accused to comprehend the death sentence is integral to due process; executing someone who, due to mental disability, lacks this comprehension would violate Articles 20 and 21.[114] The Court not only commuted Accused "X"'s death sentence to life imprisonment, but also laid down guidelines for all courts to assess claims of mental incapacity at the post-conviction stage. These decisions illustrate a clear judicial development: from acknowledging the fundamental right to life of mentally ill detainees, the law evolved to shield mentally ill prisoners proactively from inappropriate punishment, up to and including a bar on carrying out death sentences. Each case progressively strengthened the principle that the criminal justice system must treat mentally

[111] Shatrughan Chauhan v. Union of India, (2014) 3 SCC 1
[112] id
[113] Accused 'X' v. State of Maharashtra, (2019) 7 SCC 1.
[114] India Const. arts. 20–21.

ill individuals with compassion, provide treatment and review, and never punish beyond their understanding or responsibility.

3.2.2 TREATMENT AND CONDITIONS IN MENTAL HEALTH INSTITUTIONS

Another theme in the judicial evolution of mental health law in India is the improvement of conditions and treatment in mental health institutions. The Supreme Court's interventions in the 1980s and 1990s were instrumental in exposing deplorable conditions in asylums and directing systemic reforms. In *Rakesh Chandra Narayan v. State of Bihar* (1986),[115] a public interest litigation concerning the awful state of the Ranchi mental hospital (Kanke, Bihar) led the apex court to articulate cardinal principles for institutional care. The Court affirmed that a person with mental illness does not forfeit the right to live with dignity; basic amenities like proper food, water, sanitation, hygiene, and recreation in institutions are all part of the fundamental right to life under Article 21. The judgment stressed that acceptable standards of treatment and living conditions in psychiatric facilities are "non-negotiable," and the State has an obligation of care and attention to transform custodial mental hospitals into therapeutic, humane environments. This pronouncement, for the first time, tied conditions in mental hospitals directly to constitutional rights, implying that any inhumane or degrading treatment in these facilities is subject to judicial correction.[116]

Soon after, the Supreme Court tackled mismanagement at the nation's capital mental hospital in *B.R. Kapoor & Anr. v. Union of India.*[117]This PIL (filed 1983, decided 1989) revealed that the Shahdara Mental Hospital in Delhi was severely overcrowded and unhygienic, with inadequate staff and rampant neglect of patients. The Court appointed an expert committee of psychiatrists, whose detailed report documented gross violations of the 1987 Mental Health Act's standards, including lack of basic sanitation, poor food, insufficient medical care, and patients even attempting suicide due to neglect. In its orders, the Supreme Court issued 35 specific remedial directions to upgrade the facility. Crucially,

[115] Rakesh Chandra Narayan v. State of Bihar, (1989) Supp. (3) SCC 306.
[116] id
[117] B.R. Kapoor & Anr. v. Union of India & Ors., AIR 1990 SC 752

the Court directed the government to modernize the hospital on the model of NIMHANS (a national institute in Bangalore) and to attach it to a teaching institution for better staff training. When Delhi authorities were slow to act, the Court transferred the hospital's administration from the local government to the Union Government. This eventually led to establishing the Institute of Human Behaviour and Allied Sciences (IHBAS) in Delhi. *B.R. Kapoor* thus marked a significant judicially-driven reform: the Court not only addressed individual grievances but also restructured an entire institution, affirming that the state must ensure mental hospitals meet statutory standards and that failure to do so infringes patients' fundamental rights

Around the same time, in *Chandan Kumar Banik v. State of West Bengal*,[118] the Supreme Court scrutinized conditions at a mental hospital in West Bengal and denounced the prevailing attitude of indifference. The Court famously observed that the "management of an institution like a mental hospital requires the flow of human love and affection, understanding and consideration for mentally ill persons; these aspects are far more important than a routinized, stereotyped and bureaucratic approach to mental health issues.".[119] By emphasizing compassion and individualized care, the *Banik* judgment highlighted the qualitative aspect of rights in institutions: persons with mental illness must be treated as patients with dignity, not as prisoners. The Court's anguish at the "inhumane conditions" in that case resulted in directions to the state to improve infrastructure and staff behavior, underscoring that institutionalization should never compound the misery of patients. Together, *B.R. Kapoor* and *Chandan Kumar Banik*[120] set vital benchmarks: they extended constitutional rights to mental health care, holding governments accountable for running therapeutic and respectful facilities as envisaged by the Mental Health Act, 1987.

A pivotal moment in judicial oversight of institutional care was the aftermath of the Erwadi Tragedy (2001),[121] Twenty-eight inmates of an unlicensed mental asylum in Tamil Nadu were burned alive while being chained to their beds. The Supreme Court, taking suo motu cognizance in Re: Death of 25 Chained Inmates *in* Asylum Fire in Tamil Nadu, directed

[118] Chandan Kumar Banik v. State of West Bengal, 1995 Supp. (4) SCC 505.
[119] id
[120] B.R. Kapoor v. Union of India, A.I.R. 1990 S.C. 752
[121] In Re: Death of 25 Chained Inmates in Asylum Fire in Tamil Nadu v. Union of India, Writ Petition (Civil) No. 334 of 2001, Order dated October 15, 2001

the closure of all non-registered mental health institutions, enforcement of licensing provisions under the Mental Health Act, 1987, and mandated state-wise inspection drives. The Court entrusted the National Human Rights Commission (NHRC) to monitor all mental health facilities nationwide. This marked a significant doctrinal moment as the judiciary acknowledged the "duty of care" owed by the State to persons with mental illness, especially when they are in custodial care. The tragedy and its legal aftermath catalyzed the process of deinstitutionalization and accelerated advocacy for a rights-based mental health framework, eventually culminating in legislative reform.[122]

These cases also prompted the involvement of bodies like the National Human Rights Commission (NHRC) to inspect and monitor mental institutions thereafter. Notably, the Supreme Court in the late 1990s directed the NHRC to oversee reforms in asylum management (e.g., at Ranchi, Agra, and Gwalior hospitals) and to report on compliance, thereby institutionalizing continuing oversight even after the PILs were disposed of.

In recent years, judicial focus has shifted to ensuring rehabilitation and community integration of persons confined in mental hospitals. A significant development came via *Gaurav Kumar Bansal v. Union of India* (2017),[123] a PIL addressing hundreds of "cured" patients who remained stuck in hospitals for years due to the absence of community-based facilities. In July 2017, the Supreme Court ordered all States and Union Territories to establish halfway homes and rehabilitation facilities for persons who had recovered enough to leave the hospital but had nowhere to go. This order, aligned with the new Mental Healthcare Act, 2017, which recognizes the right to community living, aimed to end the practice of warehousing indefinitely recovered patients in wards. After finding poor compliance, the Court in 2021 (in a contempt proceeding in the *Bansal* case) reaffirmed the obligation of the States to set up these residences and even called for an online dashboard to track progress. By mandating concrete follow-up, the Court ensured that the legislative promise of community-based care is translated into reality. The *Bansal* case thus represents the contemporary judicial approach: moving beyond deinstitutionalization in principle to crafting mechanisms for social reintegration of persons with mental illness. In

[122] id
[123] Gaurav Kumar Bansal v. Union of India, W.P. (C) No. 406/2013

sum, through a series of thematic PILs, the judiciary has driven the evolution of mental health law from mere custodial legislations to a rights-based framework where treatment conditions, humane care, and rehabilitation are viewed as enforceable components of the right to life with dignity.[124]

3.2.3 ENSURING PROCEDURAL SAFEGUARDS AND DUE PROCESS

Indian courts have consistently reinforced procedural safeguards to protect mentally ill persons, whether in civil commitment proceedings or the criminal justice process. One aspect of this development is the insistence that depriving a person of liberty for mental health reasons must strictly follow due process. The *Sheela Barse* ruling in 1993, for example, not only freed non-criminal detainees from jails but also put in place a procedure requiring magistrates to carefully evaluate the circumstances and medical condition before committing a person to a psychiatric facility. The Court required that every such order be periodically reviewed, thereby preventing arbitrary or indeterminate detention of patients. This judicial mandate filled gaps in the Mental Health Act, 1987, by reading in constitutional due process: a person cannot be institutionalized without judicial scrutiny of the necessity, and continued confinement requires ongoing judicial supervision. Subsequent case law built on this by involving High Courts in monitoring the status of long-term inmates and undertrial prisoners with mental illness, as seen in the 2007 SC Legal Aid Committee case. Through these measures, the higher judiciary ensured that statutory safeguards such as inquiry under Cr.P.C. §§328–329 for accused persons of unsound mind, and the Mental Health Act provisions on admissions and discharge. They are not mere formalities but are earnestly implemented.[125]

Furthermore, the Supreme Court has broadened the discourse of procedural safeguards to encompass fairness and non-discrimination for persons with mental disabilities. In *Accused "X"* (2019), while dealing with a death row convict's review, the Court implicitly affirmed a crucial procedural right: the right to meaningful participation in one's legal proceedings.

[124] id
[125] Neha Singhal, Mental Health Law in India: A Critical Review, 10 Asian J. Psychiatr. 67 (2014)

Justice Ramana's opinion reasoned that if an accused cannot understand the proceedings or the punishment due to mental illness, then carrying on with the legal process (or an execution) would violate fundamental fairness. This principle is an extension of the fitness to stand trial, taken to the post-conviction stage – a significant development in Indian jurisprudence. It led the Court to enumerate guidelines for trial courts and appellate courts on assessing claims of mental incapacity, thus inserting a clear procedural checkpoint in cases involving severe mental illness. Likewise, Indian High Courts have intervened to uphold safeguards in civil contexts – for instance, the Kerala High Court in *Mother Superior, Adoration Convent v. State of Kerala* (2010)[126] Insisted on adhering to Chapter IV of the 1987 Act when authorizing detention of a person with mental illness, reiterating that judges must ensure treatment and care, not punishment, is the objective of any custodial order. Although a lower court decision, it echoes the Supreme Court's broader stance that judicial oversight is a fundamental guarantee in involuntary hospitalization or competency adjudication.

Another facet of procedural fairness is the protection of the rights of mentally ill persons within disciplinary or institutional proceedings. In a recent decision (2020), *Ravindra Kumar Dhariwal v. Union of India*,[127] the Supreme Court set aside disciplinary action against an employee who had a mental illness, holding that his errant conduct was a manifestation of the disease and punishing him without accommodation would be discriminatory. While not directly about mental health law, this case, invoking the Rights of Persons with Disabilities Act 2016, aligns with the evolving jurisprudence that procedures must be adjusted to the needs of persons with mental disabilities to avoid unfair outcomes. In the sum, over time the judiciary has woven a tapestry of safeguards: from the moment a person with mental illness comes into contact with the law be it a magistrate assessing a case for commitment, a trial judge confronted with an incapable accused, or jail authorities managing a prisoner there are judicially mandated procedures to ensure no decision affecting rights is taken without proper medical input, review mechanisms, and consideration of less restrictive alternatives.[128] This evolution reflects a shift from a

[126] Mother Superior, Adoration Convent v. State of Kerala, (2010) 3 K.L.T. 421
[127] Ravinder Kumar Dhariwal v. Union of India, (2023) 2 SCC 209
[128] Id

paternalistic approach to a rights-oriented approach in mental health law, primarily driven by the courts' insistence on due process and equality.

3.2.4 IMPLEMENTATION OF THE MHCA AND INSTITUTIONAL OVERSIGHT

Gaurav Kumar Bansal v. Union of India & Ors (SC, 2025).[129] The Supreme Court addressed the MHCA's stalled implementation in this ongoing PIL. The bench directed the Union Government to file a detailed affidavit on the constitution and functioning of the Central and State Mental Health Authorities (CMHA/SMHAs). All Mental Health Review Boards (MHRBs), as mandated by the MHCA 2017, this order (Feb 2025) highlights the courts' role in enforcing statutory institutional structures for mental healthcare. Suggested sub-section*:* "MHCA Implementation and Mental Health Authorities."

Amit Sahni v. GNCTD (Delhi HC, 2023): [130]The Delhi High Court criticized the local government's failure to constitute the State Mental Health Authority under the MHCA. In a public-interest petition, the court ordered immediate compliance with MHCA Sections 45–46 and the MHCA Rules (2018) and directed the setting up of district-level mental health boards. The bench noted that the absence of these bodies "has a detrimental impact on the treatment and care" of persons with mental illness.

3.2.5 ACCESS TO MENTAL HEALTH CARE AND NON-DISCRIMINATION

Shikha Nischal v. National Insurance Co. Ltd. (Delhi HC, 2021)[131]The Delhi High Court enforced Section 21(4) of the MHCA to ensure parity in health insurance. It held that an insurer cannot exclude psychiatric treatments based on mental illness, since the MHCA mandates that insurance "would not make any distinction between mental illnesses and physical illnesses." The court directed the insurer and the IRDAI to comply with MHCA

[129] Gaurav Kumar Bansal v. Union of India & Ors., Writ Petition (Civil) No. 1496 of 2018, Supreme Court of India, Order dated February 7, 2025.
[130] Amit Sahni v. Govt. of NCT of Delhi & Ors., 2024 SCC OnLine Del 2647.
[131] Shikha Nischal v. Nat'l Ins. Co. Ltd., 2021 SCC Online Del 2647.

rules, ordering payment to the insured. Suggested sub-section: "Access to Mental Healthcare (Insurance and Services)."

Bombay HC (2021): Relying on *Shikha Nischal*, the Bombay High Court stayed an insurer's refusal to issue a health policy to a person with bipolar disorder. The court applied the MHCA's non-discrimination principle, noting that denying coverage simply because of a mental health condition violates Section 21(4).

3.2.6 MENTAL HEALTH AND CRIMINAL LIABILITY

Common Cause v. Union of India (SC, 2018):[132] Although a case on passive euthanasia, the Supreme Court explicitly cited MHCA Section 115 in decriminalizing suicide. The Court emphasized that "a person who attempts suicide [must be viewed] as needing care, treatment and rehabilitation rather than penal sanctions." This affirmed that the law now presumes a suicide attempt signals severe stress, aligning criminal law with a rights-based approach.

Kerala HC (Vijayaraghavan J., 2025):[133] In a deeply distressing case where a mother killed her infant and then attempted suicide, the Kerala High Court set aside convictions for murder and attempted suicide. Relying on MHCA Section 115, the court held that after 7 July 2018, a trial court "ought to have… desisted from proceeding" once the accused's suicide attempt was established, unless the prosecution proved she was not under severe stress. By interpreting Section 115 to bar prosecution for all offences committed in the same transaction, the court recognized the accused's mental distress and refused to apply punitive measures.

Conclusion:

Each of the above cases carries implications for MHCA 2017's practical enforcement. For example, the regulatory-authority cases (Bansal, Sahni) would fit naturally under a section on implementation and institutional safeguards (ensuring CMHAs/SMHAs/MHRBs are set up). The insurance decisions would belong in a section on access to care and

[132] Common Cause (A Regd. Society) v. Union of India, (2018) 5 SCC 1.
[133] Sharanya v. State of Kerala, 2025 SCC OnLine Ker 15011.

nondiscrimination, demonstrating judicial affirmation of MHCA rights in private-sector contexts. The suicide/criminal cases belong under mental health in the criminal justice system, showing how courts now treat suicide and related offences as matters requiring treatment, not punishment. The judiciary's development of mental health law has been characterized by humanization of the law's approach to mental illness, whether by rescuing individuals from the oblivion of prison cells or by transforming asylums into institutions of care. Each landmark judgment contributed a piece to the legal framework: *Veena Sethi* and *Sheela Barse* asserted fundamental rights and ended unlawful detentions; *Rakesh Chandra Narayan*, *B.R. Kapoor*, and *Banik* demanded dignity and quality treatment in hospitals; the *Bansal* case pushed for rehabilitation in society; and cases like *Shatrughan Chauhan* and *Accused X* broke new ground in protecting mentally ill persons in the criminal justice system from disproportionate punishment. Together, these decisions chronicle an evolution from an era when mental health law was a neglected area to the present, where courts treat persons with mental illness as rights-bearing individuals deserving of full human dignity and equal protection of law. The Indian judiciary has thus been a catalyst in the critical transformation of mental health laws, ensuring that legal standards keep pace with constitutional values and India's international human rights commitments.

CHAPTER 4

INTERNATIONAL INSTRUMENTS ON MENTAL HEALTH AND COMPARATIVE ANALYSIS

4.1 INTERNATIONAL INSTRUMENTS ON MENTAL HEALTH

International human rights instruments have played a crucial role in the development of mental health law, facilitating a transition from custodial care to a rights-based approach. This chapter highlights key global standards, primarily the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and the WHO guidelines, that outline India's legal obligations and serve as benchmarks for assessing the Mental Healthcare Act of 2017.

4.1.1 UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (UNCRPD)

BACKGROUND:

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)[134] It is a landmark international human rights treaty that seeks to promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities, including those with psychosocial or mental disabilities. This signifies a significant transformation in how disability is addressed, transitioning from focusing on medical and charitable perspectives to a rights-oriented approach that prioritizes dignity, autonomy, non-discrimination, and social inclusion.[135]

The drafting of the Convention began in 2002 following a resolution by the United Nations General Assembly, which established an Ad Hoc Committee to consider proposals for a new international treaty on the rights of persons with disabilities. The final text was adopted by the General Assembly on 13 December 2006 by Resolution A/RES/61/106. The

[134] Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3, https://treaties.un.org/doc/Publication/UNTS/Volume%202515/v2515.pdf.
[135] Id

Convention was opened for signature on 30 March 2007, and it entered into force on 3 May 2008, following the ratification by 20 States Parties, by Article 45 of the Convention.[136]

India signed the Convention on the day it opened for signature, i.e., 30 March 2007. It ratified it on 1 October 2007, thereby undertaking an international legal obligation to harmonize its domestic laws with the provisions of the CRPD.

Article 3 of the CRPD enumerates the general principles that underpin the treaty:

- Respect for inherent dignity, individual autonomy, including the freedom to make one's own choices, and independence of persons;
- Non-discrimination;
- Full and effective participation and inclusion in society;
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- Equality of opportunity;
- Accessibility;
- Equality between men and women;
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.[137]

The Convention further includes specific provisions dealing with legal capacity.[138], freedom from torture and abuse[139]The right to live independently and be included in the community[140]and the right to the highest attainable standard of health without discrimination [141], among others. These articles are of particular relevance in the context of mental health law.[142]

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[136] Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3, art. 45.
[137] Convention on the Rights of Persons with Disabilities, art. 3, Dec. 13, 2006, 2515 U.N.T.S. 3, https://treaties.un.org/doc/Publication/UNTS/Volume%202515/v2515.pdf.
[138] art 12: Equal recognition before the law
[139] art 14- 16: Liberty and security of the person, Freedom from torture or cruel, inhuman or degrading treatment or punishment, Freedom from exploitation, violence and abuse
[140] art19: Living independently and being included in the community
[141] art 25: Health
[142] Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3, arts. 12, 14–16, 19, 25.

MONITORING AND ENFORCEMENT:

The CRPD established the Committee on the Rights of Persons with Disabilities, a treaty-monitoring body composed of independent experts. States Parties must submit periodic reports to the Committee on the measures they have taken to implement the rights under the Convention. The Optional Protocol allows for individual complaints and inquiries into grave or systematic violations.

India's Mental Healthcare Act 2017 explicitly references the UNCRPD in its preamble. The Convention, adopted on 13 December 2006 and in force from 3 May 2008, recognizes persons with disabilities, including psychosocial disabilities, as full rights-holders, emphasizing dignity, autonomy, and non-discrimination. Its general principles stress respect for "inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons".[143] In particular, the CRPD affirms:

- **Article 5: Equality and non-discrimination**: [144]

Everyone is equal before and under the law and is entitled, not subject to discrimination, to equal protection and benefit of the law. Persons with disabilities must enjoy all human rights on an equal basis.[145]. Countries that are parties to this agreement must ban all discrimination against individuals with disabilities and guarantee them equal and adequate legal protection in all matters. To foster equality and eradicate discrimination, these countries should take all appropriate measures to offer reasonable accommodations. Necessary actions to achieve true equality for persons with disabilities will not be deemed discriminatory under this Convention.[146]

- **Article 12: Legal capacity[147]**:

People with disabilities have the right to be recognized as individuals under the law in every context. Governments must affirm that these individuals possess equal legal capacity

[143] art.3 Supra note 132
[144] Convention on the Rights of Persons with Disabilities, art. 5, Dec. 13, 2006, 2515 U.N.T.S. 3, https://treaties.un.org/doc/Publication/UNTS/Volume%202515/v2515.pdf.

[146] Id
[147] art 12 Supra note 134

with others in all areas of life. Additionally, they must offer the support necessary to exercise that capacity effectively. This necessitates a move from substitute guardianship to a model of supported decision-making that honors the individual's choices and preferences. States Parties must implement all measures regarding the exercise of legal capacity with suitable and adequate safeguards to avoid abuse, in line with international human rights standards. These safeguards must ensure that decisions about legal capacity respect the individual's rights, will, and preferences. Additionally, they should be free from conflicts of interest and undue influence, be proportional and customized to the individual's specific situation, last only as long as necessary, and undergo regular assessments by a competent, independent, and impartial authority or judicial entity.[148] The safeguards should correspond to how these measures affect a person's rights and interests. In line with this article, States Parties must take all necessary and practical steps to ensure that individuals with disabilities have equal rights to own or inherit property, manage their financial affairs, and access bank loans, mortgages, and other types of financial credit. Moreover, they must protect individuals with disabilities from being unfairly stripped of their property.[149]

- **Article 15: Freedom from torture and abuse[150]**

No individual should endure torture or any form of cruel, inhumane, or degrading treatment or punishment.[151] It is the responsibility of States to implement all necessary measures to protect individuals with disabilities from such treatment, which includes banning coercive treatment and restraint.[152]States Parties are required to adopt all appropriate legislative, administrative, judicial, and other measures to prevent individuals with disabilities from experiencing torture, as well as cruel, inhuman, or degrading treatment or punishment, ensuring that they are treated on an equal basis with others.[153]

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[148] **B. Lee**, The U.N. Convention on the Rights of Persons with Disabilities and Its Impact upon Involuntary Civil Commitment of Individuals with Developmental Disabilities, 44 Colum. J.L. & Soc. Probs. 393 (2011).
[149] id
[150] art 15: Freedom from torture or cruel, inhuman or degrading treatment or punishment
[151] Michels, L. (2004). The prohibition of torture under international law and the "War on Terror".
[152] Id
[153] United Nations General Assembly (UNGA). (2019). Resolution No. A/RES/73/304: Towards torture-free trade: Examining the feasibility, scope and parameters for possible common international standards (28 June 2019).

- **Article 16: freedom from exploitation, violence, and abuse:** [154]

States Parties shall take all appropriate legislative, administrative, social, educational, and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence, and abuse, including their gender-based aspects. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence, and abuse by ensuring, inter alia, proper forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize, and report instances of exploitation, violence, and abuse.[155] States Parties must ensure that protection services are sensitive to age, gender, and disability. To prevent all forms of exploitation, violence, and abuse, it is essential that independent authorities effectively oversee all facilities and programs aimed at assisting individuals with disabilities. Additionally, States Parties must implement all necessary measures to support the physical, cognitive, and psychological recovery, rehabilitation, and social reintegration of persons with disabilities who have been victims of any form of exploitation, violence, or abuse. This recovery and reintegration should occur in an environment that promotes health, well-being, self-respect, dignity, and autonomy, while also considering the specific needs related to gender and age. States Parties must establish effective legislation and policies, including those focused on women and children, to ensure that cases of exploitation, violence, and abuse against persons with disabilities are identified, investigated, and prosecuted when appropriate.

- **Article 19: Living independently and being included in the community**[156]

States acknowledge that all individuals with disabilities have the equal right to live in the community, enjoying choices comparable to those available. To prevent social isolation, they must offer community supports and services, such as in-home assistance, residential

[154] art 16 Supra note 135
[155] Merrick, J., & Greydanus, D. (2023). Disability and maltreatment. International Journal of Child and Adolescent Health, 16(3), 169–174.
[156] art 19 supra note 136

facilities, and personal care. This principle is essential for guaranteeing the right to community-based care and inclusion. The state must ensure that:

a) Individuals with disabilities can decide their residence and living arrangements without being required to live in any particular setting.
b) Individuals with disabilities can access various in-home, residential, and community support services. These include personal assistance to facilitate community living and inclusion, helping to prevent isolation or segregation from society.
c) Community services and facilities are equally accessible to people with disabilities and respond to their needs.

- **Article 25: Health**[157]

People with disabilities are entitled to the highest standard of health care without facing discrimination. This means they should have access to health services that are as high in quality as those provided to others and that these services be delivered based on informed consent, while honoring their dignity and autonomy. This guarantee extends to mental health services and requires appropriate accommodations, such as accessible facilities and sign language interpretation.[158]

Thus, the CRPD defines mental illness as a disability. It mandates that States guarantee equal legal recognition and support, prohibit inhumane treatment, and offer community-based, voluntary care and high-quality health services as fundamental rights.

4.1.2. WORLD HEALTH ORGANIZATION FRAMEWORKS

The World Health Organization has developed multiple frameworks and guiding documents that translate these human-rights norms into health policy and legislation. Notably:

[157] art5 supra note
[158] Convention on the Rights of Persons with Disabilities, art. 25, Dec. 13, 2006, 2515 U.N.T.S. 3, https://treaties.un.org/doc/Publication/UNTS/Volume%202515/v2515.pdf.

- **WHO Quality Rights Initiative (launched 2012)**:[159]

This global initiative is focused on adopting a human rights and recovery framework in mental health, based on the UN Convention on the Rights of Persons with Disabilities (CRPD) and other international human rights standards. The World Health Organization (WHO) has created training materials, toolkits, and assessment tools to aid countries in reforming their mental health services and legal frameworks. The Quality Rights approach prioritizes person-centered care, informed consent, respect for individual autonomy and dignity, and the cessation of forced or restrictive practices. For example, the WHO recommends transitioning from psychiatric institutions to community-based services that foster inclusion and protect individuals from abuse. The Quality Rights e-training and toolkits are intended to shift mindsets and practices sustainably, empowering all stakeholders to support rights and recovery.[160]

The WHO, as part of the Quality Rights Initiative, has created a detailed set of training and guidance materials. These resources are designed to enhance the skills of mental health professionals, individuals with psychosocial, intellectual, and cognitive disabilities, users of mental health services, their families, caregivers, and supporters, as well as non-governmental organizations and disability advocacy groups. The goal is to promote applying a human rights and recovery-oriented approach in mental health, aligning with the UN Convention on the Rights of Persons with Disabilities and other global human rights frameworks.[161]

- **WHO Comprehensive Mental Health Action Plan (2013–2030)**:[162]

The Comprehensive Mental Health Action Plan 2013–2030 was endorsed by the World Health Assembly (WHA) in May 2013 through Resolution WHA66.8 and extended to 2030. This globally recognized framework aims to strengthen mental health systems while

[159] World Health Organization, WHO Quality Rights Initiative (2012), https://www.who.int/initiatives/who-qualityrights.
[160] World Health Organization, Quality Rights Guidance and Training Tools: Transforming Services and Promoting Rights in Mental Health and Social Services (2019), https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools.
[161] id
[162] World Health Organization, Comprehensive Mental Health Action Plan 2013–2030 (rev. ed. 2021), https://www.who.int/publications/i/item/9789240031029.

respecting human rights. The plan highlights that mental health is essential to universal health coverage and sustainable development and should not be viewed as less significant than physical health care. This plan sets four objectives: (1) leadership/governance; (2) integrated, community-based care; (3) promotion/prevention; (4) information systems. It highlights the importance of providing comprehensive and integrated mental health and social care services within community settings. Furthermore, it advocates for incorporating mental health considerations at all levels of health care, ensuring sufficient resources and training for the workforce. [163]The Action Plan underlines the WHO's stance that mental health is not separate or lesser; mental health services should be accessible, affordable, and non-discriminatory, aligning with the CRPD's Article 25[164] Ethos.

- **WHO/OHCHR Guidance on Mental Health Law (2023)**:[165]

In October 2023, the World Health Organization (WHO) and the UN High Commissioner for Human Rights published "Mental Health, Human Rights and Legislation: Guidance and Practice." This guidance promotes a legislative framework based on human rights in mental health. It introduces new goals for legislation, including a clear directive for mental health systems to embrace this rights-based approach.

The document details the legal measures necessary for deinstitutionalization and providing quality, individualized community services. It also includes specific strategies to eliminate coercive practices in mental health care. The guidance reflects the principles outlined in the Convention on the Rights of Persons with Disabilities (CRPD), encouraging countries to revise their laws to prevent involuntary admissions and treatments while upholding the dignity and autonomy of individuals.[166]

[163] id
[164] art 25 Convention on the Rights of Persons with Disabilities, art. 25, Dec. 13, 2006, 2515 U.N.T.S. 3, https://treaties.un.org/doc/Publication/UNTS/Volume%202515/v2515.pdf.
[165] World Health Organization & Office of the United Nations High Commissioner for Human Rights, Mental Health, Human Rights and Legislation: Guidance and Practice (2023), https://iris.who.int/handle/10665/373126.
[166] id

- **WHO Human Rights Communications**:[167]

In recent global communications, the WHO has reaffirmed that mental health is a fundamental human right**,** not merely a public health objective or a medical concern. WHO emphasizes that this right is multidimensional, encompassing substantive entitlements and procedural safeguards. Substantively, it includes the right of every individual to available, accessible, acceptable, and good quality mental health care**,** irrespective of socioeconomic status, disability, or geographic location. These four elements, derived initially from the United Nations Committee on Economic, Social and Cultural Rights' General Comment No. 14, form the core of a rights-based approach to health. They imply that services must be sufficient in quantity (availability), reach all populations without discrimination (accessibility), be culturally and ethically appropriate (acceptability), and meet medical and professional standards (quality).[168]

Beyond service provision, WHO's communications also underscore civil and political rights associated with mental health, such as th**e** right to liberty, legal capacity, autonomy, and inclusion in the community**.** This framing resonates with the UNCRPD's Articles 12, 14, 19, and 25**,** which recognize the rights of persons with mental disabilities to live independently, to make decisions about their treatment, and to be protected from arbitrary detention or coercive interventions.

WHO thus explicitly urges Member States to align their national mental health laws and policies with these international human rights standards. It promotes a shift from outdated models centered on institutionalization and coercion toward models emphasizing community-based, person-centered, and recovery-oriented care**.** In doing so, WHO also calls for the establishment of procedural protections such as independent monitoring mechanisms, complaint redressal bodies, and legal safeguards to protect individuals from abuse, neglect, or violations of rights in mental health settings.

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[167] World Health Organization, Human Rights and Health, WHO Fact Sheet (Dec. 13, 2023), https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health.

[168] Comm. on Econ., Soc. & Cultural Rts., General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the International Covenant on Economic, Social and Cultural Rights), U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), https://undocs.org/E/C.12/2000/4.

These communications collectively reflect WHO's evolving stance that mental health is not simply a matter of clinical treatment but a comprehensive human rights issue requiring legal, policy, and social reform. They reinforce the global expectation that mental health legislation must embed accountability, empowerment, and equality at its core.

In conclusion, the WHO frameworks align with the CRPD-led approach by emphasizing that mental health laws should protect the autonomy, capacity, and rights of individuals with mental illness. They advocate for developing community-based alternatives while seeking to eliminate discriminatory and coercive practices.

4.2 COMPARATIVE ANALYSIS WITH INDIA'S MENTAL HEALTHCARE ACT, 2017

India's Mental Healthcare Act, 2017, was explicitly enacted to protect, promote, and fulfil the rights of persons with mental illness, in consonance with CRPD obligations. Several provisions of the Act align closely with international norms:

Explicit CRPD Alignment: The Act's preamble acknowledges the CRPD (adopted 2006, in force 2008) and declares the need to align and harmonise Indian law with it. This intent is reflected in multiple sections.[169]

Right to Community Living: Section 19(1)[170] Guarantees right to community living". The government must support or provide community-based residential options (halfway homes, group homes, etc.) so that no one remains in a hospital simply due to homelessness or lack of family. This echoes CRPD Art. 19's mandate for independent living with community support. Likewise, Section 18(5) requires that treatment be provided "in a manner which supports persons with mental illness to live in the community and with their families".[171]

[169] Mental Healthcare Act, No. 10 of 2017, Preamble, INDIA CODE (2017)
[170] Sec 19(1): "Every person with mental illness shall have a right to live in, be part of, and not be segregated from society and shall have the right to live with dignity."
[171] Mental Healthcare Act, No. 10 of 2017, § 19(1), INDIA CODE (2017).

Non-Discrimination and Equality: Section 21 treats persons with mental illness as "equal to persons with physical illness" in access to healthcare and outlaws' discrimination on any ground (gender, religion, caste, disability, etc.

(1) Every person with a mental illness shall be treated as equal to persons with physical illness in the provision of all healthcare.
(2) There shall be no discrimination, including gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability, or any other basis.
(3) Every person with a mental illness shall have the right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government.
(4) The appropriate government shall ensure that the provisions for medical insurance for treating mental illness are made on the same basis as those available for treating physical illness.[172]

This aligns with CRPD Art. 5 and WHO's insistence on non-discriminatory, accessible care. Section 18(2) similarly stipulates that mental health services be available "without discrimination based on… disability or any other basis", reinforcing Article 25's principle of equal-quality healthcare.

- **Autonomy, Legal Capacity, and Advance Directives:**

MHCA recognizes the legal capacity of persons with mental illness. Section 4 (not quoted above) ensures capacity to make treatment decisions is assumed, and Sec 14(9) explicitly states that "all persons with mental illness shall have the capacity to make mental health care or treatment decisions but may require varying levels of support from their nominated representative". This mirrors CRPD Art. 12's demand for supported decision-making rather than guardianship. The Act provides new tools for autonomy: Section 5 grants every adult (non-minor) the right to make an advance directive (specifying how they wish to be treated or not treated), and Section 10 imposes a legal duty to follow a valid advance

[172] Mental Healthcare Act, No. 10 of 2017, § 21, INDIA CODE (2017).

directive. In practice, a review board can override an advance directive under limited conditions (Sec. 11), but the scheme nevertheless embeds the notion that a person's will and preferences should guide treatment.

- **Prohibition of Inhumane Treatment:**

Section 20 guarantees that every person "has the right to live with dignity" and shall be "protected from cruel, inhuman or degrading treatment". It lists specific safeguards (privacy, safe environment, freedom from forced work or abuse). This codifies CRPD Art. 15's ban on torture and ill-treatment and aligns with WHO's QualityRights emphasis on humane care.

- **Access to Care and Community Services:**

Section 18(1–3) enshrines "the right to access mental healthcare and treatment" of affordable cost, adequate quality, and availability. It mandates that governments provide a spectrum of services (outpatient, inpatient, rehabilitation, halfway homes, child/elder care) and integrate mental health into primary to tertiary healthcare. This reflects the WHO Action Plan objective of comprehensive community-based services and CRPD's Article 25 on health. The Act also requires emotional support for families and social services integration (e.g., patients below the poverty line receive free treatment).

- **Procedural Safeguards:**

Unlike earlier law, MHCA abolishes archaic notions of "unsoundness of mind" and default guardianship. It establishes Mental Health Review Boards to oversee admissions and rights complaints. Involuntary admissions under Section 89 (for "very high support needs" cases) are strictly time-limited, max 30 days, and contingent on dual psychiatric certification that it is the least restrictive option. Further admission beyond 30 days (Sec. 90) requires Board approval. These measures introduce accountability and minimize coercion, per WHO/OHCHR guidance.

Overall, the MHCA embeds many international norms: it enshrines community living (Sec. 19), equality (Sec. 21), dignity (Sec. 20), legal capacity and support (Sec. 14(9)), informed consent and patient choice (Sec. 5–10), and parity with physical health (Sec. 21).

These provisions demonstrate strong alignment with CRPD Articles 3,5,12,15,19,25, and with WHO's call for rights-based, community-oriented legislation. Indeed, MHCA 2017 is often hailed as a progressive, rights-based mental health law.

Despite these advances, several gaps and challenges remain:

- **Supported vs Substitute Decision-Making:**

While Sec. 14(9) of MHCA affirms capacity with "varying levels of support", in practice, the Act still relies on a nominated representative (akin to a substitute decision-maker) when a person is incapacitated. CRPD advocates have urged stronger supported decision-making mechanisms that never override the person's will. In MHCA, a review board may override an advance directive if it finds it was not made free of coercion or is legally invalid, which suggests that substitute authority persists. Thus, although MHCA moves in the CRPD direction, it does not eliminate substitute decision-making or fully operationalize the General Comment No. 1 on Article 12.[173]

- **Involuntary Treatment and Coercion:**

MHCA still permits compulsory admission and treatment under defined criteria. For example, Section 89 allows a person to be "supported admitted" (i.e., involuntarily) for up to 30 days if (among other criteria) they have threatened self-harm or violence and cannot make independent decisions. In emergencies, Section 94 allows brief compulsory treatment. From a strict CRPD standpoint (as interpreted by the UN Committee), any deprivation of liberty based on psychosocial disability is considered discriminatory. The Act tries to limit coercion through time limits and Board oversight, but it still falls short of the CRPD Committee's call to abolish involuntary commitment and forced treatment altogether.[174]

[173] Soumitra Pathare & Arjun Kapoor, Decisional Autonomy and India's Mental Healthcare Act, 2017: A Comment on Emerging Jurisprudence, in Mental Health, Legal Capacity, and Human Rights 10 (Michael Ashley Stein et al. eds., 2021).
[174] Piers Gooding, Supported Decision-Making: A Rights-Based Disability Concept and Its Implications for Mental Health Law, 20(1) PSYCHIATRY, PSYCHOL. & L. 1 (2013).

- **Institutional vs Community Care:**

While MHCA mandates community alternatives (halfway homes, integration into general hospitals), India's infrastructure lags far behind its legal commitments. In practice, long-stay psychiatric hospitals still exist, and community resources are sparse. WHO data show that India's per capita mental health expenditure and workforce remain very low, and only a fraction of districts have functioning District Mental Health Programme teams. Thus, the implementation of Sec. 18's comprehensive service mandate is uneven. Resource constraints and stigma limit the Act's impact, creating a gap between the law's ideals and reality. Many states have yet to establish the required halfway homes or train sufficient community health workers.[175]

- **Other Gaps:**

Certain areas are not fully addressed by the Act. For instance, though it requires insurance parity and penalizes discrimination in the workplace, enforcement of these provisions is weak. Social support (housing, income) for persons with mental illness remains inadequate. The Act also does not explicitly prohibit practices like solitary confinement or non-psychiatric medical restraint, which human rights activists have raised as concerns. Finally, the broader justice and social services systems (e.g., criminal law, courts, prisons) still lack harmonization with the MHCA and CRPD's standards on mental disability.[176]

The international legal framework on mental health, led by the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and supported by the World Health Organization's normative guidance including the Comprehensive Mental Health Action Plan 2013–2030 and the Quality Rights Initiative clearly articulates a transformative vision grounded in dignity, autonomy, non-discrimination, and community inclusion. India's Mental Healthcare Act, 2017, represents a significant legislative response to these global mandates, aligning with key international standards by recognizing the rights of persons

[175] Suresh Bada Math & Maria Christine Nirmala, Mental Healthcare Act 2017 – Aspiration to Action, 61(4) INDIAN J. PSYCHIATRY 429 (2019)

[176] Sreelekha Nair, Insurance Coverage for Mental Illness: A Review Through a Lens of Bioethics and the MHCA 2017, INDIAN J. MED. ETHICS (2024), https://ijme.in/articles/insurance-coverage-for-mental-illness-a-review-through-a-lens-of-bioethics-and-the-mhca-2017/

with mental illness to equality, legal capacity, informed consent, and access to community-based care. The Act demonstrates an intentional shift toward a rights-based model, incorporating principles such as supported decision-making, deinstitutionalization, and procedural safeguards. However, gaps persist, particularly in the full realization of legal capacity, the continued allowance for involuntary treatment, and challenges in implementation due to inadequate infrastructure and resource allocation. While the MHCA 2017 positions India as a frontrunner among developing nations in mental health reform, bridging the distance between legal promise and practical realization remains critical. A sustained commitment to aligning practice with the CRPD and WHO's human rights standards will be essential to realizing the law's transformative potential.

CHAPTER 5

FINDINGS AND SUGGESTIONS

This dissertation has traced the evolution of mental health law in India and critically assessed the post-2017 regime. The Mental Healthcare Act 2017 (MHCA 2017) represents a paradigmatic shift from the custodial, social-welfare model of the 1987 Act to a rights-based, human-rights aligned framework. By explicitly endorsing the values of the UN Convention on the Rights of Persons with Disabilities (CRPD), MHCA 2017 sought to guarantee dignity, autonomy, and non-discrimination for persons with mental illness. Significant reforms were introduced: decriminalization of suicide attempts, inclusion of mental illness in health insurance, and explicit legal provisions for advance directives and nominated representatives. These changes in principle remedy many historical gaps, for example, they reject the old assumption that mentally ill persons inherently lack capacity and instead affirm their fundamental constitutional right to life and liberty under Article 21.

However, many of these progressive aims have been compromised in practice. While MHCA 2017 did broaden the definition of "mental illness" and enshrine patient rights, it fell short on implementation capacity and legislative clarity. A 2024 survey found 92.5% of psychiatrists dissatisfied with the Act, with two-thirds reporting that procedural requirements deter them from making necessary treatment decisions. Likewise, provisions like advance directives and nominated representatives, while innovative, have proven unrealistic for many Indian patients and families.[177] For instance, bringing general hospital psychiatric units (GHPUs) under the MHCA (previously limited to specialty hospitals) may lengthen admissions and reduce available beds. Moreover, the Act's promise of accessible care encounters structural barriers: over 70% of people with mental illness still receive no evidence-based treatment due to underfunding, and many statutorily mandated bodies

[177] N.A. Uvais & Kaustubh Joag, Perceptions Regarding the Indian Mental Healthcare Act 2017 Among Psychiatrists: Review and Critical Appraisal in the Light of CRPD Guidelines, 11 Cambridge Prisms: Global Mental Health 1 (2024), https://doi.org/10.1017/gmh.2024.31.

(State Mental Health Authorities and district Review Boards) remain unformed or non-functional.[178]

MHCA 2017 is a clear advance over earlier laws regarding harmonization with international norms. Analyses find that, alongside the Rights of Persons with Disabilities Act 2016, Indian law is almost "in line" with WHO's framework. The Act addresses only about 55% of WHO's recommended standards (rising to 68% when including related legislation), and explicitly incorporates CRPD concepts of legal capacity and non-discrimination.[179] Yet essential gaps remain. Key WHO identified deficiencies include inadequate recognition of family/carer rights and the lack of provisions for involuntary community treatment. Similarly, MHCA's rights-based language sometimes conflicts with the CRPD's strong emphasis on "will and preferences". For example, the Act still permits substitute decision-making by default, which diverges from Article 12's mandate. As one analysis cautioned, MHCA 2017 is "highly progressive in theory" but its vague language in certain areas "may lead to inadvertent limitation of certain rights".

In sum, MHCA 2017 is progressive in principle but falls short in realization. It rectifies many historical shortcomings, discarding paternalistic admissions criteria, enshrining patient rights in law, and aligning with international standards, but its lofty promises have collided with social and institutional realities. There remains a substantial gap between rights on paper and rights in practice in India's mental healthcare.

5.1 FINDINGS

India's mental health legislation has shifted from a colonial focus on custodial care to a modern emphasis on individual rights and dignity. The Indian Lunacy Act of 1912 prioritized confinement, while the Mental Health Act of 1987 introduced a treatment-oriented approach but still had limitations. The Mental Healthcare Act of 2017 marked a significant shift by recognizing mental health as a justiciable right, promoting autonomy,

[178] World Health Organization, Mental Health Action Plan 2013–2020, at 7–9, WHO Doc. EB130/9 (2013), https://apps.who.int/iris/handle/10665/89966.
[179] Richard M. Duffy & Brendan D. Kelly, Concordance of the Indian Mental Healthcare Act 2017 with the World Health Organization's Checklist on Mental Health Legislation, 13 Int'l J. Mental Health Sys. 14 (2017), https://ijmhs.biomedcentral.com/articles/10.1186/s13033-017-0155-1.E-Bookshelf+5

access to care, and dignity, and aligning Indian law with constitutional values and international human rights standards.

Judicial decisions by the Supreme Court of India have significantly influenced mental health law by interpreting Article 21 of the Constitution to include rights related to health, privacy, and human dignity. Key rulings have emphasized humane treatment for individuals with mental illness and condemned institutional neglect. However, challenges remain in implementation due to bureaucratic inertia, inadequate budget allocations, and weak oversight, resulting in uneven enforcement of these rights across the country..

The Mental Healthcare Act of 2017 aligns well with international standards, particularly the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and WHO guidelines. It incorporates principles like legal capacity, non-discrimination, and supported decision-making while including provisions for advance directives and community living. Despite this, challenges remain in effectively implementing these rights through community services, professional training, and ensuring autonomy in clinical settings, indicating a gap between legal commitments and actual systemic change.

The Mental Health Care Act (MHCA) 2017, despite its progressive intentions, faces significant operational challenges. These include a shortage of mental health professionals, inconsistent state-level implementation, limited public awareness of rights, and difficulties with provisions like advance directives. The law also fails to address the needs of family caregivers and grassroots mental health infrastructure in rural areas. Critics point out that it lacks strong accountability mechanisms and sufficient funding. To effectively implement the MHCA 2017, a comprehensive strategy is needed that includes increased funding, community engagement, decentralized services, and improved legal awareness.

In answering the research question, the study concludes that MHCA 2017 goes a long way toward correcting the paternalism of past laws and aligning with international human rights norms. Still, significant implementation, resources, and legal clarity shortfalls limit its effectiveness. Thus, the hypothesis of the study is affirmed positively.

5.2 SUGGESTIONS

- **Strengthening Mental Health Review Boards (MHRBs)**

MHRBs were conceived as the Act's key rights-protective mechanism, but many boards remain non-existent or incapacitated. Ensuring fully functional MHRBs requires:

- **Timely Appointment and Funding:** Central and state governments must promptly constitute MHRBs in every district (or cluster) with adequate remuneration. The law mandates a full-time judge and psychiatrist on each board; filling these positions is urgent to prevent procedural bottlenecks. Dedicated budgets should be allocated for board operations, including IT support for record-keeping and virtual hearings.
- **Training and Standard Operating Procedures:** Board members – including laypersons and carers – need orientation in mental health law and patient rights. Short courses or certification programs (as proposed in the literature) can build MHRB capacity. The central government should also issue model "terms of reference" codifying the board's functions (drawing on MHCA Section 99) to avoid confusion about their role.
- **Use of Technology and Resource Sharing:** Given resource constraints, MHRBs should operate via video-conferencing to reduce travel and speed hearings. The pandemic has shown the viability of tele-hearings. Boards in neighboring districts might share expert members temporarily, or appoint part-time psychiatrists from medical colleges to sit on boards as a cost-effective pilot.
- **Transparency and Accountability:** MHRBs should maintain and publish anonymized annual reports on case statistics (e.g., number of admission/discharge appeals, AD disputes). This transparency would allow civil society and the judiciary to monitor compliance and address delays. Professional bodies (e.g., Indian Psychiatric Society) should advocate for board formation and guide interested psychiatrists to participate in MHRBs.

➢ **Integrating Community-Based Care**

MHCA 2017 envisions services "in the least restrictive environment," but it emphasizes institutional procedures in practice. Reforms should promote genuine deinstitutionalization:

- **Discharge Planning:** Enforce MHCA's Section 98 on discharge planning. All admitting establishments should be required to create standardized discharge plans and coordinate with family and local community health teams. State authorities can mandate that any hospital license include a linkage to community services.
- **Primary Care and Outreach:** Increase funding and training for primary health workers to identify mental illness and provide basic care (consistent with WHO's mhGAP). The District Mental Health Programme should be expanded so that rural and poor areas can access counselors and psychiatrists. Regular "mental health camps" and mobile clinics, which have proven effective, can be scaled up under state health missions.
- **Legal Support for Community Treatment:** Consider carefully adding a legal framework for "supported community treatment." Currently, MHCA lacks any mechanism for following up patients who refuse care at home, a gap noted by experts. Policymakers could explore a model of conditional leave or community ordering, with strict judicial oversight, to ensure that high-risk individuals continue treatment, balancing autonomy with public safety.
- **Multi-sectoral Rehabilitation:** Strengthen linkages between mental health services and social welfare schemes (housing, employment, education). For example, persons certified under MHCA should have streamlined access to disability pensions and vocational training. Coordinated planning across health, social justice, and education departments can implement the Act's vision of psychosocial rehabilitation.

➢ **Training and Capacity Building**

Effective implementation requires that all stakeholders understand the law:

- **Healthcare Professionals:** Integrate mental health law into medical and nursing curricula. Postgraduate courses in psychiatry and psychology should include MHCA training. Regular CMEs (continuing medical education) should update practitioners on procedures like capacity assessment, filling advance directives, and the appeal process.
- **Police and Judiciary:** Incorporate MHCA awareness in police and judicial training. For example, police officers should know that Section 100 allows them to take protective action for a mentally ill person without a warrant, and magistrates should recognize the primacy of medical evaluation over punitive measures. Collaborating with judicial academies and legal services authorities can institutionalize this training.
- **Families and Communities:** Educate caregivers about their rights and responsibilities under MHCA. NGOs and patient groups can provide workshops and multilingual leaflets explaining advance directives, nominated representatives' roles, and how to access grievance mechanisms. This addresses the concern that AD/NR concepts are novel and confusing for many laypersons.

➢ **Enhancing Funding and Infrastructure**

No rights law can succeed without resources:

- **Budget Allocation:** The central and state governments should substantially increase mental health spending. Currently, only ~0.06% of health budgets are earmarked for psychiatric outpatient care, which is far below need. A dedicated "Mental Health Fund" could ensure sustained financing for facilities, medicines, and staff.
- **Human Resources:** Expand training seats for psychiatrists, psychiatric nurses, psychologists, and social workers, especially in the public sector. Offer incentives (e.g., rural posting allowances, academic grants) to retain these professionals. Tele-mental health services should be scaled up, with government-supported platforms, to extend reach without proportional staffing increases.

- **Facility Development:** Invest in new and upgraded services at all levels. District and community health centers should have at least one psychiatric bed and an outpatient service. Large general hospitals should earmark wards for psychiatry so that GHPUs can comply with MHCA without displacing other patients. Funds should also support community rehabilitation centers and halfway homes, as the Act mandates.
- **Monitoring Systems:** Develop a central database to track key indicators (MHRBs formed, cases reviewed, patients admitted under MHCA provisions, complaints lodged, etc.). Regular audits of registered mental health establishments for compliance can highlight gaps in care and infrastructure.

➢ **Ensuring Rights Compliance**

To truly fulfill MHCA's promises, its provisions must be grounded in enforceable rights frameworks:

- **CRPD Alignment:** Review MHCA provisions in light of the CRPD. This may entail explicitly incorporating supported decision-making (instead of only substitute decision-making) and revising vague terms in the Act to avoid infringing autonomy. Coordination with the Rights of Persons with Disabilities Act 2016 (which emphasizes Article 12 of the CRPD) will harmonize the legal regime for people with mental health disabilities.
- **Constitutional Safeguards:** Emphasize that even persons with mental illness retain fundamental liberties under Article 21. MHCA rules and training should stress that involuntary admissions are subject to strict review (via MHRBs and courts) and that consent or best-interest standards apply. Establishing a periodic parliamentary or judicial review of MHCA implementation could serve as an additional check on state compliance with fundamental rights.
- **Legal Aid and Advocacy:** Extend legal aid services to persons with mental illness for MHCA-related matters. Legal Services Authorities should designate lawyers

and paralegals trained in mental health law. Civil society and disability rights groups must be empowered to litigate systemic violations (for example, cases of mass rights breaches in institutions).

- **Insurance and Anti-Discrimination:** Enforce mental health parity in health insurance by mandating insurers to cover mental illness claims. Strengthen anti-discrimination laws: for example, introduce explicit legal prohibitions against firing or excluding persons with mental illness from workplaces or educational institutions.

By strengthening MHRBs, expanding community-based care, building stakeholder capacity, boosting funding, and rigorously aligning the Act with human rights norms, policymakers can bridge the gap between MHCA 2017's progressive ideals and India's mental healthcare realities. Implementing these reforms will be vital if the rights of persons with mental illness are to be realized in practice, not just on paper.

In conclusion, this dissertation affirms that the Mental Healthcare Act, 2017, marks a significant stride toward embedding a rights-based approach within India's mental health framework, rooted firmly in constitutional principles and global human rights norms. While it replaces an outdated custodial model with one that values personal autonomy, dignity, and access to care, its transformative potential is curbed by enduring doctrinal ambiguities, systemic inertia, and institutional shortfalls. The Act addresses specific legacies of exclusion, yet an apparent disconnect persists between its aspirational provisions and their on-the-ground execution, leaving many intended beneficiaries at the margins. The advanced analysis highlights the need for cohesive legal, policy, and administrative interventions to effect the law's progressive vision. Ultimately, India's actual test lies not just in enacting such statutes but in ensuring that their protections resonate meaningfully in the everyday lives of its most vulnerable, an endeavor that is as much a constitutional responsibility as an ethical necessity.

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APPENDICES

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