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MENTAL HEALTH LAWS IN INDIA: UNVEILING THE LEGAL LANDSCAPE

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ABSTRACT

Mental health is increasingly recognized as a cornerstone of overall well-being, encompassing not only the absence of disease but also the attainment of physical, mental, and social vitality. In India, however, the realization of mental health as a fundamental right has been historically undermined by deep-seated stigma and a fragmented legislative framework. This research article provides a comprehensive analysis of the evolution, implementation, and challenges of mental health legislation in India, with a particular focus on the Mental Healthcare Act (MHCA) of 2017. The research article traces the legislative progression from early statutes such as the Indian Lunacy Act (1912) and the Mental Health Act (1987) to the more progressive, rights-based MHCA 2017, which seeks to safeguard the dignity and autonomy of persons with mental illness. Key features of the MHCA 2017 include the decriminalization of suicide, the provision of advanced directives, and the mandate for mental health insurance parity with physical health. The research article further explores the constitutional dimensions underpinning mental health in India, drawing on relevant articles of the Indian Constitution that, while not explicitly guaranteeing a right to mental health, collectively impose a duty on the state to promote health and well-being. In addition, it critically evaluates judicial interpretations that have reinforced a rights-based approach, thereby shaping policy discourse and implementation. Despite its progressive stance, the MHCA 2017 is critiqued for its limited focus on community-based care, challenges in operationalizing advanced directives, and the substantial resource constraints. The

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research article concludes by emphasizing that while the Act represents a significant legislative advancement, its success ultimately depends on the integration of mental health services within primary healthcare, enhanced infrastructural support, and sustained stakeholder engagement to overcome persistent socio-cultural and logistical barriers.

Keywords: *Mental Healthcare Legislation in India, Mental Health Rights and Autonomy, Mental Healthcare Act (MHCA) 2017*

1. INTRODUCTION

World Health Organization defines health as, "Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease."[1] Without mental health, there can be no health. People with stable mental health are better equipped to face obstacles head-on with poise, clarity, and inner power, which makes them more resilient and lead more balanced lives. Furthermore, people who are in good emotional and mental health are better equipped to utilize their resources, give back to their communities, and realize their full potential. Rather than only treating illnesses, mental health is a holistic concept that places an emphasis on wellbeing. But despite its large population, India still suffers from deeply ingrained societal stigma related to mental health, which makes it difficult to have candid discussions and ask for help. However, mental health is starting to receive some attention in India these days. Improving mental health services and encouraging adults' and children's emotional well-being are beginning to receive more attention.

In order to support a dynamic democratic society, a welfare state must promote social inclusion, equitable opportunity, and active participation in communal affairs.[2] When India adopted the *"United Nations Convention on the Rights of Persons with Disabilities"* (UNCRPD)[3] in the year 2007, it made a commitment to align its legal system with its principles. Realizing the necessity for updated legislation, legislators synced existing laws such as the Persons with Disability Act of 1995 and the Mental

1 Constitution of the World Health Organization, at 1, *Basic Documents*, 45th ed. (Oct. 2006), https://www.who.int/governance/eb/who_constitution_en.pdf (last visited Mar. 1, 2025).

2 Rao G.P., Ramya V.S. & Bada M.S., *The Rights of Persons with Disability Bill, 2014: How "Enabling" Is It for Persons with Mental Illness?*, 58 INDIAN J. PSYCHIATRY 121, 121–28 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4919954/ (last visited Mar. 1, 2025).

3 United Nations, *Convention on the Rights of Persons with Disabilities*, https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html (last visited Mar. 2, 2025).

Health Act of 1987,[4] with the UNCRPD.

A notable prevalence of mental health issues was found in the National Mental Health Survey, which was conducted between 2014 and 2016.[5] The survey found that the present morbidity was 10.6% and the lifetime morbidity was 13.7%.[6] In a response to this, the Indian government-initiated efforts to enhance mental health services by formulating the Mental Healthcare Act (2017)[7] and the National Mental Health Policy (2014)[8], which were both ratified by Parliament on May 29, 2018.

The Mental Healthcare Act (MHCA) OF 2017, replaced the earlier legislation called the Mental Health Act (MHA) of 1987. The revised legislation was necessary to address the shortcomings of the earlier MHA, which was deemed inadequate in protecting the rights of individuals with mental health conditions, particularly in light of the 2006 "*United Nations Convention on the Rights of Persons with Disabilities*". Despite earlier regulations like the Mental Health Act of 1987 and the Indian Lunacy Act of 1912, India has not had much experience enforcing mental health laws. This made the enactment of the Mental Healthcare Act 2017 a significant step forward.

The 2017 Mental Healthcare Act (MHCA) commits to offering mental healthcare services to persons with mental illness (PMI) while defending and advancing their rights during the treatment. However, the act falls short in addressing community-based care. Despite being a progressive, patient-centric, and rights-based legislation, the act's focus on PMI rights is primarily limited to the duration of their hospital treatment. Chapter 5, which outlines the "*Rights of persons with mental illness,*" is a crucial aspect of the legislation, but it neglects to ensure the continuity of care for PMI in community settings.[9] The MHCA 2017 is significantly influenced by western legislative approach. It is centered on the rights of the individual, offers them complete autonomy over themselves, and interferes with treatment until the patient provides informed consent. On deeper examination, this act appears to be

4 Math S.B., Murthy P. & Chandrashekar C.R., *Mental Health Act (1987): Need for a Paradigm Shift from Custodial to Community Care*, 133 Indian J. Med. Res. 246, 246–49 (2011), https://pubmed.ncbi.nlm.nih.gov/21441675 (last visited Mar. 2, 2025).

5 M.S. Gautham, *The National Mental Health Survey of India (2016): Prevalence, Socio-demographic Correlates and Treatment Gap of Mental Morbidity*, 66 Int'l J. Soc. Psychiatry 361, 361–72 (2020).

6 National Institute Of Mental Health And Neurosciences (NIMHANS), National Mental Health Survey Of India, 2015–16 (Ministry of Health and Family Welfare 2016).

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

8 Ministry of Health and Family Welfare, National Mental Health Policy of India (2014).

9 Rao G.P. et al., *Mental Health Care Bill, 2016: A Boon or Bane?*, 58 Indian J. Psychiatry 244, 244–49 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5100113/ (last visited Mar. 3, 2025).

based on the assumption that mental health practitioners and the family-members are the primary violators of the rights of PMI's, which is quite regrettable.

The actual situation, nevertheless, is very different from what one could assume for a democratic, civilized country. The prevalence of invisible mental health issues, including increased rates of marital discord, internet and smartphone addiction, aggressive behavior, violence, stress, aggression, and suicide attempts, along with rising divorce rates, highlight the need to prioritize and change the way that mental health services are provided in the community.[10]

While the MHCA 2017 has attracted most legislative attention, India's mental health ecosystem also includes the National Mental Health Programme (NMHP) launched in 1982 and its later iteration, the District Mental Health Programme (DMHP). However, these programs have suffered from chronic underfunding, weak inter-sectoral coordination, and poor monitoring mechanisms. The ground-level implementation has often remained patchy, especially in rural and tribal regions where access to trained mental health professionals is minimal.

Thus, any meaningful understanding of mental health law in India must not only assess the text of MHCA 2017, but also examine its practical enforceability alongside the persistent structural challenges that prevent mental health from becoming a lived right for many Indians.

2. India's Constitutional Perspective on Mental Health Care

The basis for the development and enactment of all other legislation in India is the Constitution. Even though there aren't many provisions in the Indian Constitution that deal with natural mental health treatment, certain of its articles do have positive implications for the right to health and are indirectly related to the right to mental health.

The Indian Constitution has provisions pertaining to health and safety in Parts III and IV. The Indian Constitution does not expressly acknowledge any fundamental right to health. However, the Indian Constitution's Article 21 guarantees both individual freedom and the right to life. In the Maneka Gandhi Case, the reach of Article 21 was broadened, and it was decided that "*the term 'life' in the article refers to*

10 Math S.B., Chandrashekar C.R. & Bhugra D., *Psychiatric Epidemiology in India*, 126 Indian J. Med. Res. 183, 183–92 (2007), https://pubmed.ncbi.nlm.nih.gov/18037711/ (last visited Mar. 3, 2025).

a life with human dignity rather than only survival or animal existence. A life with dignity is inherently accompanied by the right to health. To comprehend the nature of the State's commitment to promote the effective implementation of this right, Article 21 needs to be read in conjunction with Articles 38, 39(e), 41, 42, and 47."[11]

Article 38: The State is required to "*secure a social order for the promotion of welfare of the people*" under this article.[12] When combined with other provisions, it is reasonable to infer that a person's mental health is a crucial component of their overall welfare. Therefore, this article imposes an obligation on the State to create policies that will assist individuals in enhancing their mental well-being.

Article 39(e): This article directs the State to create policies based on certain principles to ensure that men, women, and children's employment, well-being, and mental health are not jeopardized by financial limitations that would otherwise unintentionally affect their welfare.[13] It further says that no one should be forced to work in jobs that are either dangerous for their health or inappropriate for their age or strength. Nonetheless, this constitutional clause is flagrantly broken when a large number of minors work in the firecracker industry or when men are required to work unpaid, in unauthorized long shifts in underground mining sites.

Article 41: In the event of a disability, the State is required under this article to protect the right to employment, education, and public assistance, among other things.[14] Therefore, the government needs to implement policies that support people with mental health issues in achieving social and economic stability while still battling their disorders.

Article 42: This Article is concerned with developing policies to ensure just and humane working conditions and maternity relief for pregnant women.[15] Pregnant women will benefit from such arrangements not only for their safety but also for preventing needless stress and mental suffering both throughout their pregnancy and during the postpartum period. The Maternity Benefit Act, 1961 and the Maternity Benefit (Amendment) Act, 2017, which protect the healthcare of the new mother, the expectant mother, and the child, were developed and put into effect with this article as their foundation.

11 Maneka Gandhi v. Union of India, AIR 1978 SC 597.

12 India Const. art. 38.

13 India Const. art. 39(e).

14 India Const. art. 41.

15 India Const. art. 42.

Article 47: The recommendations for raising living standards, nutrition, and public health are codified in this article.[16] It recognizes this as a primary duty of the State. As was already established, a person's general health is greatly influenced by their mental health. This article therefore places the onus of establishing the standard for public mental health primarily on the State.

Additionally, there is an indirect connection between the idea of health and Article 23. A trend of public health supervision is evident as Article 23(1) prohibits both human trafficking[17] and the spread of AIDS. Article 24 also becomes crucial as it deals with child labor and prevents the employment of children in situations that are unsafe and destructive to their health.[18] Several enabling and caring legislation have been created based on these basic values to safeguard people' health and welfare.

Although these provisions collectively reflect the State's moral and policy obligation toward promoting health, their non-justiciable nature under Part IV (Directive Principles of State Policy) limits enforceability. This constitutional limitation continues to weaken the public health infrastructure particularly in the mental health sector where public accountability mechanisms remain weak or absent.

Furthermore, the absence of an explicit "*right to mental health*" within the Indian Constitution results in inconsistent implementation across states. There is an urgent need to consider constitutionalizing mental health under Article 21 jurisprudence, especially in light of recent Supreme Court interpretations expanding the scope of life and dignity. Such recognition could serve as a transformative legal step in making mental health services both equitable and enforceable.

3. Critical Analysis of Mental Healthcare Act, 2017

Administering mental health care in the nation has changed significantly with the passage of the new Mental Healthcare Act (MHCA) of 2017. The 1987 Mental Health Act did not provide enough protection for the rights of those who suffer from mental illness. Even if the act was successful in the past, the MHA 1987 was unable to solve the issues raised as time went on and focus switched to the rights of the mentally ill.

The rights of people with disabilities and the responsibility of the state toward them are outlined in the "*United Nations Convention on the Rights of Persons with Disabilities*"

16 India Const. art. 47.

17 India Const. art. 23(1).

18 India Const. art. 24.

(2006) (UNCRPD)[19]. It requires those who sign it to grant people with impairments the following rights: The rights to information technology accessibility; the freedom to live freely and as a member of the community; the rights to personal mobility; the rights to housing and rehabilitation; the right to take part in public and political life; the right to cultural life, sports, and recreation; and many more.

Though the MHA 1987 addressed certain guiding principles laid down by UNCRPD, it fell short of being entirely consistent with the UNCRPD resolution.[20] Human rights organizations began to doubt the MHA 1987's constitutionality because they believed certain of its clauses restricted the personal freedoms of those who suffer from mental illness. No judicial entity was assigned to supervise or deal with the problems on the ground through a proper review. The MHA of 1987 stated that research on mentally ill people could only be conducted with the caregiver's permission[21], which went against the mental health patients' human rights. The MHA of 1987 was unable to overcome the stigma associated with mentally ill people admitted to mental health establishments (MHEs). Furthermore, the MHA of 1987 did not outline a clear responsibility for the relevant governments in the provision of mental health services.

The Government of India, a party to the UNCRPD, was faced with two options to address these problems and adhere to the UNCRPD: either modify the MHA 1987 to fully abide by the UNCRPD resolution, or create a new bill that would regulate the provision of mental health care in the nation. Against better judgment, the Ministry of Health and Family Welfare (MoHFW) opted for the latter option.

The Mental Health Act of 1987, which was the previous legislation, dealt with the admission and care of individuals with serious mental disease in mental hospitals who are being held against their will. However, the Mental Health Care Act of 2017 aims to regulate almost all mental health medical institutions. This might be avoided by enacting rules aimed especially at mental health facilities where people are hospitalized for treatment without their will. The significant lack of resources prevented the implementation of the Mental Health Act of 1987 across the nation.[22]

19 *Convention on the Rights of Persons with Disabilities*, arts. 4–32, https://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf (last visited Mar. 5, 2025).

20 C. Steinert, *Impact of the UN Convention on the Rights of Persons with Disabilities (UN-CRPD) on Mental Health Care Research – A Systematic Review*, 16 BMC PSYCHIATRY 166 (2016).

21 Mental Health Act, 1987, § 81(2)(ii), No. 14, Acts of Parliament, 1987 (India).

22 Math S.B., Murthy P. & Chandrashekar C.R., *Mental Health Act (1987): Need for a Paradigm Shift from Custodial to Community Care*, 133 INDIAN J. MED. RES. 246, 246–49 (2011), https://www.ncbi.nlm.nih.

But MHCA 2017 was unveiled without addressing the problems that plagued the Mental Health Act of 1987.

The MHCA 2017 was hailed as a rights-based revolution in mental healthcare.[23] Yet, this celebration often overlooks the gap between rights in principle and rights in practice. Without adequate infrastructure, trained personnel, and institutional monitoring, many of the rights guaranteed under the Act risk remaining aspirational.

There is also a fundamental contradiction between the Act's liberal ethos and the social realities of care in India. The assumption that individuals with mental illness can consistently exercise autonomy and make informed decisions may be normatively desirable, but practically unsound in many contexts where community support structures are absent or weak.

Furthermore, the MHCA 2017's silence on how it will interface with national programs such as the District Mental Health Programme (DMHP) creates ambiguity in policy implementation.[24] Despite being one of the oldest national-level programs for decentralized mental health care, the DMHP is rarely mentioned in the Act. This disconnect reflects a broader pattern in Indian health policy, where legislative and administrative frameworks often function in silos rather than in coordination.

3.1 Positive Features of the 2017 MHCA

The foundation of this legislation is found in Chapter 5, which safeguards patients' access to a range of mental health facilities (including halfway homes, sheltered housing, supported housing, inpatient and outpatient services, and rehabilitation services in the hospital, community, and home). PMI is entitled to reimbursement from the state in the event that the services are unavailable. Numerous rights are safeguarded by the act, such as the rights to secrecy, equality, and nondiscrimination, communal living, access to medical records, and protection against cruelty and inhumane treatment. The statute aims to guarantee that everyone has access to mental health facilities. Free mental health therapy will be provided to those who are homeless, indigent, and below the poverty line, regardless of whether they have a BPL (below poverty line) card or not.[25] In addition to the rights to live in a community

gov/pmc/articles/PMC3103146/ (last visited Mar. 7, 2025).

23 R.M. Duffy & B.D. Kelly, *India's Mental Healthcare Act, 2017*, India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights 81–106 (Springer Singapore 2020).

24 V. Kirpekar, *District Mental Health Program: Then and Now*, 66 Indian J. Psychiatry 603, 603–13 (2024).

25 Mental Healthcare Act, § 18(7), No. 10, Acts of Parliament, 2017 (India).

and get free legal help, the act guarantees the right to anonymity and protection from cruel, inhumane, and degrading treatment. It restricts psychosurgery[26] and bans electroconvulsive therapy (ECT)[27] in any form or for children, as well as ECT administered without anesthesia.

Regarding their mental health condition, mental health care, treatment, and physical health care, PMIs are entitled to anonymity. All medical professionals who provide care or treatment to a PMI have a duty to maintain the confidentiality of any information they learn during that process, with the exception of the nominated representatives (NRs), who need it to carry out their duties, and other medical and mental health professionals, who need it to treat the PMI appropriately and safeguard others from violence or harm.

The focus of this legislation is *"autonomy,"* which grants everyone the ability to create an advance directive. Section 5 of the act permits the filing of *"advanced directives,"*[28] which essentially grant patients the power to exercise their right and give instructions for the type of treatment they choose for the duration of their illness or for their disease well in advance. Additionally, the individual (except from minors) may designate a nominated representative to help them make decisions about their course of treatment. The MHCA 2017 also prohibits practices including isolation, chaining, unmodified ECT, and sterilizing men or women when done as a mental health treatment. The statute also regulates neurosurgical treatment for PMI, the use of restraints, and research on the condition.

The most significant and praiseworthy modification to the MHCA 2017 is the decriminalization of suicide.[29] A person who tries suicide will not be prosecuted under the Indian Penal Code (IPC) since it will be assumed that they were mentally ill or under stress at the time of the attempt. This will assist in treating and finding the mentally ill who are not yet being recognized, in addition to improving suicide reporting.

Under the new law, people with mental disorders have the same access to coverage as those with physical diseases, and the government and commercial insurance firms are required to provide mental health insurance on an equal basis with physical

26 Mental Healthcare Act, § 96, No. 10, Acts of Parliament, 2017 (India).

27 Mental Healthcare Act, § 95, No. 10, Acts of Parliament, 2017 (India).

28 Mental Healthcare Act, § 5, No. 10, Acts of Parliament, 2017 (India).

29 Mental Healthcare Act, § 115, No. 10, Acts of Parliament, 2017 (India).

illnesses.[30] Health insurers are already required by the *"Insurance Regulatory and Development Authority of India"* to cover mental diseases under medical insurance coverage.[31] This is a welcome directive.

Further, with respect to any legal problems arising from the exercise of the rights granted to them by the act, mentally ill individuals are entitled to free legal aid under the new legislation.[32] The government is required by Section 29 of the act to develop and carry out these kinds of initiatives that aim to normalize mental health and eliminate the stigma associated with it.

While these features reflect a paradigm shift in mental health law, their realization requires systemic transformation, something that the Act alone cannot mandate. The absence of a clear roadmap for capacity-building across states remains a key limitation.

3.2 Drawbacks and Recommendations for Amending MHCA 2017

The definition of *"mental illness"* given under section 2(s) of the act is *"a substantial disorder of thinking, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs,[33]"* however, *"Mental retardation"*, a condition of halted or incomplete mental development in humans, particularly characterized by subnormal intellect, is not included in the definition of "mental illness". All PMI are not covered by this law. Simply put, it pertains to people who suffer from serious mental illnesses. Further, Section 3 states that mental disease shall be diagnosed in conformity with such nationally or internationally recognized medical standards, which only serves to increase the complexity. It is imperative that the conflict over whether to define mental illness in accordance with Section 2(s) or Section 3 be settled as soon as possible.

The inclusion of mental health into primary health care is advocated by the National Mental Health Policy. The statute, however, mandates that all facilities register to treat PMI,[34] which might make it more difficult to integrate mental health services

30 Mental Healthcare Act, § 21(4), No. 10, Acts of Parliament, 2017 (India).

31 Insurance Regulatory And Development Authority Of India (IRDAI), Circular No. IRDAI/HLT/MISC/CIR/129/06/2020 (June 2, 2020).

32 Mental Healthcare Act, § 27, No. 10, Acts of Parliament, 2017 (India).

33 Mental Healthcare Act, § 2(s), No. 10, Acts of Parliament, 2017 (India).

34 Mental Healthcare Act, § 65, No. 10, Acts of Parliament, 2017 (India).

into general medical care and, consequently, to execute policies. Refusing to treat people with mental illness as inpatients, many private hospitals and assisted living facilities may state that they are not registered to do so. Therefore, the act ought to comply with NMHP. They must be excluded from the registration process in order to promote care in general hospitals.[35] To guarantee that the Act is properly implemented, it would be desirable to keep general hospitals, primary health center psychiatric units, and other primary care treatment delivery centers out of the registration purview.

This issue highlights a persistent tension between rights-based legislation and health systems capacity. By creating extensive compliance burdens on already overstretched hospitals, the Act may unintentionally discourage mental health service provision in non-specialized facilities, particularly in semi-urban and rural areas. This concern is amplified by the lack of clarity around the funding and administrative responsibilities of states under the Act.

Further, Section 4 of MHCA 2017 deals with the ability of a PMI to make decisions about mental health care and treatment which is quite faulty and may have harmful repercussions. To put it briefly, this section determines the patient's capacity based on his or her ability to: (a) understand the information; (b) evaluate the risk; or (c) convey the decision they have made.[36] A PMI may decline treatment if they have any one of the aforementioned characteristics. That indicates that a psychiatrist will only be able to treat a small percentage of PMI patients with difficulties. Therefore, it is imperative that clarification be provided, that a guideline paper for the assessment of mental capacity be published, and that Section 4 be amended.

The current framework places disproportionate weight on a narrowly defined notion of individual capacity without considering the fluctuating nature of mental illness. It risks denying treatment to individuals who may temporarily lose insight but remain in urgent need of care. Mental capacity in psychiatric contexts cannot be viewed through the same legal lens as in other medical disciplines; the law must recognize this nuance to protect the very individuals it aims to empower.

Advanced Directives are legal documents that enable any adult to express in writing their wishes for their future medical treatment in the event that they develop a

35 Rao G.P., Math S.B., Raju M.S., Saha G., Jagiwala M., Sagar R. et al., *Mental Health Care Bill, 2016: A Boon or Bane?*, 58 Indian J. Psychiatry 244, 244–49 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5100113/ (last visited Mar. 10, 2025).

36 Mental Healthcare Act, § 4, No. 10, Acts of Parliament, 2017 (India).

mental illness. It can be difficult for family members to cope with situations where a PMI cancels, changes, or revokes the advanced directives many times in a single day. The sole authority to amend or overturn the AD is the Mental Health Review Board (MHRB).[37] To permit the treatment, this would need to be completed in a relatively brief duration of time (24–48 hours). In order to treat PMI, there is a lack of financial resources, human resources (medical and legal), and community activities. This could indicate that advanced directive is not yet ready for our society. It would be wise to carry out additional research in this field before introducing this concept in India. It seems a bit hurried and ill-thought out to be rushing into legislation on this count given Indian reality.

The quasi-judicial district-level Mental Health Resources Boards (MHRBs), which supervise the efficient operation of the mental health care delivery system, can create additional obstacles to treatment delivery and cause needless delays. This might simply be due to a lack of judicial staff and other resources to operate at the district level; if these issues are not addressed, treatment may not begin as soon as it should, which could cause a lot of stress for the caregivers. The act's goal may be undermined if the problem is not addressed right away. There may be major negative effects on the mental healthcare system if these boards are not functioning regularly at the hospital level. These boards must abandon the tardy court process/procedures and allow for a quick review through the hospital's medical board, resulting in faster decision-making, allowing families to receive treatment, and relieving the judiciary of these mental healthcare-related issues.

Though the need for district-level quasi-judicial bodies reflects good governance intent, but its current structure mirrors the inefficiencies of India's broader tribunal ecosystem which is mostly underfunded, overburdened, and inaccessible. A decentralized medical review mechanism within public hospitals may serve the purpose more effectively until judicial capacity is adequately built.

The Act stipulates that the psychiatrist will be in charge of the patient's care and treatment upon release. In cases of custodial care (involuntary patients), impoverished patients, and voluntary admissions, when only the patient can be briefed or counseled regarding future treatment, this idealistic clause (Section 98) might not be feasible. The patient is free to accept or refuse therapy, and the absence

37 G.S. Gowda, E.O. Noorthoorn, P. Lepping, C.N. Kumar, R.B. Nanjegowda & S.B. Math, *Factors Influencing Advance Directives Among Psychiatric Inpatients in India*, 56 Int'l J. Law & Psychiatry 17, 17–26 (2018), https://pubmed.ncbi.nlm.nih.gov/29701595/ (last visited Mar. 10, 2025).

of a discharge plan should not be used as a justification for negligence because there are other factors, such as the patient's and family members' active involvement in the process, that will ensure continuity of care.

Section 94(3) of the MHCA, 2017 prohibits electroconvulsive therapy as an emergency treatment in order to prevent patient death or irreversible injury.[38] Notably, this type of therapy is a traditional life-saving emergency treatment for people with mental illnesses (particularly for those who have higher suicidal tendencies). Several mental health specialists have strongly condemned this portion of MHA, 2017, arguing that electroconvulsive therapy could play a major role in regulating and treating patients during emergencies.[39] Mental health professionals may jointly appeal to the Central and State Mental Health Authority, who may investigate the situation as soon as possible.

The act is heavily imbued with a rights-based outlook and, in this regard, resembles the mental health legislation of several Western nations. Nevertheless, the resources possessed by such countries are far more than those of India. The execution of MHCA 2017 faces obstacles owing to resource limitations. In the absence of minimal mental health services in the patient's area, individuals are allowed to utilize alternative mental health services within the district, with the associated treatment expenses covered by the relevant government authority. The compensation-based mental health treatments may lead to fraudulent claims and deplete the already limited resources.

MHCA, 2017 did not specify any minimum requirements for mental and medical health practitioners. This lowers the bar for mental health care and raises concerns about the ability of the workforce which is the group in whose hands this nation will place its trust and hope for healing. Investigating this crucial gap needs to be done right now. Long-term, nonetheless, appropriate changes regarding the requirements for standards should be implemented.

4. Judicial Interpretation of Mental Health

It is unfortunate that none of the Articles of the Constitution directly addresses mental health issues or calls upon the state to specifically promote mental health

38 Mental Healthcare Act, § 94(3), No. 10, Acts of Parliament, 2017 (India).

39 A. Kala, *Time to Face New Realities; Mental Health Care Bill–2013*, 55 Indian J. Psychiatry 216, 216–19 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3777341 (last visited Mar. 10, 2025).

services. The judiciary has, however, given a broader meaning of health with the available Articles of the Constitution, protecting the citizen's right to a life of dignity, which shall include stable physical and mental health.

In the case of *Dr. Upendra Baxi v. State of Uttar Pradesh,*[40] the Apex Court mandated the formation of a medical panel that would properly examine the inmates of the Agra Home and provide a report on time. This study found that 33 of the 50 individuals with mental illnesses had varying degrees of mental disease that had not been assessed at the time of their admission into the facility. Because of this, the care that these prisoners received was not suited to their specific condition, which resulted in a number of flawed treatments. In addition, fourteen people were discharged from the facility without having their mental health condition evaluated. Unfortunately, a significant number of these patients lacked the necessary financial means to return home. The Supreme Court ruled that this was an open disregard for constitutional safeguards of public health and life. The Supreme Court adopted a rights-based approach after ruling that the facility members' acts were improper.

In *Rakesh Chandra Narayan vs. State of Bihar*[41] certain essential principles were laid down by the highest Court. An extension of the right to life guaranteed by Article 21 of the Constitution is the right of individuals with mental health disorders to food, water, personal hygiene, sanitation, and leisure activities. Integration of education, training, research, and therapy is necessary to attain the desired results. Mental health quality norms and requirements cannot be negotiated.

Another significant court ruling is that of *Meenu Seth v. Binu Seth*[42] wherein the issue was that a case under the MHA, 1987 was already pending. Following the introduction of MHCA 2017, the appellants asked that the rules governing MHA 2017 be applied to their case. The Delhi High Court rejected the petition, citing MHA, 2017's section 126 2(f) as unambiguous proof that, even in the event that MHA, 2017 abolished MHA, 1987, any issues that were still proceeding in any Indian court under that law would be protected by MHA, 1987.

These decisions reflect the judiciary's interpretive creativity in expanding fundamental rights to encompass mental health, thereby compensating for legislative and administrative inaction. By reading mental health into Article 21, the

40 Dr. Upendra Baxi v. State of U.P., (1983) 2 SCC 308.

41 Rakesh Chandra Narayan v. State of Bihar, 1989 Supp (1) SCC 644.

42 Minu Seth v. Binu Seth, AIR 2018 Delhi 54.

Court not only reaffirmed the constitutional value of dignity but also signaled that public health failures are justiciable.

In the landmark 2018 ruling in *Navtej Singh Johar v. the Union of India*,[43] the Supreme Court of India decriminalized homosexuality and invalidated Section 377 of the Indian Penal Code. In doing so, the court cited the definition of mental disorder and the anti-discrimination provisions of the MHCA.

This case is a notable example of how MHCA 2017 has influenced constitutional jurisprudence beyond its core subject. By aligning itself with global standards, the Act helped the Court invalidate a century-old criminal provision that pathologized queer identities.

In particular, we can use other laws that discriminate against individuals with mental disorders to the court's ruling to utilize the right to equality and non-discrimination under Section 21 of the MHCA to forbid discrimination against them on the basis of their sexual orientation. For example, under the Hindu Marriage Act of 1955 and the Special Marriage Act of 1954, mental illness is recognized as a reason for divorce, annulment, or disqualification from marriage.

The court further argued in its ruling that, "*in accordance with Section 3 of the MHCA, mental disease must be diagnosed using globally recognized criteria, such as the International Classification of Diseases (ICD-10), which does not classify homosexuality as a mental illness*".

In *Common Cause v. Union of India*[44], the apex court's constitutional bench affirmed "*passive euthanasia,*" and observed that "*given international developments, there was a need to reconsider the criminalization of suicide.*" The court cited Section 115 of the MHCA 2017, which states that "*we must assume that a person who attempts suicide is under severe distress, instead of warranting punitive action under Section 309 of the Indian Penal Code.*" It was observed by the bench that:

> "*Section 115 marks a pronounced change in our law about how society must treat an attempt to commit suicide. It seeks to align Indian Law with emerging knowledge on suicide, by treating a person who attempts suicide being need of care, treatment, and rehabilitation rather than penal sanctions.*"

43 Navtej Singh Johar v. Union of India, AIR 2018 SC 4321.

44 Common Cause v. Union of India, AIR 2018 SC 1665.

Guidelines on the use of advance directives for passive euthanasia were issued by the bench, which also made a reference to Section 5 of the MHCA 2017.

In the 2018 Delhi High Court case *Dr. Sangamitra Acharya & Anr. v. State (NCT of Delhi),*[45] the court ordered the city's police to create a manual to raise public awareness of the MHCA provisions for the treatment of mentally ill homeless people. The manual was prepared in consultation with legal and mental health experts.

Likewise, the same court noted in *Shikha Nischal v. National Insurance Company Limited & Anr*[46]. (2021) that the Mental Health and Care Act (MHCA) acknowledges the entitlement to health insurance for those with mental illness and mandates public and private insurance providers to offer such coverage. Based on the idea of parity, this clause stipulates that mental and physical disorders must receive the same care.

Taken together, these cases reflect a growing body of judicial thought that uses MHCA 2017 as a foundation for socio-legal reasoning. The judiciary has not only defended individual rights but has also laid interpretive groundwork for systemic reform in mental health jurisprudence.

Nonetheless, the impact of these judgments depends on executive compliance, state-level enforcement, and institutional training. Judicial recognition of mental health rights must be matched by administrative readiness to implement them uniformly across India.

5. Conclusion and Suggestions

It appears that MHCA 2017 made a commendable attempt to address the persistent issues that professionals and patients in the mental health field have to deal with. The way mental health treatment is provided in our nation could drastically change as a result of this act. Despite criticism of certain parts of the act, overall, it is still more acceptable and humanitarian given the circumstances. Maybe this act will prove to be beneficial to the mental health care system in the future, provided that some necessary adjustments are made.

Although the MHCA 2017 offers a comprehensive and forward-thinking law, its implementation is contingent upon the constrained resources available for mental

45 Dr. Sangamitra Acharya & Anr. v. State (NCT of Delhi), AIR 2019 (NOC) 333 (Del.).

46 Shikha Nischal v. National Insurance Company Ltd., W.P.(C) 3190/2021, High Court of Delhi (Apr. 19, 2021).

health care. The Act recognizes the challenges of implementation given India's large population and gives the government and other stakeholders ten years from the date of enactment to comply with internationally recognized standards for human resources development. Due to a lack of funding, the MHA 1987 cannot now be implemented in its entirety. The MHCA was proposed without providing a clear plan for how those resource requirements will be met.

We are aware that the lack of infrastructure, training related to the Mental Health Act, and cooperation amongst stakeholders pose the most obstacles to the real implementation of the MHCA 2017. While all of these will have a significant impact on resources, they are essential to safeguard the rights of vulnerable individuals with disabilities. The question of competence in a cultural context should be reviewed when India's ruling class is prepared to consider the obstacles to the implementation of the Mental Health and Counseling Act of 2017. Due to the vastness of the nation, the shortage of psychiatrists, and the variability of various treatments, implementing the Act will be more difficult than enacting it.

What MHCA 2017 represents is a progressive legislative intent. What it lacks, however, is a realistic implementation blueprint. The law leans heavily on a rights-based framework borrowed from high-resource Western models, yet India's mental health infrastructure, legal literacy, and workforce readiness remain severely limited. Bridging this mismatch is the central challenge facing both policymakers and practitioners.

Enough resources must be made available in order to improve the lives of those who are mentally ill. This Act's implementation will need a lot of manpower and infrastructure, both of which our nation sorely lacks. Mental hospitals comprise the majority of the nation's mental health infrastructure. The mental health field, specifically the fields of psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing, is severely short-staffed. This is a significant barrier to obtaining the necessary staff and offering the best possible mental health care. Thus, there will need to be a significant private sector involvement.

In India, the primary health care system has not yet been integrated with psychiatric services. Before it's too late, there is an urgent need to raise the number of mental health specialists. To ensure that most victims of mental illness can live their lives without being stigmatized, it is crucial to emphasize this point. A very precise and narrow definition of mental illness will restrict legal interventions to situations in which they are absolutely required.

The government's declaration that people with mental illnesses require greater privileges is contained in the entirety of the Mental Health Care Act, 2017. The goal is to alleviate the suffering of the mentally ill, and a national mental and health program can help accomplish this more successfully. However, the current Mental Health Care Act, 2017 cannot accomplish this unless the government guarantees that these regulations are carried out. whereby breaking these laws and regulations should result in harsh punishment from the government.

The government should ensure that more awareness programs are conducted at all the levels i.e at the village panchayats, district, and national level. This ensures that proper treatment facilities are made available at all levels to the people suffering from mental illness. More compassion, concern and care should be shown towards the mentally ill patients in places where they are kept.

To summarize, India's mental health reform must evolve along three axes: legislative robustness, institutional readiness, and cultural acceptance. MHCA 2017 addresses the first; the remaining two demand long-term political will, sustained investment, and a deeply humanized public discourse. Only then will mental health cease to be a legal afterthought and become a lived right for all.