MENTAL HEALTH LAWS IN INDIA: BRIDGING THE GAP BETWEEN LEGAL PROTECTION AND SOCIAL STIGMA

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"Law must be stable, and yet it cannot stand still."

-Roscoe Pound

ABSTRACT

Mental health is increasingly recognized as an integral component of the right to life, dignity, and personal liberty under Article 21 of the Constitution of India. Over time, India's mental health legislation has evolved from a custodial and welfare-oriented framework to a rights-based approach, culminating in the enactment of the Mental Healthcare Act, 2017. This paper examines the evolution of mental health laws in India, with particular emphasis on the transition from the Mental Health Act, 1987 to the Mental Healthcare Act, 2017, which prioritizes autonomy, informed consent, non-discrimination, and access to mental healthcare as enforceable legal rights. Employing a doctrinal and socio-legal methodology, the study analyses constitutional provisions, statutory frameworks, and judicial pronouncements to assess the effectiveness of legal reforms in addressing social stigma. It argues that despite progressive legislation and judicial recognition of mental health as a human right, deep-rooted stigma, lack of awareness, infrastructural deficiencies, and weak implementation continue to hinder the realization of mental health rights. The paper concludes that bridging the gap between legal protection and social reality requires not only legal reform but also effective enforcement, social sensitization, and sustained political commitment.

Keywords: Mental health laws, Mental Healthcare Act, 2017, social stigma, Article 21, human dignity, India

1. Introduction

Mental health refers to a condition of psychological well-being that allows individuals to manage life's stresses, recognize and develop their abilities, learn and work effectively, and make meaningful contributions to society. It holds both inherent and practical importance and is a fundamental component of overall well-being. At any given time, mental health can be supported or weakened by a wide range of factors at the individual, family, community, and structural levels. While many individuals show resilience, those facing adverse conditions such as poverty, violence, disability, and inequality are more vulnerable to developing mental health problems. Although many mental health disorders can be treated effectively at relatively low cost, health systems worldwide remain inadequately equipped, resulting in substantial treatment gaps. Furthermore, the quality of mental health care is often substandard. Individuals with mental health conditions frequently encounter stigma, discrimination, and violations of their human rights.[1]

Mental health is increasingly recognized as an essential component of the right to life, dignity, and personal liberty under **Article 21 of the Constitution of India**, which protects not merely survival but a life of dignity and well-being.[2] Indian courts have interpreted the right to life to include mental health as part of fundamental human rights, reinforcing the constitutional mandate for state action and protection.[3] Historically, India's approach to mental health law was custodial and welfare-oriented, reflected in statutes such as the Mental Health Act, 1987, which focused on treatment and care of persons with mental illness but lacked a strong rights-based framework.[4]

In response to evolving human rights norms and international obligations such as the **United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)**, India enacted the **Mental Healthcare Act, 2017** ("MHCA 2017") to provide for mental healthcare and services for persons with mental illness and to protect, promote, and fulfill their rights.[5] The

[1] World Health Organization: WHO. (2019, December 19). *Mental health*. https://www.who.int/health-topics/mental-health#tab=tab_1
[2] *Sukdeb Saha v. State of Andhra Pradesh*
[3] Ibid
[4] Mold, A., Clark, P., Millward, G., & Payling, D. (2019). *Placing the Public in Public Health in Post-War Britain, 1948–2012*. https://doi.org/10.1007/978-3-030-18685-2
[5] Sugiura, K., Mahomed, F., Saxena, S., & Patel, V. (2019). An end to coercion: rights and decision-making in mental health care. *Bulletin of the World Health Organization*, *98*(1), 52–58. https://doi.org/10.2471/blt.19.234906

Act mandates the right to access mental healthcare without discrimination, obliges the state to integrate mental health services into general healthcare, and expressly safeguards rights such as equality, dignity, and protection from cruel, inhuman, or degrading treatment.[6] Despite these legislative advancements, deep-rooted social stigma, lack of awareness, and institutional shortcomings continue to impede the effective implementation of legal protections, resulting in a persistent gap between statutory rights and lived social realities. Existing scholarship acknowledges the progressive nature of the MHCA 2017 but highlights implementation challenges, including social prejudice, weak enforcement mechanisms, and limited public sensitization.[7]

This study examines the evolution and effectiveness of mental health laws in India, with a focus on the MHCA 2017 and its rights-based framework, to assess how legal reform addresses social stigma and promotes constitutional guarantees. The research asks whether progressive legislation can fully realize mental health rights in the absence of systemic change and social acceptance, and proceeds on the hypothesis that legal reform alone is insufficient to dismantle stigma and exclusion. Adopting a **doctrinal and socio-legal methodology**, it analyzes Constitutional provisions, statutory frameworks, judicial pronouncements, and secondary literature to explore the interaction between law, policy, and societal attitudes. Through this law and policy analysis, the paper highlights implementation gaps and emphasizes the need for effective enforcement, legal awareness, and systemic reforms to bridge the gap between law and lived reality, thereby integrating mental health as a central concern of India's public health and social justice agenda.

2. Evolution of Mental Health Legislation in India

India's mental health laws reflect a gradual transition from custodial control to a rights-oriented legal framework. This evolution mirrors changing perceptions of mental illness, advances in medical science, and the growing influence of constitutional and international human rights norms.

2.1 Early Approach to Mental Health Law

The earliest statutory framework governing mental illness in India was shaped by colonial

[6] Sections 18 and 21 of the Mental Healthcare Act, 2017 guarantee the right to access mental healthcare and equality in treatment.
[7] *Journal of Neonatal Surgery*. (n.d.). https://jneonatalsurg.com/

priorities rather than human rights considerations. The **Indian Lunacy Act, 1912** primarily focused on the detention and confinement of persons deemed to be "lunatics," emphasizing public safety over individual dignity.[8] The Act adopted a **custodial and welfare-based model**, where persons with mental illness were viewed as objects of care and control rather than as rights-bearing individuals.[9] This approach treated mental illness largely as a social threat requiring institutional isolation, with minimal safeguards for personal liberty, autonomy, or informed consent. The absence of procedural protections and judicial oversight resulted in widespread criticism of the law for enabling arbitrary detention and neglecting the humane treatment of persons with mental illness.[10]

2.2 Mental Health Act, 1987

In an attempt to modernize mental health governance, the **Mental Health Act, 1987** was enacted to replace the outdated colonial legislation. The Act sought to regulate psychiatric institutions, establish procedures for admission and discharge, and improve the standards of care and treatment.[11] It also introduced provisions for licensing mental health establishments and aimed to integrate mental healthcare into the broader public health system. Despite these improvements, the Act retained a predominantly **medical and institutional orientation**, offering limited recognition of patient autonomy and legal capacity. Scholars and mental health advocates criticized the Act for failing to adopt a rights-based approach and for its inadequate focus on consent, community-based care, and protection against discrimination.[12] Consequently, the law was increasingly viewed as incompatible with constitutional values of dignity and equality.

2.3 Shift to a Rights-Based Framework

The demand for comprehensive reform gained momentum with India's ratification of the **United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)** in 2007, which recognized persons with psychosocial disabilities as equal rights holders.[13] International

[8] Indian Lunacy Act, 1912 (repealed), colonial legislation regulating detention of persons with mental illness.
[9] Gaur, K. D. (2023). *Textbook on Indian penal code*.
[10] Mian, M. (2004). World report on violence and health: What it means for children and pediatricians. *The Journal of Pediatrics*, *145*(1), 14–19. https://doi.org/10.1016/j.jpeds.2004.03.054
[11] Mental Health Act, 1987
[12] S. Pathare & R. Jagade, "Mental Health Legislation in India: Analysis and Critique," *Indian Journal of Psychiatry*
[13] United Nations Convention on the Rights of Persons with Disabilities, 2006.

human rights standards emphasized autonomy, non-discrimination, and full participation in society, necessitating a departure from custodial mental health laws. This international influence, combined with domestic constitutional jurisprudence under **Article 21**, led to the enactment of the **Mental Healthcare Act, 2017**. The new legislation marked a decisive shift towards a **rights-based framework**, recognizing mental healthcare as a legal entitlement and emphasizing informed consent, dignity, and community living.[14] The reform underscored the need to align mental health law with human rights principles, thereby addressing longstanding gaps between legal policy and lived experience.

3. Mental Healthcare Act, 2017: A Rights-Based Legal Framework

3.1 Introduction to MHCA 2017

The Mental Healthcare Act, 2017 (MHCA 2017) represents a decisive shift in India's approach to mental health, moving from an institutional, custodial model to a rights-based and person-centric framework**.** The Act aligns domestic law with constitutional guarantees under Articles 14, 19, and 21 of the Constitution of India and India's obligations under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)**.** [15] Unlike earlier laws, the MHCA explicitly recognizes mental healthcare as a legal right**,** placing a corresponding duty on the State to ensure affordable, accessible, and non-discriminatory mental health services**.** The legislation emphasizes autonomy, dignity, and informed consent**,** acknowledging persons with mental illness as rights-holders rather than passive recipients of care.[16]

3.2 Salient Features of MHCA 2017

Key provisions of the Act include:

- Right to Access Mental Healthcare (Section 18): Guarantees that every person can access mental health services integrated with general healthcare.[17]

- Advance Directives (Sections 5–7): Allow individuals to specify preferred treatment

[14] Mental Healthcare Act, 2017 – Preamble and Chapter V (Rights of Persons with Mental Illness).
[15] United Nations Convention on the Rights of Persons with Disabilities, 2006.
Available at: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html
[16] Mental Healthcare Act, 2017, Preamble.
[17] Section 18, Mental Healthcare Act, 2017.

approaches in anticipation of future mental health episodes, promoting autonomy.[18]

- Decriminalization of Suicide (Section 115): Recognizes that attempted suicide is often a result of severe stress and mandates care and rehabilitation rather than punitive measures.[19]

- Mental Health Review Boards (Sections 19–22): Oversight bodies to protect the rights of patients, including review of admission, treatment, and detention.[20]

These features collectively mark a paradigm shift from paternalistic treatment models toward empowerment and rights-based mental healthcare.

3.3 Constitutional and Judicial Perspectives

The Constitution of India does not expressly mention mental health. However, judicial interpretation, particularly of **Article 21**, has expanded the **right to life** to include mental well-being, dignity, and psychological autonomy.[6] Courts have consistently held that the right to life is not limited to mere physical existence but encompasses **personal liberty, human dignity, and mental peace**.[21]

3.3.1 Key Judicial Pronouncements

- *Sukdeb Saha v. State of Andhra Pradesh*: The Supreme Court recognized mental health as integral to the right to life under Article 21 and issued guidelines for educational institutions to safeguard student mental health.[22]

- *Shatrughan Chauhan v. Union of India:* The Court held that prolonged mental suffering can constitute cruel, inhuman, or degrading treatment**,** highlighting the State's obligation to prevent psychological harm.[23]

- *Gaurav Kumar Bansal v. Union of India & Sheela Barse v. Union of India:* The judiciary emphasized the State's responsibility to provide adequate mental health

[18] Sections 5–7, Mental Healthcare Act, 2017.
[19] Section 115, Mental Healthcare Act, 2017.
[20] Sections 19–22, Mental Healthcare Act, 2017.
[21] Article 21, The Constitution of India,1950.
[22] 2025 SCO.LR 7(4)[20]
[23] (2014) 3 SCC 1.

facilities for prisoners and institutionalized persons**,** reaffirming that incarceration cannot justify neglect of mental well-being.[24]

3.3.2 Constitutional Morality vs. Social Stigma

Courts have stressed that constitutional morality must prevail over social morality. Social stigma against mental illness—manifesting in exclusion, discrimination, and denial of services—cannot override fundamental rights.[25] Decisions like *Navtej Singh Johar v. Union of India*[26] and Justice *K.S. Puttaswamy v. Union of India*[27] illustrate judicial insistence on dignity, autonomy, and privacy**,** which directly support protections for persons with mental illness.

3.4 Limitations, Implementation Challenges, and Way Forward

Despite its progressive provisions, implementation of the MHCA 2017 faces significant challenges:

- **Infrastructure and Human Resources:** Acute shortage of psychiatrists, psychologists, and psychiatric social workers, particularly in rural areas.[28]
- **Administrative Delays:** Slow constitution and functioning of Mental Health Review Boards and State Mental Health Authorities. [29]
- **Awareness and Legal Literacy:** Lack of knowledge about rights under the Act among patients, families, healthcare providers, and even law enforcement.
- **Social Stigma:** Persistent societal prejudice discourages individuals from seeking care, limiting the practical exercise of rights.
- **Federal Disparities:** Uneven enforcement across states due to variations in political will, resources, and administrative capacity.

Addressing these challenges requires **integrated efforts**, combining legal enforcement,

[24] (1986) 3 SCC 596.
[25] Vikash Kumar v. UPSC
[26] (2018) 10 SCC 1;
[27] (2017) 10 SCC 1.
[28] UN Convention on the Rights of Persons with Disabilities, 2006.
[29] Ministry of Health and Family Welfare, *National Mental Health Programme Reports*

infrastructure development, capacity building, and societal awareness programs. The MHCA 2017 is a **landmark in Indian mental health jurisprudence**, embedding dignity, autonomy, and equality into law. It aligns India with **international human rights standards**, particularly the **UNCRPD**, and signals a shift from viewing mental illness as a social or moral problem toward a **rights-based social justice concern**.

4. Social Stigma and Its Legal Implications: Ground Realities and Lived Experiences

Despite the progressive shift in India's mental health jurisprudence, social stigma continues to operate as a powerful structural barrier that undermines both legal protection and access to mental healthcare. Stigma surrounding mental illness is deeply embedded in social attitudes, cultural beliefs, and institutional practices, often resulting in exclusion, silence, and systemic neglect. These realities expose a significant disjunction between the rights guaranteed under the Mental Healthcare Act, 2017 and the everyday experiences of persons with mental illness.

4.1 Social Perceptions and Everyday Discrimination

In Indian society, mental illness is frequently misunderstood as a sign of personal weakness, moral failure, or divine punishment rather than a medical condition requiring care and support. Such perceptions lead to widespread discrimination within families, workplaces, educational institutions, and communities. Individuals with mental illness are often discouraged from disclosing their condition due to fear of social rejection, damaged marriage prospects, and loss of employment opportunities. This culture of silence results in delayed diagnosis and untreated mental health conditions, aggravating personal suffering and social exclusion.

Empirical studies and reports reveal that families often conceal mental illness to avoid stigma, prioritizing social reputation over medical intervention. Women, in particular, face compounded discrimination, as mental illness is frequently used as a ground for marital breakdown, denial of custody, or abandonment, raising serious concerns of gender justice and equality.[30] These lived realities demonstrate that stigma directly interferes with the exercise of legal rights guaranteed under mental health legislation.

4.2 Stigma as an Obstacle to Accessing Mental Healthcare

Although the Mental Healthcare Act, 2017 guarantees the right to access mental healthcare

[30] National Human Rights Commission (NHRC), *Mental Health in India: Issues and Concerns*

services without discrimination, social stigma significantly limits the practical exercise of this right. Many individuals hesitate to seek professional help due to fear of being labeled "mentally unstable," which may lead to social isolation or institutional discrimination. This hesitation is particularly pronounced in rural areas, where mental health awareness remains limited and healthcare infrastructure is inadequate. Furthermore, stigma is not confined to society alone; it often permeates healthcare institutions themselves. Reports indicate instances of insensitive treatment, lack of confidentiality, and coercive practices within mental health facilities, which discourage individuals from continuing treatment.[31] Such practices undermine the principles of autonomy, dignity, and informed consent emphasized by the 2017 Act and raise serious concerns regarding compliance with constitutional standards under Article 21.

4.3 Legal Consequences of Stigma: Rights Denied in Practice

Social stigma has tangible legal consequences, as it frequently results in the denial or dilution of legally recognized rights. Despite statutory protection against discrimination, individuals with mental illness continue to face exclusion in employment, insurance, education, and housing. Employers often perceive mental illness as a liability, leading to unfair termination or denial of opportunities, even when the individual is capable of performing professional duties.

The Supreme Court, in ***Vikash Kumar v. Union Public Service Commission***,[32] acknowledged that attitudinal barriers and social prejudice are major contributors to systemic exclusion, emphasizing that dignity cannot be compromised on the basis of disability, including mental illness. This recognition underscores that stigma itself can operate as a form of structural discrimination, violating Articles 14 and 21 of the Constitution.

4.4 Judicial Response to Stigma and the Emphasis on Dignity

Indian courts have increasingly emphasized the centrality of dignity, autonomy, and constitutional morality in protecting marginalized groups from social prejudice. In ***Navtej Singh Johar v. Union of India***,[33] the Supreme Court held that societal morality cannot override constitutional values, asserting that individual identity and dignity must be protected even in the face of widespread social disapproval. Though the case addressed sexual orientation, its

[31] World Health Organization, *Mental Health Atlas – India*
[32] (2021) 5 SCC 370.
[33] (2018) 10 SCC 1.

reasoning is equally applicable to mental health, where stigma often serves as the basis for denial of rights. Similarly, in ***Justice K.S. Puttaswamy v. Union of India***,[34] the Court recognized privacy as intrinsic to dignity and personal liberty, which has direct implications for mental health, particularly in relation to confidentiality of medical records, disclosure of diagnosis, and freedom from unwanted social labeling. Stigma-driven breaches of privacy thus amount to constitutional violations.

4.5 Societal Stigma versus Constitutional Morality

The persistence of stigma highlights a fundamental conflict between entrenched social norms and constitutional morality. While the Constitution envisions an inclusive society grounded in equality and dignity, social attitudes toward mental illness continue to reflect fear, misunderstanding, and exclusion. This conflict weakens the transformative potential of mental health legislation, reducing it to symbolic compliance rather than substantive protection.

The judiciary has repeatedly emphasized that constitutional morality must prevail over social morality; however, courts alone cannot dismantle stigma without proactive state intervention and societal engagement. Legal recognition of rights must therefore be accompanied by public education, community-based mental health programs, and institutional accountability to ensure meaningful change.

4.6 The Need for a Holistic Response

The analysis reveals that stigma is not merely a social issue but a legal and constitutional concern that directly affects the realization of fundamental rights. Addressing stigma requires a multidimensional approach involving legal enforcement, policy reform, awareness campaigns, and cultural change. Without integrating social sensitization with legal mechanisms, mental health laws risk remaining ineffective in transforming the lived realities of those they seek to protect.

5. Implementation Challenges of the Mental Healthcare Act, 2017

The Mental Healthcare Act, 2017 represents a progressive legislative commitment to a rights-based mental health framework in India. However, the practical realization of its objectives has

[34] (2017) 10 SCC 1

been constrained by several structural, administrative, and socio-cultural challenges. These implementation gaps reveal a disconnect between legislative intent and ground-level realities, thereby limiting the transformative potential of the Act.

5.1 Inadequate Infrastructure and Human Resources

One of the most significant challenges in implementing the 2017 Act is the acute shortage of mental health infrastructure and trained professionals. India faces a severe deficit of psychiatrists, clinical psychologists, psychiatric social workers, and mental health nurses, particularly in rural and semi-urban areas. According to official data, the mental health workforce in India falls far below the standards recommended by the World Health Organization.[35] This shortage restricts access to mental healthcare services, undermining the statutory right to treatment guaranteed under the Act.

Mental health establishments are also unevenly distributed across states, leading to regional disparities in service availability. Many districts lack functional mental health facilities altogether, forcing individuals to travel long distances or rely on unqualified practitioners. Such conditions render the right to access mental healthcare largely illusory for marginalized populations.

5.2 Weak Institutional Mechanisms and Delayed Implementation

The Mental Healthcare Act, 2017 mandates the establishment of key institutions such as the Central Mental Health Authority, State Mental Health Authorities, and Mental Health Review Boards. However, several states have been slow in constituting these bodies or ensuring their effective functioning. Delays in framing rules, appointing members, and allocating financial resources have significantly hampered implementation.[36]

Mental Health Review Boards, which play a crucial role in safeguarding patient rights and addressing grievances, often suffer from understaffing, lack of expertise, and limited accessibility. This weak institutional capacity restricts accountability and reduces public confidence in legal remedies.

[35] World Health Organization, *Mental Health Atlas – India*
[36] Ministry of Health and Family Welfare, Government of India, *Status of Implementation of Mental Healthcare Act, 2017* (Reports).

5.3 Lack of Awareness and Legal Literacy

A major impediment to effective enforcement of mental health laws is the lack of awareness among the general public, healthcare professionals, law enforcement agencies, and even judicial officers. Many individuals remain unaware of their rights under the Mental Healthcare Act, including the right to informed consent, advance directives, and protection from discrimination.[37]

This lack of legal literacy often results in continued reliance on outdated practices, including involuntary admissions without due process and family-dominated decision-making that disregards patient autonomy. Without widespread awareness, statutory rights remain underutilized and unenforced.

5.4 Financial Constraints and Budgetary Neglect

Despite legislative recognition of mental healthcare as a state responsibility, budgetary allocations for mental health remain disproportionately low. Public expenditure on mental health constitutes a minimal percentage of the overall health budget, reflecting the continued marginalization of mental health within public policy priorities.[38] Inadequate funding affects infrastructure development, recruitment of professionals, training programs, and community-based services, thereby weakening implementation.

Financial neglect also limits the effectiveness of insurance-based coverage for mental healthcare, despite statutory mandates for parity between mental and physical health treatment under allied legislations.

5.5 Persistence of Stigma within Institutions

Social stigma does not end at the community level; it often permeates institutional and administrative structures responsible for implementing mental health laws. Discriminatory attitudes among healthcare staff, employers, and public officials can lead to insensitive treatment, breaches of confidentiality, and reluctance to accommodate individuals with mental

[37] National Legal Services Authority (NALSA), *Legal Awareness and Access to Justice for Persons with Mental Illness*
[38] Economic Survey of India, *Public Health Expenditure and Mental Health*

illness.[39] These institutional biases undermine the dignity-centric approach of the 2017 Act and reinforce exclusion.

Judicial recognition of such attitudinal barriers is evident in ***Vikash Kumar v. Union Public Service Commission***,[40] where the Supreme Court emphasized that structural and social barriers are as disabling as physical impairments, reinforcing the need for attitudinal change alongside legal reform.

5.6 Federal Disparities and Uneven State Compliance

Health being a subject under the State List, implementation of the Mental Healthcare Act varies significantly across states. Differences in political will, administrative capacity, and resource allocation result in uneven enforcement. While some states have taken proactive steps towards compliance, others lag considerably; creating inequality in access to mental healthcare services.[41] This unevenness undermines the uniform application of fundamental rights across the country.

5.7 Need for Integrated and Sustainable Reform

The challenges discussed above indicate that effective implementation of the Mental Healthcare Act, 2017 requires more than legislative enactment. Sustainable reform demands coordinated efforts involving infrastructure development, capacity building, public awareness, financial investment, and institutional accountability. Without addressing these systemic deficiencies, the rights guaranteed under the Act risk remaining inspirational rather than actionable.

6. Comparative Perspective: India and International Human Rights Standards

The evolution of mental health law in India cannot be examined in isolation from international human rights developments. Global legal standards have increasingly recognized mental health as an essential component of human dignity, equality, and personal autonomy. India's transition to a rights-based framework through the Mental Healthcare Act, 2017 reflects a conscious effort to align domestic law with international obligations, particularly under the

[39] National Human Rights Commission, *Quality of Mental Health Care and Institutional Practices in India*
[40] (2021) 5 SCC 370.
[41] PRS Legislative Research, *Implementation of Mental Healthcare Act, 2017: State-wise Analysis*

United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

6.1 International Recognition of Mental Health as a Human Right

International human rights instruments have progressively emphasized the protection of mental health. The **Universal Declaration of Human Rights (UDHR)** recognizes the right to life, liberty, and security of person, while the **International Covenant on Economic, Social and Cultural Rights (ICESCR)** explicitly acknowledges the right to the highest attainable standard of physical and mental health.[42] These instruments establish mental healthcare as a state obligation rather than a discretionary welfare measure.

The UN Committee on Economic, Social and Cultural Rights has clarified that the right to mental health includes availability, accessibility, acceptability, and quality of mental health services, along with freedom from discrimination and coercion.[43] This approach has significantly influenced national mental health reforms across jurisdictions, including India.

6.2 UNCRPD and the Shift to a Rights-Based Model

The **UN Convention on the Rights of Persons with Disabilities (2006)** marks a paradigm shift in international mental health law by rejecting the medical and custodial models in favour of autonomy, legal capacity, and community inclusion. The Convention emphasizes respect for inherent dignity, individual autonomy, non-discrimination, and full participation in society.[44] India ratified the UNCRPD in 2007, thereby assuming an obligation to harmonize domestic laws with its principles.

The Mental Healthcare Act, 2017 draws substantial inspiration from the UNCRPD, particularly in recognizing mental illness as a form of disability, affirming patient autonomy, and guaranteeing rights such as informed consent, advance directives, and community-based living. This alignment reflects India's commitment to integrating international human rights norms into domestic legislation.

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[42] Universal Declaration of Human Rights, 1948; International Covenant on Economic, Social and Cultural Rights, 1966. Available at: https://www.un.org

[43] UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*

[44] United Nations Convention on the Rights of Persons with Disabilities, 2006. Available at: https://www.un.org/development/desa/disabilities

6.3 Comparative Jurisprudence: United Kingdom and Other Jurisdictions

A comparative examination reveals both convergence and divergence in mental health regulation. In the **United Kingdom**, the Mental Health Act, 1983 (as amended) continues to permit involuntary detention and treatment under certain conditions, though recent reforms emphasize safeguards, review mechanisms, and patient rights. The UK experience highlights the tension between autonomy and state intervention, a challenge also faced by India.[45]

Several European jurisdictions have moved towards supported decision-making models, emphasizing community care and minimizing institutionalization. These developments reinforce the global trend toward deinstitutionalization and rights-based mental healthcare, offering valuable lessons for India in strengthening implementation mechanisms and reducing coercive practices.

6.4 Gaps between International Norms and Indian Practice

While India's legislative framework largely conforms to international standards, significant gaps remain in practice. The UN Special Reporters on the right to health has repeatedly emphasized that stigma, lack of resources, and institutional inertia undermine the realization of mental health rights in many developing countries, including India.[46] Inadequate infrastructure, uneven state-level implementation, and limited awareness continue to hinder India's compliance with international obligations. Moreover, concerns remain regarding involuntary admissions, capacity assessments, and substitute decision-making, which may conflict with the UNCRPD's emphasis on autonomy and legal capacity.

6.5 Lessons for India

The comparative analysis underscores that effective realization of mental health rights requires more than legislative alignment with international norms. It necessitates sustained political commitment, resource allocation, and institutional capacity-building and societal sensitization. India's experience demonstrates that while international human rights standards provide a strong normative framework, their success ultimately depends on domestic implementation and cultural acceptance.

[45] UK Mental Health Act, 1983 (as amended); UK Law Commission Reports
[46] UN Special Rapporteur on the Right to Health, *Mental Health and Human Rights*

7. Recommendations

To bridge the gap between law and social reality, the following measures are recommended:

First, there is an urgent need for **effective and uniform implementation** of the Mental Healthcare Act, 2017 across all states. State governments must ensure the timely establishment and proper functioning of Mental Health Authorities and Mental Health Review Boards, supported by adequate financial and administrative resources.[47]

Second, **public awareness and legal literacy initiatives** must be strengthened to combat stigma and empower individuals to claim their rights. Community-based campaigns, inclusion of mental health education in academic curricula, and targeted training for healthcare professionals, police, and judicial officers are essential to change entrenched attitudes.[48]

Third, the State must significantly increase **budgetary allocation for mental healthcare**, prioritizing infrastructure development, human resource capacity-building, and community-based mental health services. Without adequate funding, statutory rights risk remaining symbolic rather than enforceable.[49]

Fourth, greater emphasis should be placed on **community-based and non-institutional care models**, in line with international best practices and UNCRPD standards. Such models promote social inclusion, reduce coercion, and enable persons with mental illness to live with dignity within the community.[50]

Fifth, mechanisms for **accountability and grievance redressal** must be strengthened to ensure that violations of mental health rights are effectively addressed. Periodic monitoring, independent audits, and judicial oversight can enhance compliance and public confidence in the legal framework.[51]

8. Conclusion

The evolution of mental health law in India marks a decisive shift from a custodial welfare

[47] Ministry of Health and Family Welfare, Government of India, *Implementation Status of the Mental Healthcare Act, 2017*
[48] World Health Organization, *Stigma and Discrimination in Mental Health: Evidence and Strategies*
[49] Economic Survey of India, *Health Expenditure and Mental Health Policy*
[50] United Nations Convention on the Rights of Persons with Disabilities, 2006; WHO, *Community Mental Health Services*
[51] National Human Rights Commission, *Monitoring Mental Health Institutions in India*

model to a rights-based framework founded on dignity, autonomy, and equality. The Mental Healthcare Act, 2017 represents a significant step in aligning domestic law with Article 21 of the Constitution and international human rights standards, particularly the UNCRPD, by recognizing access to mental healthcare as a legal right. However, this study demonstrates that legislative reform alone is insufficient to ensure meaningful protection. Persistent social stigma, lack of awareness, infrastructural gaps, and uneven implementation continue to hinder the realization of mental health rights. The gap between constitutional ideals and lived reality underscores the need for an integrated approach that combines effective legal enforcement with social sensitization and sustained political commitment. Only through such a holistic response can mental health be fully integrated into India's public health and social justice framework.