Royal International Global Journal of Advance and Applied Research
Peer Reviewed International, Open Access Journal.
ISSN: 2998-4459 | Website: https://rlgjaar.com Volume-3, Issue-8 | August - 2026

Original Article

Mental Healthcare Act, 2017: From Legislative Reform to Rights-Based Mental Health Care in India—Progress, Challenges and the Way Forward

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Manuscript ID:
RIGJAAR-2026-030804

ISSN: 2998-4459
Volume 3
Issue 8
Pp. 13-17
August 2026

Submitted: 07 July 2026
Revised: 15 July 2026
Accepted: 06 Aug 2026
Published: 31 Aug 2026

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Quick Response Code:

Web. https://rlgjaar.com

DOI: 10.5281/zenodo.23115208

DOI Link:
https://doi.org/10.5281/zenodo.23115208

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Abstract

The Mental Healthcare Act (MHCA), 2017 fundamentally transformed India's approach to mental health legislation. It replaced the Mental Health Act, 1987 and shifted the emphasis from institutional control and custodial care towards autonomy, dignity, equality, participation and protection of the rights of persons with mental illness. India enacted the legislation in the context of its United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). The Act introduced several progressive provisions, including the right to access mental healthcare, community living, confidentiality, information, access to medical records, legal aid, advance directives, nominated representatives, supported admission and Mental Health Review Boards. It also introduced a statutory presumption of severe stress in cases of attempted suicide and placed affirmative obligations on governments to provide mental healthcare and reduce stigma. Despite its transformative potential, implementation has remained uneven. Inadequate mental-health infrastructure, shortages of trained professionals, limited community-based services, insufficient functioning of Mental Health Review Boards, administrative and procedural difficulties, limited awareness, and concerns about the practical operation of advance directives and nominated representatives have hindered the translation of legislative rights into accessible care. Recent evidence also shows considerable dissatisfaction among practising psychiatrists regarding several operational provisions of the Act. This review examines the evolution, rights-based provisions, achievements and implementation challenges of the MHCA, 2017. It argues that Indian mental-health legislation should not retreat from its rights-based philosophy. Instead, governments and institutions should operationalise that philosophy through adequate financing, decentralised community care, functional review mechanisms, workforce development, digital and tele-mental-health services, caregiver engagement, service-user participation and continuous evaluation. The ultimate test of the MHCA lies in whether persons with mental illness across India can experience statutory rights as lived realities.

Keywords: *Mental Healthcare Act 2017; mental health legislation; human rights; autonomy; mental illness; Mental Health Review Board; community mental health; India; UNCRPD.*

Introduction

Mental health is integral to health, dignity and human development. India has a substantial burden of mental and substance-use disorders, while access to appropriate and affordable mental healthcare remains limited. The National Mental Health Survey (NHS) 2015–16 reported treatment gaps ranging approximately from 70% to 92% across different mental disorders. These findings indicate that the problem extends beyond the availability of psychiatric treatment. The health system must also address accessibility, continuity, affordability, dignity and protection from discrimination. Historically, Indian mental-health legislation was concerned primarily with the regulation of psychiatric institutions and involuntary admission. Earlier colonial-era legislation established an institution-centred framework, while later reforms retained significant elements of custodial regulation.

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How to cite this article:
Ingole, R. A., & Kalamdhad, S. P. (2026). Mental Healthcare Act, 2017: From Legislative Reform to Rights-Based Mental Health Care in India—Progress, Challenges and the Way Forward. Royal International Global Journal of Advance and Applied Research, 3(8), 13–17. https://doi.org/10.5281/zenodo.23115208

Policymakers and scholars nevertheless continued to raise concerns regarding autonomy, community inclusion and independent safeguards for persons subject to involuntary treatment. The enactment of the Mental Healthcare Act, 2017 marked a substantial change in legislative approach. The Act seeks to provide mental healthcare and services and to protect, promote and fulfil the rights of persons with mental illness during the delivery of such care. India enacted the legislation following its ratification of the UNCRPD in 2007, and the Act came into force on 29 May 2018. The MHCA thereform extends beyond changes in terminology or administrative procedure. It reconfigures the legal relationship among the individual, mental-health professional, family and State. The central issue is whether this rights-based framework has translated into accessible and legally compliant mental healthcare in clinical practice.

Historical and Legislative Context

Indian mental-health legislation developed within a predominantly custodial model. The Indian Lunatic Asylums Act, 1858 and the Indian Lunacy Act, 1912 reflected an institutional and protective approach. The Mental Health Act, 1987 subsequently established a modern statutory framework, but limited resources and its emphasis on psychiatric establishments constrained implementation. The MHCA, 2017 sought to address these limitations. It treats the person with mental illness as a rights-holder rather than primarily as an object of care or social control. The Act recognises legal capacity, autonomy, dignity and participation while providing safeguards where supported care is required.

The legislation thereform represents a transition:

From custodial care to rights-based care; from substituted decision-making towards supported decision-making; from institutionalisation towards community living; and from professional paternalism towards autonomy and participation.

This approach is consistent with the broader human-rights framework of the UNCRPD.

Major Rights-Based Provisions of the MHCA, 2017

1. Right to access mental healthcare

Section 18 confers a right to access mental healthcare and treatment from government-run or government-funded services. The Act further requires government to make such services available equitably and without discrimination.

2. Advance directives

The Act permits a person to make an advance directive specifying how he or she wishes to receive or decline treatment during a future period of mental illness. Advance directives are intended to preserve autonomy when decision-making capacity may be impaired. Their implementation nevertheless raises practical issues concerning awareness, documentation, accessibility, interpretation during emergencies and the availability of Mental Health Review Boards.

3. Nominated representative

The Act permits a person to nominate an individual to support decision-making and related legal processes. The provision recognises the importance of social relationships and support systems. The nominated-representative framework requires a balance among autonomy, safety, family interests and professional responsibility. Indian families frequently provide substantial support in long-term mental healthcare. Implementation should thereform avoid both the exclusion of caregivers and the substitution of professional or family decisions for the person's preferences.

4. Confidentiality, information and medical records

Sections 22–25 establish rights relating to information, confidentiality and access to medical records. These provisions recognise that persons receiving psychiatric treatment retain rights to privacy and control over personal health information. These protections are increasingly relevant as healthcare providers expand electronic health records, telepsychiatry and other digital mental-health services.

5. Legal aid and complaints

The Act provides for legal aid and establishes mechanisms for complaints concerning deficiencies in mental-health services. These provisions give affected persons avenues through which statutory rights may be asserted.

6. Regulation of admission and treatment

The MHCA distinguishes between independent admission and supported admission and subjects supported admission to statutory safeguards and review mechanisms.

Mental Health Review Boards thereform occupy an important position within the statutory framework. The legislation envisages Boards with judicial, administrative, medical and lived-experience/caregiver representation.

Mental Health Review Boards: Institutional Safeguards

Mental Health Review Boards (MHRBs) provide quasi-judicial oversight within the MHCA and are intended to safeguard persons against inappropriate detention or treatment. government to make such services available equitably and without discrimination. This provision is significant because it treats mental healthcare not merely as a public-health service but as a legally recognised entitlement. A statutory entitlement, however, has limited practical effect where services are not geographically accessible or adequately available.

Community living

Section 19 recognises the right of persons with mental illness to live in, participate in and remain part of society without segregation. It challenges the historical reliance on prolonged institutionalisation. Community living requires more than discharge from psychiatric hospitals. Governments and communities must provide housing, rehabilitation, social-security benefits, employment opportunities, family support, community-based psychiatric services and mechanisms that support continuity of care.

Right to dignity and protection from cruel, inhuman or degrading treatment

Section 20 protects persons with mental illness from cruel, inhuman or degrading treatment. The provision is particularly relevant in light of historical concerns regarding neglect, coercion and human-rights violations in psychiatric institutions.

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Rights-based mental healthcare thereform requires access to treatment together with humane treatment, privacy, bodily integrity and protection against unnecessary restraint and seclusion.

Equality and non-discrimination

Section 21 requires healthcare providers to ensure equality and non-discrimination in mental healthcare. It places the treatment of mental illness within the broader legal framework of equality and dignity.

The implications extend beyond hospitals. Persons with mental illness may face discrimination in education, employment, housing, insurance, family life and social participation. Effective implementation thereform requires coordination among health, social-welfare, education, employment and legal systems.

Autonomy and capacity

The MHCA presumes that a person has capacity to make decisions concerning mental healthcare and treatment unless the statutory requirements for determining incapacity are satisfied. This departs from the assumption that mental illness, by itself, eliminates decision-making capacity. The distinction between diagnosis and capacity is central to this approach. A person may have a significant psychiatric disorder while retaining the ability to make informed decisions about treatment. Authorities have nevertheless faced difficulties in establishing Boards with appropriate geographical coverage and functioning procedures. Previous analyses have identified concerns relating to Board composition, workload, resources and administrative functioning. The issue is significant because rights-based legislation depends on institutions capable of enforcing those rights. Where persons cannot effectively invoke or challenge a statutory right, the legal protection may remain largely formal.

MHRBs thereform require:

adequate financial and administrative support;
Sufficient geographical coverage;
Trained judicial and mental-health members;
Meaningful participation of persons with lived experience;
Digital case-management systems;
Clear timelines for decisions; and
Regular monitoring and public reporting.

Decriminalisation of Attempted Suicide

Section 115 of the MHCA introduced a statutory presumption that a person who attempts suicide is under severe stress unless proved otherwise, and provides that such a person should not ordinarily be subjected to criminal punishment. The provision shifts the legal response from a predominantly criminal-law approach towards one centred on public health, mental healthcare and rehabilitation. The Supreme Court has also recognised the constitutional significance of this framework. The broader criminal-law framework subsequently changed with the enactment of the Bharatiya Nyaya Sanhita, 2023 and repeal of the Indian Penal Code. Policymakers should thereform periodically review the MHCA so that cross-references and terminology remain consistent with the prevailing legal framework.

Progress since Enactment

Legislative and policy transformation

The principal change introduced by the MHCA is conceptual. It frames mental healthcare in terms of rights, dignity, autonomy and equality and imposes statutory responsibilities on governments concerning mental-health promotion, stigma reduction, human-resource development and service provision. The Central and State Mental Health Authorities, Mental Health Review Boards and regulated mental-health establishments constitute the institutional framework for implementing the legislation. Rules concerning the Central and State Authorities and Review Boards were notified in 2018.

Greater recognition of community care

Comply with legal safeguards and provide timely treatment. The objective should be to establish clear, standardised clinical-legal protocols rather than an adversarial relationship between clinicians and legal requirements.

The Way Forward

1. from statutory rights to practical implementation

Implementation should be assessed using indicators such as:

1. Availability of mental-health services;
2. waiting time for treatment;
3. access to essential medicines;
4. functioning of MHRBs;
5. use and review of advance directives;
6. -complaints and their resolution;
7. frequency and duration of restrictive practices;
8. continuity of community care; and
9. patient-reported experience and satisfaction.

2. Strengthen community mental-health services

District Mental Health Programmes should be integrated with primary healthcare. Each district should have functioning outpatient, crisis-intervention, rehabilitation and referral services.

Community care should include psychosocial rehabilitation, supported employment, family interventions and links to social-security schemes.

3. Reform and strengthen MHRBs

MHRBs require adequate funding and accessible procedures. Authorities should simplify procedures without compromising due process. Training in mental-health law, human rights and clinical practice should be mandatory.

Persons with lived experience should have substantive participation in decision-making rather than merely formal representation.

4. Develop practical clinical guidelines

Nationally standardised guidance should address:

1. capacity assessment;
2. supported admission;
3. emergency treatment;
4. advance directives;
5. nominated representatives;
6. discharge planning;
7. restraint and seclusion,
8. confidentiality,

tele-mental healthcare, and management of suicide attempts. Such guidance would reduce procedural uncertainty and promote consistency across

MHRBs remain necessary but are operationally demanding. Shortages of resources and trained personnel, limited geographical accessibility and weak administrative coordination can delay effective review.

A rights-based system must ensure that persons can obtain review through timely and accessible procedures rather than merely having a formal right to review.

5. Advance directives and nominated representatives

Although consistent with the Act's autonomy-based approach, advance directives and nominated representatives can be difficult to implement where awareness, documentation and legal liferacy are limited.

A 2024 nationwide survey of 600 psychiatrists reported substantial dissatisfaction with several provisions, including procedural requirements, advance directives, nominated representatives and aspects of admission and discharge.

These findings do not, by themselves, justify weakening statutory rights. They indicate instead the need to make rights-based procedures workable in clinical settings and to provide institutions with appropriate administrative support.

6. Caregiver concerns

Indian mental healthcare frequently depends on family support. Families often provide medication supervision, transportation, financial assistance and long-term care. A purely individualistic model may overlook these functions, while excessive reliance on families may compromise autonomy. Supported decision-making provides a more appropriate framework: the person's preferences remain central, while caregivers participate with consent and within statutory safeguards.

7. Financial constraints

Rights cannot be implemented without adequate resources. Mental-health budgets must support psychiatric hospitals as well as primary care, community services, rehabilitation, medicines, human resources, digital infrastructure and MHRBs.

8. Stigma and discrimination

Legal reform alone cannot eliminate stigma. Public education, workplace programmes, school-based mental-health initiatives and responsible media reporting remain necessary.

The Act also recognises the importance of public awareness and stigma reduction.

9. General hospitals and emergency care

Application of MHCA provisions in general-hospital psychiatry and emergency settings has raised practical concerns. Clinicians must simultaneously

Mental health reform.

India does not require a retreat from rights-based mental healthcare; it requires effective implementation of those rights. Adequate financing, community services, trained professionals, functioning Mental Health Review Boards, caregiver support, service-user participation, responsible digital health and systematic monitoring are necessary to implement the Act.

The effectiveness of the MHCA should not be measured by the number of rules notified or institutions registered. The relevant question is whether a person experiencing mental illness—irrespective of income, geography, gender or social status—can obtain timely, affordable, humane and respectful care while retaining the greatest possible autonomy and participation in decisions affecting their life.

The transition from legislative reform to rights-based mental healthcare remains incomplete. During the next decade, policymakers and institutions should focus on translating the statutory framework of the MHCA, 2017 into routine practice.

Institutions and States.

Invest in the mental-health workforce

Expansion of postgraduate training should be accompanied by task-sharing and competency-based training for primary-care professionals and community workers.

Medical, nursing and allied-health education should routinely include mental-health training.

Integrate caregivers while protecting autonomy

Caregivers should receive education, counselling and support. Institutions should recognise their role within a supported-decision-making framework that preserves the person's will, preferences and dignity.

7. Use digital health responsibly

Tele-MANAS and other digital platforms can improve accessibility, but providers must protect confidentiality, informed consent, data security and continuity of care in digital mental healthcare. Digital services should complement, rather than replace, local community services.

8. Strengthen accountability and research

Researchers and authorities should periodically conduct independent evaluations of MHCA implementation. Research should examine legal compliance as well as patient outcomes, quality of life, autonomy, hospitalisation, caregiver burden and user experience.

NHS-2 and future mental-health system assessments can provide evidence for policy refinement.

9. Periodically review the legislation

Implementation experience should inform targeted amendments. Recent professional surveys have identified operational difficulties, supporting periodic legislative and regulatory review. Any reform should, however, preserve the Act's core commitments to dignity, autonomy, equality, access and protection from abuse.

Conclusion

The Mental Healthcare Act, 2017 is a significant development in India's social and health-law framework. It changed the legal treatment of mental illness by recognising persons with mental illness as rights-bearing citizens entitled to dignity, autonomy, equality, community participation and access to mental healthcare.

The Act's rights-based framework operates within a health system in which resources and services remain unevenly distributed. The resulting gap between statutory entitlement and practical availability remains a central issue for the next phase of implementation.

Acknowledgement

The author expresses sincere gratitude to all those who contributed directly or indirectly to the completion of this review article on the Mental Healthcare Act, 2017: From Legislative Reform to Rights-Based Mental Health Care in India. The author is thankful to the academic institution and

colleagues for their valuable support, encouragement, and scholarly guidance throughout the preparation of this work.

Financial support and sponsorship
Nil

Conflicts of interest
The authors declare that there are no conflicts of interest regarding the publication of this paper.

References

1. Government of India. The Mental Healthcare Act, 2017. Ministry of Law and Justice; 2017.
2. Government of India. Mental Healthcare (Central Mental Health Authority and Mental Health Review Boards) Rules, 2018. Ministry of Health and Family Welfare; 2018.
3. National Institute of Mental Health and Neuro Sciences. National Mental Health Survey of India, 2015-16: Prevalence, Pattern and Outcomes. Bengaluru: NIMHANS, 2016.
4. Malhotra S. Mental Health Care Act 2017 at five years of its existence. Indian Psychiatry. 2023;65(9):971-973.
5. Gupta S, Misra M, Gill N. Mental health review board under the Mental Health Care Act (2017), India: a critique and learning from review boards of other nations. Int J Law Psychiatry. 2022; 81:101774.
6. Gupta S. Mental Healthcare Act, 2017 (MHCA), from paper to clinical practice in the mental health settings. Indian 3 Soc Psychiatry. 2022.
7. Uvais NA, Joag K. Perceptions regarding the Indian Mental Healthcare Act 2017. among psychiatrists: review and critical appraisal in the light of CRPD guidelines. Global Mental Health. 2024;11.
8. 8 Indian Psychiatric Society. Amend the Mental Health Care Act 2017: a survey of Indian psychiatrists. Indian J Psychiatry. 2024.
9. Indian Psychiatric Society. Amend the Mental Health Care Act 2017: a survey
10. of Indian psychiatrists (Part 2). Indian J Psychiatry. 2025.
11. Namboodiri V, George S, Singh SP. The Mental Healthcare Act 2017 of India: a challenge and an opportunity. Asian J Psychiatr. 2019; 44:25-28.
12. Supreme Court of India. Common Cause v Union of India. 2018; observations concerning Section 115 of the Mental Healthcare Act, 2017.
13. Supreme Court of India. Judicial recognition of the constitutional right to mental health and the rights-based framework of the Mental Healthcare Act, 2017. 2025.
14. Governsent of India. National Mental Health Programme and Tele-MANAS Directorate General of Health Services, Ministry of Health and Family welfare. 14. Insurance Regulatory and Development Authority of India. Health Insurance regulatory framework and coverage for sental illness. IRDAI.