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A CRITICAL ANALYSIS OF THE RIGHTS OF PERSONS WITH MENTAL ILLNESS IN INDIA: ISSUES AND CHALLENGES

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***Abstract*-- Mental health remains a critically neglected aspect of public health in India, despite affecting nearly one in seven individuals. The Mental Healthcare Act of 2017 marked a transformative shift in Indian jurisprudence by recognizing mental healthcare as a fundamental right and aligning domestic legislation with the United Nations Convention on the Rights of Persons with Disabilities. This article critically examines the legal frameworks governing rights of persons with mental illness in India, analysing progressive provisions introduced by the 2017 Act while identifying significant implementation challenges. Through exploration of international standards, legislative evolution, institutional mechanisms, and judicial interpretations, this study reveals that despite aspirational legislation, substantial gaps remain in translating legal rights into lived realities. The research highlights critical issues including inadequate resource allocation, insufficient infrastructure, persistent stigma, and slow establishment of statutory bodies. Drawing upon contemporary scholarship, this article offers comprehensive suggestions for strengthening India's mental health ecosystem to ensure dignity, equality, and quality care for all persons with mental illness.**

Keywords: Mental Healthcare Act 2017, Rights of Persons with Mental Illness, United Nations Convention on the Rights of Persons with Disabilities, Supported Decision-Making, Advance Directives, Mental Health Review Boards, Stigma and Discrimination

1. INTRODUCTION

The recognition of mental health as integral to overall wellbeing has emerged gradually within India's legal landscape. For decades, persons with mental illness confronted systematic marginalization and denial of basic human rights. Historical approaches were predominantly custodial rather than therapeutic, focusing on confinement instead of dignity and rehabilitation.[1] The colonial legacy of the Indian Lunacy Act of 1912 perpetuated harmful stereotypes linking mental illness with criminality, resulting in widespread human rights violations within institutional settings.

Constitutional values of equality and dignity gained prominence following independence. Article 21 of the Indian Constitution, guaranteeing the right to life and personal liberty, has been progressively expanded by the Supreme Court to encompass the right to live with dignity, including access to healthcare.[2] This constitutional foundation provided necessary impetus for recognizing mental healthcare as a fundamental entitlement rather than charitable provision.

Contemporary epidemiological evidence underscores the magnitude of mental health challenges facing India. The National Mental Health Survey of 2016 revealed that mental morbidity affects approximately ten percent of the adult population at any given time, with lifetime prevalence reaching nearly fourteen percent.[3] These statistics translate to approximately 150 million Indians requiring active mental health interventions. Additionally, substance use disorders affect more than 22% of the population above eighteen years.[4]

[1] Brendan D Kelly, "Mental health, mental illness, and human rights in India and elsewhere: What are we aiming for?" 58(2) *Indian Journal of Psychiatry* S168 (2016), available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC5282611/
[2] *Ibid*.
[3] National Mental Health Survey of India, 2015-16: Summary (Bengaluru: NIMHANS, 2016).
[4] *Ibid*.

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Despite this substantial burden, mental health historically received inadequate attention. Budgetary allocation remains below one percent of total health spending, grossly insufficient to meet comprehensive needs.[5] The treatment gap for mental disorders in India exceeds 80% , with the vast majority of affected individuals receiving no treatment despite experiencing symptoms for over twelve months.[6] This gap is particularly pronounced in rural areas where access to mental health professionals remains severely limited.

The Mental Healthcare Act of 2017 represented a paradigm shift, moving from paternalistic models to rights-based frameworks. This legislation explicitly acknowledges persons with mental illness as rights-holders rather than objects of charity. The Act was necessitated by India's ratification of the UN Convention on the Rights of Persons with Disabilities in 2007, which mandated significant reforms to existing mental health legislation.[7] The Mental Health Act of 1987 had been widely criticized for failing to adequately protect patient rights, permitting indefinite involuntary detention, and providing insufficient mechanisms for challenging treatment decisions.[8]

The 2017 Act introduces groundbreaking concepts including advance directives, nominated representatives, and comprehensive enumeration of patient rights spanning access to care, community living, confidentiality, and protection from inhuman treatment. It establishes elaborate institutional mechanisms including the Central Mental Health Authority, State Mental Health Authorities, and Mental Health Review Boards.[9] Furthermore, the Act decriminalizes suicide attempts, recognizing that individuals who attempt self-harm require mental health support rather than criminal prosecution.

However, implementation has proven challenging. More than six years after commencement, many states have yet to establish statutory authorities mandated for operationalization. Infrastructure remains grossly inadequate, with India having only 43 psychiatric hospitals and approximately 4000 psychiatrists serving a population exceeding 1.3 billion.[10] This article undertakes comprehensive examination of rights of persons with mental illness within the Indian context, analysing international standards, evaluating the Act's provisions and limitations, identifying implementation challenges, and exploring judicial intervention.

2. International Standards

The evolution of mental health law in India cannot be understood without examining international human rights developments. The Universal Declaration of Human Rights of 1948 established the foundational principle that all human beings are born free and equal in dignity and rights. Article 3 specifically articulates the right to life, liberty, and security of person, provisions particularly relevant for persons with mental illness who historically experienced disproportionate deprivation of liberty.[11]

The first comprehensive international statement specifically addressing mental health came in 1991 with adoption of the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. These Principles established important safeguards including the right to treatment in the least restrictive environment, protection against exploitation and abuse, and procedural protections for involuntary admission.[12] However, they retained certain paternalistic elements that later frameworks would challenge.

The Convention on the Rights of Persons with Disabilities adopted by the UN General Assembly in 2006 marked a watershed moment. The CRPD represents a fundamental shift from viewing persons with disabilities as objects

[5] Rohan M Duffy and Brendan D Kelly, "India's Mental Healthcare Act, 2017: Content, context, controversy" 62 *International Journal of Law and Psychiatry* 169 (2019), available at: https://www.sciencedirect.com/science/article/abs/pii/S0160252718301171

[6] "Mental Health: Current Issues and Challenges in India" 4(2) *Journal of Comprehensive Health* (2016), available at: https://journalofcomprehensivehealth.co.in/mental-health-current-issues-and-challenges-in-india/

[7] Vishwas Namboodiri et al., "The Mental Healthcare Act 2017 of India: A challenge and an opportunity" 44 *Asian Journal of Psychiatry* 25 (2019), available at: https://www.sciencedirect.com/science/article/abs/pii/S1876201819301832

[8] *Ibid*.

[9] Mental Healthcare Act, 2017, No. 10 of 2017, available at: https://www.indiacode.nic.in/bitstream/123456789/2249/1/A2017-10.pdf

[10] Duffy and Kelly, *supra* note 5.

[11] Kelly, *supra* note 1.

[12] United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, GA Res 46/119 (1991).

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of charity to recognizing them as subjects of rights capable of claiming those rights and making decisions for their lives.[13] India signed and ratified the CRPD in 2007, thereby assuming binding international obligations to align domestic law with the Convention's provisions.

Article 12 of the CRPD addresses legal capacity, affirming that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. This provision requires states to provide access to support that persons with disabilities may require in exercising legal capacity, emphasizing supported rather than substitute decision-making.[14] Article 14 addresses liberty and security, providing that existence of disability shall in no case justify deprivation of liberty.[15] Article 19 recognizes the right to live independently and be included in the community, mandating development of community-based services.[16]

The World Health Organization complemented these legal instruments with the WHO Resource Book on Mental Health, Human Rights and Legislation, emphasizing broad conceptions of human rights encompassing not only liberty rights but also social and economic rights.[17] The WHO subsequently launched the QualityRights Programme to improve quality of care and support CRPD implementation, recognizing that optimizing human rights is inherently therapeutic.

India's engagement with these international standards has been substantial though not without challenges. The Mental Healthcare Act of 2017 explicitly references the CRPD and attempts to align domestic law with its requirements. However, tensions remain between certain provisions, particularly those permitting supported admission without consent, and expansive interpretations of CRPD obligations advanced by the Committee on the Rights of Persons with Disabilities.[18]

3. Legal Frameworks In India

The legal framework governing mental health in India has evolved significantly over the past century. Prior to independence, mental health law was governed by the Indian Lunatic Asylum Act of 1858 and the Indian Lunacy Act of 1912. These colonial statutes reflected prevailing conceptions of persons with mental illness as dangerous and lacking capacity, requiring confinement rather than therapeutic intervention.[19]

Following independence, the Mental Health Act of 1987 replaced colonial legislation, introducing improvements including provisions for regulating psychiatric hospitals, establishing admission and discharge procedures, and creating state-level authorities.[20] However, the 1987 Act suffered from significant deficiencies. It was applicable only to mental hospitals, permitted involuntary admission without adequate mechanisms for review or appeal, and failed to enumerate or protect rights of persons with mental illness comprehensively.[21]

The inadequacy of the 1987 Act became evident following tragic incidents. The Erwadi tragedy of 2001, in which 28 persons with mental illness died while chained in a faith-based facility, shocked the nation and catalysed demands for stronger legal protections.[22] India's ratification of the CRPD in 2007 created binding obligations to align domestic legislation with the Convention's rights-based approach. After years of consultation, the Mental Healthcare Bill underwent 134 amendments before receiving presidential assent in 2017.[23]

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[13] United Nations, *Convention on the Rights of Persons with Disabilities* (2006).
[14] Kelly, *supra* note 1.
[15] *Ibid*.
[16] *Ibid*.
[17] World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation* (Geneva: WHO, 2005).
[18] Kelly, *supra* note 1.
[19] "Rights of Persons with Mental Illness in India" *LawBhoomi* (2025), available at: https://lawbhoomi.com/rights-of-persons-with-mental-illness-in-india/
[20] Rakesh Kumar Handa and Shivani Goswami, "Issues and Challenges Concerning Mental Health in India: Time to Brood Over" *Journal of Health Management* (2024), available at: https://journals.sagepub.com/doi/10.1177/25166069241247890
[21] Namboodiri et al., *supra* note 7.
[22] J R Trivedi, "The Erwadi tragedy" 20(3) *Issues in Medical Ethics* (2001).
[23] Kelly, *supra* note 1.

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3.1 Mental Healthcare Act 2017:

3.1.1 Salient Features and Key Rights: The 2017 Act fundamentally transforms the legal framework from custodial to rights-based approach. Chapter 5 enumerates comprehensive rights that are legally enforceable and create corresponding duties for governments, healthcare providers, and institutions.[24] The Act defines mental illness broadly as "a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet ordinary demands of life, mental conditions associated with abuse of alcohol and drugs."[25]

The right to access mental healthcare is the foundational entitlement. Section 18 provides that every person shall have a right to access mental healthcare from services run or funded by government, ensuring no person shall be denied mental healthcare on any grounds including gender, sex, sexual orientation, religion, culture, caste, or disability.[26] This provision remarkably enshrines mental healthcare as a legal right for all citizens, a stronger formulation than exists for physical healthcare.

The Act mandates that every person with mental illness has the right to community living, requiring government to provide community-based establishments including halfway homes and supported accommodations.[27] Protection from cruel, inhuman, and degrading treatment is explicitly guaranteed. Mental health establishments are required to maintain safe, hygienic conditions with adequate food and sanitation.[28] The right to information requires that persons be informed about diagnosis, available treatments, and risks in a manner they can understand.[29] The right to confidentiality protects information about mental health status and treatment.[30]

The Act's treatment of suicide represents significant policy shift. Section 115 provides that any person who attempts suicide shall be presumed to be suffering from severe stress and shall not be tried and punished under the Indian Penal Code.[31] This effectively decriminalizes suicide attempts, recognizing that persons in distress require mental health support rather than criminal prosecution.

3.1.2 Supported Decision-Making and Advance Directives: One of the most innovative aspects is the approach to decision-making capacity and introduction of advance directives and nominated representatives. The Act distinguishes between "independent admission," where a person with capacity makes treatment decisions, and "supported admission," where a person lacking capacity receives assistance from a nominated representative.[32] Critically, the Act presumes persons have capacity unless specifically determined otherwise through formal assessment.

Capacity assessment must consider comprehension, decision-making ability, and communication.[33] The Central Mental Health Authority released guidance documents emphasizing that capacity is decision-specific rather than global and may fluctuate over time.

The advance directive mechanism permits persons with mental illness to specify in writing how they wish to be treated during future episodes when they may lack capacity.[34] An advance directive may specify treatments desired or refused, preferred healthcare facilities, and the nominated representative. The directive must be in writing, witnessed, and registered with the Mental Health Review Board.[35] Mental health professionals must comply with valid advance directives except in emergencies where following the directive would lead to significant harm.

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[24] Mental Healthcare Act, 2017, Ch. V, *supra* note 9.
[25] Mental Healthcare Act, 2017, s. 2(s)
[26] Mental Healthcare Act, 2017, s. 18
[27] Mental Healthcare Act, 2017, s. 19
[28] Mental Healthcare Act, 2017, s. 21
[29] Mental Healthcare Act, 2017, s. 22
[30] Mental Healthcare Act, 2017, s. 23
[31] Mental Healthcare Act, 2017, s. 115
[32] Namboodiri et al., *supra* note 7.
[33] "Mental Healthcare Act 2017 – The way ahead: Opportunities and Challenges" *ResearchGate* (2019), available at: https://www.researchgate.net/publication/331490190_Mental_Healthcare_Act_2017_-_The_way_ahead_Opportunities_and_Challenges
[34] Mental Healthcare Act, 2017, ss. 5-12
[35] Supra note 34

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The nominated representative assists in making treatment decisions when the person lacks capacity. Significantly, the nominated representative need not be a family member; the person may choose any trusted individual.[36] This flexibility recognizes that family members may not always act in the person's best interest. Rather than replacing the person's will entirely, the nominated representative facilitates participation in decisions considering the person's values and preferences.[37]

However, relatively few advance directives have been registered since implementation, reflecting lack of awareness, complexity of registration, and uncertainty about enforcement.[38] For advance directives to become meaningful tools, substantial efforts are needed to simplify procedures and educate stakeholders.

3.1.3 Institutional Frameworks: The Act establishes elaborate institutional structures for implementation and oversight. The Central Mental Health Authority serves as the apex body responsible for developing and implementing mental health policy nationally. The Authority's composition includes mental health professionals, persons with lived experience, disability rights representatives, legal experts, and government officials.[39] The Authority develops quality standards, maintains registries of professionals and establishments, collects data, promotes research, and develops training programs.[40]

State Mental Health Authorities mirror the Central Authority's structure within respective jurisdictions. State Authorities plan and develop mental health services, ensure implementation, register and license establishments, and investigate complaints.[41] Mental Health Review Boards at district level constitute critical accountability mechanisms. Boards review admissions, treatment plans, and discharge procedures, ensuring compliance with the Act's requirements.[42] Every supported admission must be reviewed by the Board within thirty days. Boards also hear complaints regarding rights violations and can inspect establishments.[43]

Each Board includes a judicial officer as chairperson, mental health professionals, disability rights experts, and a person with lived experience or caregiver.[44] The Act defines mental health establishments broadly to include psychiatric hospitals, general hospital psychiatric units, halfway homes, and even traditional healing facilities if they serve persons with mental illness.[45] Registration requires establishments to meet minimum standards regarding infrastructure, staffing, and treatment protocols.[46]

3.1.4 Rights-Based Approaches: The Act fundamentally reconceptualizes mental health law by adopting rights-based approaches centering dignity, autonomy, and personhood. Rather than focusing primarily on admission and detention procedures, the Act devotes substantial attention to enumerating and protecting specific rights spanning multiple life domains.[47] Central to the rights-based approach is the principle of maximum autonomy and minimum restriction. Mental healthcare must be provided in the least restrictive manner and environment possible.[48]

The Act's treatment of legal capacity reflects CRPD influence. Rather than assuming mental illness negates capacity, the Act establishes that persons retain full legal capacity unless specifically determined otherwise

[36] Mental Healthcare Act, 2017, s. 14
[37] *Ibid*.
[38] "Perceptions regarding the Indian Mental Healthcare Act 2017 among psychiatrists: Review and critical appraisal in the light of CRPD guidelines" *Cambridge Prisms: Global Mental Health* (2024), available at: https://www.cambridge.org/core/journals/global-mental-health/article/perceptions-regarding-the-indian-mental-healthcare-act-2017-among-psychiatrists-review-and-critical-appraisal-in-the-light-of-crpd-guidelines/30753CEAB50D4E848787FA3919F9CD1B
[39] Mental Healthcare Act, 2017, s. 35
[40] Mental Healthcare Act, 2017, s. 38
[41] Mental Healthcare Act, 2017, ss. 43-44
[42] Mental Healthcare Act, 2017, s. 89
[43] Mental Healthcare Act, 2017, s. 56
[44] *Ibid*.
[45] Mental Healthcare Act, 2017, s. 2(h)
[46] Mental Healthcare Act, 2017, s. 52
[47] "Influence of the new mental health legislation in India" *BJPsych International* (2021), available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC8277537/
[48] Mental Healthcare Act, 2017, s. 4

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through proper assessment.[49] Participation and consultation constitute another core element. Treatment plans must be developed in consultation with persons with mental illness, considering their preferences.[50] The inclusion of persons with lived experience on authorities and boards ensures those with direct knowledge participate in policy development.[51]

However, realizing the rights-based vision faces substantial challenges. Rights remain aspirational if infrastructure, resources, and trained personnel are absent. Cultural factors including stigma and traditional family structures that may not prioritize individual autonomy can impede implementation.

4. Key Issues And Challenges

Despite the progressive Act, significant challenges impede effective implementation. Resource inadequacy constitutes the most fundamental challenge. Less than one percent of India's health budget is allocated to mental health, grossly insufficient to meet comprehensive obligations.[52] The National Mental Health Survey estimated that nearly one hundred fifty million Indians require interventions, yet existing services reach only a small fraction.[53]

India's mental health workforce is severely limited. The country has approximately four thousand psychiatrists serving over 1.3 billion people, far below WHO recommendations.[54] Clinical psychologists, psychiatric social workers, and psychiatric nurses are similarly scarce. These limited resources are concentrated in urban areas, leaving rural populations with virtually no access to specialized care.

Institutional mechanisms face serious capacity constraints. As of 2024, many states have yet to establish State Mental Health Authorities and Mental Health Review Boards.[55] Where established, they often lack adequate staffing and budgets. The absence of these accountability mechanisms means rights violations often go unaddressed.

Registration and licensing of mental health establishments has proceeded slowly. The Act's broad definition includes traditional healing facilities, many of which resist regulation.[56] Implementation of advance directives has been minimal, reflecting lack of awareness, complex registration processes, and uncertainty about enforcement.[57]

Cultural and social factors present additional challenges. Mental illness carries profound stigma, leading to discrimination and reluctance to seek treatment.[58] Nearly eighty percent of persons with mental disorders do not receive treatment despite symptoms for over twelve months.[59] Traditional family structures can conflict with the Act's emphasis on individual autonomy.

The Act's approach to involuntary treatment remains controversial. Psychiatrists have raised concerns about clinical implications of detailed capacity assessments potentially delaying urgently needed treatment.[60] The Act's provisions regarding research involving persons unable to provide consent have been criticized as creating unnecessary bureaucratic hurdles.[61] The neglect of caregivers' roles has been widely criticized. Families provide predominant informal care yet the Act focuses almost exclusively on patient rights while providing minimal

[49] Mental Healthcare Act, 2017, s. 3
[50] Mental Healthcare Act, 2017, s. 89
[51] Mental Healthcare Act, 2017, ss. 35, 43, 56
[52] Duffy and Kelly, *supra* note 5.
[53] *Supra* note 3.
[54] Duffy and Kelly, *supra* note 5.
[55] "Mental Healthcare Act, 2017" *Drishti IAS* (2024), available at: https://www.drishtiias.com/daily-updates/daily-news-analysis/mental-healthcare-act-2017
[56] *Supra* note 22.
[57] Cambridge Prisms article, *supra* note 38.
[58] *Supra* note 6.
[59] *Ibid*.
[60] Cambridge Prisms article, *supra* note 38.
[61] "Mental Health Research in India: New Challenges and the Way Forward" *Indian Journal of Psychological Medicine* (2022), available at: https://journals.sagepub.com/doi/10.1177/02537176211016088

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support for caregivers.[62]

General hospital psychiatric units face challenges meeting strict licensing requirements including minimum floor areas and staffing ratios without substantial investment.[63] Integration of mental health into primary healthcare has progressed slowly. Primary care providers generally lack mental health training.[64] The COVID-19 pandemic revealed and exacerbated vulnerabilities, with increased anxiety, depression, and substance abuse highlighting infrastructure fragility.[65]

Limited awareness of the Act among healthcare providers, judicial officers, police, and the public compounds challenges. Data collection and monitoring systems necessary for evaluating implementation remain underdeveloped.[66]

5. Judicial Intervention And Interpretation

Judicial intervention has played a transformative role in advancing mental health rights in India, both prior to and following enactment of the Mental Healthcare Act 2017. The superior judiciary has interpreted constitutional provisions expansively to recognize and protect rights of persons with mental illness, while monitoring implementation of statutory provisions and providing remedies for systemic failures.

The foundation of judicial protection for mental health rights rests on Article 21 of the Constitution. In the landmark case of *Francis Coralie Mullin v. Administrator, Union Territory of Delhi*,[67] the Supreme Court held that the right to life under Article 21 encompasses not merely physical existence but the right to live with human dignity. The Court observed that this includes bare necessities of life such as adequate nutrition, clothing, shelter, and facilities for reading, writing, and expressing oneself, as well as the right to basic healthcare. This expansive interpretation established that persons deprived of liberty, including those in mental health facilities, retain fundamental rights except those necessarily curtailed by incarceration itself.

More recently, in *Sukdeb Saha v. State of Andhra Pradesh*,[68] the Supreme Court explicitly recognized mental health as an integral component of the right to life under Article 21. The bench comprising Justices Vikram Nath and Sandeep Mehta held that mental wellbeing is inseparable from the right to life, affirming that mental health encompasses dignity, autonomy, and psychological freedom. The Court specifically referenced *Shatrughan Chauhan v. Union of India*[69] and *Navtej Singh Johar v. Union of India*[70] as precedents recognizing mental integrity, psychological autonomy, and freedom from degrading treatment as essential facets of human dignity under Article 21. In *Shatrughan Chauhan*, a constitutional bench dealing with death row convicts held that execution of persons suffering from mental illness violates Article 21, establishing that insanity constitutes a crucial supervening circumstance warranting commutation of death sentences. The Court emphasized that international human rights standards, including UN resolutions, urge states not to impose death penalty on persons suffering from any form of mental disorder.

Public interest litigation has been instrumental in exposing conditions in mental health institutions and securing judicial intervention. Early cases such as *Upendra Baxi v. State of Uttar Pradesh*[71] concerning protective homes,

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[62] BJPsych International article, *supra* note 47.
[63] *Ibid*.
[64] *Supra* note 6.
[65] Government of India, Ministry of Health and Family Welfare, "Advancing Mental Healthcare in India" Press Release (2025), available at: https://mohfw.gov.in/?q=pressrelease-206
[66] "A Systematic Literature Review of Mental Healthcare Act, 2017" *ResearchGate* (2024), available at: https://www.researchgate.net/publication/383860444_A_SYSTEMATIC_LITERATURE_REVIEW_OF_MENTAL_HEALTHCARE_ACT_2017
[67] *Francis Coralie Mullin v. Administrator, Union Territory of Delhi*, (1981) 1 SCC 608
[68] *Sukdeb Saha v. State of Andhra Pradesh*, Writ Petition (Criminal) No. 55 of 2013 (Supreme Court of India, 26 July 2025)
[69] *Shatrughan Chauhan v. Union of India*, (2014) 3 SCC 1
[70] *Navtej Singh Johar v. Union of India*, (2018) 10 SCC 1
[71] *Upendra Baxi v. State of Uttar Pradesh*, (1983) 2 SCC 308.

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Veena Sethi v. State of Bihar[72] regarding mentally ill prisoners, and *Sheela Barse v. Union of India*[73] addressing detention of persons with intellectual disabilities established the principle that courts would scrutinize institutional conditions and order remedial measures. In *Rakesh Chandra Narayan v. State of Bihar*,[74] the Supreme Court took cognizance of deplorable conditions at Ranchi Mental Hospital, leading to sustained judicial monitoring and eventual improvements in infrastructure, staffing, and patient care.

In November 1997, the Supreme Court directed the National Human Rights Commission to monitor specific mental hospitals across the country, initiating systematic oversight that revealed widespread violations including overcrowding, inadequate medical care, lack of qualified staff, poor sanitation, and denial of basic rights.[75] The NHRC's monitoring reports documented instances of patients being kept in chains, prolonged detention beyond medical necessity, and absence of rehabilitation services. These findings prompted judicial directions for improvements in budgeting, staffing, infrastructure, and family involvement in care.

Following enactment of the Mental Healthcare Act 2017, courts began interpreting specific provisions through constitutional challenges and implementation petitions. High Courts across India issued directions to state governments to expedite establishment of State Mental Health Authorities and Mental Health Review Boards mandated under the Act. Courts recognized that absence of these statutory bodies renders rights enumerated in the legislation largely unenforceable, as these authorities serve as primary mechanisms for oversight, complaint redressal, and review of admissions. In several states, High Courts set strict timelines for compliance and required periodic progress reports, exercising continuing mandamus jurisdiction to ensure implementation.[76]

The presumption of capacity established under Section 3 of the Mental Healthcare Act has been reinforced through judicial interpretation. Courts have emphasized that persons with mental illness retain legal capacity unless specifically determined otherwise through proper assessment procedures considering comprehension, decision-making ability, and communication. Determinations of incapacity cannot be based solely on diagnosis or stereotypes about mental illness but must involve individualized functional assessment of the person's ability to understand and appreciate consequences of specific decisions. This judicial approach aligns with the CRPD's emphasis on legal capacity and supported decision-making.[77]

Advance directives, while still relatively uncommon in practice, have begun receiving judicial attention as disputes arise regarding their interpretation and enforcement. Courts have generally held that valid advance directives registered under the Act constitute binding legal instruments that must be respected by healthcare providers, subject only to narrow statutory exceptions such as emergencies where following the directive would lead to death or grievous harm. The judiciary has emphasized that advance directives serve to protect autonomy during periods of incapacity and cannot be disregarded simply because they conflict with professional medical judgment about optimal treatment.[78]

The decriminalization of suicide attempts under Section 115 of the Mental Healthcare Act has generated significant jurisprudence. In *Sukdeb Saha*, the Supreme Court observed that this provision, which presumes persons attempting suicide to be suffering from severe stress and mandates care rather than punishment, reflects a broader constitutional vision requiring responsive legal frameworks to prevent self-harm and promote wellbeing. Courts have directed police and magistrates to ensure that persons who attempt suicide are immediately provided access to mental health services and counseling rather than being subjected to criminal investigation or prosecution. This represents a fundamental shift from punitive to therapeutic approaches, acknowledging suicide

[72] *Veena Sethi v. State of Bihar*, AIR 1982 SC 1473.
[73] *Sheela Barse v. Union of India*, (1986) 3 SCC 632.
[74] *Rakesh Chandra Narayan v. State of Bihar*, AIR 1989 SC 348.
[75] Pratima Murthy et al., "Mental Hospitals in India in the 21st century: transformation and relevance" 26(1) *Epidemiology and Psychiatric Sciences* 1 (2017), available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC6998657/ and https://www.cambridge.org/core/journals/epidemiology-and-psychiatric-sciences/article/mental-hospitals-in-india-in-the-21st-century-transformation-and-relevance/81EADC1F48C6ABEC95E6F8B269725329
[76] Drishti IAS article, *supra* note 55.
[77] Mental Healthcare Act, 2017, s. 3
[78] Mental Healthcare Act, 2017, ss. 5-12

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attempts as manifestations of mental health crises requiring compassionate intervention.[79]

Discrimination against persons with mental illness in employment, education, and other domains has been challenged through judicial intervention. Courts have applied Article 14's equality guarantee and Article 15's prohibition of discrimination to hold that mental illness, standing alone, cannot justify denial of opportunities where the individual possesses requisite abilities to perform required functions. The principle of reasonable accommodation, requiring institutions to make appropriate adjustments enabling participation by persons with mental illness, has been judicially recognized. These decisions operationalize the Rights of Persons with Disabilities Act 2016, which explicitly includes persons with mental illness within its protective ambit.[80]

The interface between the Mental Healthcare Act 2017 and the Rights of Persons with Disabilities Act 2016 has required judicial interpretation to ensure harmonious construction. Courts have adopted approaches recognizing that persons with mental illness benefit from protections under both statutes, which should be interpreted consistently to maximize rights protection. The judiciary has noted that both laws reflect India's commitment to the CRPD and embody rights-based approaches to disability, requiring coordinated implementation.[81]

Cases involving prisoners and undertrials with mental illness have prompted particular judicial scrutiny. The Delhi High Court, incorporating recommendations from the National Human Rights Commission, issued comprehensive directions regarding identification, assessment, and treatment of mentally ill prisoners, transfer to appropriate mental health facilities when necessary, and provision of psychosocial rehabilitation services. The Court directed judicial academies to include training on mental health law for judicial officers and emphasized that the state bears responsibility for mental and physical health of those it imprisons.[82] These directions recognize that failure to provide necessary mental healthcare in custodial settings violates constitutional prohibitions against cruel, inhuman, and degrading treatment.

During the COVID-19 pandemic, the Supreme Court expressed serious concern about human rights violations in mental health institutions and ordered states to make vaccinations available to all persons detained in mental health facilities along with staff. The Court called for establishment of a dashboard documenting numbers of persons with mental health conditions in each hospital, including those ready for discharge but remaining confined due to lack of community support, and mandated creation of halfway homes and residential care facilities. The Court tasked the Ministry of Social Justice and Empowerment with monitoring progress, recognizing systemic failures in implementing community-based care as envisioned by the Mental Healthcare Act.[83]

The Supreme Court and High Courts have emphasized the importance of continuing judicial monitoring to ensure that improvements prompted by court intervention are sustained rather than dissipating once judicial scrutiny withdraws. This approach reflects awareness that systemic change in mental health requires sustained pressure and accountability mechanisms. Courts have kept cases alive on their files to permit periodic review and intervention as needed.[84]

However, judicial intervention faces inherent limitations. Courts depend upon executive authorities to implement their directions, and judicial capacity for continuous monitoring across numerous institutions and jurisdictions is necessarily limited. Structural challenges including inadequate budgetary allocation, workforce shortages, and infrastructure deficiencies cannot be resolved through judicial orders alone but require sustained policy commitment and resource investment by legislative and executive branches. There is also risk that excessive judicialization may displace necessary democratic deliberation about mental health policy priorities and resource allocation strategies. The most effective approach likely involves judicial intervention serving as catalyst for executive and legislative action while respecting appropriate separation of powers, with courts establishing rights-

[79] *Sukdeb Saha*, *supra* note 68; Mental Healthcare Act, 2017, s. 115, *supra* note 9.

[80] Rights of Persons with Disabilities Act, 2016, No. 49 of 2016.

[81] *Ibid*.

[82] "Delhi High Court order incorporates NHRC's suggestions on Mentally ill undertrials" National Human Rights Commission of India, available at: https://nhrc.nic.in/press-release/delhi-high-court-order-incorporates-nhrcs-suggestions-mentally-ill-undertrials

[83] "India's Supreme Court Orders to Vaccinate Patients in Mental Health Facilities" Human Rights Watch (5 October 2021), available at: https://www.hrw.org/news/2021/10/05/indias-supreme-court-orders-vaccinate-patients-mental-health-facilities

[84] "Mental health in India", *supra* note 75.

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based principles and accountability frameworks but permitting flexibility in implementation approaches.[85]
Despite these limitations, judicial intervention has been indispensable in advancing mental health rights in India. The courts have established mental healthcare as a constitutional entitlement, exposed and remedied egregious institutional abuses, compelled creation of statutory oversight bodies, interpreted progressive provisions of the Mental Healthcare Act in ways that maximize rights protection, and maintained pressure on governments to translate legislative commitments into operational realities. This jurisprudence provides essential foundation for further progress in ensuring dignity, autonomy, and quality care for persons with mental illness.

6. Conclusion And Suggestions

The Mental Healthcare Act of 2017 represents a historic milestone, fundamentally transforming legal frameworks from custodial control to rights-based care. The Act aligns Indian law with international human rights standards and establishes mental healthcare as a legally enforceable right. However, the gap between legislative aspiration and practical reality remains substantial. More than six years after commencement, implementation has progressed unevenly. Many statutory authorities remain unestablished, leaving crucial accountability mechanisms absent. Resource allocation continues to be grossly inadequate. Infrastructure remains concentrated in urban areas. The mental health workforce is severely limited. Stigma and traditional attitudes continue to impede rights realization.
Based on this analysis, several suggestions emerge. First and foremost, substantial increase in budgetary allocation is essential. The current allocation of less than 1% is manifestly inadequate. Government should progressively increase mental health spending to at least three to 5% of the health budget. Enhanced funding must be directed toward expanding infrastructure, training workforce, establishing community-based services, supporting research, and building institutional capacity.
Urgent priority should be given to establishing State Mental Health Authorities and Mental Health Review Boards in all states where they remain absent. These bodies are fundamental to implementation architecture. Once established, they must be adequately staffed, funded, and empowered. Regular training for authority members would enhance functioning.
Expansion and equitable distribution of mental health workforce requires sustained attention. Short-term measures should include training primary care physicians in basic psychiatric diagnosis through programs like the District Mental Health Programme. Task-shifting approaches training community health workers can extend service reach. Long-term workforce development requires increasing training seats with specific incentives encouraging practice in rural areas.
Comprehensive awareness and training initiatives targeting multiple stakeholder groups are necessary. Mental health professionals require training on capacity assessment, advance directives, and supported decision-making. Judicial officers need specialized education on mental health law. Police training should emphasize appropriate responses to mental health crises. Public awareness campaigns can challenge stigma and inform persons about available rights.
Simplification and streamlining of advance directive procedures would facilitate their use. States should establish user-friendly online registration systems and provide standardized templates in multiple languages. Development and enforcement of comprehensive quality standards for all establishments is crucial. Standards should address infrastructure, staffing, and treatment protocols while permitting flexibility. Regular inspections with consequences for non-compliance would incentivize adherence.
Expansion of community-based mental health services requires substantial investment in alternatives to institutional care. Development of halfway homes, sheltered accommodations, community mental health centers, and mobile crisis response teams would enable persons to live in community settings with appropriate support. Integration of mental health services into primary healthcare should be accelerated. Ensuring frontline providers can identify and manage common mental health conditions would dramatically expand treatment coverage.

[85] Kelly, *supra* note 1.

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Strengthening family and caregiver support mechanisms would enhance care quality while addressing a notable gap. Caregivers require information, skills training, respite services, and financial support. Recognizing caregivers as partners in treatment would better reflect social realities and improve outcomes.

Investment in mental health research is essential for developing evidence-based policies appropriate for Indian contexts. Research priorities should include epidemiological studies, effectiveness evaluations, health systems research, and economic analyses. Establishment of robust data collection and monitoring systems would enable assessment of implementation progress. The Central Mental Health Authority should develop standardized indicators with states required to submit regular data.

Civil society organizations play vital roles in protecting rights and monitoring implementation. Government should actively partner with these organizations. Ensuring meaningful participation of persons with lived experience in all aspects of policy development is essential. International cooperation and exchange of experiences can accelerate India's progress.

Ultimately, realizing the transformative vision requires sustained political commitment, adequate resourcing, institutional capacity building, cultural change, and genuine partnership among government, healthcare providers, civil society, and persons with lived experience. While challenges are substantial, the legal framework now exists to protect and promote rights of persons with mental illness. The task ahead is ensuring this framework moves from paper to practice, translating legal rights into genuine improvements in lives of millions of Indians living with mental health conditions. Only through such comprehensive efforts can India fulfill its commitment to mental health as a fundamental human right and create a society where persons with mental illness are treated with the dignity, respect, and care they deserve.

CONFLICT OF INTEREST

The authors declare no conflict of interest related to this research article.

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